Financing Healthcare

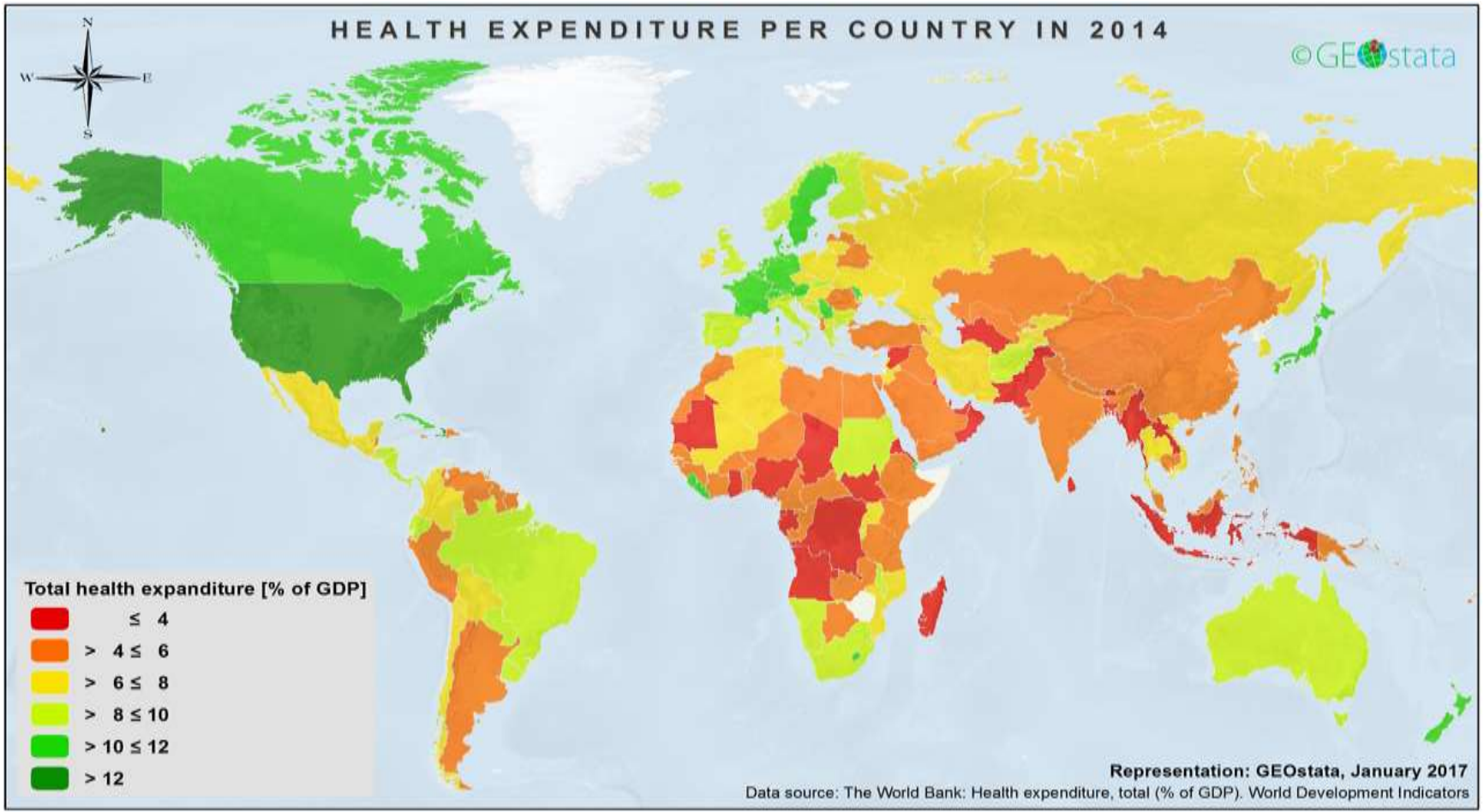
Dr. Israa Al-Rawashdeh MD, MPH,PhD
Faculty of Medicine
Mutah University
2024

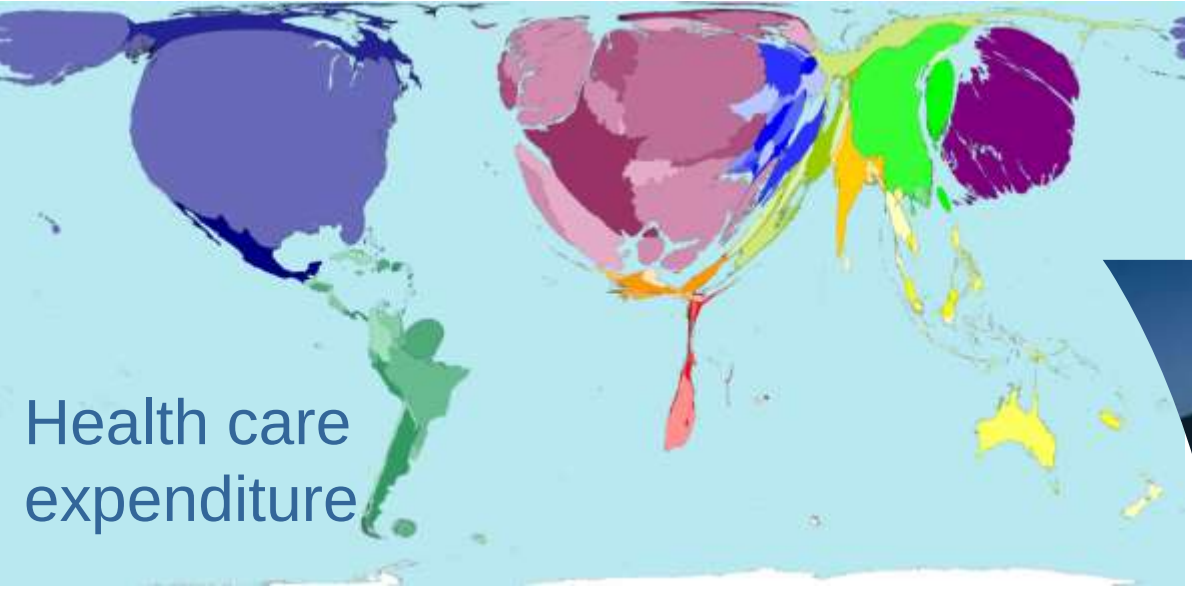
Topics covered in this lecture:

- Definitions of financing and other related terms.
- The three key functions involved in funding healthcare.
- Sources of finance.
- Allocating resources.

Introduction

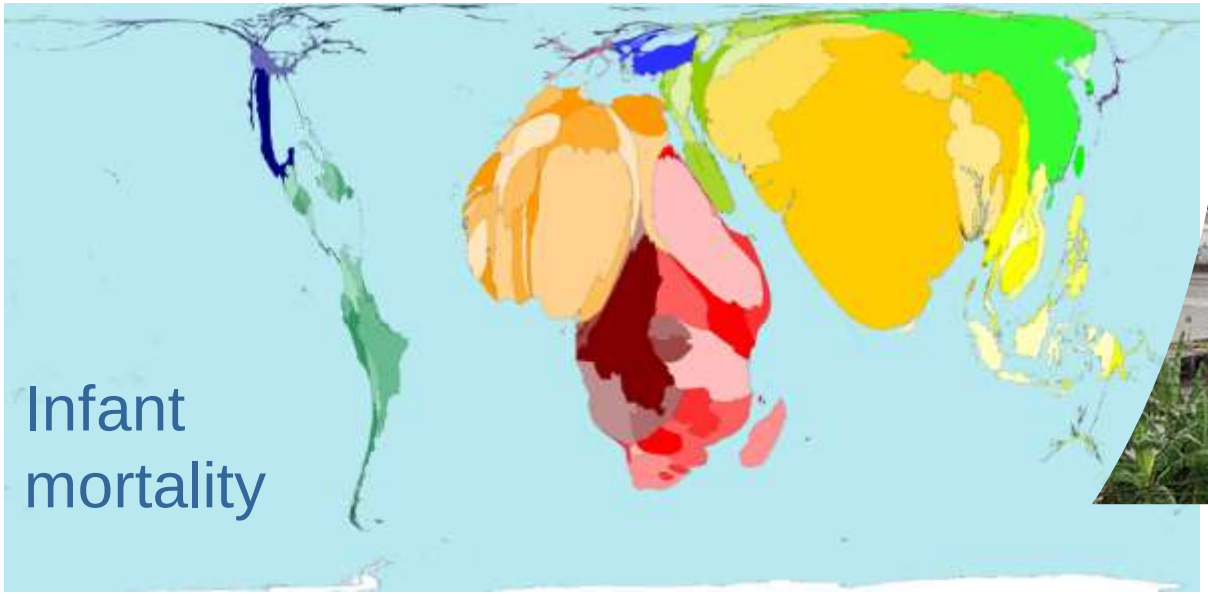
- **Health financing is a core function of health systems.**
- **Expenditure levels vary between countries.**
- **The amount spent on healthcare depends on wealth.**
- **In developing countries, financing is a major barrier to health care delivery.**





“wealthier countries are healthier countries”

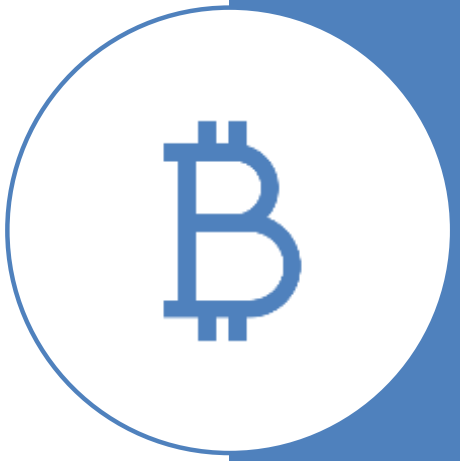
WHAT DO YOU THINK??



www.worldmapper.org

Definitions

- **Financing:**
- Finding a way to pay for something.
- The management of **funds** for healthcare.
- “The function of a health system concerned with the *mobilization*, *accumulation* and *allocation* of money to cover the health needs of the people, individually and collectively, in the health system” (WHO 2000).



Objectives when funding healthcare

All individuals who need care have access to health services **(equity)**

All services provided are best value for money **(efficiency)**

Definitions

- **Revenues: إيرادات\ عائدات**
- Are the receivables (money that is owed to the facility and that the facility will be receiving), comes mainly from payment for services provided to patients.

Business structure

- **For Profit:**
- A for-profit organization is set up with the intention of **making a profit**, similar to many other businesses.
- The goal is always to bring in more revenue than needed for expenditures (expenses, costs, and taxes).
- When these two numbers are equal, this is known as breaking even.
- Once the amount of revenue exceeds expenditures, this is called **profit**.
- A simple formula is used:

Profit = Total Revenue - Total Expenditures.

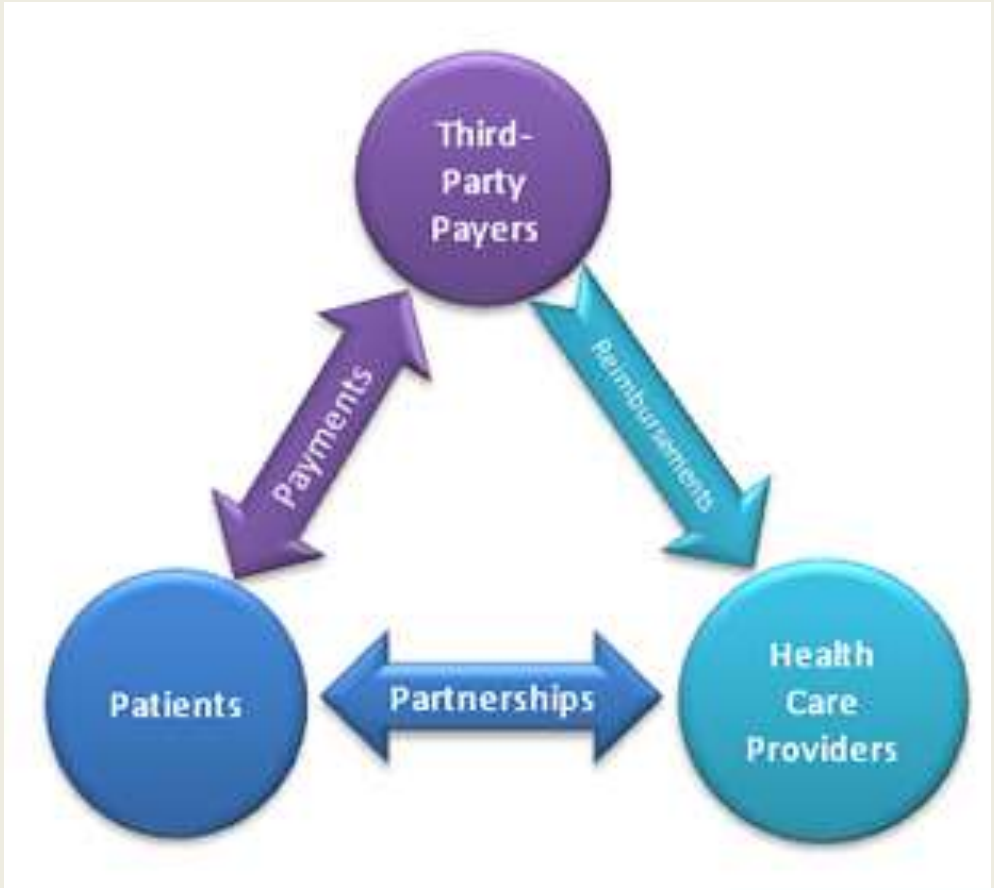
Business structure

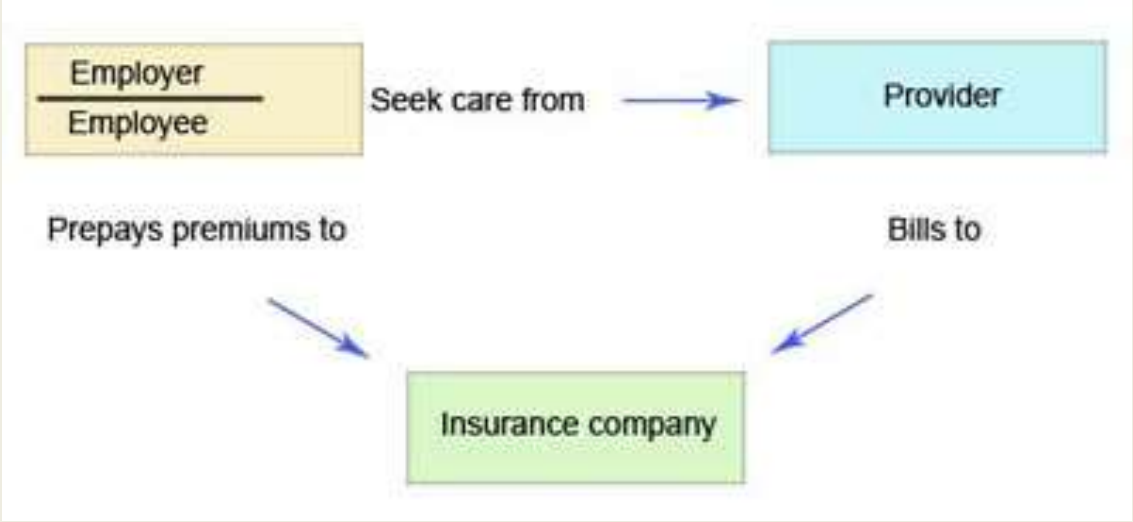
- **Not-for-Profit**:

- Still care about the balance of revenue and expenditures.
- The difference between a nonprofit and a for-profit company is that:

1. **A for-profit** facility pays out profits to investors, **a not-for-profit** organization must reinvest the money back into the facility or into enhancing the services provided by the facility.
2. **A not-for-profit** corporations are tax-exempt (do not pay taxes).
3. **Funds** coming into the company -from sources other than patient services- are considered donations rather than investments. **Donations** are often tax-deductible for the donor.

Business structure

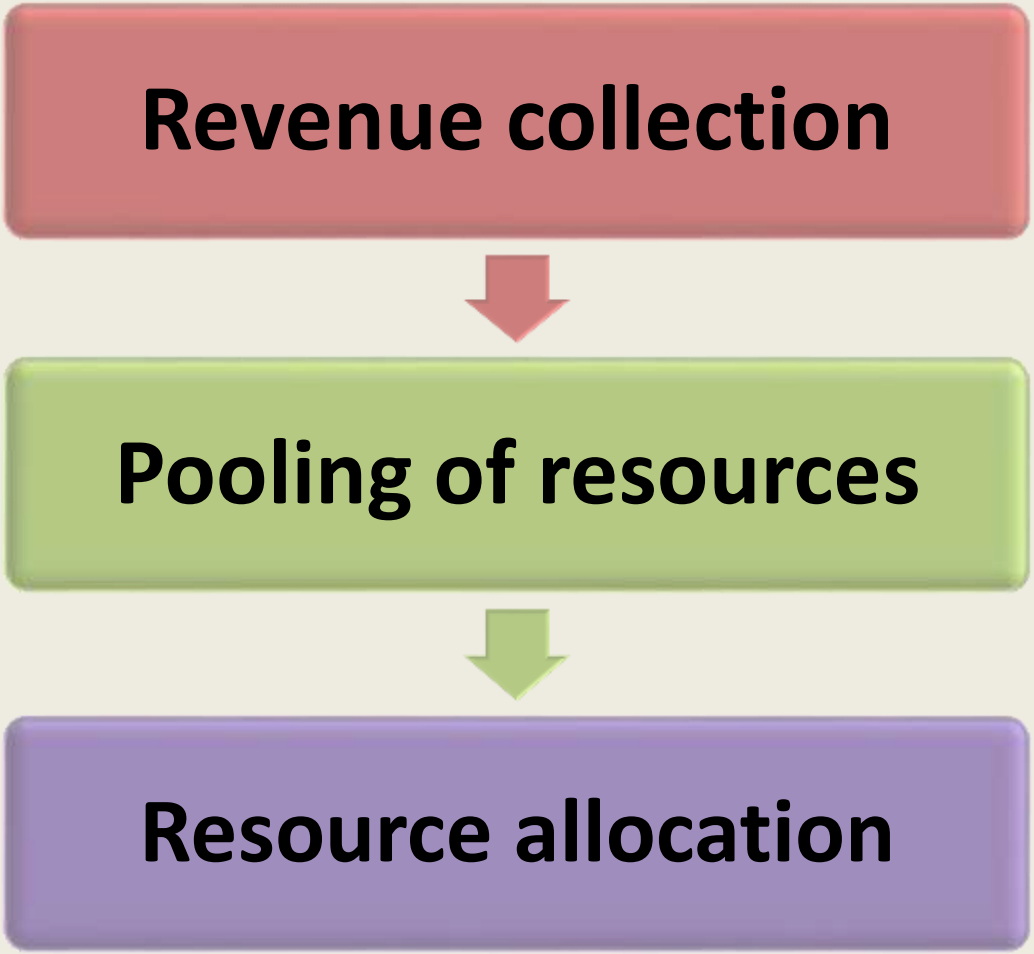




- **Third-Party Payers:**

entities or organizations, other than the patient themselves, who are responsible for covering or reimbursing the costs associated with healthcare services received by the patient.

Flow of finances



1. Revenue collection

- **Revenue collection:** The means by which a health system collects money from individuals, households or external sources.
- Revenue collection concerned with the *sources of revenue (who pays)* for health care, *the type of payment (what are the contribution mechanism?),* and *the agents that collect these revenues (who collects?).*

- All funds for health care, 'excluding donor contributions', are collected in from **the general population** or **certain subgroups**.

- Collection mechanisms include **taxation**, **social insurance contributions CIP**, **private insurance** premiums, **out-of-pocket** payments (direct payments made by a patient to a provider) and , **loans** (e.g. from World Bank).

- Collection agents (which in most cases also pool the funds and purchase health care services from providers) could be **government or independent public agencies** (such as a social security agency), **private insurance** funds, or **public and private health care providers (hospitals and health centers).**

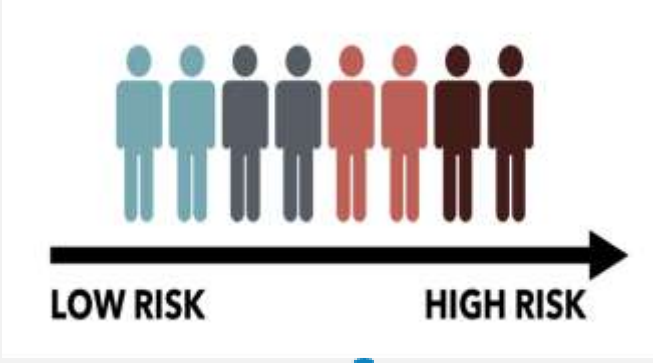
Pooling of resources

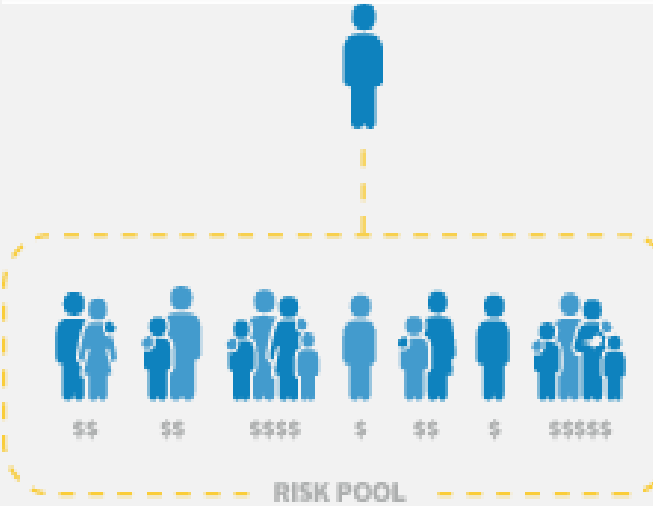
Pooling: Accumulation of *prepaid* health resources on behalf of population so that the financial risks required by certain high-risk individuals are compensated by money from lower-risk individuals.

When pooling resources:

- Money should be collected in advance – Prepayment contribution.
- Contribution should be based on ability to pay.
- Access should be based on need.
- A mix of contributors is needed (contribution>need, contribution =need, contribution <need and zero contribution with need).

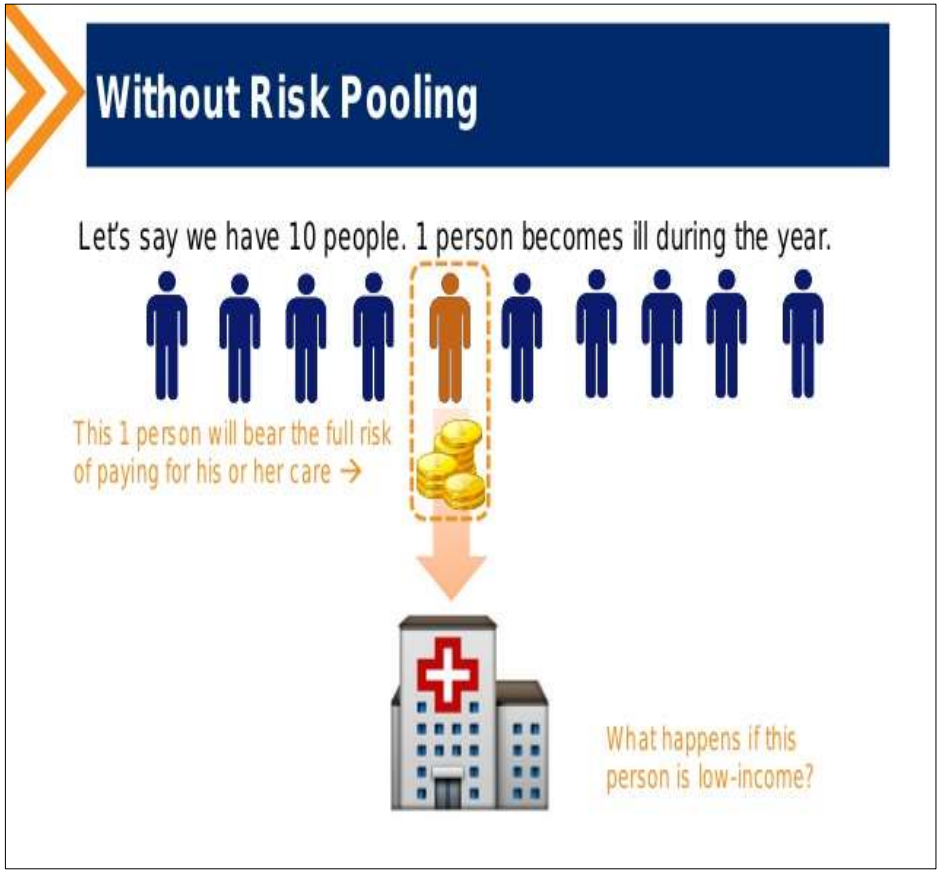
We pool two things: Funds and risk





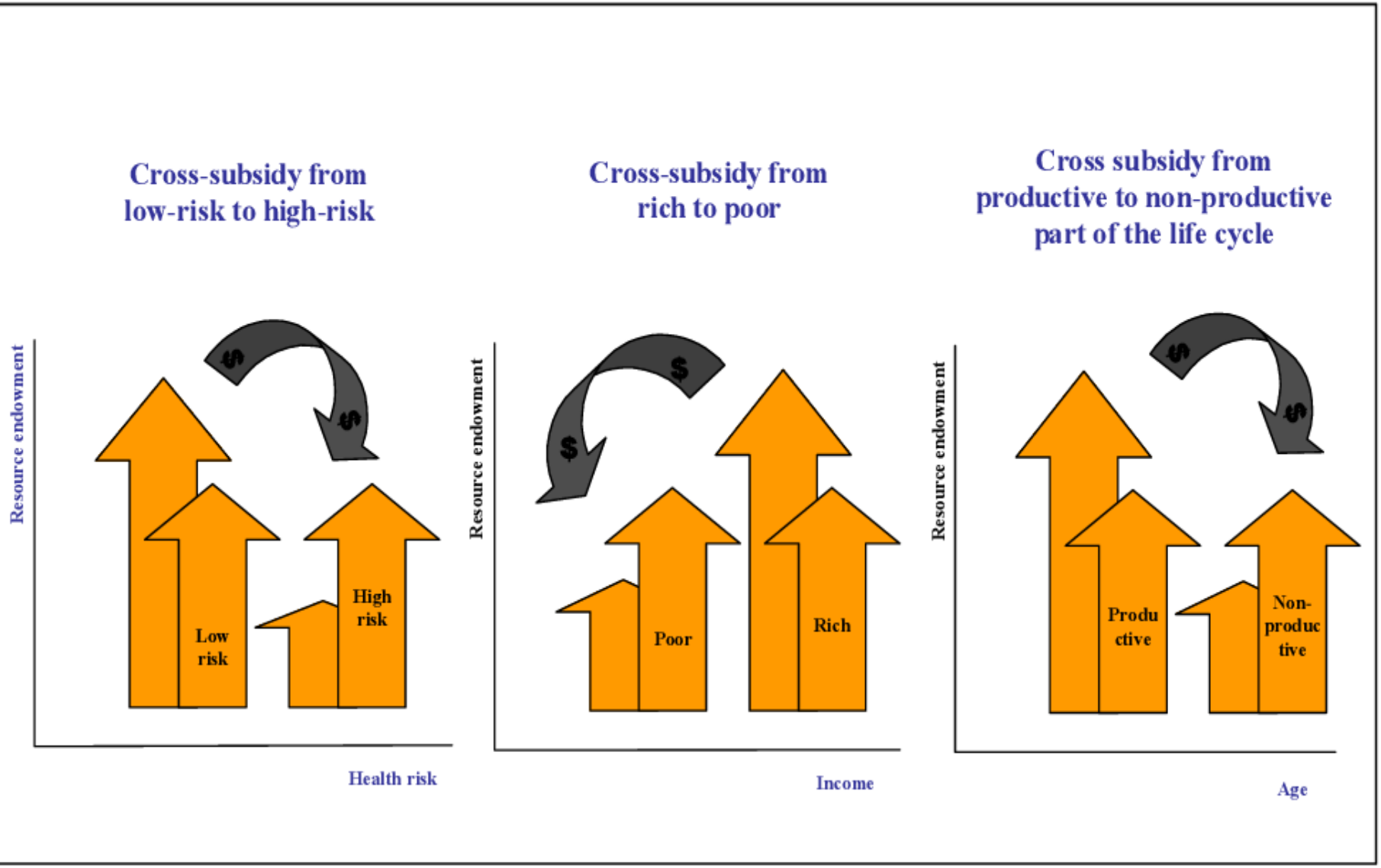
2. Pooling of resources

Sharing financial risk between contributors.



- Both tax-based health financing and health insurance involve pooling while fee-for-service (out-of-pocket) user payments do not involve the pooling of resources.
- Pooling allows for **cross-subsidization** from low- to high-risk people (example: charging more than the cost of production for a service or a group → less than the cost of production can be charged for another service or to another group).

Risk Pooling: Cross-Subsidy /Redistribution



3. Resource allocation (Purchasing of health services)

- **The transfer of pooled resources to service providers.**
- Purchasing of health services is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries.
- In many cases, the purchaser is also the agent that pools the financial resources.

3. Resource allocation (Purchasing of health services)

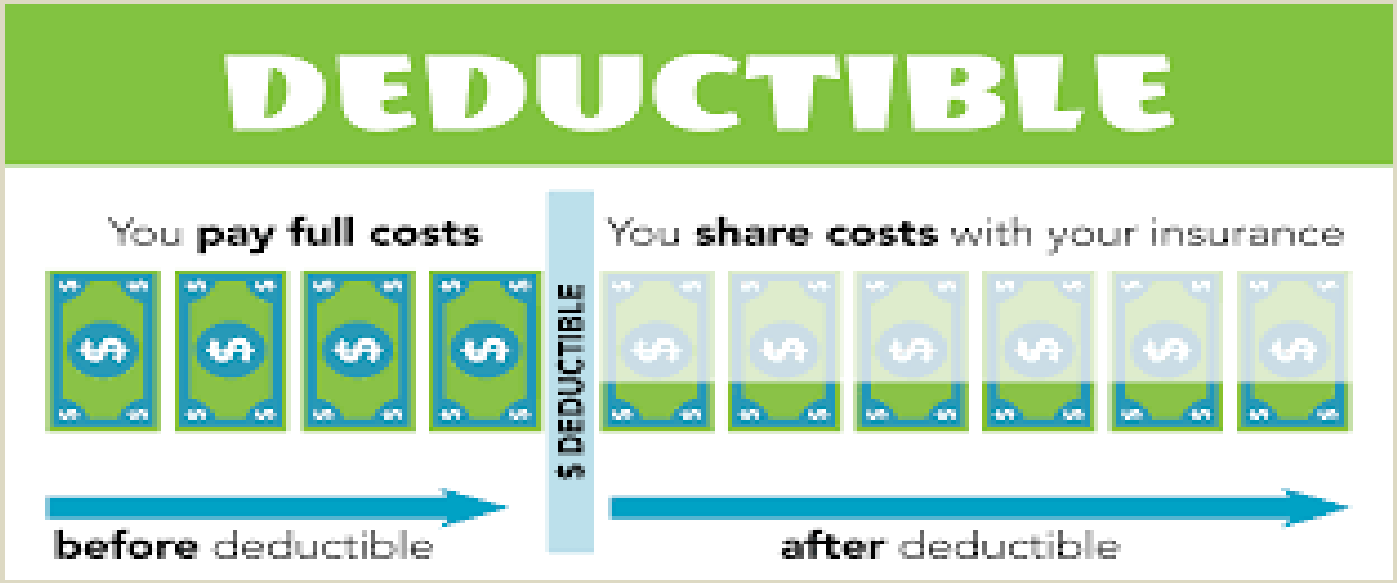
- Purchasers of health services are typically the MOH, social security agency, district health boards, insurance organizations, and individuals or households (who pay out of pocket at time of using care).
- Purchasing can be either passive or strategic;

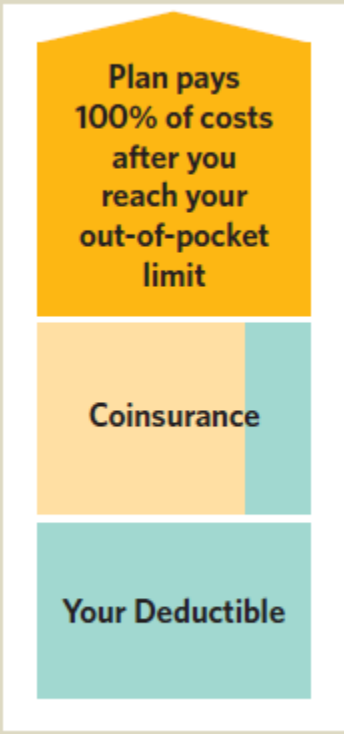
- **Passive purchasing→** follows predetermined budgets or pays bills when they are presented,
- **Strategic purchasing →** uses a thoughtful approach to seeking better quality services and low prices.

An insured patient pay any of three types of payments to the provider:

1. **Co-payment:** Also known as the co-pay, a co-payment is a fixed amount paid by the patient to the provider for each encounter *regardless of what is provided during the visit*.
2. **Coinsurance:** In some policies, the patient agrees to pay a percentage of the allowed amount, while the policy pays the rest. For example, with an 80/20 policy, the third-party payer reimburses 80% and the patient pays 20 %.

3. Deductible: This is the amount of money that <u>a patient must pay out of pocket each year before third-party payer benefits begin</u> and is stated in the policy agreement between the policy- holder (the patient) and the third-party payer.

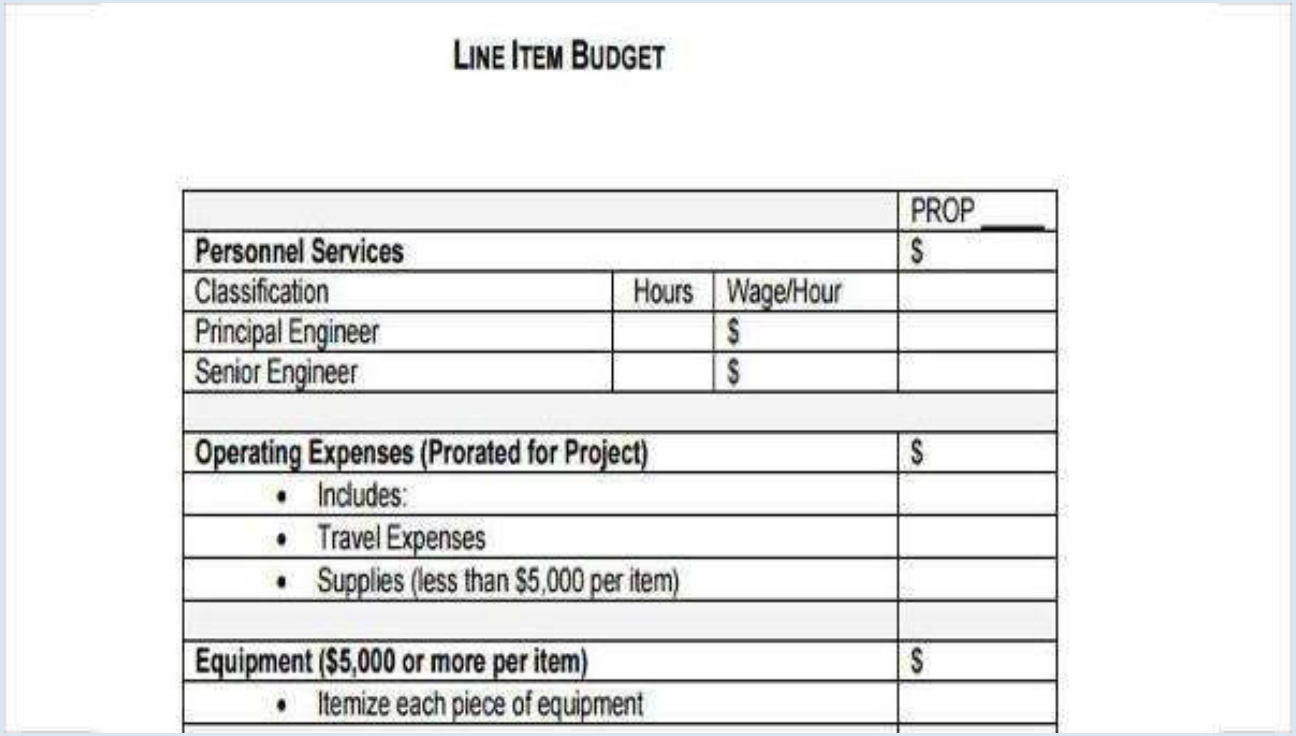




Payment Methods

- All intermediaries and revenue managers as well as individuals and households are purchasers of health care services**.**
- **The payment mechanisms are the following:**
- **Global budgets** a government agency determines the total amount of money that it has available to be allocated to all hospitals, physicians and clinics in the country . Allocations depend on the type of facility, its historical budget, number of beds (for hospitals), per capita rates, or utilization rates for past years.

- **Line-item budgets** are allocated for each functional budget category, such as salaries, medicines, equipment, and administration.



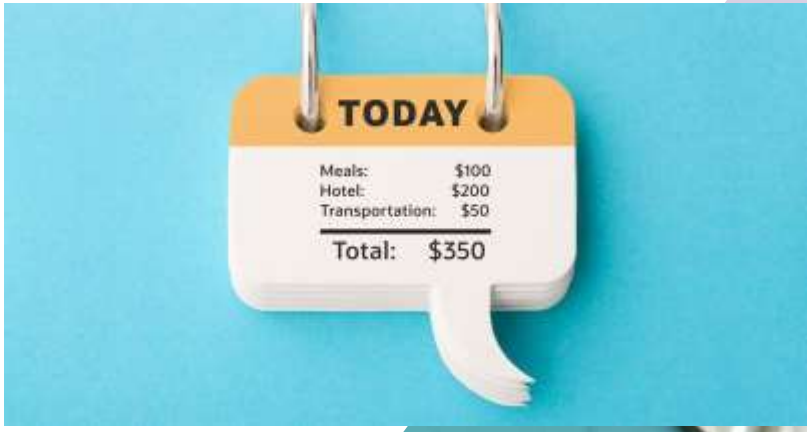
LINE ITEM BUDGET

			PROP ____
Personnel Services			$
Classification	Hours	Wage/Hour	
Principal Engineer		$	
Senior Engineer		$	
Operating Expenses (Prorated for Project)			$
• Includes:			
• Travel Expenses			
• Supplies (less than $5,000 per item)			
Equipment ($5,000 or more per item)			$
• Itemize each piece of equipment			

- **Capitation** allocates a predetermined amount of funds per year for each person enrolled with a given provider (usually a primary care provider, such as a GP).

Payment methods Cont.

- **Per diem payment** is a predetermined payment that providers receive for each *patient day of hospital stay*; the amount of the payment usually varies by hospital department.



- **Case-based payment** is the estimated cost of all interventions typically prescribed for the treatment of *a given condition*. It pays the provider for each patient treatment episode, according to a predetermined payment schedule.

- **Fee for service** is the out-of-pocket payment that patients make *for each health care service at the point and time of use* (also known as a user fee in the public sector), or payment by other entities (such as a health insurance organization) to providers for <u>individual health services</u> provided to beneficiaries.

Indicators to monitor and evaluate health system financing

- Total Health Expenditure (THE) per capita in international and US$.
- The sum of all health expenditures (including all sources of funds, external, government, and non-government including household OOPs)/ Total population.

Measures of national income

- National income is usually expressed as GDP or GNI .
- GDP is the money value of all the goods and services produced *within a country* and can be measured in three ways:

1. The output method is the value of all goods and services produced in an economy
2. The expenditure method is the amount of resources spent on the goods and services produced in an economy
3. The income method is the incomes received from producing the goods and services produced in an economy

Gross Domestic Product (GDP) and Gross National Income (GNI)

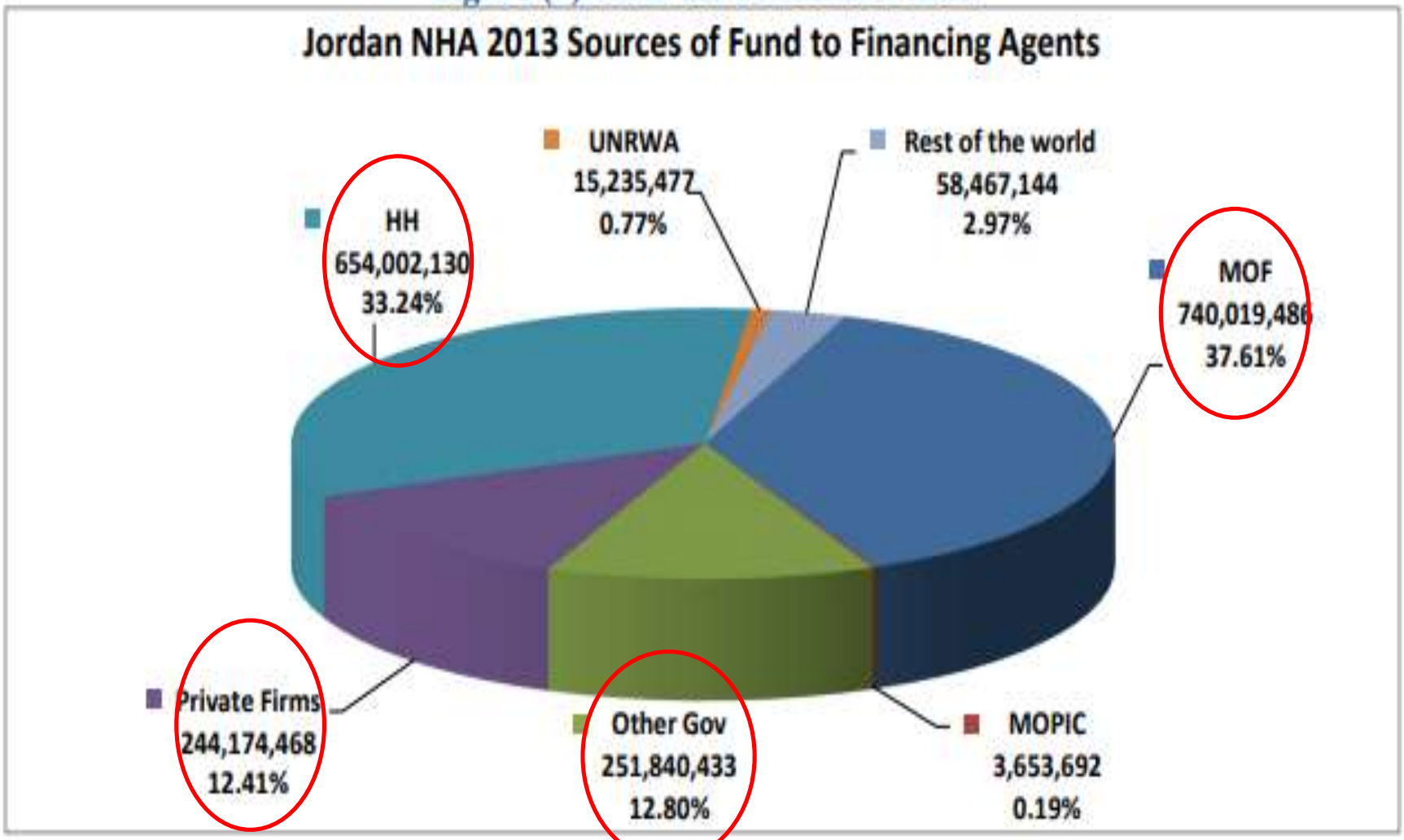
- GDP depends where the economic activity is located while GNI depends on where the people (owners of the labour and capital) are located
- The main difference between GDP and GNI is that GNI includes net income from abroad

In Jordan

- Although Jordan is ranked as one of middle-income countries, it spends annually on an individual's health about twice as much of the spending on health in these countries .
- Per Capita Healthcare Expenditure 231.8 (JD) and per capita GDP was 2939.6 (JD) (Department of Statistics, DOS 2013)

- The total expenditure on health care in Jordan amounts to JD 1.881 billion (US 2.7 billion) and the per capita expenditures to JD 231.8 (US$ 327.4). (2013)
- The total expenditure on health is 8% of the GDP and is considered high for a middle-income country.
- The Percent of Governmental Budget Allocated to Healthcare is almost **11%.**

Figure (1): Sources of Health Funds



In Jordan, health care is funded by the following sources:

- MOF was the major source of health care funds (37.61% in 2013).
- The household → the second largest source, (33.24%).
- Household contributions are made primarily through *premiums paid to health insurance* plans and more importantly by *out-of-pocket expenditures*.
- Private firms provided around 12.5%, by funding for their employees' health insurance plans through self-insurance or commercial insurers.
- Donor contributions (Rest of the worlds), without the UNRWA contributions was around 2.9 %.
- UNRWA's share amounted to 0.77%;
- other governmental entities supplied 12.8% of health care funds, MOPIC 0.19%.

Health Expenditures by sector,

- The public sector accounts for 65.7%,
- Private sector accounts for 31.6%,
- NGO for 2%,
- and UNRWA clinics for 0.7%

Health expenditures by function

- 75% is spent on curative services,
- 16% percent on preventive measures (PHC),
- 6% percent on administrative activities,
- 1.5% on training, and 1.5% on miscellaneous activities.
- The expenditure on drugs at JD 500 million is higher than most countries in Jordan's income group. It accounted for approximately 26.60% of the total expenditure on health care services.

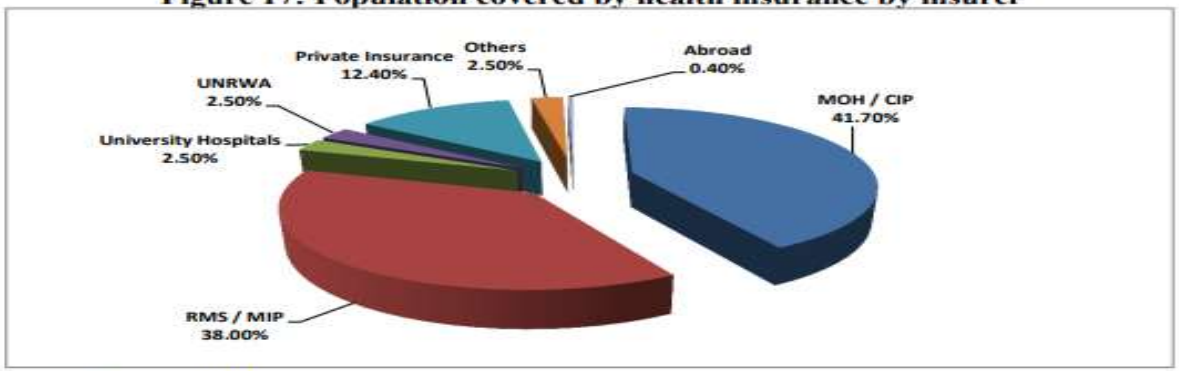
Health insurance

- Percentage of health insurance coverage was 55% of the population and 68% among Jordanian citizens (does not include the beneficiaries of exemptions provided by Noninsured Patient Affairs Unit (the Royal Court)).

Health Insurance available for:

- all civil servants and their dependents
- Children under six years old
- Segments of society that have been classified as poor by the Ministry of Social Development.
- Areas classified as least fortunate and remote areas
- Health insurance is issued to one member of the family of an organ donor (valid for five years).
- Health insurance is issued for a blood donor (valid for six months).
- for patients who suffer from certain medical conditions (certain infectious diseases, cancer, kidney diseases, tuberculosis, AIDS, and addiction to alcohol and drugs) regardless of their ability to pay

Figure 17: Population covered by health insurance by insurer



Source: Ministry of Health

Readings:

- https://applications.emro.who.int/docs/9789290226949-eng.pdf?ua=1
- https://andp.unescwa.org/plans/1159