Financing health care

An overview of concepts and regimes

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Content

Introduction

- fundamental similarities and differences
- focus on financing and payment of hospitals and doctors
- overview of possible regimes and planned changes

Introduction

- **What is meant by "*financing health care*"?**

"financing amounts to the creation, management and aiming of a source of funds so as to ensure its optimally serving a given purpose"

- **distinction**
  - **origin of the funds = primary financing system**
  - **distribution of the funds = secondary financing system**

Content

Financing health care

2 approaches:

→ focus on origin of financial means
= primary financing systems

→ focus upon distribution of available financial means
= secondary financing systems

I. Primary financing systems

Main options:

1. **Statutory health insurance**
   (obligatory contributions + fluctuating cover)

2. **National health service**
   (tax revenues + general cover)

3. **Voluntary health insurance**
   (additional contribution + additional cover)

4. **Mixed regimes (convergating forces)**

I. Primary financing systems

EU member states	*Taxation*	*Social insurance*	*Voluntary health insurance*	*User charges (including direct payments)*	*other*
Belgium	38	36	-	17	9
Denmark	80.7	-	1.9	17.4	-
Germany	11.0	64.8	7.1	7.3	9.8
Greece	33.3	24.1	2.1	40.4	-
Spain	59.3	15.3	7.0	16.3	1.7
France	3.6	71.6	7.0	16.5	1.3
Ireland	68.1	7.1	8.6	13.9	2.1
Italy	64.6	-	2.6	31.2	2.4
Luxembourg	30.0	49.8	2.0	7.9	2.8
Netherlands	10.0	68.0	15.0	7.1	-
Austria	24.0	54.0	7.5	14.0	-
Portugal	55.2	6.0	1.4	37.4	-
Finland	62.2	13.0	2.2	20.8	1.8
Sweden	69.7	13.4	Negligible	16.9	-
UK	78.8	12.3	5.6	3.2 (p)	-

I. Primary financing systems

1. Statutory (social) health insurance

- insurance contributions by those covered
- general cover of health insurance risks
- obligatory character
  - government:
    - regulates the functioning of the insurance
    - determins the level of contributions
    - determins the group of people covered
- concurrent private insurance is allowed (extended services and/or extending the group of people covered)

I. Primary financing systems

EU-examples: France, Germany, the Netherlands, Belgium

- **archetype:** - whole population is covered
  - extensive cover
  - services entirely determined by law
  - non-income related contributions

- **most "*archetypes*" are diluted**

  e.g. Belgium: - right to treatment grounded in the law, not in the contribution paid
  - treatment without contribution
  - contribution without rights to services

I. Primary financing systems

2. National health services

- financing through general tax revenue
  - = public, obligatory financing
  - = no link to services
  - = management through government
- State is owner
  provider
  financing institution
  employer
  } of health care sector

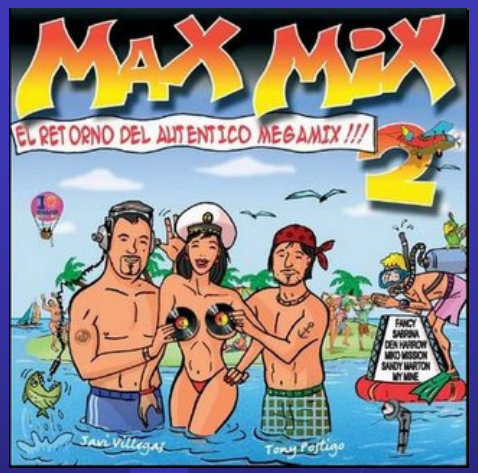
I. Primary financing systems

EU-examples

UK	Denmark	Ireland	Portugal
- 100% personal income tax - uniform services - fixed budget - government control (- small truly private sector)	- almost entirely financed by personal income tax - no separate social security body - no fees for the service provider - organised on a provincial level - opt out possibility 5%	- classic NHS - original features - 3 groups of income - the higher the income, the lower the amount of free coverage	- personal income tax - uniform services - fixed budget - government control (- small truly private sector)

4. Mixed regimes

Greece
Italy
Spain



I. Primary financing systems

3. Voluntary health insurance

- 2 types
  - **substitutes** for the statutory health insurance (Germany, the Netherlands)
  - **supplementary** to public entitlement (France, Belgium)
- for profit and not for profit insurers
- pay providers directly or reimburse patients
- some VHI companies own networks of providers
  (e.g. - Seguro Assistencia Sanitaria, Spain
  - British United Provident Association, UK)
- shift from luxury care ⟶ budget plan

Financing health care

2 approaches:

→ focus on origin of financial means
= primary financing systems

→ focus upon distribution of available financial means
= secondary financing systems
- hospitals
- doctors

II. Secondary financing systems

1. Financing hospitals

2 operating financing methods

- retrospective reimbursement
  = based on historic costs
- prospective budgeting
  = weaker or non-existing link with historic costs

II. Secondary financing systems

A. Retrospective reimbursement

= based on historic costs

⇨ finance determined by historic costs

⇨ more proven expenses = higher financial means

Health institutions indirectly determine their own budget

II. Secondary financing systems

e.g. Tarif conventionnel in France

dotation globale

- **hospitals commited to Service Public Hospitalier**
- **dotation globale**

tarif conventionnel

- **hospitals not committed to Service Public Hospitalier**
- **private (commercial) hospitals**
- **contracting the social health insurance**
- **quality and administrative obligations**
- **fee for service + nursing day fee**
- **since 1991 quantitative targets**

II. Secondary financing systems

B. Prospective budgeting

= periodic overall payment to cover all activities

⇨ those with financial responsibility master total expenditure (not the hospitals)

⇨ financial risk is transferred to institutions

↳ more financial incentives which reward efficient use of resources

II. Secondary financing systems

Prospective budgeting (Portugal, Belgium, ± France)

advantages:
- **includes financial incentives**
- **rewards efficient use of resources**
- **encourages cost consciousness**

drawbacks:
- **risk of reduced access**
- **neglect of specific (expensive) treatment**
- **risk of "*cherry picking*"**

II. Secondary financing systems

C. From retrospective to prospective

The Netherlands: open-end financing → external budgeting → functional budgeting

Belgium:

- retrospective: "*price for one day nursing*" financing granted on the basis of invoiced days

- prospective: overall budget for all hospitals
  budget for each hospital linked to performance and quality

Financing health care

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Financing health care

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II. Secondary financing systems

2. Financing doctors

- **capitation payment**
  - risk of underperforming
  - focus on primary care
- **salary**
  - lack of incentives (low cost consciousness)
- **fee-for-service**
  - strong profit motive
- **case-payment**
  - risk of boutique health care
  - if finetuned it can be a quality trigger

III. European trends

1. Introduction of competition

- Regulated competition
- Free market economy principles
- Contract model

Suitability of market as principle for health care reform?

III. European trends

2. The use of process criteria:

criteria used for measuring health care activities prior to reimbursement

- **Structural criteria:** **relate to used infrastructure (beds, doctors, nurses, equipment)**

  = allocation of budget on the basis of present infrastructure

- **Process criteria:** **relate to the medical, nursing and support process delivered to patients**

  = allocation of budget on the basis of the seriousness and costs of the disease

General conclusion

The element of finance is important in view to the government tasks in health care

- **Task to secure financially accessible health care**
  Prospective mechanisms as instrument to ensure affordability

- **Task to secure the right to reachable care**
  Financial mechanisms to calling a halt to the expansion of health care

- **Task to secure the right to top care**
  Top care versus cost containment