

Section 6: Health systems finance

*(The Lancet Commission's Global health 2035: a world converging within a generation, .
[http://dx.doi.org/10.1016/S0140-6736\(13\)62105-4](http://dx.doi.org/10.1016/S0140-6736(13)62105-4), p. 33-42)*

This report estimates that the cost of bringing health outcomes to the levels in high-income countries as:

1. For low-income countries
 - a. US\$23 billion/year from 2016-2025, and
 - b. US\$27 billion/year from 2026-2035
2. For lower-middle-income countries
 - a. US\$38 billion/year from 2016-2025, and
 - b. US\$53 billion/year from 2026-2035

When considering how to pay for health services, there are three main questions to ask:

- What will the revenue source be?
- What is the best way to organize the delivery of those services?
- How can costs be controlled over time?

Section six of the larger article looks at these three questions one at a time.

Sources of revenue

The revenue source for health services may be from public funds, private funds, donor funds, or from a combination of sources.

1. Public funds, or funding that comes from the government, may be increased through
 - a. Economic growth
 - b. New taxes on tobacco, or on natural resource production (extractive industry)
 - c. Removal of subsidies currently given
 - d. Finding efficiencies
 - e. Support through development assistance
2. Private funds, or funding that comes from the individual seeking care must be carefully considered, to ensure that there is no risk of financial hardship associated with seeking health services
3. Donor funds are likely necessary for low-income countries, but it is important to avoid relying completely on outside sources of funding. Over time, donor funding should be reduced and eventually removed.

Delivery of health services

Universal health coverage (UHC)

“Universal health coverage is the end state of universal population coverage with a comprehensive set of interventions and zero or close to zero out-of-pocket expenses for all those interventions.” (p. 34)

The UHC cube image (p. 35 and in the course PowerPoint slides) describes three “pathways” to UHC:

1. Population covered (who receives health services)
2. Interventions covered (what types of health services are available)
3. Costs covered (how much the health services cost)

One important question to consider is whether it is better to work on all three pathways at the same time, or if it is better to focus on one or two first. This decision should be made based on where the country is starting from, the values of the country, and a cost analysis of policy options.

There is often a tradeoff between the most cost-effective policies, and the policies providing the greatest financial protection.

Financial protection

The goal of financial risk protection is to prevent households from becoming impoverished due to the cost of health services. Households that are not at risk of impoverishment are more able to seek health services before becoming sick.

There are three key ways to improve financial protection:

1. Expand prepayment and risk-pooling programs to cover everyone
2. Reduce out-of-pocket and point-of-service fees, and remove completely for the poor
3. Make the available health services more comprehensive over time

Methods of financing health services

1. “Progressive Universalism” to achieve UHC
 - a. This method recognizes that UHC cannot be achieved at once, and prioritizes some forms of expanded coverage over others. There are two versions described in the text.
 - b. Version 1:
 - i. The entire population is covered, but not all health services. The health services that most greatly impact the poorest households are covered first, and these services are provided without cost sharing.
 - ii. In the “UHC cube” two pathways are fully expanded (population covered and costs covered) but the third pathway is not fully expanded (interventions covered).
 - iii. The advantage of this version is that there is no requirement to determine who qualifies as “poor”. It is also likely to have more support since everyone is included.
 - iv. The disadvantage of this version is that other health services will require private funding and may be inaccessible to the poorest households.

- v. Example: Mexico
 - c. Version 2:
 - i. The entire population is covered, but households with more income are required to contribute some cost sharing. In this version, more health services are made available.
 - ii. In the “UHC cube” only the population covered pathway is fully expanded. The other two pathways are partially expanded (costs covered and services covered).
 - iii. The advantage of this version is that more health services are available. It is also an advantage that more of the population will be involved and that the non-poor will be contributing to the financing of the system.
 - iv. The disadvantage of this version is that the system must determine which households qualify as “poor.” There is increased administrative cost, and a risk of corruption, as a result.
 - v. Example: Rwanda, Thailand
2. Expanding coverage without reaching UHC
- a. These methods do not result in UHC, but do attempt to partially expand health coverage. There are two versions described in the text.
 - b. Version 1:
 - i. This method tries to expand coverage through households voluntarily enrolling in a health insurance program.
 - ii. It does not result in the entire population being covered because there will be people who choose not to enroll, or who are unable to afford enrolling.
 - iii. A disadvantage to this approach is that it may strengthen divisions between social groups – those with and without health insurance.
 - c. Version 2:
 - i. This method provides public financing for catastrophic coverage, but requires households to pay for non-catastrophic health services.
 - ii. This approach has several disadvantages:
 - 1. It is not cost-effective
 - 2. It does not provide financial protection to households that many have chronic lower-cost health service needs
 - 3. It provides an incentive providers to choose higher-cost treatments

Controlling costs over time

It is normal to see health spending increase as GDP rises (see Figure 21 on page 20). However, some of that increase may be wasteful, and it is important to avoid “unproductive cost escalation” in health spending.

The article describes three approaches to controlling costs in-depth, and suggests others in the box on page 41:

1. Ensure hard budget constraints – that is, establish a limit to the funding available. If there is no cap placed on how much funding may be spend on health services, costs are likely to rise as there will be no competitive force to keep them controlled.
2. Minimize fee-for-service payments to providers – that is, do not pay providers for each treatment given to a patient. Such payments encourage fast visits and discourage primary care. Systems which provide a salary to providers or pay based on health outcomes are more effective at controlling costs.
3. Implement reference pricing mechanisms – that is, place a clear price limit that the public sector will pay for each health service. This standardizes costs, and keeps direct control of what will be paid.