HEALTH FINANCING POLICY BRIEF № 1

Raising revenues for health in support of UHC: strategic issues for policy makers

HEALTH SYSTEMS GOVERNANCE & FINANCING

HEALTH FINANCING POLICY BRIEF № 1

Raising revenues for health in support of UHC: strategic issues for policy makers

Matthew Jowett
Joseph Kutzin

World Health Organization

WHO/HIS/HGF/PolicyBrief/15.1
© World Health Organization 2015

All rights reserved. Publications of the World Health Organization are available on the WHO website (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications –whether for sale or for noncommercial distribution– should be addressed to WHO Press through the WHO website (www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The authors are a staff member of the World Health Organization. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

Original graph of the cover by Paprika, France

KEY MESSAGES

- From the perspective of revenue raising policy, moving towards a predominant reliance on public funding for health services is the priority for governments in order to progress towards UHC. Public funds are compulsory and pre-paid (i.e. taxes) whereas voluntary payments are considered private.
- Of primary concern is the overall level of public funding for the health sector; new earmarked revenues for health may bring additional resources, but may be offset by reducing discretionary budget allocations resulting in little if any increase in total public funding available to extend coverage.
- Dialogue between Ministries of Health and Ministries of Finance centres on the priority given to the health sector in government budget allocations. Evidence of improved and more efficient spending on health services is important to make the case for greater investment in the health system.
- Several estimates have been made regarding the level of public funding required to make progress towards UHC. No formula exists however, although evidence shows that when countries rely predominantly on private sources, many households forgo care or face serious financial problems. Ongoing analysis suggests however, that even at low levels of public spending, countries can make significant steps towards UHC.
- At the same time as developing policy on revenue raising, policy makers need to think about how public funds are pooled and used to purchase health services; it is the combination of reforms which drives improvements in health system performance.

1. INTRODUCTION

Recent years have seen a number of countries including Thailand, Turkey, Vietnam and Mexico significantly increase levels of public spending on health in order to make a step-change towards universal health coverage (UHC). This increased funding has focused on the expansion of one or more dimension of health coverage. Moving towards a predominant reliance on public funding for the health system has proved central to improving access to health services. This paper reviews the key policy issues facing Ministries of Health with respect to raising revenues for their health systems, explains how decisions on revenue raising policy have an impact on UHC, and highlights key messages for policy makers. It does so as many international agencies reduce financial support as a result of the recent downward trend in their own resources.

2. CLASSIFYING REVENUES FOR THE HEALTH SECTOR

The 2011 System of Health Accounts differentiates revenue sources as follows:

a) compulsory versus voluntary
b) prepaid versus payment at the time of service use (out-of-pocket)
c) domestic versus foreign

From a health financing policy perspective, public sources include those which are compulsory and pre-paid, whilst voluntary sources are considered private.[1] Categorizing a source as compulsory implies that government requires some or all people to make the payment irrespective of whether or not they use health services. Thus, compulsory sources are also prepaid and essentially the same as taxes. Within this category, some of the most important distinctions are:

a) **Direct taxes** paid by households and companies on income, earnings, or profits, and paid directly to government or another public agency; examples include income tax, payroll tax (including mandatory social health insurance contributions), and corporate income or profits taxes.

b) **Indirect taxes** paid on what a household or company spends, not on what they earn, and paid to government indirectly via a third-party e.g. a retailer or supplier. Common examples are value-added tax (VAT), sales taxes, excise taxes on the consumption of products such as alcohol and tobacco, and import duties.

c) **Non-tax revenues** e.g. from state-owned companies including "natural resource revenues" common in many mineral-rich countries e.g. oil and gas.

d) **Financing from external (foreign) sources** is typically categorized as public when these funds flow through recipient governments.

The key characteristics of private revenue sources are that they are voluntary, i.e. the decision to spend on health is not required by government but is rather a decision made by individuals, households, or private companies. Such payments may be either prepaid (e.g. corporate-funded health services, individual contributions to commercial or community-based health insurance schemes) or paid at the point of service as out-of-pocket spending (OOPS). The latter includes the direct purchase of privately delivered services e.g. diagnostic tests or other items such as

[1] For a discussion of public versus private sources of funding for the health sector see pp 180-183 of the System of Health Accounts located at http://www.who.int/health-accounts/methodology/en/.

medicines, formal patient cost sharing[2] required under a specific health financing scheme, and informal payments to health workers or for key inputs such as medical supplies or medicines that were officially "covered" but not available in practice.

It is important to note that public revenues for health can be managed by private entities e.g. private insurers managing a public insurance scheme as in the Netherlands, in Georgia prior to 2013, and in India. Similarly, private sources may be managed by public entities e.g. government-run voluntary insurance programmes such as in Thailand prior to 2002. This paper focuses on revenue sources, rather than the intermediaries, and considers the implications of different sources for health financing policy objectives. Whilst private financing plays a role in all health systems, evidence clearly shows that it is public financing which drives improvements in health system performance on key UHC indicators such as patient financial protection, and hence is the focus of this paper.

3. REVENUE RAISING POLICY AND HEALTH SYSTEM GOALS

Ensuring a stable and predictable flow of funds to the health sector is an important objective of revenue raising policy, given its importance to avoid disruptions in service delivery (e.g. commodity stock-outs), ensuring timely payment of salaries, and to provide a credible basis for contracting with service providers. Ensuring funds are raised in the most efficient way is also an important consideration. Improving transparency and accountability is an important intermediate health system objective; patients should have clarity with regard to how much, if anything, they will be expected to pay at the point of use (e.g. some form of user charge), and this is an important part of preventing unofficial payments. In this short paper, however, we focus principally on the direct impact of policy on two health system goals, equity in finance and financial protection for service users, whilst also highlighting the importance of stability and predictability for strategic purchasing.

Equity in finance

Equity in finance implies that the distribution of the burden of financing health services is "fair" and is itself an objective of health system financing policy. Measures of equity in finance assess the extent to which financing is progressive or regressive i.e. whether the burden falls disproportionately on the better-off, or worse-off, in society, relative to their capacity to contribute. An equal burden across the population is referred to as proportionate (e.g. each income quintile pays the same percentage of their income). Each revenue source has a different impact on equity in finance:

- **Direct tax revenues:** of these, income tax revenues tend to be progressive, whereas payroll taxes for health tend to be proportionate, as they are generally set as a fixed percentage of salary. The specific situation in any one country needs to be verified, however, for example income taxes will only be progressive if rates are higher for persons with higher incomes, and ceilings on payroll tax contributions make revenues more regressive overall (as those who earn more than the ceiling contribute a lower share of their salaries).
- **Indirect taxes** tend to be regressive, although a country's specific policies, e.g. exempting basic food items from VAT, or having higher rates on "luxury" items, may change this picture.

Out-of-pocket payments (OOPs) for health, which are not discussed in detail in this paper, tend to be highly regressive and are a major barrier to seeking treatment for many.

[2] Patient cost-sharing arrangements go under a number of labels including user fees, user charges, co-payments, co-insurance, and deductibles. Each is a form of out-of-pocket payment at the point of service that is required under the rules of various types of public or private financing schemes.

Financial protection

As noted earlier, a predominant reliance on public funding for health services is central to ensuring access to health services whilst also protecting families from potentially impoverishing levels of OOPs. The answer to the question "how much public spending is enough" is not straightforward; indeed there is no single answer as the extent to which funds are pooled, and the way in which pooled funds are spent, are equally important in determining health system performance.

Despite the above caveat, a number of efforts have been made to estimate or advocate for a level of public spending required to move towards UHC, including US$ 86 per capita (2012) or at least 5% of GDP, at least 6% GDP, and at least 15% of total government spending. What we know from the evidence is that where public financing is weak and OOPs dominate revenue sources, a larger proportion of patients face catastrophic levels of health spending as a result of seeking treatment, or indeed do not seek care at all; specifically, when public spending comprises less than 80% of total health spending there is a step increase in the number of households getting into serious financial difficulties. Considerable variation in performance is observed even at low levels of public spending, however, which supports the notion that health system performance can improve irrespective of the absolute level of spending.

The reasons for low public spending on health in many countries, and efforts to increase public spending, are many but ultimately depend on the fiscal capacity[3] or fiscal space in a country, together with the priority given to the health sector by the government in budget allocations. The overall level of government spending is primarily the concern of Ministries of Finance; for Ministries of Health, policy engagement centres on the priority given to the health sector in budget allocations.

4. HOW DOES REVENUE RAISING FIT INTO BROADER HEALTH FINANCING POLICY?

As with any effort to strengthen health systems, there are important alignment issues (or critical connections) between revenue raising policy and other areas of health financing policy, and with other health system functions, including:

- Will different sources of public revenue be ***pooled*** together? Some countries manage payroll tax revenues in a social health insurance scheme, separate from government allocations directly to government health facilities or such allocations to other financing schemes; many other countries pool together or explicitly coordinate funds from different revenue sources.
- If the health financing system includes contracts between a publicly funded "purchasing agency" and health service providers, is the flow of budget funds to that agency stable and predictable (e.g. planned budget allocations are both fully executed and also executed on time)? Instability in funding flows can undermine the contracting process between purchaser and providers, and shortcomings in this dimension of revenue-raising can thus impede efficiency-oriented reforms in health financing, and the ability of the health system to delivery those services to which the population are entitled.

The efficient use of funds is influenced through policies around pooling and purchasing, and connects closely to revenue raising: every dollar saved through an efficiency improvement is, in effect, equivalent to an additional dollar allocated to health by the Ministry of Finance. Indeed, demonstrating efforts to improve health spending is a powerful part of making the case to the Ministry of Finance for investment in the health sector.

[3] One indicator of a country's fiscal capacity is total or general government health expenditure as a % GDP.

5. WHAT DO WE KNOW FROM THEORY AND PRACTICE?

Much of the empirical evidence highlighted in this paper confirms well-established theory. For example adverse selection[4] in insurance markets was first conceptualized in 1970, but its message holds relevant and largely true today for health sector schemes based on voluntary funding, whether profit- or non-profit motivated, and whether in high, middle or low-income countries. The message is that population coverage will remain limited in voluntary schemes, as is the case in many community-based health insurance initiatives, and hence contribute little in terms of making progress towards UHC. Evidence shows that globally voluntary health insurance accounts for a small percentage of health expenditures, more than 5% in forty-one countries, and over 20% in only six countries.[5]

Overcoming adverse selection in voluntary schemes and indeed progressing towards universal health coverage, requires two conditions to be met, namely **subsidization** and **compulsion**, the latter fundamental to our earlier definition of public funding (i.e. some form of taxation, including indirect taxes, and not necessarily requiring individuals to contribute directly for their health coverage). These conditions have important implications for the many initiatives, such as community-based health insurance, introduced in an effort to raise funds for the health sector. Whilst the growth in such schemes has often been a response to low public spending on health, their scale and overall impact has been limited except in Rwanda and China where they have become quasi-compulsory through systematic government efforts to extend enrolment including significant subsidization.

Two additional points of note for low and middle income countries in particular. **First**, because of the structure of the economy, with most of the workforce not in salaried employment, the main source of compulsory revenues for the health system will be the government budget. Direct contributions for health coverage, such as payroll taxes for health insurance, will not generate sizable revenues given the very narrow levy base.

Second, many countries are exploring the potential to raise new funds through so-called "innovative financing" e.g. new or increased taxes on mobile phone use, or unhealthy foods. Certainly, these can help to expand fiscal capacity, and the health sector should benefit whether or not the revenues are earmarked for health. Even where earmarking is introduced, however, health policy makers need to remain focused on total levels of public spending for health, and not merely the earmarked amount, given the possibility that budget allocations from discretionary revenues may be reduced, offsetting the revenues from newly introduced earmarked taxes.

---

[4] Adverse selection refers to the greater tendency for higher risk individuals to join voluntary health insurance schemes, limiting the scope for risk-sharing, which requires a balanced mix of higher and lower risks. An upward pressure on premium contributions results, with relatively low risk individuals more likely to leave the scheme, leading to a further reduction in the scope for risk-sharing and putting yet further upward pressure on premiums.

[5] Reference: National Health Accounts Database, WHO Geneva. Data for 2013.

6. WHAT IS THE WORLD HEALTH ORGANIZATION'S PERSPECTIVE?

WHO's approach to revenue raising for health is, first and foremost, guided by UHC and overall health system objectives. Specifically, a country's revenue raising policy has a direct impact on patient financial protection, as well as how fair, or progressive, the burden of funding health services is.

Our perspective is also guided by evidence which shows that progress towards these two indicators, both central to UHC, requires health systems to be funded predominantly by public sources i.e. compulsory and pre-paid. Typically this includes a range of direct and indirect taxes incorporating, in many countries, mandatory payroll contributions to a health insurance scheme; in low and middle income countries, however, such schemes rely heavily on budget revenues;. Whilst private financing plays a role in all health systems, the evidence is clear that, where its role becomes large, it typically has a harmful impact on progress towards UHC. Out-of-pocket payments are a particularly regressive way to fund health services and, broadly speaking, when public sources comprise less than 80% of the total, many patients either forgo needed care or face severe financial difficulties.

WHO supports Ministries of Health in their engagement with Ministries of Finance over the priority for health in budget allocations; demonstrating the efficient use of existing funds is a fundamental part of this argument. However, the weak fiscal capacity observed in many lower income countries sets a constraint or limit on the fiscal space available to increase public spending on health, something over which MoH's have little influence.

Finally, whilst the extent to which the health system in a country relies on public sources is important, countries with a similar reliance on public sources can vary significantly in health system performance, for example on measures of patient financial protection. For this reason the WHR 2010 stresses that making progress towards UHC is not only about "more public money for health" but also "more health for the money". WHO's perspective is that revenue raising policy must also be carefully considered in light of other policies, and aligned with them, in particular the way in which funds are pooled and spent.

REFERENCES

Acharya, A, Vellakkal, S, Taylor, F, Masset, E, Satija, A, Burke, M, Ebrahim, S. 2012. The impact of health insurance schemes for the informal sector in low- and middle-income countries: a systematic review. World Bank Research Observer 28(2):236-266.

Akerlof, G.A., Quarterly, T. & Aug, N., 1970. The Market for “Lemons”: Quality Uncertainty and the Market Mechanism. The Quarterly Journal of Economics, 84(3), pp.488–500.

Atun, R. et al., 2013. Universal health coverage in Turkey: enhancement of equity. The Lancet, 382(9886), pp.65-99.

Bitran, R. 2014. Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries. HNP Discussion Paper. Washington, DC: The World Bank.

Knaul, F.M. et al., 2012. Health Policy The quest for universal health coverage: achieving social protection for all in Mexico. The Lancet, 380 (9849), pp.1259–1279.

Kutzin, J. 2008. Health Financing Policy: a Guide for Decision-Makers. Health Financing Policy Paper 2008/1. WHO Regional Office for Europe. EUR/08/5085965.

La Forgia G, Nagpal S. 2012. Government-Sponsored Health Insurance in India. Are You Covered? Directions in Development 72238. World Bank, Washington D.C.

Limwattananon S, Neelsen S, O’Donnell O, Prakongsai P, Tangcharoensathien V, Van Doorslaer E, Vongmongkol V. (May 2013). Universal Coverage on a Budget: Impacts on Health Care Utilization and Out-of-Pocket Expenditures in Thailand. CESifo Working Paper Series No. 4262

Maeda A. et a. 2014 (July). Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies. Directions in Development. World Bank, Washington D.C. ISBN: 978-1-4648-0297-3

Mcintyre, D. & Meheus, F., 2014 (March). Fiscal Space for Domestic Funding of Health and Other Social Services. Centre on Global Health Security Working Group Papers Fiscal Space for Domestic Funding of Health and Other Social Services, 44 pp.0–45.

Meng, Q & Xu, K., 2014. Progress and challenges of the rural cooperative medical scheme in China. Bulletin of the World Health Organization, 92, pp.447-451.

Musango, L. et al. 2013. Strategies towards universal health coverage in Rwanda: lessons learned from extending coverage through mutual health organizations. The African Health Monitor, 17, pp. 6-10.

Tandon, A. Cashin C. 2010 (February). Assessing public expenditure on health from a fiscal space perspective. Health, Nutrition and Population (HNP) Discussion Paper 56053. Washington, DC: World Bank

Wagstaff, A. & van Doorslaer, E., 2001. Paying for Health Care: Quantifying Fairness, Catastrophe, and Impoverishment, with Applications to Vietnam, 1993–98. World Bank Working Paper 2715.

Xu, K. et al., 2010. Exploring the thresholds of health expenditure for protection against financial risk, Geneva.

Health System Governance, Policy and Aid Effectiveness (HGS)

Health Financing Policy (HFP)

Cost Effectiveness, Expenditure and Priority Setting (CEP)

WE ARE ALSO PROUD TO HOST THE SECRETARIATS FOR:

Work with us so we can support countries to reach our shared objective: country health governance and financing systems that ensure universal and sustainable coverage

For additional information, please contact:

Department of Health Systems Governance and Financing
Health Systems and Innovation
World Health Organization

Email
healthfinancing@who.int

Website
http://www.who.int/health_financing/en/