HEALTH CARE SYSTEM FINANCING SYSTEMS: AN INTER-COUNTRY COMPARISON

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Background

Health care system is the organization of people, institutions, and resources to deliver health care services in order to meet the health needs of target populations. According to the World |Health |Organization (WHO), the goals for health systems, are good health, responsiveness to the expectations of the population, and fair financial contribution. There is a wide variety of health care systems around the world, and these systems generally have five primary methods of funding, such as: i.) General taxation to the state, county or municipality, ii). Social health insurance, iii.) Voluntary or private health insurance, iv.) Out-of-pocket payments, and v). Donations to charities (1).

Classifications of Health Care Systems

1. Traditional Sickness Insurance: fundamentally a private insurance market approach with a state subsidy. (Example: Germany)
2. National Health Insurance: a national-level health insurance system. (Examples: Canada, Finland, Norway, Spain, and Sweden.)
3. National Health Services: state provides the health care. (Examples: United Kingdom, Denmark, Greece, Italy, New Zealand, Portugal, and Turkey.)

Mixed systems: contain elements of both traditional sickness insurance and national health coverage. (Examples: Switzerland, and the United States of America)

In the United States, ownership of the health care system is mainly in private hands, though federal, state, county, and city governments also own certain facilities. Figure 1 shows that more money per person is spent on health care in the USA than in any other nation in the world (2),even though the USA does not ensure that all citizens have health service coverage, and the system does not deliver equivalent value for the money spent. In 2004, the Institute of Medicine report observed "lack of health insurance causes roughly around 18,000 unnecessary deaths every year in the United States"(3), while a 2009 Harvard study estimated that 44,800 excess deaths occurred annually due to lack of health insurance. Also, the WHO), in 2000, ranked the U.S. health care system as the highest in cost, first in responsiveness, 37th in overall performance, and 72nd by overall level of health. **Figure 1**

The U.S. system has some huge holes compared with the coverage in many other systems. In December 2011, the outgoing Administrator of the Centers for Medicare & Medicaid Services, Dr. Donald Berwick, asserted that 20% to 30% of health care spending in USA is a waste due to the following five causes (4),

1. Over-treatment of patients,
2. Failure to coordinate care,
3. Administrative complexity of the health care system,
4. Burdensome rules
5. Fraud

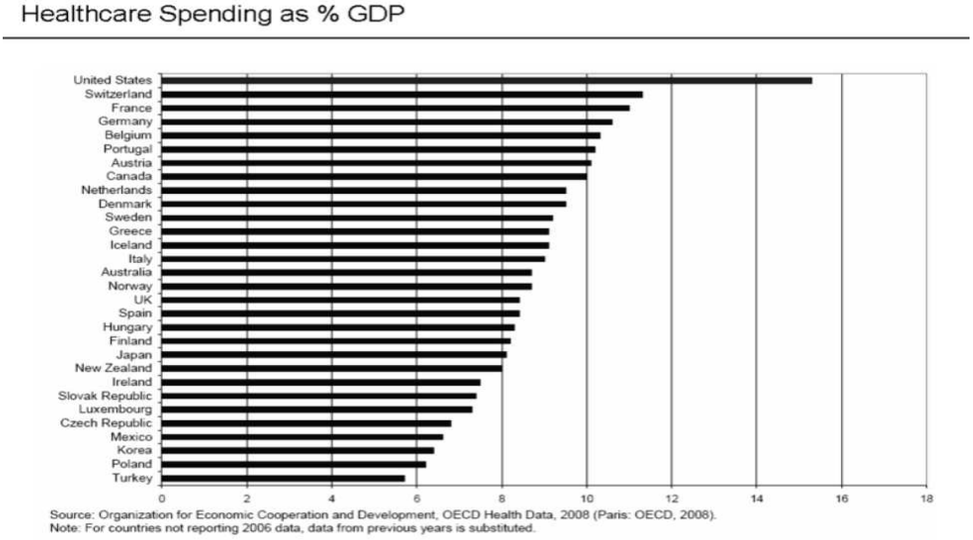

Figure 1

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United Kingdom

Most health care in the U.K is provided free at the point of need, being paid for from general taxation to all permanent residents by the National Health Service (NHS). It is a publicly funded healthcare system, which accounts for most of the Department of Health's budget. In addition, there is a private healthcare sector which is considerably smaller than its public equivalent.

The general practitioner (GP) is the gatekeeper to the health care system. (GPs are not government employees. Rather, they are self-employed and receive about half their income from capitation contracts.). . All patients must be referred to consultants by GPs.

The World Health Organization, in 2000, ranked the provision of healthcare in the United Kingdom as the fifteenth best in Europe and eighteenth in the world(5). The NHS has a high level of popular public support within the country: an independent survey conducted in 2004 found that users of the NHS often expressed very high levels of satisfaction about their personal experience of the medical services they received: 92% of hospital in-patients, 87% of GP users, 87% of hospital outpatients, and 70% of Accident and Emergency department users (6).

Although the United Kingdom spends less on health care than the United States and many other countries, by most measures of mortality and morbidity the UK does about as well than those countries.

Germany

Germany has a universal multi-payer health care system with two main types of health insurance: Sickness Insurance Funds and Private Insurance. Legislation required workers in various occupations to enroll in sickness insurance funds, which is paid for with joint employer-employee contributions. Small numbers of persons are covered by tax-funded government employee insurance or social welfare insurance. Persons with incomes above the prescribed compulsory insurance level may opt into the sickness fund system, which a majority do,. The sickness funds are required by law to provide a comprehensive set of benefits. (e.g. physician ambulatory care provided by physicians in private practice, hospital care, home nursing care, and a wide range of preventive services).

The German health care system is characterized by the "three S's"- Social solidarity (the sense that all citizens are concerned with the provision of equal access to health care). Subsidiary (decentralization to public and private organizations), and Self- governance.

According to the World Health Organization, Germany's health care system was 77% government-funded and 23% privately funded as of 2004 (7). The system is decentralized with private practice physicians providing ambulatory care, and independent, mostly non-profit hospitals providing the majority of inpatient care.

In Germany the delivery of health care is similar to that found in the United States, but in U.S., for the most part, large numbers of employee groups, independent insurers, and providers reach agreements without direct government intervention. Also in Germany co payments were introduced in the 1980s in an attempt to prevent over utilization and control costs. As a result , German health system has been relatively successful at controlling costs.

China

In China the New Rural Co-operative Medical Care System is a 2005 initiative to overhaul the healthcare system, particularly intended to make it more affordable for the rural poor. Under this system, the annual cost of medical coverage is 50 yuan (US$7) per person. Of that, 20 yuan is paid in by the central government, 20 yuan by the provincial government and a contribution of 10 yuan by the patient. As of September 2007, around 80% of the rural population of China had signed up for this which amounted to about 685 million people.

Figure 2

Chinese Federal Health Expenditure as % of Total Health Expenditures

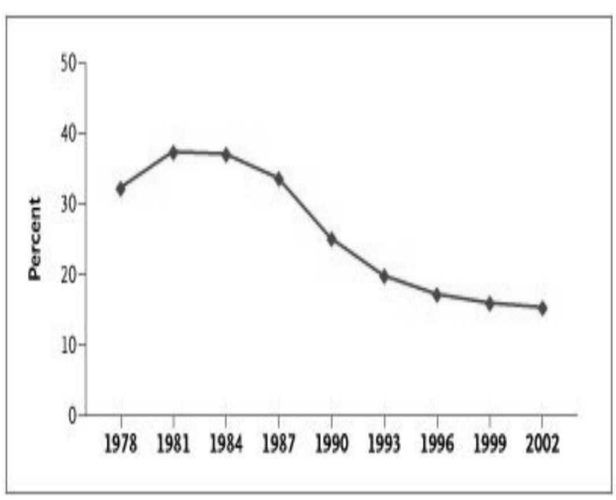
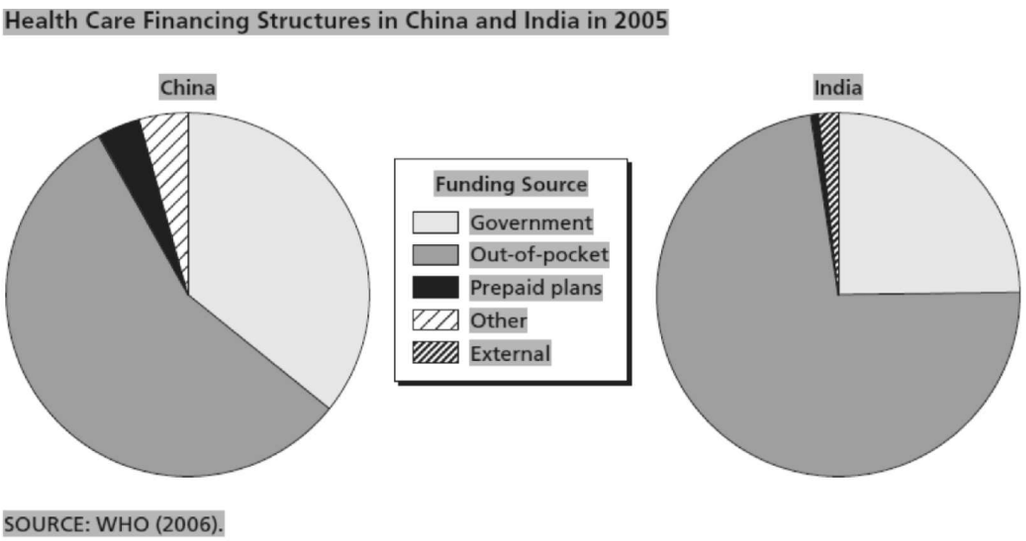


Figure 2 shows that China reduced federal funding of healthcare from 32% to 15% between 1978 to 2002. The provincial or local governments have more “control” over the health care service in China. If patients go to a small hospital or clinic in their local town, the system will cover roughly 70-80% of their bill. If the patient visits a county



clinic, the percentage of the cost being covered falls to about 60%. If the patient requires a specialist in a modern city hospital, the plan would cover about 30% of the bill (8).

India

The share of public financing in total health care in India is just about 1% of GDP compared to 2.8% in other developing countries. Health system of India is a complex mixed health system. It is a system of publicly financed government health system and a fee-levying private health sector. Over 80% of the total health financing is private financing, much of which is out-of-pocket payments (i.e. User charges) and not any prepayment schemes.

Various measures have been initiated to raise the resources for health, such as public private partnerships (tele medicine), voluntary and community health insurance, income tax exemption to set up private hospitals in the rural areas, and encouragement to private agencies in secondary and tertiary levels of healthcare.

Figure 3

Figure 3 shows the healthcare financing structures in China and India in 2005. In both systems out of pocket funding is more than government funding.

Experience from Other Countries for Sri Lanka to Enhance the Health System

Sri Lanka has achieved a relatively high health status given a low level of spending on its health-care services, and provides universal health services for all its citizens free at the point of delivery. In the face of rising health care costs the actual government expenditure cannot meet the financial requirements of health needs, and many governments in developing countries are considering options other than general tax revenue to finance their health services. Tax-based financing is currently insufficient and there needs to be greater emphasis on social health insurance. Sri Lanka would benefit from a social insurance model where a health insurance fund would be established with contributions made statutory by law.

With the existing resource allocation mechanisms of Sri Lanka there is little opportunity for significant improvement in service efficiency, cost effectiveness, quality or ability to focus on the poor without a substantial change. This necessitates the inclusion of more management autonomy, improvements in finance and management systems and financing including allocations based on needs, together with more rational planning and funding of services.

There is a need to ensure that equitable and fair distribution mechanisms are in place between and within provinces to reduce overcrowding in large hospitals by considering quality and cost-effectiveness. Therefore, Sri Lanka will have to make effective decisions on health-care service management by considering the following:

1. Regular surveys to ascertain the patients' and the public's views on the responsiveness of the health system, and their views which will facilitate their increased participation in the planning and management of services. Also consulting policy makers on what changes are needed to develop a responsive and people centered service.
2. Clinical accountability and the development of peer group reviews and clinical audits as well as other methods of monitoring patient satisfaction and the quality of service delivery.
3. Quality assurance in a systematic manner that enhances team spirit.

4. Clear protocols and accreditation processes to upgrade and sustain standards in both the state and private sector.
5. New technologies and innovations to be evaluated and where they clearly demonstrate their value and impact, introduce such methods into the state sector considering cost-effectiveness.
6. Policies to be developed to share investment in this area between the state and private sector where it is cost-effective.
7. The state sector to be encouraged to purchase services from the private health sector for state sector patients based on cost effective studies, and vice versa.
8. Re-certification of doctors, nurses and other health care workers at regular intervals with discussions of the appropriate professional bodies.
9. Develop a proper Health Care system for Sri Lanka to succeed all the health challenges by studying the experiences of other countries.

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