



# WORLD HEALTH ORGANIZATION

FIFTY-SECOND WORLD HEALTH ASSEMBLY  
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## Ministerial round table

### Finding the money: dilemmas facing ministers

#### POLICY OBJECTIVES

1. Financing issues pose numerous challenges to ministers of health throughout the world. Concerns over levels of finance, whether too little or too much, can divert attention from the wider objectives of health financing policy, which are:

C to allocate and manage resources in order to improve the health of the population while reducing avoidable inequalities

C to distribute the burden of revenue-raising fairly across the population

C to allocate and manage resources to achieve a fairer distribution of services, while ensuring that they respond to people's expectations

C to protect individuals, families and communities against impoverishing levels of health expenditures

C to progress on each of the above to the greatest extent possible within the limits of available resources.

2. These objectives imply that health finance is concerned with much more than the level of funding. The content of a health financing system can be summarized as the collection, management and allocation of funds for the health system. Countries have made different choices regarding the methods and institutional arrangements used to implement these functions, and their experience highlights a variety of issues and dilemmas.

#### HEALTH FINANCING SYSTEMS: LESSONS AND CHALLENGES

3. **Funding sources** are households, firms and government (including donor funds), and **collection/contribution methods** are taxation, prepayments for insurance, and out-of-pocket payment by individuals at the time of service use. Evidence from a number of countries suggests that public funding sources through general or earmarked taxes provide the most equitable and efficient means of generating and collecting revenues for health. Not all countries can benefit equally from this knowledge, however. Comparisons of health expenditures reveal that the public sector share of health expenditure increases with national income. Poorer countries collect less tax revenues as a share of GDP, and so find themselves relying on a larger percentage of private health funding, even if they might prefer other options. Hence, the need to

steer, regulate or otherwise organize private funding sources is greater in poorer countries. All countries need to better coordinate public and private sources in a comprehensive health financing strategy, but the importance of this challenge is not the same in all countries.

4. The **institutional arrangements** for **managing** the funds collected for the health system and **allocating** these funds to services differ widely across countries. In some countries, a single institution (e.g. ministry of health, local government, social insurance fund) is responsible for managing and allocating funds for a comprehensive set of services on behalf of the population living in the entire country or a defined geographic area. Other countries have segmented systems, with different institutions for managing and allocating health resources for different groups in the population. Between these ends of a continuum are countries with different degrees of integration of finance, allocation and service delivery functions. Evidence on the effects of different options is less conclusive than for funding sources and collection mechanisms. Segmented systems appear to be inconsistent with both efficiency and equity, because they duplicate health system functions and create unequal “health systems” for different social groups within the population. More evidence is needed on the actual performance of different systems in terms of the objectives defined above, however.

5. The **methods used to manage and allocate resources** generate important incentives for those delivering health services. Some countries have moved from “traditional” allocations to health facilities (e.g. based on number of beds, previous budgets, etc.) to new approaches based on assessment of the population’s **need** for services. The methods can be characterized as funding/subsidizing the **supply** of services as compared to the **demand** for services. Examples include subsidies for the purchase of health insurance, per capita allocations (often weighted for indicators of “need” or cost) to providers or insurers, and reimbursement of providers for services rendered. All methods of payment or subsidy generate “mixed” incentives. These can be anticipated, however, and corresponding regulatory methods adopted to mitigate the effects of the “negative” incentives. For example, paying hospitals on a per case basis should promote cost-consciousness, but this may lead to “underprovision” of needed services per case or frequent readmissions. Thus, this payment method should be accompanied by systematic review procedures to ensure that admissions are appropriate and good quality care is provided.

6. The diversity of institutional arrangements and methods for implementing critical functions, and the diversity of country contexts, suggests that there is no single blueprint for the right mix of institutions, public and private roles, provider payment methods, and so forth. The mix in any particular country should be evaluated against the objectives of policy. Evidence from a wide range of countries suggests that certain arrangements perform poorly in terms of the objectives, e.g. unregulated fee-for-service reimbursement of providers, extensive reliance on out-of-pocket payment, unregulated competition among voluntary insurance funds. Unfortunately, there is not such clear evidence supporting parallel conclusions of “positive” experiences with particular strategies that hold true in a wide range of country settings.

## **THE WAY FORWARD**

7. Countries therefore need to make their own assessment of the consequences of their health financing system and the effects of reforms. To do this requires information. First, information is needed on the level and allocation of resources across institutions and services. National health accounts are a tool for, literally, “finding the money” in health systems, i.e. identifying the level of funding for each institution involved in the collection of revenues for health services, the allocation of these revenues to service providers, the provision of services, and associated regulatory and management functions. Second, information is needed on the performance of the health financing system in terms of the objectives defined above. Therefore, health system

performance indicators must be measured, and the causes of changes in these indicators analysed in order to derive evidence-based policy recommendations.

8. In practice, health financing reforms are driven by a complex set of political and other factors, of which the technical “evidence” on the effects of policies is but one. Effective reform is difficult, in part because it involves a trade off among the interests of different groups. What a policy analyst may perceive as “inefficiency” or “waste” is actually some other person’s or group’s “income”. Change is also difficult because historical policies have long-term consequences. For example, it may be that the recurrent cost consequences of previous investments in tertiary hospitals can only be modified gradually. A past decision to create a social insurance scheme may have fragmented the health system along social class lines and created a wasteful duplication of functions, but it may also have created a strong constituency of satisfied beneficiaries resistant to changes that may threaten their interests in the name of systemic, population-based goals.

9. This does not imply that good evidence is not important, however. Clear evidence on the effects of various health policies on the goals of health systems can make a powerful contribution to the political debate. It can also help decision-makers by improving understanding of the consequences of past policies both in terms of health system goals and the interest groups likely to be affected by proposed changes. “Finding the money” to improve health system performance will always be difficult, but good evidence on where the money is now, how it is being used, and the effects on health system goals is essential for sound and effective reform.

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