A Framework for Understanding the Financing of Health Care

by Max Price

In talking about the private sector, the public sector, nationalisation and privatisation, people often use the same terms when they actually mean different things. Using some simplified models of the health sector, this article will attempt to illustrate some of these different meanings in order to clarify the terms of the debate.

The main point of this article is to show that the economic structure of the health sector must be understood in terms of three different questions:

· Where does the finance come from and how is it channeled into health care?
· Who provides the health services?
· Who owns the health services and who employs the health careproviders (HCPs)?

This paper is therefore not about the consequences of different types of health services and is not intended to pass judgment on the pros and cons of the different models.

Sources of finance

There are a number of ways in which health care can be paid for. One method is that of users or consumers of health care paying for services when they are ill. There is a

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Note: the term "health care providers" (HCPs) which is used in this article refers to doctors, nurses, dentists, and others whose job involves the provision of health care.

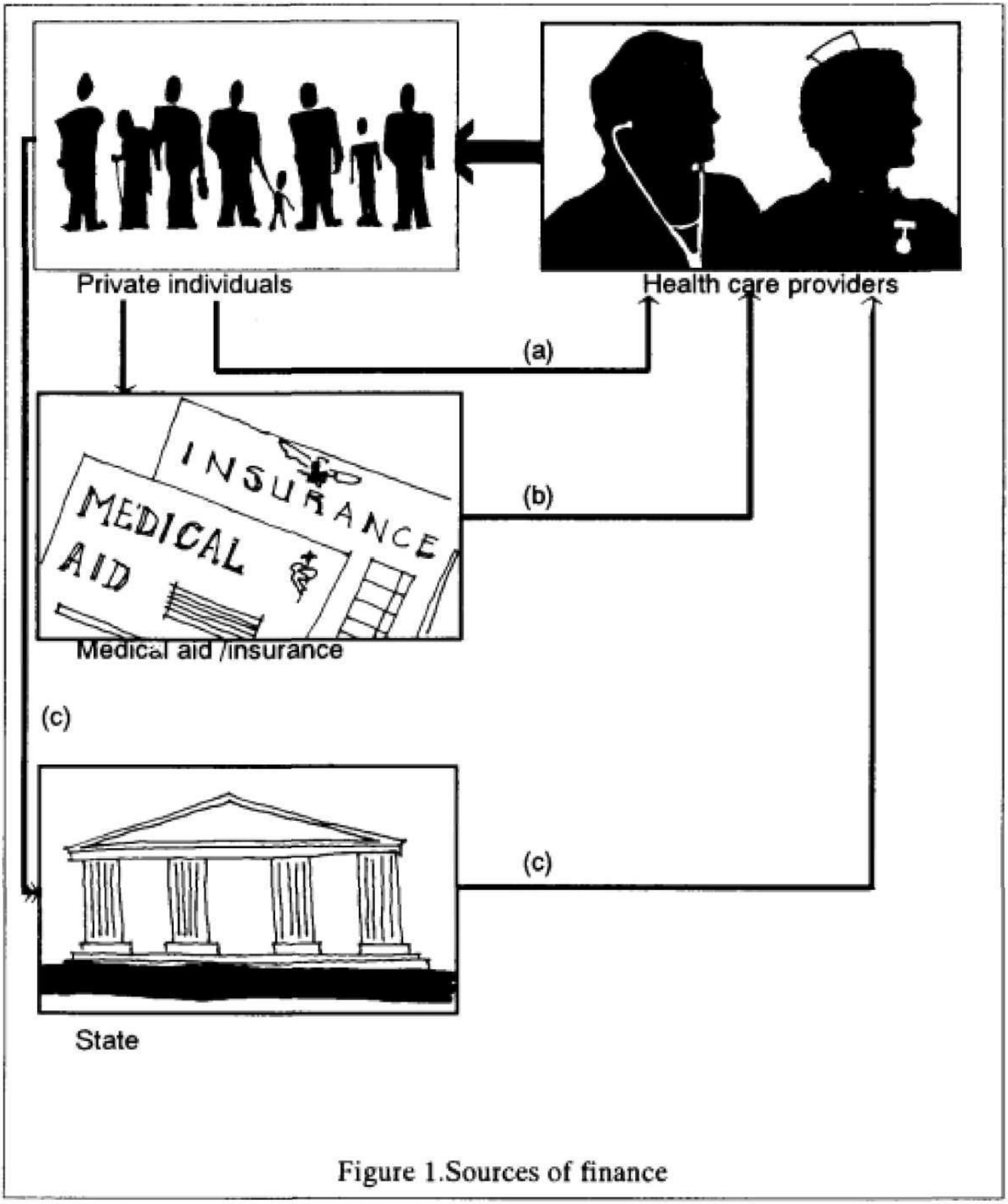


Figure 1.Sources of finance

direct exchange of money paid by the consumers to the health care providers who in return provide health care services, medicines, etc. **(See fig 1, arrow (a))**.

Individuals may need very expensive health care at any time and they may not have enough money available when they need it. So, many people get together, pool their money each month, and that money goes to the few that are sick. In other words, by paying a little every month, even when they are healthy, they are receiving the

security of knowing that if they need it, they would be able to pay for an emergency. This "risk sharing" is formalized into institutions such as burial societies, stokvels, and medical insurance/aid schemes **(see figure 1, arrow (b)).**

People also pay taxes to the government and government pays the health care providers, hospitals, and pharmacists to provide care and medicines to the people **(see figure 1, arrow (c)).**

In South Africa all these levels co-exist. For example, in insurance systems, the patient often has to pay the first R5.00 or 20% of the bill directly to the health care

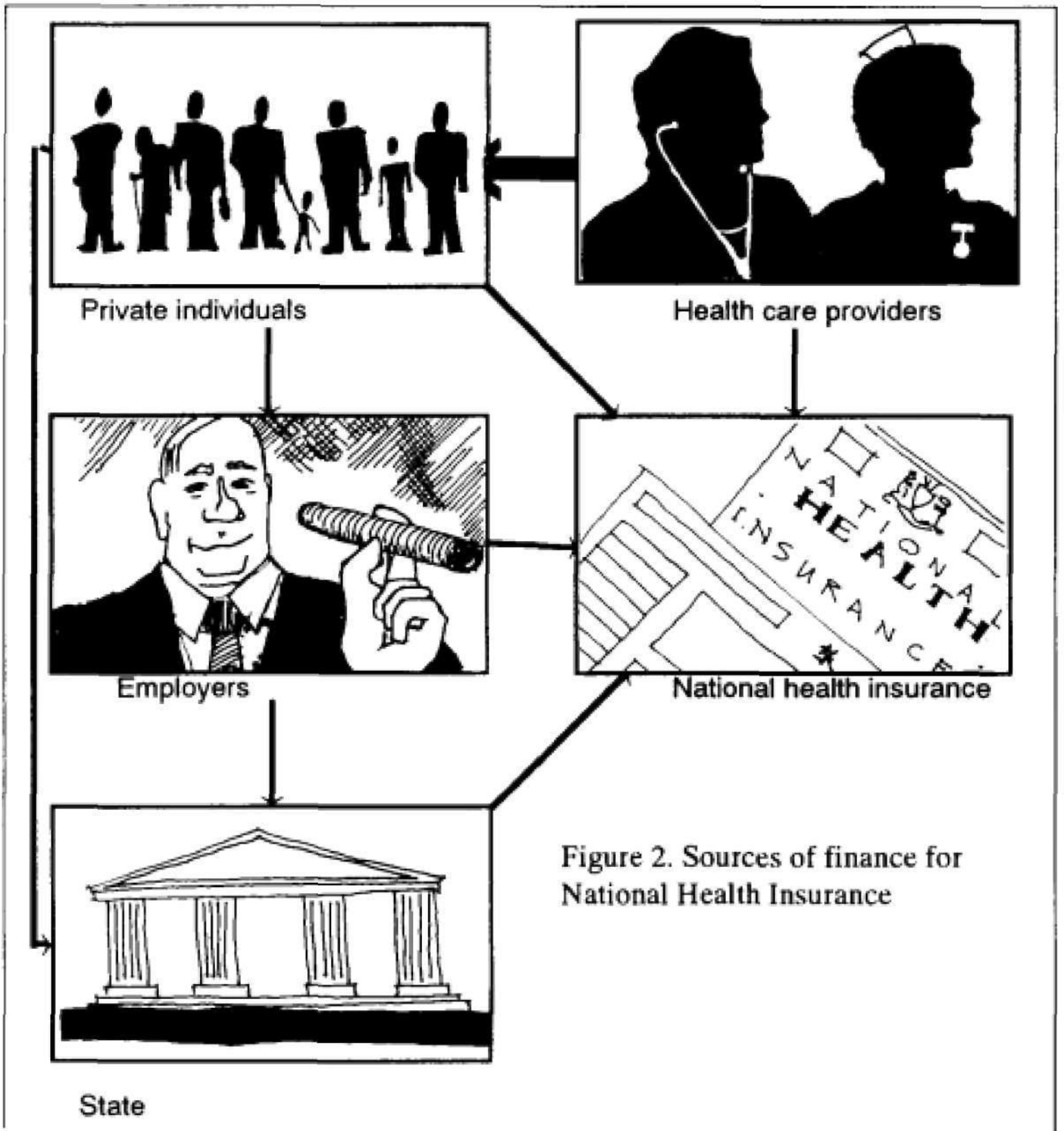


Figure 2. Sources of finance for National Health Insurance

providers. Patients receiving treatment at state hospitals also have to pay some of the costs.

In some countries health insurance is closely linked to the state, and is referred to as "national health insurance". The state subsidises the insurance on behalf of people who are unemployed and cannot afford to contribute to the scheme directly **(see figure 2).**

In talking about these SOURCES OF FINANCE we should bear in mind that all finance ultimately comes from individual people (or from their employers), but that it may be channeled in different ways. In general, some options are public **(figure 1, arrow (c))** and others private **(figure 1, arrows (a) and (b))**.

One of the meanings of "privatisation" is the shift from public sources to private sources of funding. For example, this is usually what the International Monetary Fund (IMF) and World Bank mean when they push for privatisation in health - the introduction of "user charges" or direct payment by the patient to the provider. Conversely, a National Health Service requires the channeling of finances through government or a national health insurance.

The different ways of financing health services have implications for equity, efficiency, redistribution, preventive/curative biases etc. For example, taxation may allow for easy redistribution of health services, while direct (private) payments by individuals may lessen the overuse of scarce health resources. There are many debates about the consequences of different financing arrangements. Unfortunately space does not allow a discussion of all these consequences.

Ownership and employment

Let us now look at the HCPs - i.e. the doctors, nurses, psychologists, pharmacists, etc. - as well as the hospitals, clinics, etc where they work. We discover that there are another 3 models reflecting their relationships with these different sources of finance. These are models of OWNERSHIP AND EMPLOYMENT **(figures 3, 4 &5)**.

First, HCPs may be self employed, independent providers, choosing whom they wish to treat, where to work, how hard to work, etc. Secondly, HCPs may be employed by the state, for example in provincial hospitals or the Soweto primary care clinics. Hospitals may of course be owned by the state. Thirdly, doctors may be neither self-employed nor state employed. They may be employed by a non-state organisation such as the Alexandra Clinic or a Health Maintenance Organisation (HMO), or one of the other private hospitals, or they may be contracted to the state.

In Britain the General Practitioners (GPs) have considerable autonomy and are almost self employed, but they are contracted to the state and get paid a fixed amount

per patient by the state. They also may not care for more than a certain number of patients and may not work in an area where there are too many GPs.

When some people talk about "privatisation" they are referring to privatisation of ownership, such as selling off publically owned hospitals, or doctors moving away from public employment into private practices. Conversely "nationalisation" is taken to mean the abolition of privately owned hospitals and private practitioners, in other words, state ownership of all hospitals and state employment of all health care

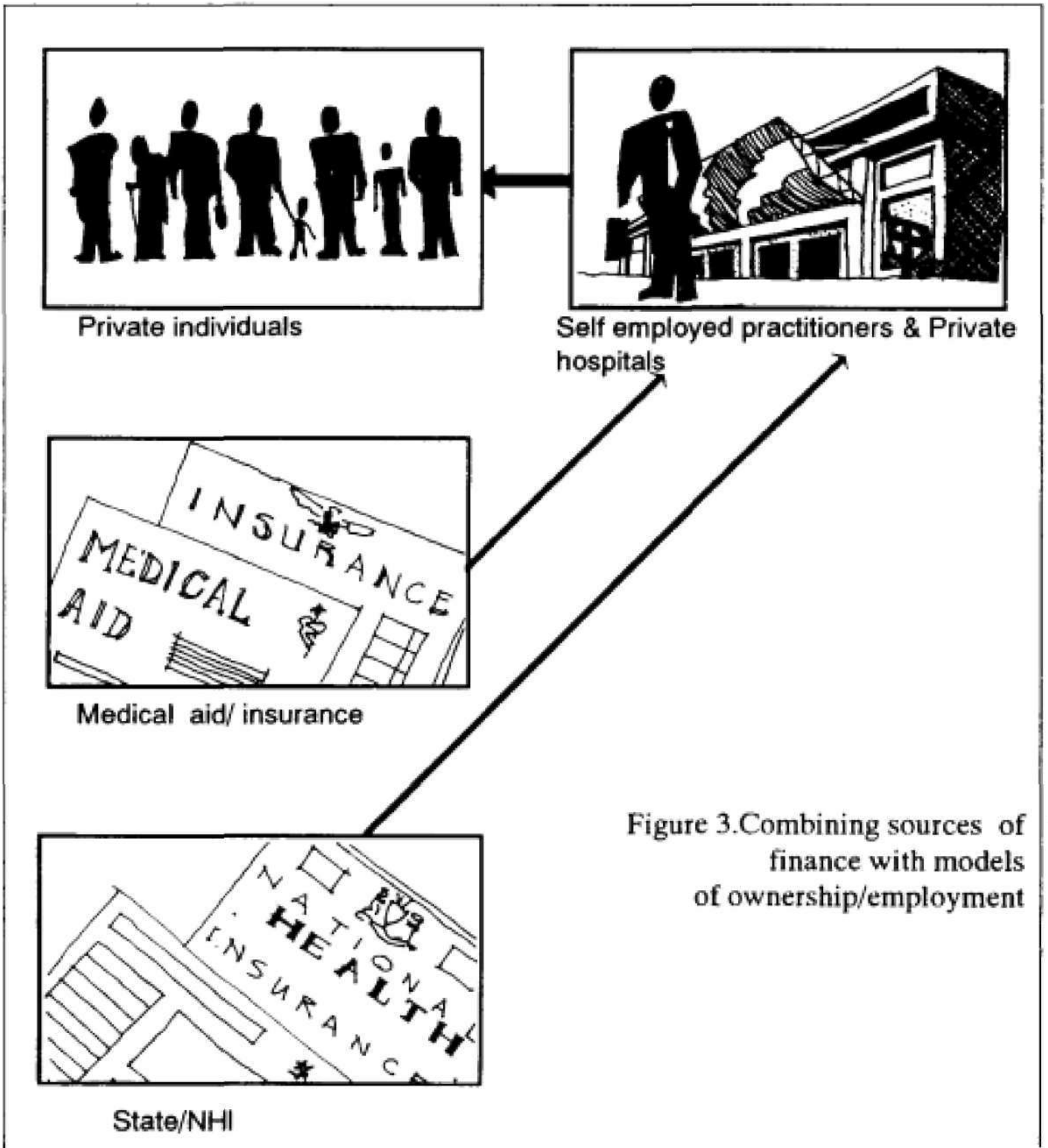


Figure 3.Combining sources of finance with models of ownership/employment

providers.

This is where a lot of the confusion arises. The different levels of financing are NOT tied to the models of ownership and employment. In discussing these issues we need to seperate out the consequences of policies regarding ownership from those regarding financing.

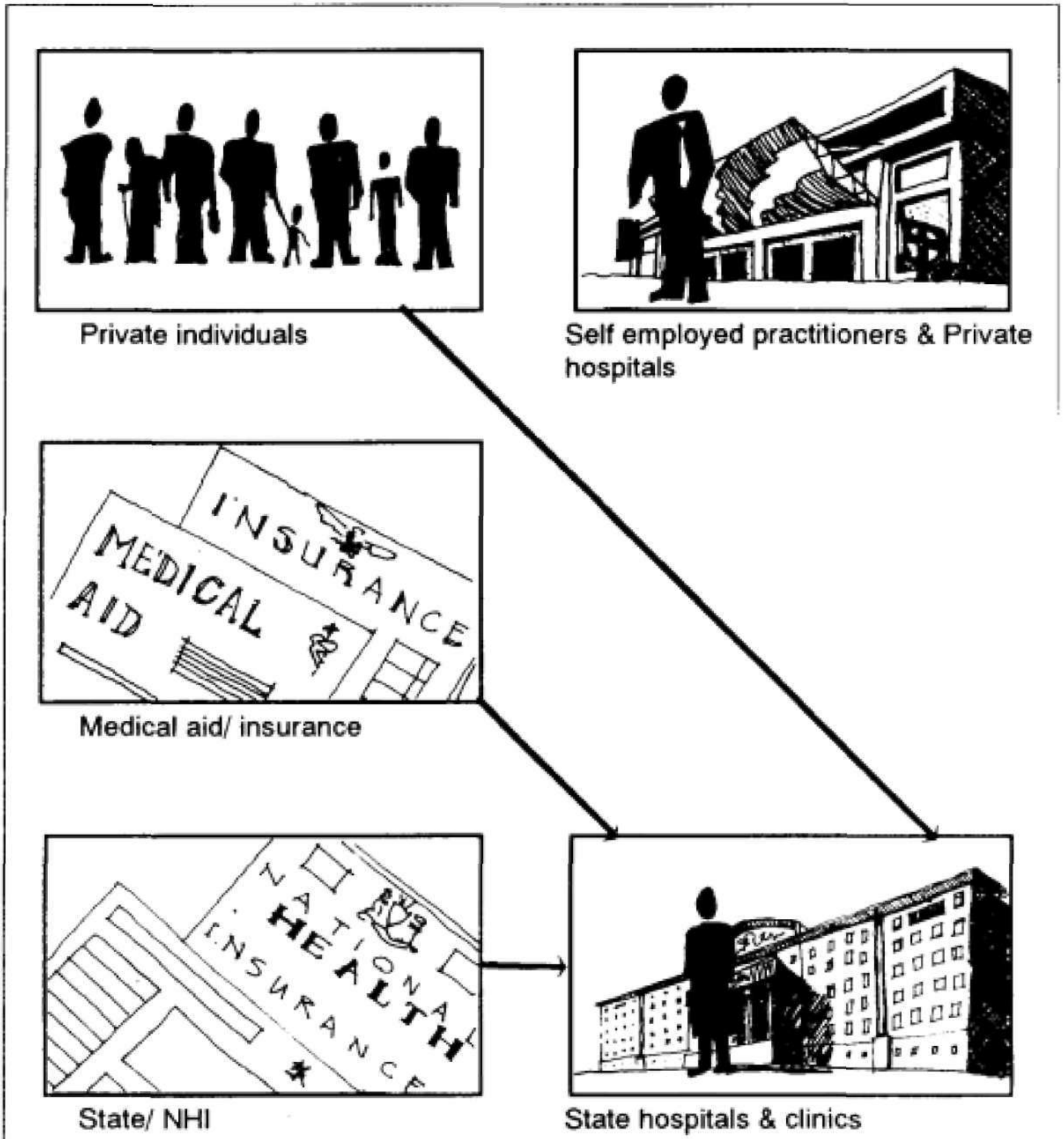
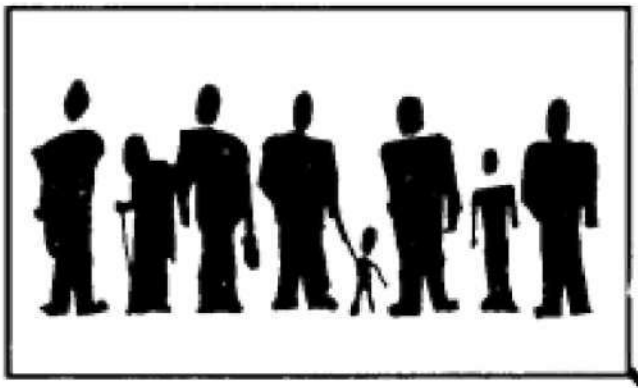


Figure 4. Combining sources of finance with models of ownership/employment

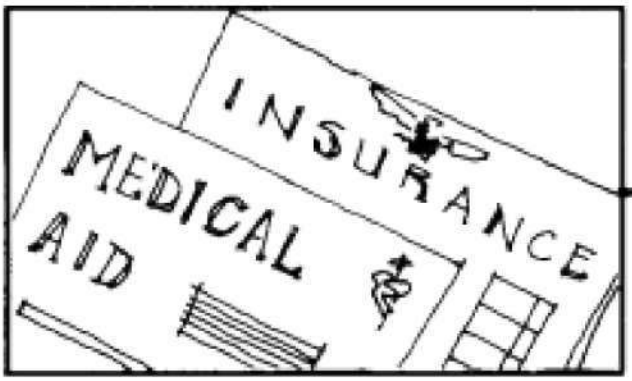
Ownership, employment and sources of finance - different combinations

Figure 3 shows that private, self-employed health care providers can be financed out of private, quasi-public or fully public finance sources. For example, the elderly in the



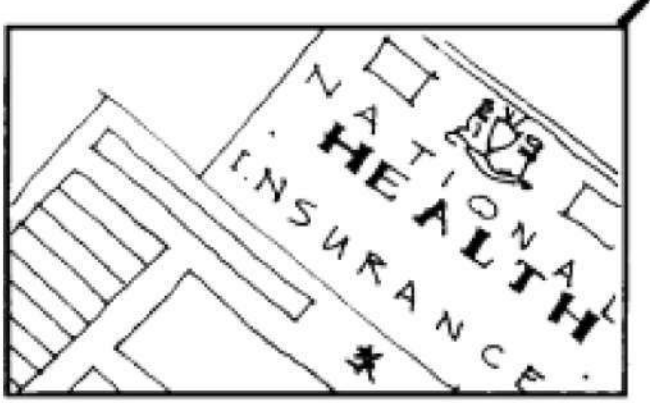
Private individuals

Self employed practitioners & Private hospitals



Medical aid insurance

Some HMOs, NGOs, British GPs *(1)*



State/ NHI

State hospitals & clinics

Figure 5.Combining sources of finance with models of ownership/employment

(1) Health Maintenance Organisation, Non-governmental Organisation

USA are financed by the government Medicare system but go to private, self employed providers. The public source of finance in this case means that private ownership is not, in itself, an obstacle to receiving health care (of course, there may be other reasons for not liking private ownership, but we must be clear what these reasons are).

Figure 4 shows how, even with public ownership and employment of HCPs, there can be many different methods of financing. The World Bank's adjustment policies are forcing many countries to charge individuals to use the public health services ("user charges"). This may well create obstacles to health care for the poor, in spite of the nationalised ownership of the health services in these countries.

Figure 5 shows again that all 3 levels of financing can be matched with non-profit private, and quasi-public forms of ownership and employment.

Conclusion

Although these models obviously simplify the situation, we see now that privatising or nationalising sources of finance can leave the ownership patterns unaffected. On the other hand, nationalising or privatising ownership need not in itself change the accessibility of health care.

There are clearly complex interactions which must be teased out if we are to go beyond slogans and engage in meaningful debate. But it also means that, in order to achieve our objectives of affordable, accessible and equitable health care for all, there are more subtle instruments available than nationalisation.

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