NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH SCIENCE

COURSE CODE: PHS815

COURSE TITLE: HEALTH CARE FINANCING

COURSE GUIDE

PHS815: HEALTH CARE FINANCING

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PHS815 **COURSE GUIDE**

INTRODUCTION

PHS815- Health Care Financing is a two (2) unit course with three (3) modules and nine (9) units. Health care financing involves methods of raising money for efficient use in health care services. It includes strategies used in the allocation of the funds raised for health care services. National health expenditures are supported by federal and state governments as well as non-governmental organizations. That shows that health care expenditure in public health involves judicious spending of money for all activities in the entire health sector, regardless of who operates or provides the services. There are factors that have historically affected the planning of public health financing by helping to reinforce poor health outcomes. There is therefore, the need to understand Nigeria's health care financing options, and the challenges encountered in the current arrangements so as to pose analytical questions on which way forward in improving the health of Nigerians.

WHAT YOU WILL LEARN IN THIS COURSE

The course will guide you to understand what public health financing entails. It will provide a general overview of the methods and sources of health financing. It will elucidate the rationale for allocation of funds to health care systems and show how services are prioritized. It will explain the factors that encourage inefficiency in health care services. It will discuss relevant laws guiding health care resource allocation and theories in public health financing. This course will assist readers to know what successful public health financing policies are. The course highlights methods of reducing financial barriers and describes how to use concurrent methods to raise sufficient funds for health care services, as well as the strategies for using the funds raised wisely. The course identifies ten leading sources of

inefficiency in public health care financing and also explains how to monitor and prevent universal health coverage from financial risk indicators. This course provides knowledge and skills that health care managers, policy makers and planners need for effective financing management. It discusses policies, strategies and practices health care workers at state and national levels could adopt to address health care financing issues in the health care industry.

COURSE AIM

The aim of this course is to highlight the methods, sources, and policies that guide health care financing.

COURSE OBJECTIVES

Bye the end of this course students should be able to understand:

1 factors that encourage production of health care
2 How incentives and the allocation of resources are done
3 the theories and sources of health care financing
4 the macroeconomic levels of health care financing
5 the policies guiding health resources allocation
6 economic consequences of decision making in resource allocation
7 the major categories of health expenditure
8 the health care financing markets
9 factors that influence inefficiency in health care systems
10 the methods of health care financing in Nigeria
11 the functional health care financing strategies

WORKING THROUGH THIS COURSE

This subject is simplified with the use of illustrations, pictures and others so as to assist the students to better understand the course with little efforts. The simplicity of the subject is such that will increase the ability of the students to acquire effective health care financing, skills.

THE COURSE MATERIAL

The main components of the course are:

- The Study Guide
- Study Units
- Reference/Further Readings
- Assignments
- Presentation Schedule

STUDY UNITS

The study units are as listed below:

PHS815 **COURSE GUIDE**

Module 1 will introduce the various methods of health financing in public health . Units one and two will examine health care expenditures at the macroeconomic levels of health systems. It will emphasize human resources and will show the factors that contribute to the inefficiencies that occur in health care industry. Unit 3 discusses the relevant laws in health resource allocations and will explain their economic consequences in health care delivery.

Module 2 discusses health care financing administration in public health practice. Units one will identify the factors that determine effective organizational changes in health sector. It will examine the respective roles of health care practitioners in the effective and efficient delivery of health care services to consumers. It will concentrate on factors and conditioners that increase the utilization of health care services. Unit two will discuss the factors that enable health workers to achieve the objectives of universal health coverage (UHC). Unit 3 will concentrate on methods of health planning and show how effective planning can accelerate the development of health care systems.

Module 3 focuses on assessing various methods of expenditures and the sustainability of health care financing. It shows how such expenditures are administered to the benefits of consumers. Units one and two will critically examine the health outcomes of the economic linkages and the policies guiding health care financing. The principles that guide effective health will be discussed at the microeconomic levels of health insurance. The frontiers and opportunities in providing executive health care will be assessed. Unit three will discuss the

factors and conditions that guarantee the sustainability of health care financing in health care systems.

ASSIGNMENT FILE

There are two types of assessment students are required to have in this course. Tutor marked assignments (TMAs) which should be submitted to the facilitators and will count for 30% of the total marks. The second is the written examination which will be taken at the end of the course and this will constitute 70% of the marks. This final examination will last for $1^{1/2}$ hours duration and will be conducted at the study centers

PRESENTATION SCHEDULE

There will be a time-table prepared for the completion and submission of the TMAs as well as attending tutorial classes. Students are required to submit all assignments at the stipulated time.

ASSESSMENT

There are three types of assessment in this course. The first is the self-assessment exercise. The second is the tutor marked assignments while the third is the written examination to be taken at the end of the course. The TMAs are submitted to the facilitators for assessment in line with the stated deadlines in the assignment file. The TMAs will account for 30% of the total mark while the written examination which will last for $1^{1/2}$ hours will constitute 70%.

TUTOR-MARKED ASSIGNMENTS (TMAs)

This is the continuous assessment component of the course which accounts for 30% of the students' total mark. The student will take three (3) TMAs, all must be taken before the student is allowed to sit for the end of course examination. The students' consistent reading and doing all the assignments will enable the students to have deeper understanding of the course and guarantee better performance.

Students should endeavor to ensure that all the assignments done get to the facilitators on time. If for any reason a student could not complete the assignments the facilitator should be contacted to find the possibility for an extension as request for extension after the deadline may not be granted unless in an exceptional case.

Students are encouraged to read through the entire course contents before presenting themselves for examination. The self-assessment activities and TMAs are very useful since the end of course examination covers all aspects of the course

FINAL EXAMINATION AND GRADING

The final examination for this course will consist of $1^{1/2}$ hours written paper which will be 70% and TMAs which will carry 30% bringing the total to 100%. The written paper will cover all areas of the course including the TMAs already done. Therefore, the students are expected to cover all the units in the course.

COURSE MARKING SCHEME

Table 1: Course Marking Scheme .

Assignments	**Marks**
Tutor Marked Assignments (TMAs) 1 – 3	Three TMAs, three marks at 10% each, i.e. 30% of course marks.
End of course examination	70% of overall course marks
Total	**100% of course materials**

Table 2: Course Organisation

Unit	**Title of Work**	**Weeks activity**	**Assessment end of unit**
	Course Guide	**Week**	
1	Description of health care financing and human resources planning	Week 1	Assignment 1
2	Health care expenditures and the macroeconomic level of health care financing	**Week 2**	Assignment **2**
3	Laws of health resource allocation and economic consequences of resource allocation decisions	**Week 3**	Assignment **3**
4	Frontiers and Opportunities in Executive Healthcare	**Week 4**	Assignment **4**
5	State of critical care reimbursement	**Week 5**	Assignment **5**
6	Governance issues in health financing, planning stages and Ethics of Managed Care	**Week6**	Assignment **6**
7	The impact of human resources on health sector reform	**Week7**	Assignment **7**
8	Principles of leadership and delegation in public health	**Week8**	Assignment **8**
9	Health economics and intensive care administration	**Week9**	Assignment **9**

HOW TO GET THE BEST OUT OF THIS COURSE

In this course the units will act as the university lecturer. This is among the advantages of distance learning education where you can read and work using specially designed materials at your own time and convenience. The study guide explains what and where to read as well as relevant books to consult. Just like what the lecturers do students are given some exercises to guide them during their studies.

There are sets of learning objectives meant to guide the readers to understand the course. The moment students finished each unit they are advised to go back to the lectures to assess the extent they have achieved the objectives listed. If students do this constantly, the chances of passing the course will be high.

Self-assessment exercises are also provided to aid the students' understanding of the course as well as assist them to measure the extent they have achieved the objectives of the course. Self-assessment test will also help the students during TMAs. Students are advised to attempt all the tests.

These are the practical strategies for working through the course

1. Read the course thoroughly and repeatedly

2. Have study schedule and always refer to the course overview.

3. Endeavor to stick to your study schedule.

4. Assemble all your reading materials at one place and work according to the study units starting from unit 1. Read the introduction and the objectives of each unit. Read along with the units the recommended materials for further reading.

5. Do all your assignments conscientiously as they have been designed to address the objectives of the course.

6. Review the objectives to ensure that they have been addressed. If in doubt, consult the facilitator.

7. Start with the objectives of the next unit if confident that the current unit objectives have been achieved.

8. When TMAs have been submitted to the tutor do not wait for the assignment to be returned before doing the next one. Do the assignments progressively so as to keep to the time schedules. After completing the TMAs then read for the final examination.

FACILITATORS/TUTORS AND TUTORIALS

Sixteen (16) hours are assigned for tutorials for this course. Students will be notified of the dates, time and location for the tutorials. Students are assigned to a facilitator and the name and phone number of the facilitator will be provided to them.

The duties of the facilitator are:

1 To mark and make comments on the assignments
2 To monitor students' progress and offer necessary assistance needed by the students
3 Mark the mailed TMAs and return same as soon as possible

It is necessary for students to attend the tutorials. This is the only face to face encounter students have during the course. This is also where students can ask questions and receive answers to their questions.

SUMMARY

Public Health Financing (**PHS815)** involve methods of raising funds, spending and managing the funds in health care. This course assesses how the funds raised are used to finance a wide array of programs and services in health. The course explains 3 main functions: resource mobilization mechanisms, financial management and resource expenditures. The course considers human resources as issues that deal with people such as compensation and benefits, recruiting employees**,** onboarding employees, performance assessment, training, and the development of organizations culture.

This course is important because it exposes why increased financial resources for health do not necessarily translate to improved health. It addresses the bottlenecks of health care in Nigeria and shows how weakly coordinated pooling mechanisms, lack of strategic purchasing, and unsustainable risk pools affect health care delivery.

On successful completion of the course students will be able to identify different sources of health financing mechanisms and expenditures, know laws guiding resource allocation, ethics and theories of health financing, know the composition of human resources in health systems, human resources risk management and the dos and don'ts in financing Universal Health Coverage.

Review Questions

1. Define health system financing?
2. Why is financing for Universal Health Coverage important in Nigeria?
3. Give two (2) reasons why setting objectives are important in health systems?
4. Explain the health care financing strategies that would provide equitable, efficient, and affordable health care to all Nigerians?
5. Distinguish between strategic and operational planning
6. Explain the importance of planning in health care financing
7. Describe in details strategic planning in health care financing
8. Explain how sustainability in health financing can be achieved in health care

MAIN COURSE

CONTENTS

MODULE 1: INTRODUCTION TO HEALTH FINANCING

UNIT 1: DESCRIPTION OF HEALTH CARE FINANCING

CONTENTS

1.0 INTRODUCTION

This unit will explain sources of health care financing and the policies guiding resource allocation. It will also describe various sources of health care financing and the health expenditure patterns. Health systems are responsible for not only improving the health of individuals, but also protecting them against the financial costs of disease and morbidity. One of the challenges faced by governments is to reduce the burden of out-of-pocket (OOP) healthcare payments for their people by providing subsidies and extending prepaid programs. OOP payment is the weakest and most unfair payment approach for health care. From the perspective of protection against risk, this approach is considered to be the worst possible form of healthcare financing. OOP payments can negatively affect access to health services, expose households to catastrophic health expenditure (CHE) and also slow the progress of universal healthcare coverage. The bottlenecks in health financing mechanisms in Nigeria constitute the weak coordinated pooling mechanisms that give rise to poor strategic purchasing, and unsustainable risk pools.

This section will also consider private and public financing of public health. It will examine the various mechanisms used to foster health from an economics perspective. This will then lead to a brief description of the way in which public policies can be used to change health care financing and subsequently, the services provided. Health care financing comprises 2 main functions: resource mobilization mechanism (raising money for health) and financial management (efficient management of resources raised). However, increased financial resources may not necessarily translate to improved health due to poor financial management.

2.0 OBJECTIVES

By the end of reading this unit, students will be able to:

1 Understand health care financing and its management
2 Identify various methods of health care financing
3 Explain the policies guiding resource allocation in health care systems
4 Know the benefits of health care financing
5 Learn the factors that affect the efficacy of NHIS in Nigeria:

3.0 MAIN CONTENT

3.1 DESCRIPTION OF HEALTH CARE FINANCING

Financing health care services encompasses the following: personal payments at the time of service delivery, financing through health insurance (prepayment) by the employer and employee at the workplace as well as general taxations supplemented by private organisations and non-governmental organisations (NGOs) . Health financing comprises 2 main functions: resource mobilization mechanism (raising money for health) and financial management (efficient management of resources raised). Ultimately, every country desires the government to fund health care services either for the entire population or at least for the vulnerable groups such as the elderly, the disabled, infants and the poor. Government's funding is very necessary especially to take care of the services that health insurance plans cannot effectively cover, particularly in the cases of non-communicable diseases that could degenerate to disability. This funding is also important in the control of epidemics as well of in the cost-effective interventions like immunizations which are for the good of the public.

However, there is keen competition for funds to support health care services in the system, but the way in which money is allocated during budgeting affects the way the services are provided and also the setting of the priorities for services. Therefore, the total expenditures

for health care and how the funds are spent are the most fundamental issues in health care financing. Allocation of resources for health care services requires skillful planning processes so as to ensure equity in services to various socioeconomic groups in the society.

Health financing policy focuses on mobilizing and pooling financial resources and allocating the resources to health care providers (purchasing) in an equitable and efficient way. This policy is supposed to encourage the provisions of quality health care services that are affordable and accessible to all, especially to the populations in rural areas.

One could ask the question, what is the "right" amount of health care financing in Nigeria? This is a political decision which will reflect the social and economic value the government places on the health of its citizens. This question will reflect how well the health care systems in the country are financed when compared with those in other countries. The question will also explain how the wellbeing of the health workers in the health industries is treated. Virtually many countries have now recognized the importance of better health care financing and the role such financing can play in enhancing health so as to make health care nationally and universally available and acceptable.

Health workers are responsible for advising the government on the impacts of poor health care financing and performance decisions on the running of health care systems. This calls for sound decisions in the methods in which health care expenditure is spent from all sources in the entire health sector, regardless of who operates or provides the services. This gives credence to the ways in which national health expenditures are derived whether from government or non-government sources and also show how money is used to finance wide arrays of programs and services in the health care industry. Realizing that there is competition for funds in any system, it is important to note that the way in which money is allocated affects the way the services are provided and also the setting of priorities for services. Therefore the system of financing in a country greatly affects the services provided.

3.2 HEALTH CARE FINANCING STRATEGIES AND MAJOR SOURCES OF FINANCING HEALTH CARE SERVICES

The way a country finances its health care systems determines the health status of its citizenry. The selection of adequate and efficient method(s) of financing health care services as well as the organizational delivery structure for health care services is essential in achieving the objective of providing health care for all citizens in Nigeria.

There are five functional health care financing strategies. These are:

1 general tax revenues,
2 social insurance,
3 voluntary insurance,
4 charitable donations (also referred to as financial aid), and
5 individual out-of-pocket expenses.

These strategies will be briefly discussed.

3.2.1 General Tax Revenues

Financing public health with **general tax revenues** is common in affluent Western countries with substantial economic stability where productivity and income allow financing with tax revenues to occur. However, the tax revenues that are generated in less developed countries including Nigeria are smaller and are spread over other important public goods thereby making other public health efforts including education, infrastructure, and economic development of a low priority. That is why the tax base and consistency required for

developing, administrating, and sustaining public health efforts are often excluded from financing public health activities with general tax revenues.

When this revenue is used to pay for public health activities, the taxes are considered *direct, indirect, or excise taxes*. **Direct taxes** are paid by individuals to governments and this tax cannot be avoided by either behavioral or consumption decisions. By virtue of citizenship or ownership of any property, individuals are expected to pay direct taxes. **Indirect taxes** are taxes paid when transactions occur within a government's purview. Indirect taxes are considered as taxes on consumption. Here, taxes are collected at the point of sales or services where the seller collects the tax from the consumer and later delivers the tax revenue collected to the government. **Sales taxes, value added taxes** (VAT), **goods and services taxes** (GST) are the examples of common indirect taxes. Indirect taxes therefore, apply to all goods or services, while **excise taxes** which are much more specific , are taxes placed on the production or sale of certain goods or services that can be used by governments to change the population's consumption behavior by increasing the cost of a particular good or service. For example, an excise tax placed on cigarettes will increases the price of cigarettes on consumers thereby, help to generate additional tax revenue.

3.2.2 Social Insurance System

Social insurance system provides minimum level of economic protection for citizens in the form of giving them comprehensive system of health care like retirement, long-term care, and unemployment insurance that are financed jointly by employers and employees. Social health insurance plays an important role in the public health system by advancing disease prevention, health promotion, resource and capital planning, as well as the participation and management of disease registries which are according to WHO , components of the essential health operations .

3.2.3 Voluntary Insurance

Voluntary insurance occurs when employers and/or individuals choose to purchase insurance from private firms so as to mitigate the potential loss of income associated with illness or the costs of health care consumption. In some countries, voluntary insurance systems are used to finance the health needs of the population instead of the social insurance systems . In such countries, voluntary insurance covers about two-thirds of the health needs of non-elderly working population, but the percentage to be enjoyed varies and tends to decrease during periods of poor economic growth. Therefore, both social and voluntary insurance financing mechanisms concentrate more on the delivery of acute health care services than the essential operations of public health services. However, in addition to the disease management and health promotion functions of social insurance, insurance whether social or voluntary provides other services such as health education, public and private partnerships for some diseases. For example, HIV/AIDS prevention and treatment that require close teamwork with other health care providers. Public health will not function adequately without the support of private insurers to pay the private practitioners for treating those who are ill, otherwise, the tax revenue designated to HIV/AIDS prevention alone will be insufficient to manage the prevention and treatment at the individual patient level.

3.2.4 Charitable Donations, Financial Aid

Charitable donations, financial aid, and the work of **non-profit organizations** in the development and financing of public health cannot be understated because all countries, regardless of their wealth, history, and where they are in the market maximization or minimization spectrum, rely to some extent on charity and non-profit organizations. Some non-profit organizations will provide the same or similar services as the for-profit organizations or the governments will do. Others are the sole providers of services that target needs that are inadequately addressed by for-profit organizations and governments. For example, the Diabetes Associations promote health by health educating the population will serve as catalysts for initiating research. Similar roles are also carried out by the

Cancer Organizations or the Heart and Stroke Foundations. These organizations, as much as possible, meet the needs of individuals by creating awareness on diseases prevention through providing education and resources beyond that which the local and national governments are unable to provide. Without the financial and expertise assistances these non-profit organizations provide , the burdens placed on government funds to meet the needs of these individuals will increase substantially.

It is also important to note that international charitable work for countries comes in three forms: *non-governmental organizations* **(NGOs),** *bilateral assistance***, and** *multilateral assistance*. NGOs are usually organized to be independent of the influences of governmental agencies and as such , provide services ranging from acute care to financial aids and technical assistances for particular health needs including community outreach projects. For instance, international health-related NGOs like Oxfam spends over €991 million annually to remedy injustices in allocation of funds, and to address the concerns of the poor in accessing many public health projects. International NGOs also spend money directly on program implementation, development, and maintenance .

3.2.5 Bilateral Assistance

Bilateral assistance comes directly from a government agency within a single country. The largest source of bilateral aid comes from the United States Aid for International Development (USAID), which spends over $8.6 billion annually. The United States is not alone in providing aid, other developed countries have agencies that also provide technical assistance or financial support. However, most bilateral aid relationships are products of historical associations that were occasioned by the colonialism of the 19th and 20th century. For instance, Japan continues to support its former East Asian colonies, while England and France provide aid to countries they colonized in Africa. However, continuous pressure on global economic markets may force some government agencies to revisit their expenditure levels so as to move them forward. The problem is that austerity measures coupled with slow

economic growth have compelled most developed countries to balance global public health needs with immediate and local demands.

3.2.6 Multilateral Relationship

When health financing is contributed by multiple countries, the financial support passes from being a bilateral relationship to a *multilateral relationship.* Institutions such as the World, Asian and African Banks; UNICEF; and World Health Organization (WHO) implement multilateral aid. WHO spends over US$3.9 billion on the following public health initiatives : prevention of HIV/AIDS and malaria in Africa, education of leaders and technicians on how to achieve the Sustainable Development Goals so as to improve public health initiatives. Initiatives in Africa, the Eastern Mediterranean, and Southeast Asia account for the majority of WHO expenditures, with Europe, the Americas and the Western Pacific receiving substantially less aid.

Considerable amounts of money are contributed bilaterally, multilaterally, and via NGOs, but the contributions from developed countries account for less than 5% of the total funding sources meant for health care in developing countries. Nonetheless, their contributions are also impactful because in low-income countries where the Gross National Income is < $1,025 per capita, the general tax revenue covers less than 40% of healthcare costs. The remaining costs in these low-income countries are made up of charitable donations from NGOs, and financial assistance. However, because there are no voluntary or mandatory social insurance programmes in most developing countries, external funding alone contributes over 50% of the total health care financing in such countries. For instance, in Sub-Saharan Africa, 54% of healthcare is provided by NGOs, multinational health efforts, and individual government development agencies.

3.2.7 Individual Out-of-Pocket Payments

Finally, even in developed countries with universal health coverage**, individual or out-of-pocket payments** represent an important mechanism of health care financing. These payments at times, are made as payment-in-full for a particular service received , or as cost sharing instituted by insurance or government plans in the form of deductibles, co-payments, and co-insurance. Here, the economic theory of supply and demand applies here. However, by introducing or increasing out-of-pocket payments for health care services, individuals are likely to consume fewer services. Out-of-pocket payments can be problematic to consumers as consumers are likely to weigh the potential benefits of payment with the quality and quantity of services received. This will determine the choice of services to be accepted in the mix of multiple and competing priorities. Therefore, the rate of consumption may make the individual healthy or unhealthy as some individuals who consider the cost of services high in price may not access the services. The higher the price for the consumers to pay, the more the demand curve will be intersected at a point closer to the vertical axis. This point of intersection is associated with fewer acceptance of services to be consumed and will cause a decrease in the total healthcare expenditures. If the health costs for services are reduced for consumers, it will encourage increased access to health care services offered in normal **private good**. When the good is considered private , the consumption of the good will reduce the availability to others and can even exclude individuals who do not have the ability to pay. For example, if markets are used to disperse health care, an individual who injures his or her ankle who requires an x-ray is consuming a private good because by using the x-ray machine and spending time with the doctor, the availability of the doctor and x-ray to screen other patients becomes limited. Therefore, direct out-of-pocket payments will further limit or exclude those who are unable to pay for the services or those who place greater emphasis on other priorities. As a result, direct out-of-pocket payments for healthcare services can constitute a barrier in obtaining services that can improve health. This is why some researchers view out-of-pocket payment that exceeds 20% of the total health expenditures as a substantial barrier. Below is a Table containing sources for financing health care services

Table 4: Sources for Financing Health Care Services

Public	**Private**	**International Aid**
Federal, state and local government general revenues; mainly from taxes: income, excise, resources, business, inheritance, value added, capital gains, property, special taxes	Private health insurance	United Nations affiliates
Social security payroll tax	Personal expenditures	Foundations
Compulsory health insurance	Private donations, bequests	Religious organizations
Lotteries	Private foundations	Other non-governmental organizations
Dedicated taxes: cigarettes, alcohol, gambling	Voluntary community service	World Bank
	User fees	Government bilateral aid

3.2.8 Sources of Health Care Financing in Nigeria

Using the following listed sources of health care financing for effective health care services in Nigeria has been a challenge because of limited institutional capacity, corruption, unstable economic system and political interests.

3.2.8.1 Tax Revenue

This is a method of financing health systems where government revenues are the main source of health care expenditure and this is referred to as tax-based systems. Here funds are usually generated through taxation or through other government revenues. Though the Nigerian government generates revenue through taxation, but the bulk of the revenue is derived from the sale of oil and gas. Revenues are raised at the federal, state, or local government levels but the federally generated revenue is shared according to a formula and this forms the majority of the funds for the other tiers of government. The states and local governments are closer to primary health care (PHC) and as such, these tiers of government are expected to provide adequate funding for PHC services. Owing to the low internally generating revenue capacities of these tiers of government, where they largely depend on the allocation of funds from the federal government, as such, their financing capacity to PHC services is minimal. The problem is that the federal allocations to the states and local governments are not earmarked and as such, they are not required to give budget and expenditure reports to the federal government. This means that the federal government has no significant control on funds allocated for both secondary and primary health care services in these tiers of government.

3.2.8.2 Out-of-Pocket Payments

Out-of-Pocket Payments are payments made for health care services at the point of service. The charges levied for health care services are termed as user fees but the scope of the user fees is quite adjustable and can include combination of drug costs, medical costs, entrance fees, and consultation fees. Out-of-pocket payments account for the highest proportion of health expenditure in Nigeria. Out-of-pocket expenditure as a proportion of the total health expenditure (THE) averaged at 64.5% from 1998 to 2002 and later increased to 74% of THE

showing that households bear the highest burden of health expenditure in Nigeria. However, user fee was introduced by the Nigerian government in 1998 under the Bamako Initiative which advocated for cost sharing and community participation to improve the sustainability and quality of health care services. It was anticipated that user fee will help to increase the resources available for health care and thereby, improve efficiency as well as equity to health care. However, the influence of user fees on consumers is unclear and therefore, the argument is: will user fee be retained or removed as a source of health financing since the effects on revenue generation , health care seeking behaviour, access to care, efficiency, and utilization of services in Nigeria are not clear. There is also a strong argument that user fee, if it does not encourage affordability and quality improvement in services, will result in low utilization of health care services because the willingness to pay may not translate to ability to pay. The poor economic growth in Nigeria, limits the ability of health care consumers to pay for services received. To pay for health care might need the households to sacrifice their long- term economic well-being. This type of sacrifice is referred to as catastrophic health expenditure.

User fees for the treatment of malaria in the under-5s and pregnant women have been removed by the federal and some state governments. Suggestions have been made on the use of waivers and/or exemptions in in other cases , but the implementation of the waiver and exemption is fraught with challenges that have made it ineffective in many settings. For instance, difficulties have been experienced in the following areas: criteria to use to classify people as poor, lack of administrative capacity, willingness of the health workers in enforcing the guidelines for waiver and/exemption, and the inconsistencies in granting exemptions. Nonetheless , because of these challenges few benefits have been recorded for waiver and/exemption and therefore , have given doubts as to whether these should be termed as favorable policy options for health consumers.

3.2.8.3 Social Health Insurance

Social Health Insurance (SHI) is a system of financing health care by making contributions to an insurance fund that operates within the framework of government regulations. This type of health financing is a form of mandatory insurance scheme that operates on a national scale and provides funds that will cover the cost of health care with a social equity. The insurance scheme is expected to eliminates barriers in obtaining health care services at the time of need especially the vulnerable groups. In SHI, every individual is required to make contributions except in the case of the vulnerable groups (the poor, the unemployed) that the governments contribute funds on their behalf . In the case of those employed, their employers will contribute on their behalf.

The Nigerian government established the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the objective of improving access to health care and reducing the financial burden of out-of-pocket payments for health care.
The NHIS which became operational in 2005 is organized into the following social health insurance programmes (SHIPs):

1 Formal Sector;
2 Urban Self-employed;
3 Rural Community;
4 Children Under-Five;
5 Permanently Disabled Persons;
6 Prison Inmates;
7 Tertiary Institutions ;
8 Voluntary Participants; and
9 Armed Forces, Police and other Uniformed Services.

It is only the formal sector of SHIP that is currently functioning and that is why membership of formal sector SHIP is mandatory for federal government employees. This mandatory membership has yielded about 90% coverage . The formal sector SHIP has now included all state and local government employees, but only Bauchi and Cross River States have so far

achieved full coverage. This is why there is not much increase in the extent of coverage NHIS has made since it became operational showing that only very few individuals benefit from NHIS. Another reason why many people have not benefitted from the NHIS is that the act establishing it made NHIS optional. However, the following factors affect the efficacy of NHIS in Nigeria:

1 poor medical facilities,
2 shortage of medical personal,
3 lack of awareness,
4 poor funding
5 possible mismanagement and
6 bureaucracy

3.2.8.4 Community-Based Health Insurance

Community-Based Health Insurance (CBHI) is a form of private health insurance where individuals, families, or community groups finance or co-finance the costs of their health care services. Private health insurance includes non-profit and for-profit plans. Usually, private health insurance is voluntary while SHI schemes are mandatory.

CBHI is designed for people living in the rural area as well as for people in the informal sector who cannot get adequate public, private, or employer-sponsored insurance. CBHI involves the community in its management but the effects of CBHI on equity, quality, and efficiency of the health care services rendered are unclear. This is because even when the charges are relatively small , enrolment is still very low particularly the poor ones, thereby, making existing inequalities worsened, since the poor are less likely to enroll and have improved access to care and financial protection.

The Nigerian government aims at using CBHI as the health care financing scheme that will cover people who are employed in the informal sector and in the rural areas. This has been

introduced in some States including Anambra, Lagos, Kwara and others. However, designing, implementing, managing, and sustaining CBHI in the communities are complex and may require technical expertise, and management skills. These are some of the challenges that limit the success of the scheme in most communities in Nigeria. Basically, the sustainability of CBHI is negatively affected by the low enrolment rates. The factors that contribute to the low enrolment in CBHI include:

1. **Lack of** trust by the community in the organizer or manager of the scheme,
2. Unclear attractiveness of the benefit of CBHI package,
3. Uncertainty in the affordability of the premium, and
4. Doubt in the quality of the health care services.

To increase enrolment rate in CBHI in Nigeria, there should be a sliding scale in premiums, that will allow financial contributions to be set according to the ability to pay. In this case, the households can choose to make contributions in whatever forms of payment they could afford. There is also need for awareness creation in the rural areas while funding by government is advocated to ensure the financial viability of CBHI in Nigeria.

3.3 Policies and Plans for Financing Health Care in Nigeria

Health financing policy focuses on mobilizing and pooling financial resources and allocating them to health care providers in an equitable and efficient manner so as to provide essential health care services of good quality to all, especially to the populations in rural areas. The following are the guiding principles in health financing policy:

3.3.1 Revenue Collection

The out-of-pocket expenditure in total health expenditure needs to be substantially reduced because of the financial burden it creates .It creates catastrophic and impoverishing expenditure which makes a good number of people not to seek care when sick. That is why in Nigeria, the out-of-pocket expenditure cannot be considered as a reliable source of funding health care because it is not capable of sustaining resilient service delivery for the populace. Ideally, revenues should come from prepaid sources in which the main source of funding should be the budget, with the additional support from donor funds.

3.3.2 Pooling

Introducing separate schemes for formal sector employees are usually avoided because of the resultant strong fragmenting and distorting effects such will have. Such will contribute to unequal access to health care services which will make it difficult to correct at a later stage. There is need to provide services that will benefit all population groups. However, community based health insurance scheme is not a solution for increasing financial protection of the population or for generating more financial resources that will fund essential health care services. Therefore, there is need to encourage community involvement in the management and quality control of health care systems. This is a welcome idea in health care financing.

3.3.3 Purchasing

Purchasing mechanisms are essential in channeling funds where they are needed. The mechanisms provide guidelines to incentivize providers on quality and efficiency as well as ensure equity across the whole country. For instance, performance-based or result-based financing is an option that follows when coupled with free health-care policies (gratuities). Per-capita funding can also effectively contribute to the development of health care services in areas that are underserved.

The Nigerian government has various policies and plans that address health care financing. These policies and plans focus on these:

1 how to achieve universal health coverage (UHC) with emphasis on how and where to raise sufficient funds to sustain health care services;
2 how to overcome financial barriers that exclude the poor from accessing health services; and
3 how to provide an equitable and efficient mix of health care services.

The policies and plans are made up of:

1 the National Health Policy,
2 Health Financing Policy,
3 National Health Act (2014) and
4 National Strategic Health Development Plan (2019-2022).

3.3. 4 National Health Policy

The key thrusts of the National Health Policy in health financing are to:

1 expand financial options for health care services
2 strengthen the contributions of the private sector and prepayment based approaches for financing.
3 engage communities and households in community-based schemes for the financing of health care services.

Public-private partnerships are also strategic approaches that are used as health financing options at all operational levels. Specific provisions of this policy include:

1 increasing government funding to international standards,
2 prioritizing primary health care (PHC) services
3 prioritizing funds allocation to the rural poor

4 increasing efficiency by redistributing resource allocations at all levels of care to ensure adequate allocation of funds for preventive and promotive cares.

3.3.5 National Health Financing Policy

The Federal Ministry of Health enunciated National Health Financing Policy in 2006. This policy seeks to:

1 promote equity and access to quality and affordable health care,
2 ensure high level of efficiency and accountability in the system
3 develop a fair and sustainable financing system.

However, the overall goal of this policy is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable health care provision and consumption.
For the revenue mobilization and pooling strategies to increase and guarantee fair financing by protecting the risk of vulnerable financing, the followings will occur:

1 Mandating federal, state and local governments to allocate at least 15% of their total budgets to health care in line with the 2000 Abuja declaration
2 Establishing Social Health Insurance (SHI) and Community-Based Health Insurance (CBHI) schemes; within the context of the National Health Insurance Scheme (NHIS) so as to cover the informal and rural populations, which constitute 70% of the population, as a measure toward universal access
3 Supporting states to develop state health insurance schemes that will be regulated by the NHIS
4 Supporting voluntary (private) health insurance and discouraging retainership
5 Identifying, adapting and scaling up of financing schemes that expedite universal coverage, for example, drug revolving fund schemes, deferrals, exemptions and others
6 Harmonizing external aids and partnerships for health financing

7 Promoting domestic philanthropy
8 Minimizing the burden of out-of-pocket expenditure and the resultant catastrophic health expenditure.

The policy demands that "as much as possible efforts should be made to discourage out-of-pocket health expenditure" and improve funding of disease specific interventions. At present, less than 5% of the national budget is allocated to health and also less than 5% of the Nigerian population is covered by NHIS. However, state health insurance scheme is only inaugurated in two states out of 36 states of the federation.

3.3.6 National Health Act (2014)

The National Health Act accented in 2014 provides legislative clarification and funding sources to support primary health care services. The Act affords Basic Health Care Provision Fund which will significantly increase government financing for primary health care services. The Act targets universal health coverage (UHC) with basic services. Specifically, the fund is financed from:

1 consolidated fund from the federation, with an amount not less than 1% of its value
2 Grants from international donor partners; and
3 Funds from any other source.

Ideally, it is proposed that:

1 50% of the fund shall be used to provide basic minimum package for health care services to all citizens, in suitable PHC facilities through the NHIS
2 25% of the fund shall be used to provide essential drugs for primary healthcare
3 15% of the fund shall be used to provide and maintain facilities, equipment and transport for primary health care services

4 5% of the fund shall be used to develop human resources for eligible PHC facilities; and
5 5% of the fund shall be used by the Federal Ministry of Health to provide National Health Emergency and Epidemic Response.

The Act intends that National Primary Health Care Development Agency shall be responsible for disbursing the funds, for essential drugs for PHC, for facility maintenance and human resource development through State Primary Health Care Boards. The agency shall also be responsible for the distribution and maintenance of materials to Local Government Health Authorities. The Act indicated that for any state or local government to qualify for federal government block grant, that the state and Local Government Area (LGA) must contribute not less than 10% and 5% respectively of the total cost of the project.

3.3.7 National Strategic Health Development Plan 2019-2022

National Strategic Health Development Plan (National Health Plan) is a shared aspiration meant to strengthen the national health system and improve the health status of Nigerians. The plan is all-embracing health development document for reference by all actors so as to enable them deliver shared results framework to which everyone will be accountable for achieving the goals and targets as contained in the results framework. The health plan, which has also been developed in tandem with the guidelines of the National Planning Commission of Vision 20:2020 process (including the V20:2020 implementation plan) is the reference for the health sector. The overall goal is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient, and equitable health care provision and consumption at local, state and federal levels.

Nigeria being the most populous country in Africa, with over 198 million people, 49.4 percent female and most under 30, the United Nations Department of Economic and Social Affairs has predicted that by 2050, Nigeria will become the third most populated country in the world. Poor maternal nutrition, suboptimal infant and young child feeding practices,

limited access to nutritious food and inadequate health service care are the underlying causes of child under-nutrition. The prevalence of hunger in rural areas is associated with low agricultural productivity; poor infrastructure, including transport and banking; limited access to safe water, sanitation and hygiene; inadequate health and education services; and gender inequalities resulting in 40 percent of children aged 0–59 months chronically malnourished (stunted), 11 percent acutely malnourished and 32 percent underweight.

The Economic Recovery and Growth Plan 2017–2028 prioritizes financing agriculture , food security, and social safety. However, associated 2017 Budget of Recovery and Growth, funds social investment programme that focuses on job creation, school feeding and cash transfers to vulnerable populations. Currently, the country's political tensions, criminality, conflicts and insurgence have affected health care financing in the health sectors.

WFP targets food security and nutrition assistance to conflict-affected populations. The country's strategic plan consolidates WFP's presence by leveraging partnerships and maximizing results through complementary actions . This is based on increased security and stability so as to allow WFP to phase out its direct operations over the first three years of the plan. Notwithstanding this , the strategic plan ensures safe and secure access to increased gender-transformative livelihood support and nutrition sensitive activities by promoting self-reliance and resilience.

The CSP WFP will shift focus from direct operational engagement to national and local institutions and to communities, with policy environment that will be supported by a dedicated budget plan. Drawing from the 2017 zero hunger strategic plan with government strategies and policies, the CSP proposes six interlinked strategic outcomes that will reduce hunger and under-nutrition through partnerships. This will address both humanitarian and development issues, in line with international policy on the humanitarian–development–peace nexus. WFP puts women at the centre of its action. The CSP covers a period of four years, from January 2019 to December 2022. It aligns with WFP's Strategic Plan (2017–

2021) and the United Nations sustainable development and partnership framework for Nigeria for 2018–2022 and the 2030 Agenda for Sustainable Development.

3.3.8 Governance Issues in Health Care Financing

Governance in health-care financing is one of the core components of health sector reform that measures health financing issues like :

1 mobilization of funds,
2 distribution of financial risks,
3 allocation and utilization of services, and
4 provider payment incentives.

However, comprehensive information on health financing such as **costs,** and expenditure is lacking. This lack of information constitutes a limitation that affects the use of appropriate health policy analysis to strengthen health financing governance at all levels of health care. Ultimately, good governance will encourage effective use of roles and functions of financing health systems that are well integrated in the provision and regulation of quality health services that will ensure balanced share of the public, private, and voluntary sectors. This means that good governance will achieve universal health coverage for all with an affordable and sustainable financing framework. It will also strengthen health financing methods that are capable of achieving improved financial management systems. Here, emphasis is on enforcement of regulations that will implement equitable and fair financing policies that are based on accurate and reliable financial information. Therefore, the essence of good governance should be to encourage detailed transparency in the collection of funds, pooling of resources, purchasing and payment for health care services. That is, to ensure that the financing payment mechanisms to providers have effective system of checks and balances without incurring high administrative and transaction acts. Above all, there is the need to attain effective and efficient policy goals that will encourage proper allocation and utilization of scarce resources to achieve Health for All. Where these do not exist, it will be unlikely that

health systems will work, services delivered, and health status improve. Poor governance undermines the quality of services and the acquisition and spending of public funds. Addressing these problems will ensure the adoption of clear rules, and regulations that will enforce discipline and public trust.

3.3.9 Policy Analysis of Heath Care Financing

A specific policy analysis will assess health care options individually against identified criteria so as to incorporate a weighting procedure that will rank the options. This will only be part of the picture if there is clear understanding of how policy is actually made. This might constitute rational policy which provides a basis for scientific consensus among the stakeholders. Alternatively, it might build some criteria for judging pragmatic options or political factors such as the feasibility of an option in a particular political context.

In whichever way, it will be explicit on the range of factors that are likely to affect the effectiveness of any policy in both the outputs and outcome results respectively. This is often responsible for extremes of optimism and disillusionment which some consumers experience in assessing the national health reform programmes. For example in governance where fundamentally three categories of systems such as statist systems, market systems whether private, public, or mixed; and self-governing systems are used with varying degrees of state regulation which providers, financiers, and employers are now adopting in organizing health care delivery.

Statist systems have now replaced the market with public planning, where market systems rely on either private markets that have evolved historically or on the creation of market structures and incentives within the previously publicly planned systems. Self-governing systems are systems where central state control is limited, and where professional relationships rather than market relationships between stakeholders predominate. For example, in the physicians' association, nurses' association, medical records' association and others, the state deals with these associations directly as institutionalizations of major social interests. Here, a

reasonably stable decision-making machinery is supervised by the state but not dominated by the state . As a result, most advanced health-care systems are hybrids in various ways. The question is: To what extent is the cultures and incentives in the organization adequately associated with the health care services provided? While using incentives here to answer some of the pressing questions, it is important to distinguish between macro and micro incentives and show which of the governing systems encourage these incentives. Statist systems, for example, are very good at the macro cost control level. In terms of micro-level allocations such as assisting the health care providers or clinical teams to achieve objectives, statist systems are flexible. That is, sometimes they are good and at other times they are not. The question is: Why do some governance systems allow meso-level planning authorities during health care financing? This is to avoid the excesses of both state and professional controls where there are misleading interests that negatively affect incentives by paying attention to achieving only the systems' desired outcomes.

While all the systems are likely to be hybrids, it is important to ensure that the dominant incentives they uphold will achieve the important objectives that are set by government on behalf of the health industry. Therefore, there is the need to ensure that no cross-cutting policies with incentives capable of generating negative outcomes on the populace are encouraged. This has been a well-known occupational hazard that causes purchaser/provider split with different policy streams vying for dominance at the expense of patients' health market choices. This split negatively affects the health care market.

In considering options against criteria, attention is paid on how to distinguished the impacts of the political structure of the top health executives from the overall governance and management of the health care financing market for the consumers. This is, whether or not health care services ought to be managed strategically at arm's length by government or not. Nevertheless, the question to be considered is: what roles and functions do different levels of health care providers play in initiating coherent governance structure that will be capable of articulating consistent policy that will benefit the health market ?

4.0. CONCLUSION

The Nigeria government uses various mechanisms for public health care financing. However, the health financing system is still struggling with government low investment due to extensive out-of-pocket payments, limited insurance coverage, and low donor funding. Therefore, achieving good health, equity, patients' and providers' satisfaction will not be easy. However, there may be a way forward for Nigeria if an out-of-pocket payment is deemphasized. This will require strengthening the health care financing system so that everyone who requires health care services is able to access them at affordable price. This means that citizens should be able to benefit from any of the financing mechanism in accessing health care services.
Nigeria's weak institutional capacity, technical expertise, and poverty, will make it to rely on a combination of mechanisms in other to achieve effective health care financing system. This means that for Nigeria to achieve universal health care coverage services for the poor, it will move from out-of-pocket payments to other mechanisms of financing. Although it may not be easy to completely abolish user fees, user fees for interventions that require wide coverage should be reduced or removed so as to enable the poor access services. The SHI and CBHI should be scaled up to achieve wider coverage. Also donor funding should be put into more effective use so as to augment the other mechanisms of financing.

5.0. SUMMARY

The time has come for Nigerian government to see health care financing as an investment, which requires an effective management and political commitment for it to be profitable to the citizens. Factors such as lack of awareness, corruption, and unstable economy have undermined the progress of health care financing in Nigeria. These factors should be addressed exigently. Another important challenge in Nigeria's health care system is lack of sound planning and policy making. This could be attributed to dearth of relevant research. Health care financing needs to be situated on sound research findings so that planning will be

evidence based. Collection of reliable and timely data for planning and evaluating policies should be improved in Nigeria.

6.0. TUTOR MARKED ASSIGNMENT

1. List three guiding principles in health financing policy,

2. Explain the three main focus of the policies and plans of health care financing in Nigeria,

3. State the overall goal of national health financing policy

4. List the four components of Nigerian health policies and plan

5. Explain the benefit of CBHI,

6. What conditions entitle a state government and local government to benefit from federal government's block grant

7. Explain why some governance systems allow meso-level planning during health care financing ?

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MODULE 1 INTRODUCTION TO HEALTH FINANCING

UNIT 2 HEALTH CARE EXPENDITURE AND THE MACROECONOMIC LEVEL of HEALTH CARE FINANCING

CONTENTS

1.0 INTRODUCTION

This section on health care expenditure will describe Nigerian total health expenditure and the challenges encountered in achieving a successful health care financing system. These challenges include: limited institutional capacity, corruption, unstable economic and political context. These have been identified as the factors that contribute to why some mechanisms of financing health care have not worked effectively. Readers will learn the status of budgetary component of health expenditure in Nigeria and compare it with what is obtainable in other African countries. Also students will learn how a well-functioning health financing system is described and what gives rise to catastrophic health expenditure. This section will examine the health financing opportunities of various countries in Africa and compare it with that of Nigeria. It will explore the main functions of health financing and establish the extent to which funds are effectively and efficiently managed. It will evaluate the extent to which the vulnerable individuals have access to health care. However, there is keen competition for funds to support health care services in the system, but the way in which money is allocated during budgeting affects the way the services are provided and also the setting of the priorities for services to the populace. Therefore, the total expenditures for health care services will be explored.

2.0 OBJECTIVES

By the end of reading this section students will be able to:

1 Understand the determinants of catastrophic expenditure
2 Identify whether federal, state and local governments implement health financing strategies in line with the National Health Financing Policy
3 Explore the extent to which efficiency and equity in the allocation and use of health sector resources at all levels are functional.
4 Understand the value of strategic purchasing in health care financing
5 Explain health expenditure patterns in Nigeria

3.1 Health Expenditure Patterns and Fiscal Contents

Nigeria's health expenditure is relatively low when compared with other African countries. The total health expenditure (THE) which is the percentage of the gross domestic product (GDP) has been less than 5%, and this falls below THE/GDP ratio in other developing countries like Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%), and South Africa (7.5%). The total government health expenditure which is the proportion of THEwas estimated as 18.69% in 2003, 26.40% in 2004, and 26.02% in 2005 showing that this has remarkably increased over the years. That is, it increased from 1.7% in 1991 to 7.2% in 2007. Nevertheless, the budgetary allocation for health is still below the 15% which the Nigerian government signed in the Abuja declaration. Given the level of government spending, it becomes very difficult for it to provide essential health care services for the populace. Moreover, the unstable oil prices in the world market, the low tax base, and other pressing issues, make expenditure on health care in Nigeria very difficult.

Per capita health expenditures vary widely. The problem is that the total per capita expenditure on health does not reflect the efficiency with which the resources are supposed to be used because many countries with low overall levels of health expenditure also allocate the meager resources inefficiently.

However, irrespective of how efficiently a country may allocate money, if a country spends less than 4 percent of GNP on health, the health care of that country will be poorly developed. Only countries spending between 4 and 5 percent of GNP may have universal coverage, but often, they achieve this through low staff salaries, inadequate equipment, and spreading limited resources too thinly. Problems increase when there are unduly large hospital systems with large number of physicians adopt siphoning effects on health care spending, or when resources are spent in the cities to the disadvantage of the population in the rural area.

Developed countries that spend between 8 and 18 percent of GNP on health care have placed health care among their vital priorities .

WHO Global Strategy for Health Development has stressed the importance of efficiency in the use of resources as a vital element of health development and recommends preferential allocation to primary and intermediate care services, especially for currently underserved rural populations. In most countries, reallocation of resources has been suggested so as to strengthen primary care and adopt new technology and health programs which will be cost-effective and adjudged as possessing anticipated benefits. Where financing of health care is centralized, there will be rational allocation of resources but this will depend on adequacy of total financing and rational allocation policies that will promote equitable access to services and a balance between one service sector and another. Allocation of money for total health expenditures means there will be many alternatives to choose from. Therefore, wrong allocation of resources to sectors within the health sector will be wasteful and even counterproductive. For example, giving excessive funding to tertiary care while primary care is neglected will be counterproductive since greater numbers of individuals live in the rural areas.

One of the issues that prevent quality health care delivery to achieve UHC in Nigeria is the inadequate general government expenditure on health (GGHE) which is a percentage of the government general expenditure (GGE). In the year 2012, 6% of GGE was proposed as GGHE which is contrary to the agreement of the African Union's Abuja declaration of 2001 which states that 15% of the government's budget should be allocated to health care. Over the years, federal government allocation to health has been about 3.2% of the total federal spending. However, the GGHE as a percentage of THE has increased from 3.2% to 3.5%. This shows that the federal level allocation for health is far short of the Abuja declaration target of 15% of the national budget

Health care financing is visible and central on the global health stage, especially, for countries wishing to achieve universal health coverage (UHC) so as to improve their health

status in the face of declining donor funds. The range of services or programs requiring funding for all population groups includes:

1 *Institutional care* – teaching hospitals, general hospitals, mental and other special hospitals, long-term nursing care, residential care, *Pharmaceuticals and vaccines,*
2 *Ambulatory care* – primary care, family practice, pediatric, prenatal, and medical specialist; medical, diagnostic, and treatment;
3 ambulatory and day hospital clinics; surgical, medical, geriatric, dialysis, mental, oncological, drug and alcohol treatment,
4 *Elderly support service centers,*
5 *Categorical programs* – immunization, maternal and child health, family planning, mental health, STIs, HIV, tuberculosis preventions, screening for birth defects, cancer, diabetes, hypertension,
6 *Dental health,*
7 *Community health activities* – healthy communities, health promotion in the community for risk groups; smoking restriction, promotion of physical fitness and healthy diet; environmental and occupational health; nutrition and food safety, safe water supplies, special groups,
8 Research
9 Professional education and training

A situation where funds are limited, unless where services are highly decentralized to ensure that essential services that are capable of promoting national health needs and equity in all the states are adopted, setting policy and standards to determine health targets with adequate funding to promote national priorities will be difficult.

3.2. Macroeconomic Level of Health Care Financing

Health care financing has progressed from personal payment at the time of service delivery to financing through health insurance (prepayment) by the employer and employee in the

workplace. This is common in most industrialized countries where governmental financing is by social security or general taxation and then supplemented by private and non-governmental organizations (NGOs) and not by personal out-of-pocket expenditures. Every country desires its government to fund health care either for the total population or at least for the vulnerable groups such as the elderly, disabled, children and the poor as obtainable in developed countries where the government's funding amounts to nearly 50 percent of total health expenditures.

In macroeconomic financing, health expenditures are derived from government and non-government sources and are used to finance a wide array of programs and services. Health systems are responsible for improving the health of individuals, and also protecting them against the financial costs of disease and morbidity. One of the challenges faced by governments in macroeconomic financing is to reduce the burden of out-of-pocket (OOP) healthcare payments for people by providing subsidies and extending prepaid programs. OOP payment is termed as the weakest and most unfair payment approach for health care from the perspective of protection against risk.

OOP payments can affect access to and utilization of health care services. It limits the progress toward universal healthcare coverage. OOP and high medical fees will make members of the households to face catastrophic health expenditure (CHE) when the household's OOP payment exceeds the capacity to pay then the household will experience CHE. Then CHE becomes the major challenge for the households, especially those in low- and middle-income countries like Nigeria. Here, CHE will affect the health of all the household members, and can result to a cycle of poverty in health. This is why poorer households are often forced to borrow money, sell assets or property, reduce consumption of food or resort to making savings to pay for their health care expenses, thereby, causing them extreme poverty. WHO considers CHE and the Fair Financial Contribution Index (FFCI) as useful indicators of equity in household financial contribution to health systems.

Millions of people around the world suffer from financial hardship as a result of OOP healthcare payments. According to WHO report, about 44 million households and more than 150 million individuals all over the world encounter CHE every year. The increasing costs of health care and the challenge of achieving equity in the financial contribution to health systems globally have raised concerns in communities on how to finance health care systems. To this end, WHO has declared financial risk protection as a major component of universal health care coverage.

Health-care financing is termed as one of the core components of health systems and most health care sector reform measures address health financing issues like mobilization of funds, distribution of financial risks, allocation and utilization of services, as well as provider payment incentives. Ultimately, good governance is what will determine the proper roles and functions of financing health care systems that are well integrated with the provisions and regulations of quality. Good governance will ensure that health care services will provide stable public, private, and voluntary sectors health care services that are capable of developing universal health coverage for all within affordable and sustainable financing frameworks. It will also strengthen health financing methods with improved financial management systems. Here, emphasis is placed on enforcement of rules and regulations that are based on accurate and reliable financial data and information management. Therefore the focus of good governance should be on detailed financing functions, collection of funds, pooling of resources, purchasing and adequate payment for health care services. These financing and payment mechanisms should be regulated effectively with checks and balances so as not to incur high administrative acts that can affect effective and efficient allocation and utilization of scarce resources toward Health for All.

WHO has identified three kinds of visual limitations that affect the effectiveness of health care financing mechanisms. These visual limitations are:

1 Turning a blind eye to corruption , this is a clear example of bad governance,
2 myopia and

3 tunnel vision,

Good governance requires oversight, clear standards, and the ability to hold providers and payers accountable for their actions. Where these do not happen, it becomes unlikely that health systems will work effectively. This means that services will not be delivered, and the health status will not improve. Poor governance weakens the quality of services and the acquisition and spending of public funds. Corruption destroys the foundation of health-care finance by diverting funds collected, thus, undermine procurement rules in the purchase of inputs. Corruption allows funds to disappear between the point of collection and points of delivery. For example, health workers can successfully steal petty things like drugs, light bulbs**,** food and others. Stealing these petty things is also robbery. Apart from these, corruption includes underperformance by health-care providers where money is paid for little or no work which amounts to spending money that has no impact. Addressing these problems will produce clear rules, oversight, and enforceable discipline for those who violate public trust.

3.3. Catastrophic Health Expenditure and Fair Financial Contribution Index

The household capacity to pay (CTP) is used to determine the percentage of households facing catastrophic health expenditure (CHE). WHO attributes 40% of the household CTP as a suitable threshold for CHE. The CTP is therefore, income of the household minus its subsistence expenditure. The total expenditure of the household will represent effective income because it reflects the accurate purchasing power of the household. The subsistence expenditure is calculated using the household total expenditure on food. For CTP, it is calculated by subtracting the subsistence expenditure from the total expenditure. This will also give the ratio of OOP health care payments to the CTP which will amount to the household's financial burden due to health payments. In all, if the calculation is equal to or more than 40%, then, that household is considered as facing CHE.

3.3.1 Fair Financial Contribution Index (FFCI)

This is an indicator one can use for measuring fairness in health financing. The range of this index varies from ***0 to 1***, and the fairer a health financing system is, the closer the numerical value of this index will be to ***1***. In assessing households' impoverishment due to health expenditure, two indicators of the index measurement, fairness in financial contribution index (FFCI) and the percentage of households facing CHE will be used. The World Health Organization defines a well-functioning health financing system as one that raises adequate funds for health in ways that will ensure that people can access and afford needed services and are protected from financial catastrophic health expenditure (CHE) as well as from impoverishments that are associated with having to pay for health care services. Health financing has three key functions: revenue collection, pooling of resources, and purchasing of services. Programs that will improve health financing will work at multiple levels so that they can strengthen all the three functions in both public and private health sectors. At the policy level, program partners should work with country governments to strengthen the governance frameworks, including regulations, policies, and organizational structures of that country so as to manage health financing services efficiently, effectively, equitably, and with adequate quality. Programs should build the local capacity in other to track public and private health spending. At the health facility levels, programs will strengthen the capacity for budgeting and financial management.

4.0. CONCLUSION

Health-care financing as a core component of health systems should address health financing issues like mobilization of funds, distribution of financial risks, allocation and utilization of services, as well as payment of incentives. However, comprehensive information on health financing such as costs, prices, and expenditure should be readily available. Health financing system should raise adequate funds for health in ways that will ensure that people can access and afford needed services. This will protect people from financial catastrophic health

expenditure (CHE) as well as from impoverishments. It is thus essential that those making policies should have solid understanding of the principles of economics and also how local factors influence the behavior of individuals, government and private entities.

5.0. SUMMARY

The three key functions of health financing revenue collection, pooling of resources, and purchasing of services work in multiple levels to improve health financing and strengthen both public and private health sectors. The resources needed for an effective public health system depend on private, as well as public, financing. A variety of mechanisms are used to achieve a combination of public and private health care financing contributions. The "right" amount of health care financing a nation can spend for the populace is a political decision which reflects the social and economic value the nation places on health. This affects issue of how well health care workers are paid in comparison to other professions. It also affects the supply of physical and human resources for health care in the society. Virtually all developed countries have recognized the importance of national health and the role of health care financing in guaranteeing successful health care financing policies.

6.0. TUTOR MARKED ASSIGNMENT

1. Explain how CTP of a household is calculated?
2. Explain the fate of a household if CTP is equal to or more than 40%?
3. Give three functions of health financing
4. List the determinants of catastrophic health expenditure
5. Explain two implications of out-of-pocket health expenditure in health care service

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MODULE 1 INTRODUCTION TO HEALTH FINANCING

UNIT 3: LAWS OF HEALTH CARE RESOURCES ALLLOCATION AND THEIR ECONOMIC CONSEQUENCES

CONTENTS

1.0 INTRODUCTION

This section will examine the laws guiding resource allocation as well as the governance issues in health financing. It looks at comprehensive information on health financing and expenditure as well as the limitations that affects health policy analysis. It will also examine the ethics of managing public finance and health, health-financing decision processes and concerns.

Barriers in demand are as important as supply factors in deterring patients from obtaining treatment. Many developing countries focus on promoting health care utilization as an important policy to improve health outcomes and to meet the obligations to make health services accessible. However, many laws and policies focus on improving physical access rather than focusing on the pattern of health care service utilization related to demand. Understanding the determinants of demand for health care services will introduce and implement appropriate incentive schemes that will encourage better utilization of health care services. The health-care consumers have very little idea of the marginal valuation of the particular treatment received. The consumer is very often not paying the full price for that treatment because the cost is frequently covered, at least in part, by insurance or government. These will mean that the traditional approach to demand does not work very well for health-care services and the supply side is problematic.

2.0. OBJECTIVES

By the end of reading this unit, students will be able to:

1 Know the economic consequences of decisions made in resource allocation
2 Identify the focus of health financing policy
3 Identify the factors that affect the availability of critical care resources in communities
4 Examine how health policy analysis can strengthen health financing governance at all levels.

5 Understand the usefulness of the laws of resource allocation in health care systems

6 Know the rules guiding need, use, and demand in health care services

7 Know the factors that influence utilization of health care services

3.0 MAIN CONTENTS

3.1 Laws of Health Care Resource Allocation

The economic consequences of decisions some countries make in resource allocation are the major issues that determine health care economics. Every country needs to address issues that will initiate reforms that are capable of changing positively the health needs and the economic results of previous decisions made. A country should compare the extent to which its national health expenditures have consistently succeeded in reducing the rate of cost increase in the health care services of the populace. However, there are several laws that guide the resource allocation of a nation. These laws are expected to enable policy makers to focus health financing policies on mobilizing and pooling financial resources in such a way that the allocation of the resources to the health care providers will be carried out in an equitable and efficient way. These laws include:

1 Sutton's law: Willy Sutton specialized in bank robbery. He robbed banks in such a way that fascinated journalists and an interview was organized to find out the reasons he had for robbing only banks. When he was asked," why do you only specialize in bank robbery?" In his reply, he said "Well, that's where the money is". His expression during the interview is currently used by health planners to show that health care services will emphasize the aspects that are better financed. This law translates the idea that if more funds are available for treatment services than preventive care services, that prevention of diseases will be relatively underfunded. That will mean that treatment services will receive greater emphasis than prevention.

2 Capone's law: Al Capone was a well-known gangster who with his colleagues planned the division of Chicago. In their plan, he arrogated the southern part of Chicago to himself while his colleagues took the northern side. The law explains that resources are allocated according to mutual interests. This expression in the health context means that planning in health care service will reflect the interests of providers and not that of the general public. The law further explains that the concept of macroeconomics planning serves the interest of the general public at the expense of that of the individual patient.

3 Roemer's law: *This law believes that* hospital beds, once built and insured, that the beds must be filled to capacity. That the supply of hospital beds is a key determinant of health service utilization, especially if the public has health insurance benefits that cover hospitalization. Consequently, the law believes that it is only by changing hospital payment systems with incentives that will reduce utilization rate. For example, the law explains that hospital bed supply and occupancy are usually reduced with the introduction of out-of pocket and diagnosis-related group (DRG) methods of payment. The law believes that encouraging incentives that will enhance both increase in the hospital bed supply and utilization of services, are crucial determinants of the efficiency and effectiveness of health care financing and planning in the health industry.

4 Bunker's law: *The law believes that the more* there are surgeons in a health care system, the more the health care system will generate surgeries. This means that the greater the number of surgeons employed in a health care system, the more the number of surgeries they will perform and the less the number of referrals they will make to other health care professionals. The law has however, modified its belief by including that the exclusive functions of caregivers and gatekeepers discourage referrals. The law explains that the regimented health care functions of professionals and gatekeeper in a health care system will limit referrals and self-referral to other specialists in professional organizations and

governments. These monopolies in functions the law explains limit health care financing, training opportunities and licensing for some specialists.

The law emphasizes that a country's national health financing policies and strategies can only be effective if refocused and made operational in order to contribute to the revitalization of the primary health care systems. This can be achieved by adhering to the guiding principles of health financing like revenue collection, pooling, purchasing, and public finance management. In this way, services will be extended to the poor population groups. The law clearly explains that by observing the guiding principles of revenue collection, that the out-of-pocket expenditure in total health care will be substantially reduced. This will discourage catastrophic and impoverishing expenditure as well as limiting the chances of people foregoing care. The law acknowledged the need for a reliable source of funding that will enhance resilient service delivery systems. This law believes that revenues for health care services should come mainly from prepaid sources like the budget.

The law views pooling as essential in the extension of universal health coverage that will benefit all population groups. Giving separate schemes for formal sector employees must be avoided because such will have strong fragmenting and distorting effects and will contribute to unequal access to health care services, which will be difficult to overcome. The law sees community based health insurance as not a solution for increasing financial protection of the population or as capable of generating financial resources needed in essential health care services.

The law commends purchasing mechanisms as useful means of channeling funds where they are needed. Purchasing enables health care providers to initiate quality and efficient services that will guarantee equity in health care services of a country. Public finance management is viewed as the basis for reducing the limitations in effective channeling of funds. The law posits that public finance management is a necessary output-based budgeting to enhance health service delivery availability, and health financing reforms that will prevent low budget execution rates, late disbursement and others. One immediate way of enhancing health care

coverage is to encourage free health care policies for specific population groups. This should involve a comprehensive package so as to build strong institutional capacity. Therefore, the law believes that the decisions made in resource allocation to health care systems will determine whether negative or positive health outcomes will be recorded. Hence, reforms to adjust for changing health needs and the economic results of previous decisions are necessary to encourage positive health outcome.

3.2 The Ethics of Managed Care

The current revolution in healthcare financing has transformed some of the traditional assumptions of medical ethics. The most important change here is the departure from a dyadic doctor–patient relationship to provider-consumer relationship. Doctors in the new dispensation are transformed into 'providers,' while patients into 'consumers'. Others are termed as 'third parties' and as many persons as possible that are interested in the relationship can join.

In the ethics, marketplace transactions of the managed care will concentrate on the physiological interventions provided. Health care is seen as an industry which will radically transform all healing processes by physiological interventions that will take place in a defined period of time. Here, physicians are seen as technicians, while patients are the recipients of the technology, and both are likely to be strangers to one another. Medicine is converted from a human service to a commodity that should be purchased. In the interest of efficiency in the economy, all the transformations are necessary. In the current managed care, there are suggestions that health practices should be subjected to ethical scrutiny. Certainly, some schools of thought feel that most of what is going on is neither ethically justifiable, nor serve the ends it was purported to serve. The transformation of medicine from that of a profession to that of a trade has been justified as a cost-saving measure to increase consumer choices by advertising to lower costs. The value that was placed on doctors' autonomy where

consumers have very little choice to know the types of health care services they are given despite paying for the health care service received has been abrogated. One recurrent problem which the health market is yet to address is the wrong investment opportunity where some amounts of money can be siphoned away from service delivery into the pockets of top executives and shareholders. Nonetheless, the market solution has not addressed this point but has only succeeded in lowering costs without adequately addressing quality of service, distribution and allocation of services.

The ethical physician is certainly not satisfied with a system that has been designed to limit his authority in the type of care given to his or her patients. Realizing that resource allocations are limited, the ethical physician will endeavour to provide health care services to patients without compromising integrity. Many of the practices of managed care are deceptively unethical. For example, the policy prohibiting physicians from discussing treatment options with patients. Such policies do not enhance consumer choice, but rather, will reduce patients' autonomy thereby, compromise their informed consent. Thus, the physician is made to play the role of a double agent where disclosure will not be entertained.

Many other practices of managed care are slightly unethical. For instance, the distorted advertisements where health workers use inadequate disclosures on health care services. Some of these practices limit effective health care service by discouraging competitiveness in practice. Managed care is therefore, an ethically unstable response used to reduce health care financing dilemma in health care systems. This means that managed care should be subjected to thorough ethical evaluation before use because a just society should give accountability to its citizens.

3. 3 Need, Demand and Use

3.3.1 Need

The term need is used by both health and non-health professionals in different and varying contexts. Jonathon Bradshaw defines four ways in which need is perceived such as:

1. Normative need, based on professional judgment (such as the need for medical treatment)
2. Felt need, which comprises individual's perceptions of variations from normal health
3. Expressed need, which can be the vocalization of need or how people use services
4. Comparative need, based on judgments by professionals as to the relative needs of different groups

The population's ability to benefit from health care interventions is used as a working definition of need. It is therefore important to distinguish between the need for health, and the need for health care. The former includes health problems where there is no realistic or available treatment, and which do not enlighten the planning of health care services. This is the epidemiological approach to health care needs assessment. Need is assumed to exist when there is an effective and acceptable intervention, as well as the potential for health gain. The ability to benefit from health care can be influenced by several factors including:

1. the epidemiology of the disease
2. the effectiveness of interventions (Need for redefining needs)
3. Health and Quality of Life Outcomes

Therefore, a comprehensive needs assessment requires an assessment of evidence of effectiveness.

3.3.2 **The Demand for Health Care Services**

Demand for health care services is the expression of felt need, which is the services that people ask for. Demand is influenced by factors such as :

1. Illness behaviour which is itself influenced by age, gender, education, and socioeconomic class
2. Knowledge of services
3. Influences from the media.
4. the supply of services, which is itself influenced by the use of guidelines, and evidence of clinical and cost-effectiveness.

From the laws of supply and demand, demand for health care increases with supply or accessibility, thereby making demand a generally poor proxy for need. It is necessary to note that need, supply and demand all overlap to a degree as shown below

Individuals make choices about medical care. They decide when to visit a doctor when they feel sick, whether to go ahead with an operation, whether to immunize their children, and how often to have checkups. The process of making such decisions can be complicated, because it may involve accumulating advice from friends, physicians, and others, weighing potential risks and benefits, and foregoing other types of consumption that could have been financed with the resources used in purchasing medical care. This section presents some simple tools for describing these choices and making estimates of the effects of certain factors, such as prices, incomes, and health status on demand for health care services.

Economists have employed two alternative models for describing the way individuals make choices regarding health care utilization and related decisions. A simple approach, which will be used for the most part of this section is to term health as one of the several commodities which individuals have well-defined preferences, and to use orthodox consumer theory to investigate the determinants of demand. **The question now is: do individuals have preferences for health, or for health care?** One can argue that in general, health care is only valued to the extent that it improves health and that health should be nascent in the description of consumers' preferences. Realizing that demand for services is easily observed and quantified, so recording between the two concepts is required.

A second approach to be used in analyzing health care choices is the use of

Intertemporal model of consumption decisions which views health as a stock variable within a human capital framework and that health care use can certainly have long-lasting effects. The idea of health care as representing an investment in health is popular here. This approach has been pioneered by Grossman (1972) in a model in which individuals consume health care not because they value health per se, but because it improves their stock of health, which is used as a productive resource. Cropper (1977) extended Grossman's model to account for the disutility that illness causes on individuals, and to examine the differences in the demand for preventive and curative care as well as the dynamics of demand over people's life cycle. Inherent in human capital theory, these models value health care services because of their potential to improve productivity. While this is clearly one outcome of better health, the consumption value of improved health status suggest that such measures are at lower limits.

This section will equally describe the demand for health care services using an orthodox static utility-maximizing framework. The first issue to be addressed here is the appropriate choice of goods that will enter the utility function. It is therefore, natural to think that individuals will have preferences for health care services directly depending on their health needs and the ability to pay for health care services. Since these preferences will change, there is the need to make the utility function state dependent. Alternatively, if individuals have preferences for health, health care services will then be demanded only as an input into the production of health, and the level of demand for services would be determined by the extent to which the services satisfy the individual's underlying preference for health. Preferences for health will be independent of health status, and health care demand will change if the onset of illness change the extent to which medical care services improve health. The second approach here can be used to examine the effects of health status, income, and price on the demand for medical care.Owing to the existence of health insurance, many health care services are now provided.

At little or no monetary prices, this model will suggest that demand should be infinite, or extremely high. Indeed, excess demand by some insured individuals is a problem in many industrialized economies, but in the developing countries, the concern is underutilization .

The main reason for the underutilization here is lack of supply, especially in rural areas. Though in some cases, even when clinics and services are available, utilization rates are also low due to no pecuniary costs for the consumption of the medical services and also its poor quality. With this in mind, travel costs and quality variations can be as well included into the model of demand. It is necessary to recognize that the demand for medical care is not constrained to a choice of how much, but also to what kind. This is why individuals can choose to visit any hospital, clinic, or traditional healer, as well as how often to do the visit. The knowledge of these demand patterns will enable policymakers to target services more effectively. Therefore, information on demand can be used for social welfare services.

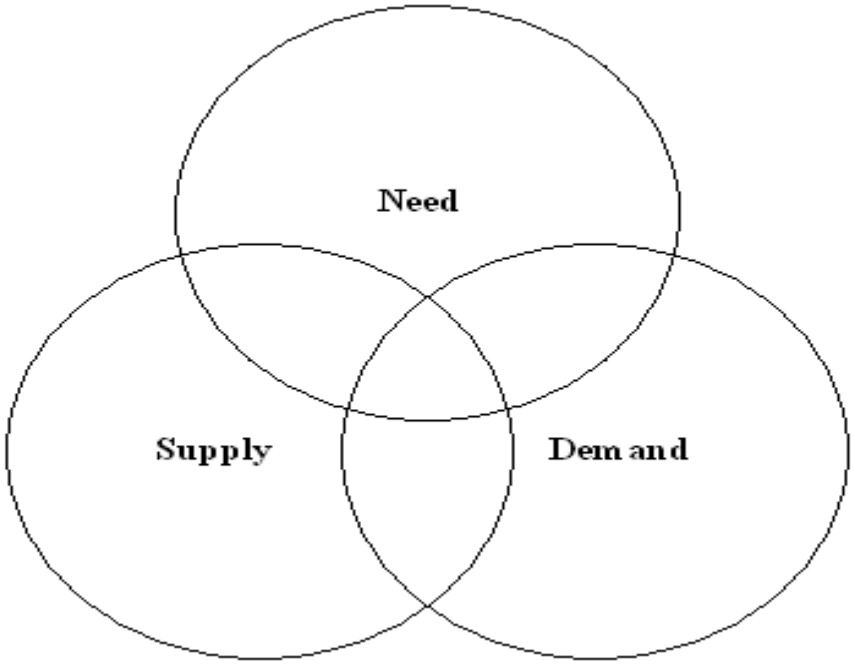
Some quality improvements can conceivably reduce the demand for health care by improving the health status of individuals. For example, higher quality care service will reduces the need for repeat visits, and the demand for care will fall as quality increases. It is thus necessary to remember that when examining demand functions, certain parameters are considered fixed, such as health status (changes that shift the position of the demand curve). Thus, other things being equal, higher quality will shift the demand curve out, but it will also improve health status such that the demand curve will shift back and even further. These shifts will be problematic when estimating the effects of quality on health care demand. In examining the relationship between pricing policies for health care and the effects of quality on demand, the simple argument is that if the higher quality shifts the demand curve out, then higher prices will be charged, for attaining the same or a greater level of effective health care, thereby, mobilize more resources for the health sector. Here two points can be deduced:

1 First, increases in quality are not free, and so when more resources are mobilized through cost recovery, at least a portion of these resources (and perhaps all of them) will be spent to attain and maintain the higher level of quality.

2 Second, there is no reason why higher prices will create higher-quality levels. Only if the resources made available through higher charges are channeled into quality provision will this occur.

The question now is: Do high medical care charges represent the most equitable and efficient means for providing quality improvements for consumers of health care?

Figure showing how Need, Supply and Demand Interact



Courtesy of Authors

3.3.3 Measurement of Utilization of Services

Utilization of services can be measured by the following:

1 Service-based activity, such as referral rates, bed occupancy, intervention rates

2 Population-based activity such as prescriptions, immunization coverage, surgical rates

Factors that influence variations in utilization are:

1 Statistical factors (incomplete data, bias, etc)

2 Demand factors (age/sex composition, morbidity rate, illness behaviour)

3 Supply factors (availability of services, professional judgment); which are usually the main reason for variation in use of services.

In the **inverse care law,** Julian Hart describes the relationship between need, use and availability of services, as the availability of good medical care which tends to vary inversely with the need for care in the population served. This law operates fully where medical care is mostly exposed to market forces, and operates less where exposure to medical care is reduced.

3.3.3 Price Determination

Looking at how supply and demand interact in a competitive market to determine the price and recognizing that firms with market power set prices, the condition that marginal revenue equals marginal cost will be used in price determination. Unfortunately, in understanding the market for health care, these tools are not very useful. To understand why, imagine a hotel room is to be booked, you can just call up any hotel and find the price of a room. Or you can go to the hotel's website and check prices and also find information about the hotel online. Now compare this to a hospital. It is much harder to get information about prices, by simply walk in or checking through the website. You can in fact find out prices for hospital procedures if you look hard enough. For example, there is a website that allows you to find charges for different procedures you can "shop" for, say, different types of knee surgery. But these charges will not necessarily reveal the true price to a consumer because the costs of

doctors and other inputs are not included. Also, if a consumer has insurance coverage, meanwhile, the individual needs to find out what portion of the bill will be covered by the insurance. However, finding out the price of a procedure is quite complicated.

The questions now are: How are hospital prices determined? What are the prices that are considered? Which of the prices are considered? The price the consumer paid or the money received by the hospital? Most important prices are determined by the interaction of some big players, including the government, insurance companies, and pharmaceutical companies. This interaction gives the sources of income for hospitals and doctors. Hospitals and doctors get paid by insurance companies, households, the government and few individuals. Because of these , the government is a big player in the health-care market. Government decisions determine the demand for health-care services. Governments do not take prices as given especially for the elderly and disable. In such cases, the government sets rates for certain procedures, and health-care providers respond. In other cases, the government is involved in negotiations with pharmaceutical companies.

Insurance companies provide additional sources of revenues to the hospital. If a consumer is policyholder and admitted in a hospital, the insurance company will reimburse the hospital for part of the cost of care. It will also reimburse the doctor directly. How much of the cost that is reimbursed depends on the insurance policy. If the consumer undergoes an operation, the amount of money the insurance company will pay the hospital is set by an existing agreement. As a result, hospital administrators face a complex set of repayment schedules. Reimbursement rates for a given service will depend on who is buying the service, whether Medicaid, Medicare, or insurance company and each has different payment rates. Because of these differences in reimbursement rates, doctors and hospitals sometimes decide not to provide services to certain patients. For example, doctors sometimes turn down Medicaid patients because of their low rates. This practice of requiring prepayment is part of a trend in the health industry. Hospitals are adopting the policy of advance payments so as to improve their finances, thereby making medical care contingent on upfront payments. Naturally,

hospitals bill consumers after receiving care but now, due to increasing bad-debt and charity-care costs, hospitals are asking patients for money before they get treated. Hospitals have turned to this practice because of the large number of patients who do not pay their bills after treatment.

4.0. CONCLUSION

Demand is influenced by the supply of services, which is in itself influenced by the use of guidelines, and evidence of clinical and cost-effectiveness. As with the laws of supply and demand, demand for health care increases with supply or accessibility, making demand a generally poor proxy for need. Need, supply and demand are influenced by service-based activity, such as referral rates, bed occupancy, intervention rates and population-based activity such as prescriptions, immunization coverage, surgical rates. Variations in utilization of health care services are due to a number of factors including statistical factors such as incomplete data, bias, and demand factors like age/sex composition, morbidity rate, and illness behaviour. Supply factors like availability of services and professional judgment will also form further reasons for variations in use of health care services.

However, knowing what planning is will not be enough. It is also important to know why there should be a health care plan in the first place. As health care providers, the aim is to achieve the health goals of health care consumers. Primarily, there should be a clear understanding of what needs to be done and why there is need to do it. The need to prioritize and make decisions realizing that there are limited resources for the implementation of the health care services should not be ignored. Consumers are generally concerned to have the maximum access to the best possible medical care and so are prepared to accept whatever information providers advance to them whether correct or incorrect.

5.0 SUMMARY

Due to informational problems for households, market power by suppliers, and government intervention, the market for health care cannot be analyzed by using standard supply-and-

demand curves. Spending on health care today has an effect on your health status in the future. In that sense, this spending is an investment. The demand for health services, like other goods, depends on your income and the price of the services. Unlike your demand for many other goods, your demand for health services is influenced by the costs of health insurance. Also, unlike the case for many other goods, consumers who demand health services are relatively uninformed about the service they are buying. The production function for health takes inputs, such as doctors, nurses, and machines, and produces health-care services.

Where there are multiple sources of health financing, it becomes more difficult to develop effective national planning to prevent inequity between socioeconomic groups. When multiple agencies are involved in health insurance or direct government granting systems for specific services, there are gaps (inadequate coverage or access) in services, usually for politically, geographically, and socially disadvantaged sectors of the population, who may have the greatest needs. Under such circumstances, public health services very often will become oriented to provision of basic services for people excluded from health benefits because of lack of health insurance. This places a great financial burden on public health services, which are generally underfunded in some clinical services.

6.0 TUTOR-MARKED ASSIGNMENT

1. Explain one of the immediate ways of enhancing health coverage
2. Explain how health care financing has transformed some of the traditional assumptions of medical ethics
3. List the factors that determine the price and quantity of health care
4. Explain the factors that determine the demand for health care services
5. List three reasons why the conventional supply and demand model may not fit the market for health services
6. Explain how demand for health services is influenced by age
7 Explain why spending on health is an investment

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MODULE 2 **HEALTH CARE FINANCING ADMINISTRATION**

Unit 1 **Effective Organizational Change in Health Sector**

Unit 2 **Approaches for Reaching Universal Health Coverage (UHC)**

Unit 3 **Health Service Development and Planning**

UNIT 1: EFFECTIVE ORGANIZATIONAL CHANGE IN THE HEALTH CARE SECTOR

CONTENTS

1.0. INTRODUCTION

Changes in health care financing, telecommunication, service orientation, and office efficiency are consecutively creating a more conducive environment for the health industry to thrive well. A major stimulus in favor of the smooth running of the health systems is the progress toward consumer-driven health care. This is now a very common orientation because the financial transaction between physicians and patients is now more direct than before. Patients now have more choice and authority in spending for health care. Also using commonly managed health care settings is becoming less and less as patients can now make preferences for the type of health care to use depending on cost. The public can now actively participate in decision-making on the type of tests, treatment, medications, and other services that should be available to them. The extreme burden in financing health care has resulted in the need to create new ways for consumers to obtain health care at a lower cost.

2.0 OBJECTIVES

By the end of this section, students will be able to:

1 Understand the limitations in public health care services
2 Know the factors that positively influence health care services
3 Understand the factors that encourage effective organizational change in the health sector
4 Understand why there is resistance to change in the health sector
5 Understand the strategies that regulate WHO guidelines for health care development
6 Know how health care can produce health

3.0 MAIN CONTENTS

3.1. Intensive Care Administration and Global Strategy for Health Care

WHO has issued a Global Strategy that will act as guide for Health Care Development. This strategy stressed the importance of efficiency in use of resources as a vital tool in health care development. Here, WHO recommends preferential allocation of funds to primary and intermediate health care services, especially for the underserved individuals in the rural areas. In developing countries, there is need for reallocation of resources to help in strengthening primary care and adopt new technology and health programs that will be cost-effective in the anticipated benefits.

In countries where there are multiple sources of health financing, it will be difficult to develop effective national planning strategy. In such situation, the government should provide supplemental funding to prevent inequity between the socioeconomic groups as well as between urban and rural populations. This is necessary because if multiple agencies are involved in health insurance or in managing government grants for specific services, the services are bound to experience gaps in form of inadequate coverage or access in services as a result of those who are politically, geographically, and socially disadvantaged in the population. These may even be those who may have the greatest need for the services. Under these circumstances, public health services will now be concerned with the provision of basic services for people who have been excluded from health benefits probably, because they do not have health insurance. This will place some financial burden on public health services, which are generally underfunded when compared with clinical services. Therefore, national health insurance should be encouraged for the disadvantaged individuals like the elderly, the disable and the children. The issue of universal coverage for health care should not be neglected when considering financing health care for rational allocation of resources, though this will depend on adequacy of the total financing and the allocation policies to promote equitable access to services. It is evident that misallocation of resources in the health

care sector will be wasteful and even lead to counterproductive health system where there may be excessive funding of tertiary care to the disadvantage of the primary care.

Intensive care administration focuses on efficiency, effectiveness , affordability, and time savings are enormously important to consumers. This is why currently, the use of cellular phones, wireless technology, the internet, e-mail, text pagers, and video phones are used so as to makes it easier for patients and their physicians to communicate with each other. Using these devices , they can have face to face interaction anywhere, at any time at little or no cost. Therefore, health service providers are encouraged to provide additional services through prompt follow-ups. Initially , before the intensive care administration, these services were not traditionally possible. Physician – patient initiated contacts can influence health outcomes positively by ensuring that there should be adequate follow-up on some tests done on patients' abnormalities, behaviour and lifestyle changes, exercise and stress management, medication options so as to be guided on specialist referral on the tests, and also treatments. The arrays of the benefits emanating from the use of intensive care administration are almost inexhaustible . It is certain that easy access to physician-patient communication of any sort is an opportunity to revolutionize affordable preventive health care for the public.

3.1.1 Health and Development

Basically, as countries develop economically, the structure of economic and social organizations changes. At first, the country's industrial sector will grow at the expense of the agricultural sector both in employment and in value added. Subsequently, the service sector will increase as a share of the economy. With the population becoming more urbanized, the traditional social structures will be less important, and the distribution of income will change. The effects of these changes in the social structure on health outcomes will be ambiguous because when the nature of health problems changes, the effect on the overall health status of the population will be difficult to ascertain. For example, changing from agriculture in the

rural area to engage in industrial production in the urban area will reduce the incidence of most infectious diseases that are common in rural areas like schistosomiasis, but such a decrease in incidence may be associated with an increase in diseases related to pollution, including lung cancer. There is also ambiguity on effects of rural-urban migration. Urban populations have lower transportation costs than the rural populations. Generally, they have greater access to health care providers and other public goods than the rural populations but they have to contend with the health problems of overcrowding such as contracting an infectious disease like tuberculosis. The urban populations have greater chances of developing increased stress levels than the rural populations. Notwithstanding the ambiguous effects of development on health, increases in income, and in the consumptions of goods and services that improve health will result to a positive relationship between health status and the stage of development.

There are two important consequences of the improvements in health.

First, as populations become healthier, they also age. This is known as the demographic transition, and this occurs for two reasons. There is a direct effect as the health of individuals improves, they live longer. In this case, at a given birth rate, the net addition to the population increases yearly, as well as the older people in the population. Second, the fertility rate, that is the average number of children born by a woman in her life tends to decline. This is an indirect effect of the change in health status on the population structure. This is because it stems from individual choices on the number of children desired. If the behaviour of an individual is unaffected by improvements in health, then birth rates will increase as the number of deaths at birth fell. Therefore, factors that influence better health, greater economic security, and fertility rates will be diverse and interconnected. If the reason for bearing children is to use them as productive resource, then, reduced child mortality rates will mean that fewer births are required to sustain a desired level of income security. However, adults prefer children as a productive resource, and children born have a certain probability of being productive, that is, remaining alive till their youth. As this probability increases the child mortality rate falls, the number of births are expected to fall in line with such a reduction, with the number of children living remaining unchanged.

However, if there are costs associated with birth and, in practice, with rearing an unproductive child until age 5 or 6, then as the survival rate increases, the average cost of obtaining a productive child falls, and the optimal number will increase, suggesting that the average age of the population could fall. However, an additional factor to consider is the risk faced by adults when the probability of the pattern of the demographic transition over time depends on the timing of both the mortality effect and the fertility effect. The fact is that some individuals can use a given amount of income more effectively to improve their health than others. Better-educated individuals, in particular, can transform given quantities of resources into higher levels of health, so that educational attainment can be included as capable of improving the explanatory power of a regression.

3.2 Health Care as an Input into the Production of Health

The sole purpose for the consumption of some goods and services is to improve health. The most obvious of these are the services provided by health care workers. There are other important services that are consumed. For instance, the nursing care services that are provided by parents to children. Here, we are interested in the basic technological constraints that determine the way resources can be transformed into health care so as to better health status of individuals. It is often necessary to analyze the effects of medical care on health outcomes at aggregated levels by relying on gross medical care expenditures per capita and variables such as the number of clinics, hospital beds, and physicians per capita as useful explanation. However, it is obvious that the direct outputs of medical care are both multiple and diverse, and as such, aggregation will hide important microeconomic effects like efficiency and equity.

In the basic microeconomic theory models, the alternative production possibilities available to a production unit usually an organization are described by a production function $\mathbf{y} = f(x)$, which gives the output $\mathbf{y}$ produced for a given combination of inputs, $\mathbf{x} = (xi, \ldots, \mathbf{x})$ which is a vector. This helps in deriving a cost function, $\mathbf{c(w, y)}$, that gives the minimum cost of producing $\mathbf{y}$ units of output when the vector of prices of the

inputs is set at ***w = (wl, ... , wj).*** There are a number of complications that can be introduced when considering the production of medical care. First, the hospitals, physicians, clinics, and other facilities which serve different purposes and produce different goods. And within each of these units, multiple goods are produced, such as immunizations, family planning services, emergency surgery, treatment of on-going chronic diseases, and so forth. Second is the way in which these institutions produce different products and services which are patient-specific.

The same service rendered to different individuals may cost different amounts, depending on the health of the individual, his willingness and ability to respond to treatment, and the like. Some patients are more costly to treat than others. Also, the production and delivery or marketing of the services are more intimately connected than with the standard consumption goods of textbooks. In ordinary production theory, the production decision is more or less independent of the marketing decision. Textbooks can be produced first, and then sold to consumers at a price and in a fashion that best suits the seller. Health care, in contrast, is produced and consumed coincidentally. When once it is allocated to a patient, it is not possible for that patient to transfer the good to another patient, as can be done with a textbook. This means that, because good health is a fundamental input of an individual's capacity to work and live, the organization may or may not correct a poorly distributed health care by redistributing income through the tax and transfer system, even when a sufficiently sophisticated system exists.

These observations will lead to what we call intensive and extensive margins in the production of health care. Production is increased on the intensive margin if the inputs used in the treatment of an individual, or group of individuals, are increased. Alternatively, production is increased on the extensive margin when the number of patients and types of cases increase. Therefore, measures of the health care production on the extensive margin will include hospital admission rates, number of women provided with birth control services, and the rate of immunization. At the same time, measures of production on the intensive margin include such things as the average length of hospital stay per person admitted, the number of

drugs per person treated, and the number of booster shots received by immunized children after the first shot.

Like many other economic production processes, increases in output in the intensive and extensive margins will first show some decrease and then increase in marginal and average costs. For example, when considering the production of hospital admissions, the first of the admissions will be very costly, because of the construction of the hospital, but additional costs to the patients will be relatively low. It is only when crowding starts in the hospital to an extent that the individuals' hospital stays will be ineffective that the economic cost for admissions will again increase. Also, in another example using the education of women on birth control, it will initially be costly when the programme is started, but if in the urban areas, the marginal cost for providing the information and services will be quite low. It is only when much of the urban population has been covered, that the extension to the rural population becomes more expensive. The marginal and average costs for increasing production on the extensive margin will increase. Using the examples of the intensive margin to explain further for the length of a hospital stay, there will be administrative costs that will be associated with the initial admission, but these will diminish for a given admission rate, that is, for a given extensive margin choice. Here, longer stays will increase crowding to the extent that marginal and average costs will be increased. Similarly, the costs of drugs will rise as increasingly expensive treatments will be used in succession.

However, when viewing marginal and average productivity and costs, it is important to keep other inputs constant. It is plausible that the underlying productivity of health care will not change but will increase in other inputs such as income, education, and nutrition, may have reduced the effect of medical care. Therefore, the links between medical care and health outcomes, suggest that at an aggregate level, medical care has a low marginal productivity. For example, if one has little chance of avoiding infection because of living where there is lack of sanitation, then the productivity of medical care may be very high, because of being constantly ill. But if one lives where there is clean water and good sewerage, then the

productivity of medical care will be low, because there will be no much need for medical care. These differences are seen on both the intensive and extensive margins.

3.3. Health Care Markets

There are five health care markets that can be analyzed. These are:

1 Health care financing market
2 Physician and nurses services market
3 Institutional services market
4 Input factors markets
5 Professional education market

Health care market should not be seen as something homogeneous that can be bought and sold in a single market. The point is that the simple framework of supply and demand will not be sufficient enough as to understand health care market. Besides, there are many types of markets. Each as listed above has its own peculiarities and features. There are three reasons why inefficiency exists in each type of market. **First**, is the presence of market power, **second** is the various information problems, and **third** is that some aspects of health care have the characteristics of a public good.

The assumptions of textbook models of economic markets can apply in health care markets, though some important deviations may exist. This is why some countries have risk pools where healthy enrollees subsidize to take care of the rest. Insurers usually cope with the adverse selection which takes place when unable to fully predict the medical expenses of enrollees. Adverse selection destroys the risk pool. The features of insurance market risk pools, such as group purchases, preferential selection "cherry-picking", and preexisting condition exclusions are outlined to cope with adverse selection. Insured patients are usually less concerned about health care costs than they would have been if they were to pay for the

full price of health care they received. The resulting moral hazard will increase the costs of care, as demonstrated by the famous RAND Health Insurance Experiment. It explains that insurers use numerous techniques to limit the costs of moral hazard, including imposing co-payments on patients and limiting physician's incentives so as not to provide costly care. Therefore, insurers now compete for choice of service offerings, cost sharing requirements, and limitations on the type of the physician to consult.

Consumers in health care markets suffer from lack of adequate information about what services they need to buy and which providers will offer the best value proposition. Health economists have stressed the inherent problem with supplier induced demand, where providers base treatment recommendations on economic gain, rather than on medical criteria. Researchers have also documented substantial "practice variations", whereby the treatment will be based on service availability rather than inducement and practice variations. Some economists argue that demanding doctors to have medical license to practice will put some constrains on their inputs, thereby inhibit innovation, and increases cost to consumers. The problem is that this practice will only benefit the doctors themselves and not the patients. Let us now examine other related issues that can help to improve the health care systems. These are:

.1 **Medical Economics**

This is concerned with using economic theory to examine the phenomena and problems that are associated with the health care financing and its application to the second and third health markets. That is, the markets of physician and institutional service providers. It explores the contributions of physicians and other institutional service providers on the welfare of consumers during services. Typically, it looks at the cost–benefit analysis of pharmaceutical products and cost-effectiveness of various medical treatments to consumers. It emphasizes decision-making in medical treatment for consumers and for health policy makers using mathematical models to synthesize data from biostatistics and epidemiology for the overall benefit of the public.

2 Mental Health Economics

Mental health economics incorporates various subject matters, ranging from financing all health care services including labour and welfare. Mental health directly considers the economic principles that will positively enhance individuals' abilities to contribute to human capitals. For instance, it examines mental health problems of individuals that can alter the human capital accumulation of the affected individuals thereby render them dependent. The externalities here will include the influences that affected individuals in the surrounding human capital, such as those in the workplace or in the home. Therefore, the overall economy will also be affected.

Mental health economics will present some challenges to researchers. For instance, individuals with cognitive disabilities will not effectively communicate their preferences for health care services. These are the challenges that are encountered in placing value on the mental health status of consumers, especially, in relation to the individual's potential as human capital. Another challenge is in using mental health economic studies as means of evaluating consumers' productivity. However, statistics from such studies will not capture the "presenteeism", that is, when consumers are at work with lowered productivity level to quantify for the loss of non-paid working time, or capture externalities such as having affected family member to care for.

Studies by Petrasek and Rapin (2002) have shown that mental health care will reduce the health care costs and the efficacy by decreasing employee absenteeism and improving functioning to demonstrate the decline in mental health care services. However, there are three main reasons for the decline. These are given as:

1 stigma and privacy concerns,
2 the difficulty in quantifying medical savings and

3 physician incentive to medicate without specialist referral

Therefore, it is suggested that improvements could be made in mental health by reducing cost of health care services, promoting active dissemination of mental health economic analysis, building partnerships through policy-makers and researchers, as well as employing greater use of knowledge brokers for active services.

3. Behavioural Economics

Studies have recommended behavioral economics as an important factor in improving the financing of health care systems. Behavioural economics in health care is relevant because health care systems have been inherently underfunded and this has introduced difficult situations for all consumers. Game theory has been relevant in explaining the strategic interactions among groups of rational decision-makers. This theory serves as a useful tool for modeling and guiding difficult decisions in health care financing. For instance, in the doctor-patient relationship where a doctors prescribe medication like opioid pain-killing which is highly addictive to a new patient who presents with pain just to minimize cost,. Here relieving the patient's pain and suffering is the doctor's primary objectives. Moreover, doctors consider patient's satisfaction scores on cost of treatment when deciding whether and how to treat the patient. From the patient's perspective, the patient can present with real pain to the doctor, thereby, requesting pain-mitigating treatment legitimately, or can present with fake pain just to satisfy an existing addiction or for some other illicit purpose since the drug may not be so costly. However,, the physician may suspect that the patient may not be in pain, and because there is no objective test to prove the patient's true pain levels the physician will go ahead to prescribe opioid to satisfy the patient's desire. Also because the patient's satisfaction scores will impact on the doctor's wages, the doctor may over-treat the patient if and when the patient asks for certain treatments in order to receive better satisfaction scores and to continue to be relevant.

A standard solution technique utilized in game theory is Nash Equilibrium, where the players agree on a common strategy. Here, neither the physician nor the patient will achieve a favorable outcome by exchanging actions. Using Nash Equilibrium in this difficult situation

is helpful in enabling both the physician and the patient to take decisions that will lead to cooperation and trust between them. This is vital in the financing of health care service. In applying the Nash Equilibrium technique to the doctor's decision to prescribe opioid, if actually the patient has real pain, the rational choice for the doctor will be to treat the patient to generate funds whether the patient has fake pains or not. Therefore,if the patient has fake pain, it is still in the doctor's best interest to treat the patient so that the doctor elicits a good satisfaction rating that will attract the patient again. Otherwise, the patient's low satisfaction score if denied treatment will result in poor reputation and loss of income for the health system. Therefore, the doctor will prescribe opioids regardless of whether the patient needs them or not. The patient who is addicted to opioids will demand these opioids for a short-term satisfaction notwithstanding that the long-term use will eventually harm the patient's health and society at large. Such a behaviour will lead to wasted resources and poor outcomes for the patient. The mutual best response, which is the Nash Equilibrium outcome for this game is for the patient to present with real pain, and for the doctor to prescribe narcotics, with payoffs in the form of patient- doctor satisfied relationship , high satisfaction score so as to be professionally rewarded.

For the situation where the patient has 'fake pain' and the doctor prescribes narcotics will appear the same as the described Nash Equilibrium. However, there are differences that will cause this situation not to be a Nash Equilibrium. That is when the doctors are bound to a code of medical ethics where some regulatory restrictions will be applied. In this case, prescribing addictive drugs to someone not in need can lead to long term consequences such as increasing the opioid epidemic. In the present situation, the patient will end up unsatisfied as the patient's health condition will worsens because of opioid addiction and the doctor's reputation could become jeopardized.

4.0 CONCLUSION

Demand for health care services is a luxury good, and as income increases, a higher share is devoted to health care. If the expansion curve bends toward the consumption axis, we say that

h is a necessity, and its expenditure share falls as income rises. For an individual with a particular health status, changes in the price of medical care will affect demands for ***c*** or ***s***, and probably both. An increase in the price of services pivots the budget line inward in **(*c*,*s*)** space, requiring a reduction in consumption of at least one of the two goods .There are two related reasons for reduction in health care demand. First, the quality of medical care services may be sufficiently low that demand, even at low prices is discouraged. The second is that consumers may well incur significant additional costs in consuming medical care above any monetary prices charged. These costs include, for example, forgone income and travel costs.

It is natural to hope that restricting the supply of doctors might reduce consumption. However, it is usually expected that reductions in supply will increase prices. To fully understand these possibilities, interactions between supply and demand should be examined.

physicians' services will lead to an increase in the quantity that physicians desire to supply. The offsetting income and substitution effects are the possible changes in the competition and opportunity costs between equilibrium prices and quantities obtained in medical care markets. Therefore, economic consequences of decisions made in resource allocation are the major determinants of health care economics in the reforms for changing health needs.

5.0 SUMMARY:

One of the important ways in which medical care differs from other goods and services is that the consumer needs are uncertain. Individuals make choices about medical care. They decide when to visit a doctor and the type of treatment to accept when sick. The process of making such decisions can be complicated, because it may involve accumulating advice from friends, physicians, and others. Individuals are exposed to substantial risks because of uncertain medical care expenditures which may be very large.

Most market failures in the health sector derive from the presence of externalities. However, one of the more fundamental public goods in any market, including that for health care, is information, and the issue of information has been linked to public good. Having established how markets may fail to provide efficient levels of goods and services, alternative policy

interventions are used to correct the distortions. Policy interventions are divided into market-improving instruments such as establishing property rights, adjusting prices with taxes and subsidies, and also direct public provision with welfare-based approach to project appraisal. Willingness to pay is positively correlated with income, and it is the appropriate measure of benefits when distributional weights are derived from the welfare functions. The distinction between the provision of insurance and medical care in both demand and supply controls efficient implementation of policies in public and private systems.

6.0 TUTOR MARKED ASSIGNMENT

1. Give the main reason why supplier induced demand exist in health care market
2. list 5 types of health care markets you know
3 Describe four ways of conceptualizing need
4. Explain what you understand by the cohort survival function (or survival curve)
5 Explain two issues that contribute to epidemiological transition
6 Describe two categories of public good
7 . Explain three reasons why inefficiency exists in health care markets
8. Describe four ways of conceptualizing need

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MODULE 2 HEALTH CARE FINANCING ADMINISTRATION

UNIT 2 APPROACHES FOR REACHING UNIVERSAL HEALTH COVERAGE (UHC)

CONTENTS

1.0 INTRODUCTION

This section will use Universalist approach to examine the coverage of universal health coverage. This requires understanding how the state budget is considered as a means to fully or partially subsidize the enrollment of this health programme. This is particularly necessary for the poor as well as for other vulnerable population groups. This requires building strong institutional capacity. This area will further show the extent to which Nigerian government

has functional policies and plans that will address health care financing so as to move closer to UHC (Universal Health Coverage) realization. Issues including how and where sufficient funds for health can be raised, how to overcome financial barriers that prevent several individuals from accessing health services and how to provide an equitable and efficient mix of health services will be evaluated.

The problem with charges in health care is that of suitable criteria for exempting the poor from payments. The argument that those who can afford to pay should pay for the full cost of the health care services used makes it difficult to classify those who should be exempted from payment. However, there are non-governmental health providers who will exempt the poor. There is need to identify the factors that motivate them to do this. Also, it is necessary to state that it is incorrect to assume that the only costs for health care services are the charges which are levied by health providers after treatment. It is important to know that there are additional costs such as time away from other activities . This is very important when considering free payment for the vulnerable groups.

2.0 OBJECTIVE

By the end of this section, readers will be able to:

1 Understand issues associated with effective financing of UHC
2 Identify the factors that can enhance UHC
3 Understand how health care financing is administered
4 Describe the economic consequences of decisions made on resource allocation
5 Know why health insurance should begin with universal coverage

3.0 MAIN CONTENTS

3.1 Improving Universal Health Coverage

The way a country finances its health care system is a critical determinant for reaching UHC. This is so because, effective financing mechanisms will determine whether health services exist or not. It will also show the extent to which services are available and affordable to the populace. The main thing is whether people can use health care services when they need them. This can be achieved by a well-planned combination of all health care financing mechanisms which include:

1 Tax-based financing
2 Out-of-pocket payments (OOPS)
3 donor funding
4 Health Insurance
5 Exemptions
6 deferrals (to delay until a later time at times, for 6 months) and
7 Subsidies (money paid by Government to reduce cost of services).

The main thrust is on how to generate adequate revenue for financing health care services for diverse groups of people, without much task on the formal sector workers. In Nigeria, the formal sector workers are the main group of people that make contributions in form of tax and/or agreed upon deductions. These contributions can easily be accessed from source and they constitute 47% of what the working populations contribute. The situation is different with the informal sector. About 53% of these working populations do not effectively pay due to ineffective tax collection system as well as inefficient formula for calculating the amount to be collected. There is also lack of transparency, dedication and confidence among those mandated to collect the fund.

There are however, three known approaches of how to improve universal coverage in areas where those employed in formal sector are small in number. These include:

1 Contributory schemes; like community-based health insurance (CBHI) where households in a particular community contribute to the Insurance Scheme

2 Tax-funded health scheme, where health services for those outside are funded from tax

3 Introduction of a "one-time National Health Insurance Scheme (NHIS) premium payment policy" as an avenue to protect those not employed in formal sector from financial risk.

It is necessary to note that health system financing is an essential component of UHC but progress toward UHC requires coordinated actions across health systems. Therefore, attention should be paid to strengthen human resources for health.

3.2 Coverage of Informal Sector and Poor Population Groups

One method of enhancing coverage in the rules for managing public finance is to focus on funding free health care policies that will eventually expand to a more comprehensive package. There is need to realize that public health finance is not limited to the boundaries of specific segments of public health such as prevention, protection, or promotion. The focus of public health finance is on the entire public health system, including other programs and interventions. Therefore, health insurance should begin with universal coverage so as to avoid focusing financing on formal sector employees alone. Considering budget as the means for fully or partially subsidizing the health care needs of those outside the formal sector employment will be benefit the poor and other vulnerable population groups. Achieving this will require strong institutional capacity because the economic consequences

of decisions made in resource allocations are the major determinants of health care financing systems.

Each country is expected to cope with issues that affect reforms so as to adjust with changing health needs and the economic results of previous decisions that negatively influenced health care. There is need for a country to evaluate the total national health expenditures spent on health so as to compare with what other nations of the world spend. This process will enable the country to know whether to reduce or increase the cost of health care since health care expenditure involves money spent from all sources for the entire health sector.

Knowing the total expenditures for health care and how the funds are spent are the most fundamental issues in health planning. The allocation of resources to achieve improved health care requires a skillful planning process so as to balance spending and ensure equity for all socioeconomic groups in the society. This is important so as to achieve the role financing systems will play in making health care universally accessible.

3.3 Critical Care as a Product Line

The critical care division of the hospital has been described as a business plan for hospitals. The plan to isolate the major sources of critical care patients and their relatives is meant for either profit or loss for the division. In analyzing this using the cost accounting methods as employed by the hospitals, hospital-to-hospital transfers have been found to generate more revenue than the critical care. The health care providers, by focusing on source of revenue as a unique "product line" has enabled them to promote these services more widely than that of the critical care.

However, sustainable "products" vary from institution to institution. Factors that will show whether a particular service offered by the intensive care unit (ICU) is profitable or not include: the availability of critical care resources, the presence or absence of a network of

hospitals for referrals, and the organizing structure of the hospital . Looking at the gap reimbursement creates in critical care services for consumers especially those under the Medicare , will cause many institutions not to achieve profit from their ICU services regardless of identifiable sources of revenue. Nevertheless, to discourage losses as the health care market evolves, reimbursement should be discouraged, but rather, efforts should be made to identify viable sources of revenue that will benefit the critical care units.

3.3.1 User Fees When Income Is Reduced as a Consequence of Ill Health

Some health policy issues are controversial when user fees are to be paid despite reduced income as a result of ill health. The case for charging critically ill patients for health services has been viewed as the cause of frivolous use of health services even at most critical periods. The fact that patients abandon health services because of how to pay for services suggest that such patients if allowed to pay at least the marginal cost of what is provided, there is every likelihood that they may access services to improve their health.

There is an argument that critically ill patients make frivolous use of health services because of not being sure whether the health services they paid for will improve their health or not. There is also an assumption that charges do not deter critically ill patients from accessing services, but rather, that it is the negative relationships they experience from the health care providers that deter them. Both assumptions are questionable because only the sick who perceives the seriousness of his or her illness knows when and how to seek services. However, the costs of health care services include the following: charges which are levied by providers, the amount of time away from other activities, the type of interaction experienced during treatment and these constitute the drawbacks experienced in health care services. That is why some schools of thought believe that factors such as: hours of service, travel time, waiting time, perceived seriousness of health problems, availability of health providers and of drugs, attitude of

workers on patients treated, are what determine the consumers' decisions on when, how and where to seek health care and not the price of the services.

The fundamental problem with health care charges is the conditions to be used to identify those to be termed as poor so as to exempt them from paying user fees. The issue that those who can afford to pay should pay the full cost of the health services they received makes it very difficult to exempt some people from payments. Using differential fees to protect the poor is often very difficult to apply. However, the willingness to accept payments in kind by waiting until resources are available for payment like what traditional healers do is encouraged. This is necessary because willingness to pay may not automatically mean ability to pay as some individuals may prefer to enter into a debt with high interest rates rather than face the humiliation of claiming exemption. Therefore, user fees and out-of-pocket payments which are the main mechanisms for health financing are inequitable forms of financing that deny the poor from financial protection and expose them to catastrophic health expenditures.

3.3.2 Equity in Health Care Financing

Determining the capacity to pay is essential in measuring equity in health care financing. Theoretically, a household's capacity to pay is equivalent to the total resources that a household can mobilize for purchasing health services, including savings, selling assets, and borrowing from financial institutions, relatives , friends and others. Practically, several factors can be used to measure household capacity to pay. These include:

3.3.2.1 Gross Income or Net Income

Pre-tax gross equivalent income is used to determine the capacity to pay because one is expected to move from the pre-tax to the post-tax income distribution. If taxes and social security contributions are regressive, the poor will pay a higher percentage of their income than the rich. In neutral, which is proportional to income and progressive, the poor will pay a lower percentage of income than the rich. In most developed countries, gross income is used

to monitor the progressivity of health-care payments. Health care payments however, will include public taxes and compulsory insurance as well as private sources of voluntary prepayment and out-of-pocket payments. There is a strong argument that using net income instead of gross income to measure the household's capacity to pay is an adequate indicator and that redistribution is not the purpose for the payments.

3.3.2.2 Household Income or Expenditure

The choice between income and expenditure often depends on the accuracy of available information. In most developed countries, income data are linked to the registration system and as such, are more reliable than reported expenditure from the household. But in most developing countries where registered income data are not available, reports on household expenditures are considered more reliable than reported income. However, there is an argument that in developed countries, expenditures instead of current income should be used because expenditures are viewed as less liable to short-term fluctuations, and therefore are useful in approximating the ability to pay.

3.3.2.3 Household Non-food Expenditure or Non-subsistence Spending

According to World Health Organization (WHO) report of 2000, household non-food expenditure should be used as a proxy for capacity to pay. The argument for using non-food expenditure is that a household should first meet its basic food requirements although other basic needs such as shelter and clothing as well as the need to be fulfilled, before considering its contribution to a health system.

Food is considered as a household's basic need. A rich household will spend more money on food than a poor household. Therefore, the same subsistence spending for all households with

adjustment for the size of the household will take place. The 1.25 dollar a day poverty line, as stated by the World Bank and the national poverty line can be used as subsistence spending. To reduce bias on the classification of subsistence spending , WHO has advised the use of food expenditure of the household whose food share of total household expenditure is at the middle of all households in the country so as to determine the household's ability to pay. Today, many consumers receive poor quality health services even when they pay the out-of-pocket. Therefore, carefully designed and implemented health financing policies can help to address these issues.

4.0 CONCLUSION

Several mechanisms are used to determine equity in health financing. Variations in policies across nations are to be expected, but this will pose some challenges in the efforts to promote universal health coverage and provision of public health initiatives. Encouraging evidence-based approach in resourcing public health initiatives will be of great benefit to health system outcomes, as expenditures for public health services for populations will be differentiate from health care delivery point of view. There is need to identify factors that will affect supply and demand as well as household's ability to pay user fees. Offering quality health services will encourage the realization of the Sustainable Development Goals which emphasize among others, eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality, empowering women, reducing child mortality rates, improving maternal health, combating HIV/AIDS, malaria, and other diseases, ensuring environmental sustainability, and developing a global partnership for development.

However, there are strategies that will enhance some guiding principles to encourage progress towards UHC. These important strategies can be used to check the extent to which appropriate incentive in the environment can be created.

5.0. **SUMMARY**

Experience demonstrates that progress in health services is possible in countries with high income levels. Such countries have achieved essential, equitable and effective progress in health care services. A country's health financing functions will provide valuable lessons that can help in realizing equity in resource allocation. Labels such as "social health insurance," "community insurance" or "tax-funded systems" have little meaning by themselves if the complex choices and options they contain are not made available for the individual's benefit. These are expected to pool resources to the extent that available funds will be used to ensure the availability and quality services to consumers.

Health financing reforms cannot simply be imported from one country to another given the unique context of each country and its starting point in terms of health financing arrangements. Therefore, the underlying causes of performance will differ in each country and as such, these causes are what the reforms will address in the health financing strategy.

6.0. TUTOR MARKED ASSIGNMENT

1. Differentiate between common goods and club goods in public health
2. Identify the main challenge of allocating and financing common goods
3. List 7 health financing mechanisms that can improve Universal Health Coverage
4. What do you understand when goods are termed as non-*exclusive* and *non-rivalrous in nature.*
5. Explain the guiding principles that encourage the progress of UHC

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MODULE 2 HEALTH CARE FINANCING ADMINISTRATION

UNIT 3 HEALTH SERVICE DEVELOPMENT AND PLANNING

CONTENTS

1.0. INTRODUCTION

National health planning stages will be examined from different perspectives. The costing scenarios adopted by health planners during funding of health services will be explored. The essence of health planning during health care financing is to presents steps will move health

care services forward. Health planning opens entirely new vista of opportunity that will improve the quantity, quality, and effectiveness of health care services. The methods adopted during planning will help to develop administrative mechanisms that will create positive relationship by accommodating the views of all health providers during financing of health care services. The relationships are so important in the modern day health systems. Efforts to understand health problems and approach them with realistic solutions in orderly fashion will lead to successful planning in financing disease control and prevention programmes . This is the basis and key to health planning. The ability to identify problems and their solutions, as well as to evaluate the successes and failures will result in planning and developing healthy health care systems.

This section examines planning processes and clarifies approaches that enhance planning heath care financing. It assesses why planning should become an intellectual exercise and be focused on its functions in improving health care financing in health care services. This is necessary because health care, as physical planning, has developed without adequate attention to the health factors that affect effective health care financing. Unless corrected, this fragmentation of planning may lead to competition between diverse plans with the result that instead of aiding in the area of carrying out of effective health programs, it will concentrate on fixing splintered health objectives that may be of little benefit to consumers. This section will explore how some unwarranted expectations on planning can create problems in the financing of the health industries. Here, the current and emerging consumer health needs, resources, and opportunities in health care systems will be assessed.

2.0 OBJECTIVE

After reading this section, readers will be able to:

1 Identify different stages of health planning
2 Know the causes of poor planning processes
3 Identify the factors that encourage successful health care financing policies
4 Know the benefits of planning in health care financing
5 Describe end of life issues

6 Learn the financial characteristics of planning

7. learn the relevant theories in health care planning

3.0 MAIN CONTENTS

3.1 Health Service Planning

Health planning represents the principal step in the process of initiating and accomplishes things that are necessary in improving the health status of individuals in the societies. Health services planning can mean different things to different people when applied to health care and design of a health facility. Therefore, health services planning have been described as a process that will appraise the health needs of the population in a geographical area. It is this process that is assumed will determine how the needs can be met in the most effective and efficient manner through the allocation of available resources. Ultimately, all planning in health is expected to identify the needs of the target population so as to determine the best method and means of meeting the needs. However, within the health sector, there are unique planning processes that defer from what obtains within the industry. These unique processes include:

1 Emotional dimensional planning

This aspect of planning deals with the rates of utilization of health care services provided to consumers. The fluctuations in demand are very important to health providers in considering the fact that health service providers deal with the life-and-death situations in the hospitals.

2 Complex relationship planning

Complex relationships are crucial in the health care industry realizing that the industry is made up of several professionals with various training methods. These professionals operate at virtually uncoordinated manner at cross-purposes because of the characteristics of the variety of different consumers they handle.

3 Financial characteristics planning

This type of planning deals with making the decisions on how the end-users on consumption of services will pay for the services provided. This decision varies according to the type of health care service the consumer received.

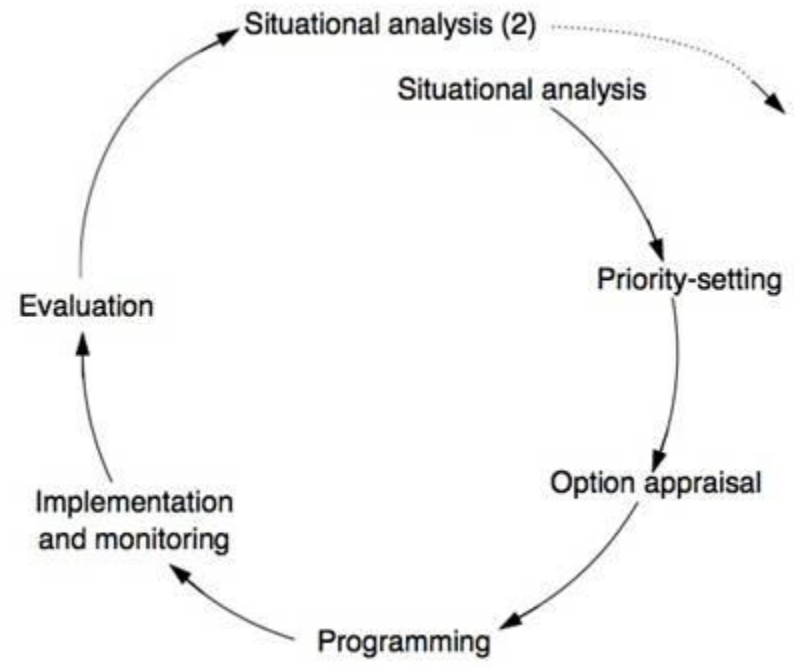
4 Diversity of functions planning

This planning takes place because of the consideration that different professionals perform different functions and therefore, there is the need to coordinate the multiple functions simultaneously so as to benefit the consumers. The functions that need to be coordinated range from, providing health care needs at hospital and community levels so that each professional sees his or her role as contributing to the safety of the public. Health care needs vary according to the age structure and health profile in a population. The likelihood of people seeking care is determined by a range of social and cultural factors and will impact upon demand for care. Therefore, likelihood of people receiving care is determined by a coordinated policy decisions that will influence the volume of activity in the health system.

3.1.1 Health Service Planning Stages

Health Planning Theory Cycle by Johnson, 2008, will be used to explain the health service planning stages. Planning as a collective effort by professional groups or organizations is used in modifying the behaviour and conditions of other people and occurs in various stages. The health planning cycle elaborates in details the step by step processes in planning. It is structured to allow health providers to successfully identify and solve health problems in

orderly manner. The steps include: health situation analysis, setting up objectives and goals, assessment on the resources, setting up priorities, formulating plans, programming and implementation, monitoring and evaluation of the programme. These stages will be briefly discussed below.



Stages of planning

Courtesy of Authors

1 Situation Assessment

This is the analysis of the current health status of individuals in a country. It is also the knowledge of what the effects of the expected trends in a country's health and health systems are. This usually involves information gathering to ascertain the extent of determining the health status or illness profile of the population.

2 Priority Setting

This entails the identification, balancing and ranking of the priorities made by stakeholders. This step is involved in setting up goal and objective. It is also known as setting the direction of a plan. Despite the goals and objectives, this step is also involved in establishing standards and criteria for comparative purposes between plans and alternative.

3 Identifying Effective Strategies

This is the identification of strategies that are capable of addressing the priorities. This step concentrates on the assessment of the resources. Assessing the current resources will determine the feasibility and practicality of proposing alternatives. The proposed alternatives should be within the boundaries of available resources. In this planning stage, material availability, capital and human resources will greatly affect the final alternatives in the planning.

4 Costing Scenarios

This will involve estimating the costs of different scenarios that will correspond to the priorities or strategies in the short, medium or long term activities. As planning can be from multiple alternatives, choosing the right one will be greatly affected by resources factor. Therefore, setting up priorities is crucial particularly in a situation

where limited resources are major issue. Here, highest priority in the alternatives will be properly ordered in the allocation of available resources.

5 Resource Planning and Budgeting

The estimations of resource and inputs including human resources, medical devices, medical equipment, pharmaceuticals and facilities that are necessary to provide the expected services for consumers are made. It is also the expansion of a detailed plan that is expressed in formal and measurable terms that will show how these resources are acquired and used for the health services during a specific time period. In order to achieve the goals and objectives as stated earlier, the crucial step will be to formulate systemic and written plan . This will include a detailed specification of the plan at macro and micro levels. All the steps in the formulated plan will contain the components of the resource requirements as well as the expected outcome of the planned steps.

7 Programming and Implementation

This involves the translation of the National Health Policy/Strategy/Plan and in some cases, the Medium-Term Expenditure Framework through which annual operational plans that will form the basis for programme implementations in health care are made. Plans formulated earlier in the other steps will be converted into programmes for approval and implementation. It is necessary to note that good implementation is greatly affected by proper administrative support.

8 Monitoring and evaluation

This is the progress of all the reviews that are undertaken periodically by stakeholders and supported by established reactive mechanisms for all corrective actions. The performance evaluation is based on a set of indicators that possess well defined baselines and targets. Monitoring refers to daily assessment of the functions in the

programmes. Evaluation is assessment of the whole programmes with particular emphasis on the final outcome.

3.1.2 Health Service Planning Approaches

There are various approaches to health service planning .These approaches range from problem solving, long-term, short-term, operational plans to narrative approaches. These approaches use relevant objectives to realize equity in the plans to fund health care services in all the geographical areas. There are two broad types of this planning. These are:

1 **Activity planning: this** is concerned with the maintenance of existing health situations and the setting up of implementation timetables for monitoring all services to consumers.
2 **Allocative planning:** this emphasizes the changes in health care and the making of decisions on how scarce resources will be used for effective and efficient health care services to the public. It also prioritizes the activities to be undertaken.

There are many reasons for initiating a health services planning process in health care financing. The reasons can emerge from, the community members, interested organizations or individuals needing health care services. However, the problem with health care plans is the influence of the political, social and economic classes in the unfair and selfish recommendations they make for the health care industries. Therefore, health planning for

health care financing should be undertaken bearing in mind the anticipated changes arising from the following:

1. Health care reforms which will change the accountability and decision- making techniques within the national health scheme NHS

2. **Health care needs** which will change with time according to the age structure and health profile in the population served. For example, with the increasing numbers of old people, this will mean that there will be an attendant increase in disability and illness in the society especially those with dementia, musculoskeletal and cardiovascular diseases, as well as sensory impairment where there should be increase in the funding. Therefore, the health and social systems will need to address the treatment and care of the increasing numbers of people with these health problems.

3. **Technological advances: these** will continuously challenge the resources in the health services. Technology and medical advances are the major drivers of health expenditure and they have the potentials to improve the outcomes and the efficiency of the health services. therefore, there should be increase in the funding.

4. **Evidence-base programmes**: these are the setting up of quality standards and recommendations for specific services that should require increased funding.

Usually, planners encounter some challenges in balancing the objectives with the relevant technical dimensions that will achieve the realities to which the planning is taking place. Some of these challenges planners are faced with include:

1 **Rising expectations of consumers**: consumers expect that the public services they receive should be more affordable, accessible, efficient, and consumer friendly in terms of service convenience and quality than what they get elsewhere.

2 **The demographic challenge**: with the ageing population and increasing numbers of people with long-term health conditions including serious disabilities there will be increase in health demand to an extent that can overwhelm the health providers in terms of management.

3 **The revolution in medical technology: New costs will be created** by increasing the services of NHS to prevent, cure and manage diseases, so as to alleviate suffering and extend life expectancy.

4 **Continuing variations in the safety and quality of care**: there will be the challenge of expecting an overworked NHS staff to provide care at the highest possible safety and quality in every place and at every time in particular through honest and open information on the outcomes of services achieved by health providers where funding is limited.

Table :5 Health planning terms and activities

Terms	Activity
Economic/development planning	National level activity aimed at steering the economic or development policies, primarily through public expenditure or fiscal policies
Strategic plan	Document outlining the direction that an organization intends to follow, with broad guidance on the implications for services or action
Business plan	Strategic plans prepared by business organizations setting out

	their direction, and usually providing income and expenditure projections
Regulatory planning	Activities of State planning bodies with planning guidelines for private sector activities
Service planning	Planning that focuses on the services to be provided. This is used to differentiate capital planning from other types of planning.
Capital planning	Planning that focuses on capital developments of an organization such as building programmes.
Project planning	Planning that will focus on discrete time-limited activities
Human resource/manpower planning	Plans that focus on the human resource requirements of an organization.
Physical plans	Plans that relate to the construction of elements
Operational plans	Activity plans that will detail precise timing and mode of implementation.
Work plans	Operational plans referring to the activities of a small unit or of an individual.

3.1. 4 Theories in health Care Planning

Theories in health care planning are crucial. They provide needed frame of reference for organizational systemic guidance which clearly draw the boundaries and parameters for each health service. Theories are important in providing fundamental concepts that have been developed by previous practices. Planning health care without theories can result to poor planning and this will have economic impact particularly in developing countries where there are constrains and limited resources . This means that without theories, planning and

implementation of good health care will be faulty because of political interference and myopic self-interest.

However, there are three main planning theories in health care. These theories will be briefly explained below.

1 The Rational Planning Theory

This theory is used in the planning phase of certain activities in health service. It uses comprehensive, systemic and analytical approach in the planning process. The theory helps in identifying problems, and chooses the best alternative for implementing, evaluating and monitoring the outcome based on the chosen alternatives. The theory is ideal for planning health care services because of its simplicity and apparent logic. Moreover, there are five principles to adopt when using rational planning theories during planning process. These principles are:

1. ends of reduction and elaboration,
2. designs and courses of actions,
3. comparative evaluation of consequences,
4. choice among alternatives and
5. implementation of the chosen alternatives.

Planners often encounter some disadvantages when using rational planning theory. These advantages include:

1. decision-making process as group based-decision
2. assessment accuracy as the sole factor for alternative solutions,

3 planners define the problem to be solved instead of the goal to be achieved

4 the theory is time consuming by using ten steps

There are also some advantages when using rational planning theory. These are:

1 Its comprehensive approach helps to generate alternative solutions to a problem and,

2 It helps to generate criteria for objective assessment of a situation during planning process.

3 It has accurate and complete knowledge of all alternatives solutions, preferences, goals and gives the consequences for the alternatives.

4 It has a non-political involvement,

5 The theory is surrounded with factors that guide planners during planning for health care financing.

There are ten major steps in rational planning theory. These include:

1 data collection,

2 analysis of data,

3 forecasting of the future context,

4 establishing goals,

5 designing alternatives,

6 testing the alternatives,

7 evaluating the alternatives,

8 selecting the best alternatives,

9 implementation, and

10 monitoring

This means that rational planning theory will focus on designing the alternatives, testing alternatives, evaluating alternatives and selecting alternatives prior to the implementation

process. The situation in which the steps in rational theory are applied in problem identification is known as *medical dessert*.

Regarding health planning in health care facilities, some countries have encountered many challenges in their planning. Specifically, problems exist in the distribution of health care workers due to the geographical disparities in the countries. Certain areas particularly rural communities and suburbs are usually isolated and undeserved with health services. This type of problem is known as *medical desert* because of the challenges that are faced in human resource management in distributing health care workers to certain areas.

2. Incremental Planning Theory

Incremental theory has been used extensively as an alternative theory to improve the shortcomings of rational theory. It works best in a limited period of time with limited data, information and resources. The number of options is usually less than that of rational theory of planning and sometimes, it can be influenced by political parties. This means that in the incremental planning theory, there is a partisan involvement, where planning occurs sometimes as a result of mere understanding among stakeholders. Here, social values may play a vital role in decision-making during the planning. Occasionally, prescriptive model is used in a situation where decisions are made when there is a consensus decision on how things should be. It is usually a quick change, and this will be in response to rapidly changing variable. Incremental theory is used in crisis situations where rapid decision is needed. In this situation, goals, value and alternatives are all considered together.

As with other planning theories, the incremental theory has its own shortcomings. These shortcomings are:

1 Incremental theory can only cover partial health planning that means it is not comprehensive.
2 Its focus is mainly on increments,
3 it does not look at a crisis or problem holistically.
4 Its main concern is on how to solve the current problems ,

5 Does not consider long- term problems.

6 It considers policies based on the past for the current practices ,

7 Data are usually scarce, and analysis is based on value.

8 It has a low understanding of management of situations like in disease outbreaks.

This shows that in incremental planning theory, analysis of a situation is not holistic. Though objectives and goals are set, but they are only for short- term purposes and not for long-term. Things of highest priorities are set, tackled and rectified first. Short-term programming and implementation plans are essential but, monitoring and evaluation are not of utmost priority because the emphasis is on current issues. However, if issues arise as a result of the planning process, the planning will only provide solution for the immediate problem. Incremental planning can be used in planning strategies for combatting tobacco smoking. The theory helps to introduce immediate strategies that will make tobacco less accessible and affordable.

3 Mixed Scanning Theory

Mixed scanning theory is a hierarchical method of decision- making. The term scanning refers to search, collection, processing and evaluation of information as well as drawing of conclusions which are the elements in decisions making. Mixed scanning contains rules for allocation of resources for all levels of decision making. It also contains rules for evaluation and the proportion of scanning will follow changes in the situation faced. Mixed scanning strategy is illustrated as scanning by satellites with two lenses which are wide and zoom lenses. In any decision making, mixed scanning allows for choosing a major strategy as well as a sub-strategy which is followed by detailed examination of options within the sub-strategy.

The steps involved in using mixed scanning theory in planning are listed below:

1 The continuous review of issues that have been happening, the identification of major issues that need detailed attention for future direction, and development of health services.

2 The selection procedure to sort out the fundamental issues that were identified by the review process which will be subject to detailed study and planning.

3 Detailed planning of the relatively small subset of issues selected for incremental.

Once the details of current situation are obtained, the health planning objectives are outlined to improve the current health situations that are faced. Mixed scanning strategy is a timely and effective decision- making process where allocation of resources is made to suit the needs at a particular point. Using mixed scanning strategy to implement a programme will promote monitoring of an action that has no improvement in the situation. Here, continuous monitoring is essential in health planning cycle because health care system involves rapidly changing environment that influences the health care demands and needs. Mixed scanning strategy believes that when one decision is taken against the other, that there will be relationship between the higher and lower organizational ranks. Those at higher ranks, especially the experts are more likely to focus on details that affect them and neglect the overall picture facing the administration. Hence, in the evaluation stage, mixed scanning strategy adopts a flexible method that allows various levels of scanning to adapt to specific situations.

3.1.5 **Concerns about health service planning**

The dilemma that resulted in the need for planning is the gap between available resources and health needs that led to making choices on how to effectively use scarce resources. Most times the plans made will not be implemented or are implemented but will not respond adequately to the needs of the populations. For example, the inequality in resource allocation between preventive care and curative care, between different social classes, between different geographical areas, between staff salaries and medical supplies, and between salaries of different cadres of staff has caused a lot of conflict in the health industry. If planning is to be effective in the near future, it becomes necessary to understand the reasons for these inequalities that can contribute to poor planning. However, there are factors that give rise to poor planning. These factors include:

1. **Submerging change under the planning process:** this happens when planning becomes an end in itself thereby, neglecting the real aim of effecting change
2. **technical failure to analyse needs** : this occurs when resources are inaccurately estimated.
3. **top-down fashion of imposing plans:** plans are carried out without the involvement of both the health-care providers and the communities in the decision taking.
4. **isolation of the planning process:** poor planning occurs when the planning process is isolated from other decision-making **processes** like budgeting and human resource planning.
5. **excluding politics during planning process:** this happens when the inherent political nature of the environment is not considered

There are concerns about the confusion and competition that are now emerging in the field of health service planning , which if not addressed will be detrimental in achieving the functions of planning. One aspect of this confusion is the proliferation of uncoordinated planning activities that are not related to health care. For example, planning treatment programmes together with vocational rehabilitation planning, mental health planning, health facility planning, and all the planning organized under comprehensive health planning without considering the specific technicalities in each service. Similarly, developing physical planning without adequate attention on the health factors. Unless this fragmentation of planning is corrected, it may result in carrying out health programmes with fragmented health objectives.

Another area of concern in planning is the case of unwarranted expectations that planning should solve all the problems of the health industry. Conversely, planning is now becoming an intellectual exercise which is not focused on the reality of its function of improving health care services. There is need to balance total health resources with total health needs so as to accommodate other areas with health implications. Therefore, it will be useful to distinguish between the three known types of planning activities which are:

1 agency administrative or programme planning,
2 interagency categorical planning, and
3 comprehensive planning.

These three factors will be discussed briefly below.

1 **Agency Administrative or Programme Planning**

This is the type of planning done by an agency for its programme activities . In the programme planning , programme objectives , standards of operation, and measures to accomplish efficiency are set to fulfill the agency's mission .

2 **Interagency and Categorical Planning:**

This is the type of planning which prepares, plans, and sets programmes for limited developmental objectives that will involve interagency relationships. Categorical planning is usually aimed at a single health program or condition. This is often the mechanism of choice for redirecting existing programs and the development of new designs of service.

3 Comprehensive Health Planning:

This entails the continuing planning process for people in an area which aims to assess the current and emerging personal and environmental health needs, resources, and development opportunities. It seeks to formulate goals, objectives, policies, and guidelines for long-range health resource development as well as to prepare plans and programs which will:

1 identify and evaluate alternative courses of action and the relationships among the activities,
2 specify the appropriate scheduling of such activities,
3 study other relevant factors affecting the achievement of desired health development and,

4 Provide an over-all framework and guide for the preparation of categorical and programme plans.

Health services and the problems solved by each planning process must be a part of the total social system. In this context, over-all development of an area becomes one of the broad areas of planning in the comprehensive health planning. In other words, comprehensive health planning must relate to the coordinated functional planning system for an area. While there is no single format for conducting planning, the following principles will assist communities and agencies in health care planning processes:

1 The planning functions must be under the direction and leadership of a health professional so as to reflect the views of important groups and stimulate the implementation of planning recommendations by influencing necessary political action including provision of funds. That means that the public and professional interests must be effectively represented in the formulation of policies, plans, and programmes.

2 Planning at every level and forms must be interrelated. The three forms of planning activities should be safeguarded by using separate delegations. While there is a recognized requirement for comprehensive health planning to provide general frameworks for health activities, there is the need to strengthen and expand the planning processes and competencies to categorize the programme objectives.

3 There is a necessity for a clear-cut definition of the area to be served by the comprehensive health planning agency. The area delineated for comprehensive health planning must represent an effective planning region that is not limited by the boundaries of political jurisdictions. Therefore, it

should be defined on the basis of the following factors: population served, the characteristics of the health service system, the setting in which it operates, and the problems to be solved. These factors which are related to geography may be difficult to define, given the variability of health problems and service areas/ communities. This means that comprehensive health planning agencies should identify a single region for which comprehensive health planning will be performed.

4 Comprehensive health planning is demanding and expensive process and, therefore, the full realization of its potential benefits, will require the employment of skilled professional staff with scientific, and technical capabilities.

5 The problems shed in the regions served will require special attention and handling by professionals. The principal focus of the origin of the problem should be the determinant factors in deciding the responsibility for the analysis and for recommending methods for handling the problem.

6 The planning agency should exert influence on the agencies and institutions with the power to give money, to license, to accredit training so that it will be clear when the recipient meets the recommended guidelines. Such will bring administrative, financial, professional, and legal pressures to bear on the agencies and institutions thereby make the planning process an instrument of programme implementation.

7 There may be the need to create new organizations or a combination of them for the purpose of comprehensive health planning. In the latter situation, it is important that guidelines for relationships, between the new

organization and the already existing planning bodies, should be clearly defined. Planning requires special attention on the part of the planners so that the social, emotional, and traditional forces which will make change difficult will be recognized.

8 One of the principal functions of comprehensive health planning is the encouragement for a strong agency programme planning. There should be shared functions which be dependent on others for success if effective programmes are to be achieved.

It should therefore, be understood that comprehensive health service is all encompassing and involves the systematic use of all services necessary to adequately finance the protection and promotion of health care of consumers. Comprehensive health service means several things to some individuals. To the individual with an acute disease problem, it means the health services necessary to cure the illness. To the bioscientist it means the most sophisticated treatment of pathology. To the general public, it means the convenience, affordability and accessibility of health care resources for daily requirements. It is therefore necessary that comprehensive health services should be interpreted in planning for personal and environmental health services within the context of the specific programme under consideration. The obligation placed on each professional , agency, or institution is to consider what can be done to meet the needs of the public. Functions that cannot be performed must be planned by establishing relationships with other providers. Such action will enhance appropriate utilization, and thereby achieve maximum efficiency in meeting the comprehensive health needs of the population. Therefore, comprehensive health service is a social service that will change with the health industry and technology serving human needs. The ability to provide health care in a better environment increases as the professional manpower and essential facilities are developed. This shows that comprehensive health service will be a beacon for leading the health profession to greater service.

3.2 Strategic Planning in the Health Care Industry

There has been a tremendous change in the health care industry. Significant changes have occurred and are still occurring in every day service. Given the unpredictability of how the health care market will change, the question is: is there any use for those in the industry to go through a strategic planning initiative? The answer is definitely yes, but the next question is: how will this be accomplished? To be successful in moving the industry forward, there is need for organizations to have proposals that will be based on the best future assumptions they can identify using strategic planning efforts. It is therefore, important to have key assumptions on how the services in the industry will be different from other services. Organizations then can describe what will be needed in future assumptions, so as to design a strategy that will bridge the gap between where the industries are today and where they will be to enable them achieve future success. The next question to ask is: if all the assumptions of the industry for future change are made, then what can the industry do to build an effective strategy for the realization of the assumptions?

It is true that the health industries are experiencing a lot of change which may be very strategic realizing that some of the developing countries have relative political participation in under- funding health care. There are some key assumptions that the industry can make that are inevitable irrespective of any potential political or regulatory shifts. If the essential assumptions in the health care industry are identified, especially in the area of disease prevention, then the industry will build response strategies accordingly. It is necessary to present the following ideas as examples of assumptions that could be considered in the healthcare sector for the next five years which could form the basis for strategic discussion. However, these ideas are not meant to be all inclusive, but just to demonstrate that there are fundamental assumptions that can be identified even in organizations where significant uncertainties exist. Let us use these examples to demonstrate how assumptions can be used in strategic planning:

1 **The Need to Provide Increased Quality Patient Care:** This idea for a strategic planning, will be focused for the next five years and will continue to be on the need to deliver highly impactful, cost-effective health care. Here, whether this assumption is driven by key stakeholder requirements or customer expectations, all that is required is that the successful players in the health care industry will be those that can generate healthy outcomes for their patients. Therefore, the strategic plan will be built around improved effectiveness and efficiency in delivering quality patient care. This will be the fundamental requirement in the future. There are no surprises here, because any strategic decision in the health care sector must begin with quality patient care. The point is that the ability to recognize health care outcomes will be the bases for any future success in the health industry.

2 Need for Continued Increase in Consumer population and demographics: The fact remains that the consumer population is going to increase in the next five years. That means that in future there will be more people needing care from the health care industry. That is, the health care industry will experience dramatic increases in patient populations and also a significant impact in the demographic shifts and this trend will continue for the next five years. The question is: how will these assumptions impact on the resources required for service delivery in the health care sector?

3 Need to Have Changes in Labour Supply: The assumption is that the health care industry has experienced growth in labour supply over some years but this trend is not expected to continue. Some schools of thought have postulated that the growth of labor supply should only be around .04 percent for at least the next decade and should even be smaller in the following decades. This is because the trend will be more of the aging workforce over the decades. This should change with the workforce

being more evenly balanced across age groups in the future. Now the questions are: How will this impact on the availability of skilled workers and their levels of experience in the health care industry? What will this mean in the method of recruiting and retaining the workforce?

4 **Need to Increase on Wellness and Prevention.** The assumption is that increase in nutrition innovation will be driven by consumers' demand for wellness. Patients will need counseling on weight management and diet therapies so as to be healthy. This will lead to increased focus on these services within the health care industry. Programmes like smoking cessation and fitness are already tied to health outcomes and will continue to be important in the future. The question here will be: How will this trend impact on the future services health care practitioners will provide? What quality of information will health care providers make available to their patients?

5 **Emerging Technologies in the Healthcare Industry:** The assumption is that in the next five years, the global health care industry will be a highly connected environment powered by large data networks, cloud computing, and mobile devices. Worldwide, there will be widespread increases in the number of connected health care networks that will provide seamless integration between care providers, patients, pharmaceutical companies, health insurers, and other interested parties. Strategic planning under this assumption will be patient-centered, affordable, and very innovative. These assumptions will need breakthroughs in technologies that will influence improved patient care and effective operational processes capable of moving the health industry forward. This will impact on the types of skills needed in the health industry in future.

6 **Rising Operating Costs Impacting on the Financial Viability of the Health Care Industry:** Stakeholders need to find out innovative ways of raising revenue and decreasing costs for consumers. They need to ensure that rising costs will not impact on the future viability of health care services. Therefore, there is need to change how to do business.

These assumptions could be discussed by the stakeholders of the health care industry so as to formulate the 3-5-year strategic planning. With proper discussion on the assumptions, dozens of additional assumptions that will improve the future of the health care industry will emerge. The fundamental issue is that even in an industry that is experiencing rapid and constant changes, there will still be the necessity to make future plans on how to move forward. The types of assumptions to make and how to use a strategic planning framework to transform the future of the health care organization are essential.

Another example here is the end of life issues which entails that the health care planning document that should be used will be the Physician Orders for Life-Sustaining Treatment form (POLST). POLST is designed to honour the end-of-life wishes of the patients. This treatment form contains accessible physician orders that will adhere to the patient's wishes and treatment goals. The patient is followed from home, to emergency services, and to a hospital or other facility. Not all countries have POLST programs in place but it is necessary for the smooth running of the health industry.

3.3 Health Development Funds

3.3.1 Global Health Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria is an international financing and partnership organization that aims to leverage and invest resources to end the epidemics of HIV/AIDS, tuberculosis and malaria so as to support

attainment of the Sustainable Development Goals. Global Fund raises funds in three-year cycles known as replenishments and the funding comes mainly from the public sector, with about 95% of total funding coming from donor governments. The remaining 5% of the funding comes from the private sector, private foundations and financing initiatives. As an international financing and partnership organization, the Global Fund mobilizes and invests more than US$4 billion in a year to support programs run in developing countries .It is therefore, the world's largest financier of AIDS, TB, and malaria prevention, treatment, and care programs having disbursed more than US$41.6 billion to support these programs.

Therefore, Global Fund is a financing mechanism rather than an implementing agency. Programmes are implemented by in-country partners such as ministries of health and Global Fund staff members will monitor the programmes. The implementation of the programmes by Global Fund requirements is that all programmes should be supervised by Country Coordinating Mechanisms, country-level committees that consist of in-country stakeholders including a broad spectrum of representatives from government, NGOs, faith-based organizations, the private sector, and people living with the diseases. This system is what makes the Global Fund secretariat smaller than other international bureaucracies.

The Global Health Fund will demand an agreement with any recipient country and also a roadmap showing how funds are allocated to the comprehensive basic package of health care. This is a condition for continued international health harmony. With combinations of general taxation, social insurance, private health insurance, community health financing schemes including micro-health insurance, and out-of-pocket user charges for domestic health financing, Global Health Fund assists recipient countries to have appropriate health financing means for specific health solutions. As an important additional 'tool' to detect corruption and any misuse of funding, the participation of civil societies are encouraged.

There are some advantages when Global Health Fund covers a comprehensive basic package of health care. Some of the advantages include: providing means of rationalizing large numbers of international health aid relationships that involve many bilateral agreements, and coordinating single-disease agreements that will lead to the harmonization procedures to achieve efficiency. The single Global Health Fund, if adjusted and co-owned by civil society, will reveal real priorities. The pooling of this fund will facilitate the efforts of the civil societies in achieving the responsibilities of advocacy and monitoring. The civil societies will mobilize the idea of generating increased domestic health financing as well as making sure that all the funds will be well spent. To achieve this, the civil societies put pressure to end the practice of illegal "flight capital", where large sums of money that could have been used to reduce health inequities leave poor countries to 'safe' bank accounts in rich countries without being detected by regulatory agencies. Also the practice of routing international health aid through a single Global Health Fund prevents the attachment of political or economic strings. For example, using the development assistance to entice a recipient country into voting in a particular way at the United Nations, or providing favourable conditions for exploiting the natural resources of developing countries will be avoided.

Therefore, increased and sustained international aid for health will result to stagnating and decreasing domestic health financing, which will lead to limited gains and undermine the rich countries' willingness to sustain international health commonality.

3.3.2 **Fundraising**

Global Fund raises funds through public sector contributions which constitute 95 percent of all finances raised. The remaining 5 percent of the fund comes from the private sector and other financing initiatives like Product Red. The main countries that are contributing to the fund are: United States, France, the United Kingdom, Germany, Japan, Sweden, Norway, France, the Netherlands, and Spain.

3.3.3 Global Fund partnership

Global Fund has partnership with UNDP in the fight against HIV/AIDS, tuberculosis and malaria . This partnership has saved millions of lives by contributing to people living fuller, and productive lives to support their families and communities. The results of the partnership show the following benefits:

1 millions of people currently on HIV treatment
2 millions of cases of malaria treated
3 millions of bed nets distributed to protect families from malaria
4 thousands of cases of TB successfully treated
5 thousands of people treated for multi-drug resistant TB

Through the support UNDP provides in the implementation of Global Fund grants, UNDP has therefore, contributed in ensuring that healthcare reaches the following : those in crisis and post-crisis countries, countries with governance challenges and countries under sanctions. UNDP helps to strengthen the capacity of national partners by transferring full responsibility for the management of Global Fund grants to national organizations. UNDP supports governments in creating enabling environments that will protect people's rights and promote access to HIV, TB and malaria services. That is, UNDP engages in discussions on how the affected communities and relevant ministries could reduce human rights-related barriers to access healthcare.

UNDP works in collaboration with governments, development partners, private sector and civil society, in leveraging the experiences and expertise of UN agencies such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nation's Population Fund (UNFPA), the World Food Programme (WFP) and others, to ensure

that health services are provided to those in need. The results of the partnership of UNDP with Global Fund has contributed to the progress in the following sustainable development goals :

1 SDG 1 (reducing poverty),
2 SDG 3 (health and well-being) and its target to end the epidemics of AIDS, TB and malaria by 2030.
3 SDG 5 (gender equality),
4 SDG 10 (reducing inequalities),
5 SDG 16 (peace, justice and strong institutions) , and
6 SDG 17 (partnership for the goals)

3.3.4 National PHC Development Fund

PHC as the cornerstone of the Nigerian health system, has been in shambles, with its direct consequences on the overall performance of the health system. Poor financing has been one of the problems of PHC in Nigeria. Addressing the problem of underfunding that has stifled PHC is of uttermost importance in the policy agenda of the NPHCDF as proposed in the national health bill. NPHCDF is a pool of fund set aside for primary health care, with guidelines on how the funds should be allocated. The fund pools resources from the government, international donor, and private sectors. The guideline for allotting the fund is as follows:

1 Provision of basic minimum package of health services through the NHIS (50%);
2 provision of essential drugs for primary health care (25%);
3 the provision and maintenance of facilities, equipment, and transport (15%); and
4 development of Human Resources for Primary Health Care (10%).

These funds will be disbursed by the national primary health care development agency (NPHCDA) through the state primary health care boards to local government health authorities. This will be based on the commitment and adherence to the provisions of the act that set up the development fund. NPHCDF, if properly managed, will assist PHC to overcome the persistent problem of underfunding thereby, consolidate the efforts to improve health care services in Nigeria. This fund will also assist the public-private partnerships to mobilize funds for health care in Nigeria. With the establishment of the fund, foreign aids could be paid into the fund and disbursed centrally thereby, address the issue of national priority as against the current situation where the three tiers of government get grants independently from foreign donors which are used for services that may not align with national priorities. Therefore, PHCDF initiative is very laudable and if effectively managed, will be the panacea for PHC in Nigeria.

Health financing mechanisms in Nigeria do not operate optimally. Allocation and use of resources are neither evidence-based nor results-driven. Resources are not allocated equitably or in a manner that will minimize wastage and improve efficiency. None of the mechanisms effectively protects individuals/households from catastrophic health expenditure. Issues with social health insurance cut across legal frameworks and use of Health Maintenance Organizations (HMOs) as purchasers. The effect is that attainment of Universal Health Coverage is greatly compromised. In order to improve efficiency in health financing mechanisms, more funds whose spending will be adequately tracked should be allocated for purchasing health care services. The legislation that established National Health Insurance Scheme should be amended such that social health insurance becomes mandatory for all citizens. Therefore, efforts to increase public funding for health care at all levels of government in Nigeria should be explored alongside other options for health financing such as public-private partnerships and overseas development assistance.

4.0. **CONCLUSION**

In Nigeria, achieving good health outcome, equity, patients, and providers' satisfaction is very challenging. However, there may still be a way forward for Nigeria. This will require strengthening the planning and funding of health care systems to the extent that everyone who requires health care services is able to access them without being denied due to inability to pay. Global Health funds should be properly utilized to ensure that the prevalence of malaria, TB, and HIV/AIDs will be reduced to the barest minimum. Given the weak institutional capacity, technical expertise, and high level of poverty, Nigeria will continue to rely on a combination of mechanisms to achieve effective health care financing system. To accomplish universal coverage of health care services for the poor, Nigeria must move from out-of-pocket payments to other mechanisms of financing health care. User fees for interventions that require wide coverage should be reduced or removed to enable the poor have increased access to health care. Donor funding should be put into more effective and efficient use to augment the other mechanisms of financing.

5.0. SUMMARY

Health care financing should be seen by the Nigerian government as an investment, which requires an effective management and political commitment for it to be profitable to the citizens. Factors like lack of awareness, corruption, and unstable economy that have undermined health care financing in Nigeria should be addressed exigently. Lack of evidence based planning and policy making has been a challenge in Nigeria. Health care financing needs planning that will be evidence based. Nigeria should explore all efforts to increase public funding of health at all levels of government alongside health financing options like public-private partnerships and overseas development assistance.

There are internal and external actors that play the role of financing the health sector in Nigeria. Internal actors in the health sector include: the Federal Ministry of Health and its

Agencies, Private Sector, Civil Society, Development Partners, and Academia. The external actors to the health sector include: the Federal and State Governments, National Assembly, Ministry of Finance, Ministry of Budget and National Planning, Federal Inland Revenue Service, Customs, the Budget Office, Central Bank, Accountant General Office, Auditor General Office, among others.

6.0 TUTOR MARKED ASSIGNMENT

1 .List the five principles of rational planning theories

2. Explain what you understand by medical dessert

3. Explain the importance of planning in health care financing.

4. Differentiate between strategic and operational planning

5. Describe the functions of the three types of planning activities

6. list 6 sustainable development goals in which Global Fund has contributed to the progress

7 Explain the factors that have undermined health care financing in Nigeria.

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MODULE 3 HEALTH CARE FINANCING AND THE SUSTAINABILTY OF HEALTH SYSTEMS

UNIT 1 HEALTH OUTCOMES, ECONOMIC LINKAGES AND POLICY

CONTENTS

1.0 INTRODUCTION

Health care financing concerned with issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care services to consumers. It is important in determining how to achieve improved health outcomes and lifestyle patterns through interactions between individuals, health care providers and clinical settings. There is need to evaluate the types of financial information: costs, charges and expenditures meant for the health care service of the public. In health care financing, the externalities that will consider health and health care, particularly in the context of the health impacts of the treatment for diseases that are not adequately funded. The health status and trends of managing such diseases will supply answers to the following questions: What influences health other than adequate health care financing ? What is the value of health? What factors influence the demand and supply f or health care? What determines the micro-economic **e**valuation of treatment levels? What constitutes effective evaluation of the health care system? How effective and efficient are the planning, budgeting and monitoring mechanisms in health care financing? This section will conceptualize public health financing using the trends and health care status for optimization. The supply and demand theory maintain that as the price of health services declines the consumer consumption of the service will increase. The converse is also true. If the price of a good increases the consumer consumption of the services will decrease. However, the resource/health optimization concept will refer to the meeting point between the private and public benefits both in monetary and non-monetary terms. That means that the consumer consumption of services should be exactly offset at the private and public costs both at monetary and non-monetary terms so as to enable the consumers spend less on health care services.

This section will assess the economic techniques, the health issues and the underlying forces that determine the policy interventions that constitute constraints in health care financing.

The presence of insufficient administrative capacity, otherwise optimal user fees for medical care which will turn out to be undesirable, if revenue collection leads to theft attempts at local clinics will be examined. It examines the economic performances of the health care systems including output measures such as gross domestic product (GDP).

2.0. OBJECTIVES

By the end of reading this section, students will be able to:

1 Identify t he factors that influence supply and demand of health care
2 Know the effectiveness of budgeting and monitoring mechanisms
3 Explain the effects of price increase on the consumption of health care services
4 Identify how health is linked to income
5 Assess relevant market interventions of medical care systems,
6 Assess the effects of induced demand.
7 Know how to measure consumers' health status
8 Understand how policies encourage market failures
9 Know what constitutes public good
10 Explain how epidemiological transition is linked with demographic transition

3.0 MAIN CONTENTS

3.1 HEALTH STATUS AND TRENDS

The measurements of health status and trends in health outcomes over time are measured across demographic groups. These measures focus on mortality rates, life expectancy, and morbidity measures and are disaggregated according to age, sex, and cause of death or illness. The patterns and nature of mortality and morbidity have changed recently and will continue to change in developing countries like Nigeria. This is what is called epidemiological transition

and is linked with the concurrent demographic transition, where population age structures undergo significant changes as societies develop. However, there are detailed descriptions of the traditional measures of health status which are life expectancy, mortality rates, and morbidity rates that are necessary in the promotion of health and well-being of individuals in a developing country like Nigeria. Surprisingly, where the needs are greatest, the means tend to be least, and the relative poverty of many developing countries constrains attempts to improve health status indicators. It is imperative that the available resources should be equitably and efficiently allocated so that the economic approach to the analysis of health and health care needs will be achieved. A suitable economic frameworks that will aid the analysis of policies that affect health outcomes in both the positive and normative issues in the economics of health and health care financing, as well as the externalities that give rise to good health care.

3.1.2 Measuring Morbidity in Practice

One of the differences between mortality and morbidity measures of health status is the ease with which mortality can be measured against the difficulties that surround the measurement of the morbidity. Death is a binary variable because one is either dead or not. Morbidity is a continuous and multidimensional variable which has both objective and subjective components that make its quantification difficult. There are two main categories used in measuring mortality rates. These are : "observed" or objective rates which is based on clinical tests or medical examinations, and "self-perceived" or subjective rates, based on reports by individuals on how sick they are or feel. The objective measures include: antibody concentrations in the infected individuals, analysis of functional capacity, and expert opinions from the medical practitioners. The rates of morbidity will respond to changes in the nature and extent of the disease in a community. For example, malaria cases will increase when there is mosquito upsurge. Subjective measures which are based on interviews with the patients will

respond to the underlying pathology and also to the changes in the perceptions and expectations of individuals.

This explains why some countries have higher rate of self-perceived morbidity than others. Such self-perceived measures of morbidity are likely to be unreliable, unless the individuals have very similar socio-economic and cultural characteristics. In this case, one approach is to assume that the variations in morbidity rates stem from changes in the characteristics of underlying diseases and their treatments, and that slow changes will reflect changing subjective criteria. It will be interesting to compare the objective and subjective measures of illness for certain conditions. For example, individuals may feel they have intestinal parasites, but an examination may reveal none. Similarly, some individuals may consider themselves undernourished, and on objective measures only very few may be malnourished. At the same time, some may report lower-back pain, and only an insignificant number of them may be confirmed by an objective basis. These do not necessarily suggest that such individuals overestimated their health status or that they are hypochondriacs. However, some medical conditions may be objectively measurable but will have limited effects on functional capacity or general wellness, at least in the short run. Also, if individuals have lived all their lives with a parasitic infection, subjectively, they may feel reasonably well but on the other hand, some individuals may feel they have low back pain instead of the parasitic infection.

3.2 The Determinants of Health

There is need to investigate the factors that affect the health of individuals and populations. The level of education of individuals is a significant determinant of health status, and improvements in parents' literacy are correlated with improvements in children's health. Again, education, as an investment in human capital, should not be expected to increase health status by itself but as a proxy for effective use of other health improving goods and services. That is why an important correlate with health outcomes is income, both at the disaggregated level (such as individual or household) and at the aggregate level (like regional or national).

This pattern can be observed over time and across countries and is an important strategy for improving health in broad-based economic development.

Knowing that healthy people are more productive than the unhealthy ones, the relationship from health to income is important. This is evidenced by the economic impact of a disease like AIDS that shows that the direction of causation is from income to health. The pattern of the demographic transition over time will depend on the timing of both the effects of mortality and fertility. In high-income countries, these effects occur simultaneously in such a way that while the age structure shifts, the population growth rates will remain stable. But this growth rate will rarely reach 2 percent yearly. However, in developing countries, declines in mortality rates will precede declines in fertility rates, thereby, leading to high population growth rates of up to 4 percent. This divergent experience represents the product of the origin of changes in mortality rates. Assuming the effects of better health on fertility rates, will require cultural and behavioral responses for the changing environments to occur at similar rates, then high transitional population growth rates in developing countries can be explained.

The next consequence of improved health is that of the pattern of disease changing as development proceeds. This is known as the *epidemiological transition,* and it results from two effects. First, as some diseases and causes of ill-health are eliminated or controlled, the relative importance of other diseases rises in arithmetic progression. This means that the diseases that are controlled early are relatively less costly to combat than others. That shows that reductions in the improvement of health indicators such as life expectancy over the development process issues will result in the measurement of productivity in health production.

Another issue that contributes to the epidemiological transition is that, as individuals live longer, diseases that commonly affect older individuals will increase in absolute terms. For instance, the prevalence of heart disease is low in children but high in adults who are over 50 years, but if a good number of children live up to adulthood, then there will be increase in population-wide incidence of heart attack related deaths. Similarly, reductions in maternal

mortality will lead to larger numbers of older women and also to a high prevalence of post-menopausal health problems.

3.3.1 Income-Health Linkages

Studies have shown a positive correlation between income and health status, both on cross-sectional and longitudinal bases. For example, the cross-sectional analyses of the links between per capita gross national product (GNP) and health status for some countries differ, while some are high, others are low. This explains the variations in the life expectancy at birth, infant mortality rate, and the child mortality rate. The only variable of health status for which per capita income does not provide explanation is the crude death rate.

However, the structural relationship between income and health status has shifted with time because life expectancy has continued to show positive correlation between health status and income on a cross-sectional basis. There are two basic explanations for the shifting relationship between income and health. The first is the ease with which good health is maintained because of technological innovations such as scientific discoveries of the causes and treatment of diseases and the positive investment in public infrastructure like sanitation systems, and the like. Here, health does not only increase with income because people are better-off, but it also increases because it is more affordable. The second explanation for the shift is individuals' preferences that can change with time. With enhanced income, individuals will become more concerned about health. For example, the escalation in the numbers of sports clubs, fitness magazines, and health food stores in some rich countries, have made people to be very health conscious to such an extent that may not be of great importance in explaining the trends in the wide range of income levels.

The technological advances that have allowed improvements in health particularly in scientific and technical knowledge have both public good and capital good characteristics. Therefore, it is not advisable to use cross-sectional relationships, even if augmented by longitudinal information, to make direct inferences about the effects of income on health. This is particularly true when considering the effects of short-term recessions in economic performance, characterized by falls in real GNP. While health status is unlikely to improve

during such episodes, any deterioration will be relatively small, when compared with the direct use of regression elasticities. Only when economic downturns are of long duration to accommodate depreciation in health-related physical and institutional infrastructure, that health status decline will be affected proportionately. Clearly then, it is the use of income that is of importance in the determination of health status. The general rule is that as income increases, consumption of health-improving goods and services also increases. But health improvement is not the only objective of individuals' consumption of certain health-reducing goods and services but also the level of income.

A useful approach of examining the link between income and health is to examine the way consumption of certain goods and services affect health, and to identify how the use of these goods and services is related to income. The most obvious input into good health is medical services, including both curative and preventive treatments. Such services, however, particularly curative care, should be less emphasized if other goods and services including clean water, nutrition, effective and safe shelter, and so on are available and used effectively. Improvements in behavior, such as washing of hands with clean water and appropriate use of mosquito nets, can have substantial impacts on health.

The fact is that income is determined by available resources, technologies and by production choices, that is, the effective use of these resources. For instance, a country with more iron ore can produce more steel with the same inputs of other goods and services than the one with less iron ore. This will mean that the income of the first country will be higher than the second. But assuming the two countries have the same levels of other inputs, the health status as a function of income, is unlikely to differ. Also, if both countries have the same income, that is, to produce the same amount of steel, then the first country will have better health than the second, other things being constant. Here, we have seen the ability of income in causing health improvements. But clearly one inputs into production, and the determination of income as a healthy work force. It is therefore, conceivable that health will cause increases in income.

Consumption of some other goods and services has potentially negative effects on health status. These effects include exposure to pollution, increased

likelihood of motor vehicle accidents, overconsumption of alcohol, smoking, indulgence in unsafe sex, and consumption of unhealthy foods such as those with high fat contents. Some of these items, particularly pollution and road accidents, are issues to the extent that they are unavoidable or at least costly to reduce as byproduct of available production processes. Sometimes, these economic activities constitute home production because the output is not marketed but consumed directly. For example, burning of dried cow dung, using high sulphur coal for household cooking and heating can result in increases in pollution levels in the environment. Also using poorly maintained cars for private transport on bad roads can increase road accidents. Other goods that negatively affect health include: alcohol, cigarettes, and high-fat foods which can only become affordable at certain levels of income. This is particularly true if consumption of sufficient quantities of the goods is required before significant negative health effects are observed. At the same time, some goods may become less affordable as income increases, because the opportunity costs that are associated with their consumption increases. Basically, most goods will become more affordable as income rises.
Therefore, consumption entails a potential loss of income in an extreme case, through death. Hence, opportunity cost of consumption will increase sufficiently for the net price to increase significantly. Therefore, despite the existence of some externalities like immunization, one's health depends primarily on one's own consumption of medical care, food, shelter, clothing, water, sanitation, and so forth.

3.3.2 Health-Income Linkages

We have examined the potential effects of income on health status. In this section, effects of health o income will be x-rayed. The effect centered on the extent of consumption that was made possible by higher income generation that gave rise to greater access to medical care utilization. The empirical analyses on the linkages between income and health showed that health improvements will lead to increases in income.
In this section, the effects of health on income will be discussed. The empirical techniques and evidences on the direction of causality will be treated. Labour constitutes the most

important factor in the production of health care. That is why changes in productivity of heallth can significantly affect total income. There are two factors that affect the productivity of labour. The first is the skills of individuals that are derived from the innate physical and mental capabilities. These are the education, training, and other investments in the human capital. The second is the efficiency of labour organization and management. Improvements in health can affect labour productivity through the above mentioned factors. Ideally, healthier people will be fitter, stronger, and more energetic than the unhealthy individuals to raise funds for organizations. Therefore, time spent on the job will be more productive, although the extent of this effect on labour productivity will depend on the type of work involved. More importantly, the amount of time unhealthy individuals spend on sick leave or absent from work for whatever reasons will have detrimental effect on their total annual output. This is because a worker who is absent from work cannot engage in productive activities that will attract additional income for an organizational. Absenteeism is seen as an inefficient form of incurring unnecessary cost in an organization. For example, overstaffing an organization with workers who are constantly sick will result as an unhealthy insurance mechanism against the progress of the organization. If the labour services are organization-specific, relying on outside spot labour market will result to overstaffing, and this will be socially inefficient. The need for a worker to care for sick relatives will mean that the productivity of healthy individuals is also reduced as a direct consequence of ill health. This means that income is reduced when a healthy relative stays home from work to look after a sick member of the family. However, if such amount time is spent at work if not for the sake of ill-health, then, the worker's productivity can be said to have fallen. The organization's income will still fall because the sick individual is not at work. A more significant effect of illness on family members, especially over a long- term period is the need for children and others in the family to forego vital years of schooling if one or both parents are chronically ill.

Improvements in health will increase life expectancy, and produce positive effects on the experience level of the active labor force. Some schools of thought argue that a young labour force is more productive than the older labour force. Also that having a more mature pool

of workers with greater experience will be advantageous and more time saving to an organization more than the young labour pool with less experience. The significance of this effect has not been supported by other schools of thought because they argue that with the recent rapid technological growth and skills that engaging llarge number of staff will render some redundant. Of course, taking account of the institutional structure is important in making inferences from these opinions. For example, if promotions and pay increases are based strictly on years of experience, without any relationship to productivity, then the positive results attributed to experience will not indicate a positive relationship between output and the experience of the labour force.

Realizing that it is not income per se that improves health, but how that income is used is the determining factor. Average income may not capture the availability of resources to all members of a society if the distribution of income is uneven. Therefore, the health status of a household is a function of both household consumption decisions and the general level of health in the community, especially with regards to infectious diseases. Thus, the average income will affect household health, in such a way that including distributional variables will not remove the influence of average income on the total aggregate of health outcomes. Of course, if income is considered perfectly using public transfers in kind and cash, then, the external effects of the living environment and exposure to diseases will be measured. For instance, an individual living in a cholera infested slum with 500 naira will be clearly worse-off than an individual with the same monetary income but living in a salubrious suburb. If their respective incomes are adjusted to capture the differences in living environments, then average income will not be a significant explanation of their health status, if all other things are equal.

4.0 CONCLUSION

There are two related reasons for reduction in health care demand. First is that the quality of medical care services may significantly lower the demand even at a very low price. The second is that consumers may incur additional costs in the consumption of medical care services at above the monetary prices charged. The costs incurred will include the forgone income while in the hospital as well as the travel costs.

It is natural to hope that restricting the number of health care systems might reduce consumption of health care services but it is expected that reductions in number of health care systems will increase prices. To fully understand these possibilities, interactions between supply and demand should be examined.

The offsetting income and substitution effects are the possible changes in linking competition and opportunity costs in health care. There should be equilibrium in prices and quantities of medical care services obtained in medical care markets. Therefore, economic consequences of decisions made in resource allocations are the major determinants of effective health care financing for consumer health needs.

5.0 SUMMARY:

One of the important ways in which medical care differs from other goods and services is that the consumer needs are uncertain. Individuals make choices about medical care. They decide when to visit a doctor and the type of treatment to accept when sick. The process of making such decisions can be complicated, because it may involve income , advice from friends, physicians, and others. Individuals are exposed to substantial risks because of uncertain medical care expenditures which may be very large.

Most market failures in the health sector derive from the presence of externalities. However, one of the more fundamental public goods in any market, including that for health care, is information, and the issue of information has been linked to public good. Having established

how health care markets may fail to provide efficient and effective levels of goods and services, that will improve the health status of consumers, alternative policy interventions are needed to correct the distortions. Therefore, willingness to pay is positively correlated with income, and it is the appropriate measure of health benefits when measured from the organizational functions. The distinction between the provision of insurance and medical care in both demand and supply will control efficient implementation of policies in public and private health care systems.

6.0 TUTOR MARKED ASSIGNMENTS

1. Explain why spending on health is an investment
2. List the factors that determine the price and quantity of health care
3. Explain the factors that determine the demand for health care services
5. Explain how demand for health services can be influenced by age
6. Discuss the production function of health
7. Explain the positive correlation between income and health status
8 Explain two issues that contribute to epidemiological transition
9. Explain what you understand by an inefficient resource
10 . Differentiate between public goods and goods with externalities
11 Use two examples to explain the shifting relationship between income and health.

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MODULE 3 HEALTH CARE FINANCING AND THE SUSTAINABILTY OF HEALTH CARE SYSTEMS

UNIT 2 OPPORTUNITIES IN EXECUTIVE HEALTH CARE

CONTENTS

1.0 INTRODUCTION

Health care utilization is characterized by the level of actual consumption that an individual takes when faced with illness/injury. This consumption rate will differ with factors like income, cost of care, education, social norms, and traditions, quality of service and

appropriateness of the services provided. It is expected that as far as health care is concerned, an individual making a decision in case of illness/injury will use multidimensional approach.

The perception of health/illness relates to engaging in preventive behavior and self-care. The importance of self-perceived health status will incorporate a clinical framework that will analyze the social assessment and treatment of disease conditions as well as the social environment of individuals. Here, self-perceived health is strongly correlated to the risk of dying. Behavioral approaches are used to determine the willingness-to-pay (WTP). However, using this method can often result in grossing over the distributional implications of the demand estimates and the expenditures in financing public services. This section will examine the cost-effectiveness analysis as a fundamental part of technology appraisal processes for agencies in health care services. It will assess the extent to which the use of cost–utility analysis (CUA) approach will measure outcomes in a composite metric of both length and quality of life, the Quality-adjusted life year (QALY) in health care markets. It will examine how technological advancements in health care relate to the use of these approaches to enhance good health. **Therefore, the effectiveness of the principles underlying the development of clinical guidelines, quality standards, and their application to health and social care will be emphasized.**

If a central function of government is to allocate resources to meet needs, maximization of resources could be strengthened if these decisions were based on evidence. With the introduction of machines in work places, employers now expect high output thereby, minimizing labour cost. When a machine required several workers to operate its different functions, supervisory and control procedures will be necessary to manage the workers owing to factors like how different duties are assigned among workers, worker relationships, communication, and job division. Factory authorities usually draft rules, regulations, work time, job assignment procedures, pay structures and they further design plans for getting a maximum output of the labour through job specialization. There are many different leadership

theories, using a variety of different models. The most important thing is to understand the impact of the leadership style on others, the ability to delegate and the negative aspects of the delegation. Many good leaders change their leadership styles so as to meet the needs of those they are leading. Good leaders will delegate effectively by spreading the workload. Whatever the leadership style may be, communication is one of the keys to successful leadership.

2.0 OBJECTIVES

By the end of this section you will be able to:

1. Understand the qualities of a good resource allocation

2. Know how to describe the organization of a hospital in economic terms

3. Identify how inputs are combined to produce more outputs,

4. Identify the principles underlying the development of clinical guidelines in health care administration

5. Assess the effectiveness of quality standards in health care

6. Emphasize the applications of health and social care services

7. Understand the factors that can improve health and social service quality

8. Understand how rising prices can affect the consumption of public good

9. Know the processes of team building in health industries

3.1 NORMATIVE ANALYSIS FOR HEALTH POLICY AND PROJECTS

It is rational for most developing countries with low labour costs to import a large share of their prescription drugs. Sometimes it is economical especially when imported in some easily transported form like powder and then process the raw materials locally into tablet form. In this case, imported inputs allow for the organization to exert more control over the procurement and distribution of drugs than otherwise could have been the case. This can be either a blessing or a curse. In the organization's role as a benevolent planner, the quality and price of the drugs to protect and promote consumer well-being can be regulated. However, the extent to which the border control personnel and officials in the organization can engage in corrupt activities, can increase the rents available to the corrupt officials. On the positive side, a single importer may be able to exercise some level of monopsony power in purchasing large quantities of drugs on behalf of the organization. The possibility of such action is increased in the market for drugs in comparison with other imported commodities to the extent that the relative size of fixed costs will be much higher for the drugs. This means that if suppliers prices can discriminate among other organizations or countries, by charging some more than others, then those willing and are able to pay more might be induced to pay a larger fraction of the fixed costs than poorer organizations or countries. If large numbers of small purchasers are to bargain individually with a large international drug company, they may be unlikely to achieve such discounts. That is, bulk purchases are economic at both the import and distribution stages . Economies in the scale of transportation and storage will mean that it will be preferable for health care centers to get supplies that can last for a reasonable length of time. In this case, the health centers will be expected to purchase the drugs in advance, therefore, they will be require to use either existing source of capital or have access to well-functioning capital markets. In the absence of these resources, it will be difficult to take advantage of the economies associated with bulk purchases, even if the centers are to charge consumers high prices at the time of use to cover the costs. To reduce this issue, United

Nations Children's Fund (UNICEF), assists some developing countries to band together to purchase bulk supplies of cheap drugs from international drug companies which will be later distributed to the countries.

Describing the organization of a hospital in economic terms can be difficult when notions of ownership and control are ill-defined, and the objectives of those in control are vaguely characterized. On the other hand, measuring a hospital's performances in productivity terms is difficult, considering the uncountable services they offer, therefore, examining the objective performances of hospitals, as well as the application of the physician's supply will not be practicable. The striking feature of many non-government hospitals in some developing countries is that they term themselves as not for profit organizations. Exactly what such status means for the behavior of decision-makers within these hospitals is not always clear. One would expect that, such a status did not mean that resources were wasted, so that any potential profit would be removed by inefficiencies. This hardly seems a reasonable goal for any organization to adopt, nor for a government to foster. The best way to understand the nature of a not-for-profit hospital is first, to consider its alternative profit-maximizing as a hospital. As with any other productive industry, the profits from such an enterprise will measure the economic surplus from production to the value of outputs sold over inputs used that typically accrue to the shareholders. Under the assumption that the owners of the hospital will control decisions regarding its business activities including the kind of doctors to hire, the suppliers from whom to purchase inputs, the potential patients to target in advertising campaigns, and so on, the surplus here represents a return to their capital investment and entrepreneurial actions.

It is common to judge the desirability of alternative resource allocations by the efficiency and equity. Resources are used and allocated efficiently if there is no waste. If a resource used is inefficient, then, there is a waste. The wasted resources could have been used to make some people comfortable. Two types of efficiency based on the economic activity under consideration have been identified. First, when a fixed quantity of resources is used in producing a collection of outputs , then the production process is technically efficient if it is

not possible to rearrange the way in which the inputs are combined in order to produce more outputs, and not less of others. That is, when an output is produced, in such a way that it is not possible to use the inputs in a different way to increase the level of outputs. Equivalently, the use of resources is efficient if reducing the quantities of any of the inputs reduces the amount of outputs. For example, when the production of medical services is using physician time, nursing staff, drugs, and other inputs. Some of the allocations of these inputs can be used to produce some levels of health improvement more efficiently than others.

The second type of efficiency includes the production of goods and services, as well as their distribution among individuals. A resource allocation is efficient if it is not possible to redistribute the available resources in a way that makes some people better-off without making others worse-off. A change from the use of inefficient allocation of resources to that of an efficient allocation can make some individuals worse-off. The requirement is that from the new arrangement of resource use, it should be possible, in principle, to compensate those who were made worse-off, while maintaining others at a level of well-being that is greater than their initial level.

It is difficult to determine what constitutes equal availability of health resources when the needs of individuals differ because of different living environments, occupations, and so on. Difference can also occur when the quality of services differ for example, differences in the training of the physician , and if access costs differ for example rural versus urban dwellers . In addition, if the general distribution of income is very uneven, an equal distribution of health care may not be the most effective way of improving the well-being of the poor. For instance, equal provision of high quality medical equipment may not be valued by the poor urban labourers but rather, that of the general income transfers. If for some reasons an individual is paid less than is commensurate with his or her productivity, then the benefits of improved health will accrue to others in lower prices of the good he or she produced. Or there will be higher profits for the owners of the firm for which he or she works, but this will not be in the manner of a public good. In this case, there will be externalities associated with

his or her consumption of health care. Some health goods and services represent public goods. These goods can be categorized into two distinct classes.

1 The first class is the goods characterized by their impact on the physical or environmental conditions that surround individuals. That is where they live and work. Those in the second class have no direct physical effect, but they provide information, which is perhaps the purest of public goods. Goods in this first class are important examples in developing countries because they include actions that will improve the quality of the environment, such as vector control, spraying for mosquitoes and air quality control to reduce pollution. Again, the link between public goods and goods with externalities is unclear. For example, education is sometimes termed as an aspect of public good, particularly when mothers receive it. There is strong evidence to suggest that children of educated mothers have better prospects, but in education, it is more representative of an externality than a public good.

2 The second class of public goods includes information provided to allow individuals to make better decisions or to save them the costs of finding the information themselves. Such services include accreditation of physicians, which relieves consumers the task of evaluating the quality of the doctor, a job one may not do very well and may not have the time to do it especially, in an emergency. Similarly, the control of the quality of drugs by a public authority will mean that physicians and individuals can be sure of the nature of the medications they prescribe and consume. Of course, in this case, the public needs to have some degree of trust in the government to provide correct and accurate information that is, the quality of the public good must be sufficiently high for it to be valued by consumers.

The problem with public goods is that organizations will have little incentive to produce them, because virtually all the benefits will accrue to others. If an organization should charge others for the benefits they receive from a public good it provides, this issue will be easily overcome, and the private market will

provide adequate levels of public goods. But if this mechanism is charged, it will require that the organization will first levy charges, and second that it will stop individuals who have not paid from using the goods. The second requirement of excluding individuals who have not paid is often not done, and so private providers are not likely to reap sufficient financial returns to cover the costs of optimal provision of public goods.

3.2 IMPACT OF RISING PRICES ON CONSUMPTION OF PUBLIC HEALTH GOODS

Financing public health services with out-of-pocket payments may not give the most desirable outcomes in the services rendered. Many public health interventions seek to maximize the consumption of the services like disease management programs, health promotion efforts, nutrition services and other such activities by removing all the barriers that will negatively affect participation that out-of-pocket payments may present. By financing health with out-of-pocket payments will indicate what individuals are willing to pay for the services and also for the consumption of the services at that given price. This procedure does not necessarily improve the health condition of the total population served. In the actual fact, there may not be any relationship between the level of services individuals consume and the health outcomes experienced. There are always efforts in public health to improve air quality in the environment, disseminate knowledge, protect parks and open spaces that are not normal to private goods but rather to **public goods**. These goods are non-*exclusive* and *non-rivalrous in nature.* This means that all individuals will have access to the goods and that the use of the goods by individuals will not reduce their availability for others to consume . Therefore , charging individuals for consumption of these public health goods will be logistically difficult and doing so will cause the transition of the goods because they will possess all the encumbrances to consumption that private goods carry.

In public health, c**ommon goods** or services are those to which everyone has access to but of which there is a limited supply. The main challenge of allocating and financing common goods is the ability to find a relevant mechanism that will ensure equity and maximize the utility of the services. Therefore, allocating common goods based on what individuals are willing to pay with out-of-pocket payments will attract the same disincentives as private goods discussed earlier. As a result, common and public goods should be financed with tax revenue or some charitable/financial aid.

Public health goods that are considered as **club goods** are inversely related to common goods because there is sufficient supply to meet the needs but access is limited. This access limitation is as a result of willingness to pay since access is not free like that of the common goods. Common goods target the vulnerable population who disproportionately benefit from the public health intervention provided. Here, rather than canvassing the entire population, attempts are made to maximize the effectiveness by limiting the population served to those who will derive the greatest benefit. Club goods are usually financed with out-of-pocket payments if the perceived benefits clearly outweighs the costs, but participation and program dissemination are improved with tax financing, social insurance, and financial aid that may not carry disincentives to participation.

3.3.1. The Economic Crisis in Health Care Financing

The initial cause of the economic crisis was the sharp increase in oil prices in 1982, initiated by OPEC, the cartel of oil-producing countries. The low- and middle-income countries which were not oil producers were immediately faced with what is now called a credit-crunch. Their exports were not sufficient to finance the import of oil at much higher prices, in addition to other needs. Many high-income countries reduced other imports so that the oil could be bought at the higher prices. This had a further effect on the balance of payments of poor countries

because of the world demand and this made the prices of the raw materials to declined sharply. Consequently, poor countries had to export more to earn the same amount of foreign exchange. When they were unable to do this, they were forced to devalue their currencies and seek loans from the International Monetary Fund, which in turn laid down terms that required a closer balance between tax revenue and public expenditure. This was most readily achieved by cutting the latter. And the areas of public expenditure which were most often cut were the social sectors , mainly health and education, while the vast spending on defense remained intact.

In the health sector the cuts were often greater in (rural) primary health care, rather than (urban) secondary or tertiary care. The results of the so-called 'structural adjustment programmes had devastating effects on poor people in developing countries. The real benefits of structural adjustment were enjoyed by the rich world countries with cheaper coffee, cotton, cocoa and so on.

Meanwhile, the oil producers were placing their large profits in the leading banks in rich countries. These banks in turn searched for profitable and safe investments for the funds they were holding. The poor countries became the targets for lending on an enormous scale. It was believed that investments guaranteed by governments were bound to be safe. Often these funds were not put to use in strengthening local economies but rather in postponing politically unpopular measures which would increase tax revenues or decrease public expenditure. Moreover, some funds returned to the banks in the rich countries as secret deposits of the politicians and high ranking civil servants handling the loans. Thus the strains on the balance of payments caused by the higher oil prices were followed by even greater strains in trying to pay the service charges due to foreign debts. And with devaluations, these debt service payments became even larger in the local currency.

Overall, the economic crisis resulted in decreasing public health financing. Ministries of Health typically responded with the postponement of maintenance of buildings, non-replacement of equipment and vehicles, and the undersupplying of drugs and other medical products and petrol. At the same time staff salaries were reduced. Ministries of Health did not

disengage staff, but those who left were not replaced. Owing to the absence of vehicles and petrol, staffs in outpost health facilities were no longer supervised. The number of patients started to decrease with the supply of drugs and other essentials being uncertain. Staff responded to the lack of demand and the fall in their pay by spending less time at their jobs. Instead they engaged in other activities to support themselves and their families, including demanding illegal payments from patients for their services. The reaction of a large number of poor countries, including Nigeria, on this breakdown of the government health system, was to look for additional sources of finance for their health services. As foreign aid for health stagnated during the 1980s, poor countries had to look for additional resources from inside the country by not depending on donor countries. One obvious source of revenue was to introduce or increase in user fees for public health services, and Nigeria also introduced these in a phased manner.

In the meantime, the world has become the 'victim' of another economic crisis that is now called the 'economic downturn'. The current financial crisis is affecting people and countries all over the world, rich and poor; and as usual, the poor will suffer more than the better-off countries in the end. At the end of the economic crisis, poor countries experienced a pullback in investments. Consensus was given to the global economic interdependence and there was increase in the world financial architecture. However, the financial architecture allowed overconfidence in the market mechanism, and this gave rise to deregulation in some rich countries. This resulted in the current global crisis, and hardly is there any serious consideration for a return to the closed autonomous economies.

Government leaders who now make statements that suggest protectionism are being criticized immediately by colleagues, economists and the media. At least, lessons have been learned from previous crises. Some governments of rich countries have now realized the importance of not reducing international aid. This realization is positive signs. One can now argue that a globally shared responsibility on the economic crisis will effectively address world poverty and inequity.

3.3.2 Team Building in Public Health:

People in the workplace talk about team building , but only few of them have the understanding and the experience of teamwork, and how to maintain effective team for the sustainability of health care services. Belonging to a team will enable a worker to understand the objectives of the organization and work towards the realization of the objectives. In a team-oriented environment, workers contribute to the overall success of the organization by working with fellow team members to produce results for the organization. No matter the specific job function and the department a team member belongs, the individual is unified with other staff members to accomplish the overall objectives of the organization. This translates to building an effective and focused team.

To have an effective teamwork, a leader should communicate clearly the expected performance and outcomes for the team members so as to enable team members understand why the team was created. The leader should make the work of the team to receive sufficient emphasis in the areas of the effective management of time and money, as well as the discussion and attention given to team members to make them committed in accomplishing the expected outcomes. This will make the team to have enough freedom and empowerment necessary to accomplish the aim of forming the team. The following questions which will help to reveal the activities of the team can be asked: Do team members understand the stages of the team development? Is there an established method for the team to give and receive feedback? Do all team members understand the roles and responsibilities of each team members? Do team members feel they are responsible and accountable to the team's achievements? Answers to these questions will show the extent to which the team members are innovative and collaborative.

4,0. CONCLUSION

In the meantime, the world has become the 'victim' of economic crisis that is now called the 'economic downturn' which many countries are working hard to overcome the doldrums. The current financial crisis is affecting effective health care financing for consumers in many countries all over the world, both rich and poor. Where there is a highly decentralized health care management system, having centralized functions are essential to promote national health needs and equity between regions. Demand is also influenced by the supply of services, which is itself influenced by the use of guidelines, and evidence of clinical and cost-effectiveness.

There are variations in policies guiding effective health care financing in health care services. Some of these policies pose challenges in the efforts to promote universal health coverage. The gain here is the formation of effective and focused teamwork services with unified purpose for supporting public health initiatives. There is need to move forward with an evidence-based approach to enhance resources for public health services that will greatly benefit health systems outcomes for the public. This benefit will help to differentiate between public health services for populations and health care delivery to individuals which will invariably permit supply, demand, and the impact of potential economic policies on public health services.

6.0. SUMMARY

Health financing information, such as information on a country's health spending, health costs, and efficiency, is vital in making informed decisions about national health systems. Educating beneficiaries to make good health care choices is necessary. Being healthy also means that one can work and earn wages. One of the costs of poor health is lost days at work and this is a cost to the individual and to the society as a whole. If one is in poor health, then there is the isk of losing wages for the days when one cannot come to work. This is why many employers provide insurance for the lost wages through the provision of sick days. If one is sick, the individual is not expected to work but will still be compensated up to a contracted number of

days per year. Demand therefore, is the economic concept that describes consumer's desire to pay a price for goods or services received. If all other factors are constant, then, a rise in the price of a good or service will reduce demand and a decrease in the price of a good or service will increase demand. That is why health care demand is gradually rising in many countries.

One method of enhancing effective leadership and delegation guidelines for managing public health finance is to focus on supporting sound health care policies that will eventually be expanded to a more comprehensive package. Realizing that public health finance is not limited to specific segments of public health therefore , prevention, protection, and promotion of services will focus on the entire public health system, with efforts in policy implementation to support programs and interventions. Public health services begin with encouraging universal coverage to avoid focusing the finances to limited groups. That is why different leadership, delegation and planning theories may be suitable in some settings, just because of the availability of resources , social acceptance and political influence. Therefore, no one concept can fit every situation in public health services no matter the unique decisions adopted.

6.0. TUTOR MARKED ASSIGNMENT

1. Explain what you understand by supplier induced demand
2. List 4 financing issues that health care financing as a component of health system can address
3. Explain what you understand by economic downturn
4. Differentiate club good from common good
5. State three things a leader using **leader supportiveness style of leadership will do**
6. **Differentiate between internally oriented worker from externally oriented one**

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MODULE 3 HEALTH CARE FINANCING AND THE SUSTAINABILTY OF HEALTH CARE SYSTEMS

UNIT 3: THE SUSTAINABILTY OF HEALTH SYSTEMS.

CONTENTS

1.0 INTRODUCTION

The economic crisis in many developing countries like Nigeria has contributed to the unprecedented attention on the issue of health care financing sustainability. The issues for

attention are on cost-effectiveness, quality of care, and patients' satisfaction on services received. Enough attention has not been paid to the sustainability of financing health care systems. This is a fundamental concept in the health care policy that needs to be carefully considered because as labour decreases, the capital and wages will be increasingly insufficient to cover the rising cost of health care for consumers. At the same time, as the cost of Social Health Insurance through employment contributions rises with medical costs, it becomes dangerously competitive in the economy and the health consumers will be negatively affected. Therefore, this section will discuss the way health care resources are raised, pooled and spent to maintain financial sustainability in the health care systems.

2.0 OBJECTIVES

By the end of this section, you will be able to:

1. identify the benefits of a good health financing system
2. know the effects of Social Health Insurance
3. explain why a systemic view of health financing is necessary
4. understand the effects of pooling in UHC health care financing
5. identify the factors that encourage health care financing sustainability
6 learn different types of pooling

3.0 MAIN CONTENTS

3.1 PUBLIC HEALTH CARE FINANCIAL MANAGEMENT (PFM)

It is a basic fact that countries cannot make progress towards universal health coverage (UHC) without relying on a share of the public funds, and putting effective public financial management (PFM) at the core of the UHC program. Enhancing how public funds for health are managed through the PFM system is critical in the progress to be made in realizing UHC objectives using available resources. An effective and transparent PFM system will encourage

efficiency and equity in health spending thereby, guarantee better results in the health sectors. Evidence shows that, countries without an effective overall PFM reforms, will experience limitations in how public resources are planned, allocated, used and accounted for in the health sector.

In most developing countries, there is need for the basic foundations of PFM such as budget formulation, execution and accountability functions when strengthened by reforms that will necessitate dialogue between finance and health authorities. This dialogue will enable assess, share and review of PFM bottlenecks that may threaten the realization of UHC programme. It will also enable the identification of priority areas for action. Therefore, as most countries embark on health financing reforms, there is also the need to engage in better coordination of PFM and health financing reforms that will improve consistency and efficiency so as to maximize progress. The gaps in understanding the issues and involvements in both PFM and health financing interventions should be addressed.

To assist in addressing these gaps, The World Health Organization, African Development Bank and other partners organized series of regional and sub-regional meetings with key financing and budget officers from the Ministries of Health and Ministries of Finance on the need to harmonize health care initiative . Also in April 2016, WHO's Department of Health Systems Governance and Financing organized a follow-up meeting that brought together representatives of national health and finance authorities, as well as other public finance and health financing policy experts and practitioners, to discuss key issues involved in productive health financing that will enhance universal health coverage (UHC) in several countries. The meeting provided opportunities for assessing each country's progress in the implementation of Public Financial Management and Health Financing, as well as in identifying key areas that will achieve better results.

The key areas that were emphasized include:

1 Health financing and PFM systems that are needed to be aligned in other to achieve their common objectives of equitable access to quality health services. Productive and active dialog between Ministries of Health and Finance in the progress of the UHC agenda.

2 Resources for health that should be consolidated and accounted for in the overall government budget to achieve the flexibility in purchasing mechanisms that will ensure that priority services and interventions reach the populations that need them.

3 Transition from aid and sustainable financing issues to ensure sufficient revenues and managing the expenditures. Transition that will provide an opportunity for a system-wide approach for improving the efficiency with which resources are used.

4 Fiscal space for health assessments that should be included in the overall government budgeting cycle that will take into account the political economy considerations.

1 The economic crisis in many countries that will give rise to agitations on the likelihood of the contributions of cost-effectiveness, quality of care, and patient assistances in the sustainability of the health systems. Basically, little or no attention was paid to the issue of who pays for health care in other to achieve the sustainability of financing. The question is: how will the sustainability of health financing be achieved in the health system? The answer to this question is fundamental in the success of health care policy because in the global economy, as the labour decreases relative to that of capital and wage, there will be insufficient funds to cover the rising cost of health care and encourage sustainability. At the same time, as the cost of Social Health Insurance through employment contributions rises with medical costs, it becomes a risk to the affordability in the economy. These reasons

explain why the distribution of health care cost is borne by all sectors including the production sector financed by income taxation through comprehensive National Health Insurance to achieve health system objectives, especially during the period of economic recessions. This is important so as to avoid relying on employer-employee contributions alone for health care cost. These procedures were seen as the factors that will ensure health system sustainability.

In the past, the health systems shared one common concern of how to achieve an average 7 % of national Gross Domestic Product (GDP) collected from taxes and labour contributions to financing health care services. At this period, two types of public health systems emerged and were named after their political instigators. These were:

1 **Bismarck systems**: this was based on social insurance, with a multitude of public insurance funds to be financed by employer-employee contributions that will be independent of health care provision.

2 **Beveridge systems** : this system emphasized that public financing and health care delivery should be handled with one type of tax financed structure like the National Health Service (NHS) .

However, with the emergence of these two generic systems, the argument on the possibility of access, quality and cost started to emanate. Financing was termed as a health system that is concerned with the mobilization, accumulation and allocation of money to cover the health needs of people, individually and collectively. It was later in the year 2000 that the World Health Organization (WHO) explained that the purpose of health care financing should be to make funding available, and to set the right financial incentives to health providers so as to ensure that all individuals will have access to effective public health and personal health care. WHO in 2007 then described a good health financing system as one that raises adequate funds for health in a manner that people can use needed services that will protect them from financial catastrophe or impoverishment associated with having to pay for the services they

received. Similarly, that a good health financing system will provide incentives for the health providers and users in a manner that will encourage efficiency.

From the two WHO definitions, the concern was about raising adequate funds, to reduce the implications on payers on the economy. With recessions on the economy, universal coverage as the main pillar of social cohesion and welfare became endangered with implications on equity and financial protection. Then the willingness to disburse the necessary funds for sustainable development of the health system became a problem especially in developing countries. The source for financing health care is now a political issue that needs some attention. This fundamental issue is being overlooked in the concept of economics of health policy.

The evolution of health financing during the last half century reveals a fundamental shift in the core issues. Initially, health systems were designed for populations that are expected to live for an average of 65–70 years. With the retirement age at 60–65 years, lifetime earnings and savings will be less sufficient to finance a decent health system because health expenditure meant for the welfare of all will be rising. The question is: what will be the source for financing health care? In most developed and developing countries, health care is financed more or less through taxation and labour contributions. In these countries globalization will bring increased economic inequality and economic uncertainty thereby, causing uncertainty on the sustainability of health financing. Nevertheless, some very rich individuals finance their health care through private health insurance despite the equity issues involved.

3.2 RECESSION AND ECONOMIC UNCERTAINTY

The frequent recession that affects income inequality has caused a drop in the demand for health care. Massive unemployment and economic distress that have put some strain on public budgets, will increase the demand for public health services, and also limit access to private services. The extreme pressures after the economic crisis will introduce limitations in

financial sustainability as funding and value for money will result to the inability of the society not to fulfill its implicit or explicit obligation of satisfying need-based demand for health care. The question is: who are those that must pay for health care services and how?

The answer to the question of who must pay for health care and how, lies on the assessment system of the society. It is a political question with undertones of social involvement, personal responsibility, and freedom of choice. Discussions on health system sustainability will continue to be a delicate question of financing, because reliance on out-of-pocket expenditure for health care financing is not acceptable on equity and financial protection grounds. Therefore, income from taxation can cover the increasing cost of health care for the populace. The moral factor of "who pays" and "how" should be important because as the population ages, technology advances, globalization, and economic recessions put strains on the sustainability of financing sources. The question should now focus on how to obtain and manage the savings efficiently so as not to compromise the competitiveness of the economy which encourages sustainability. Therefore, only savings in the form of taxes on all incomes produced by the society, including wealth and capital will be a sustainable source of funding in the long-term.

A good number of people finance the health needs of all their family members themselves but this will not guarantee sustainability. Health financing may determine how pressures on health systems are carried out without loss of equity, quality and financial protection. Social Health Insurance has negative labour market effects and also negatively affects competitiveness due to higher labour costs. In addition, as unemployment increases, incomes decline and pressures on health budget and public infrastructure are pushed to extremes, evidence has indicated that public health systems financed through taxation can be responsive to economic pressures and effective in health expenditure consolidation.

Political concerns associated with economic imperatives as well as moral considerations may force changes in health care service financing in both the developed and developing world. National health insurance financed through taxation should drive the quest for more

sustainable and responsive health systems. Another question is: How will populations ageing lead to uncontrolled health expenditure growth?

With the number of older people increasing in the population, there is much concern that this will translate into higher health spending in the future given that older people, on the average, have higher health care costs than their younger counterparts. Population ageing is not, and will not be a major driver of growth in health expenditures. Moreover, in countries where age demographics are changing but the size of the older population is not yet large, the costs of improving coverage and access to services for older people is likely to be manageable. Therefore, there is need to invest in financing the health care system while the population is relatively young.

3.3 POOLING IN HEALTH CARE FINANCING SYSTEMS

The function of pooling and the ways that countries organize this is critical for the countries' progress towards universal health coverage. The risk in pooling is the effective spreading of the finances needed for paying for health care services, so as not to allow sick individuals to fully bear the cost of treatments. The large number of people covered by the pool and the diversity of health risks in the pool are crucial to the redistribution and the positive implications for UHC goals.

The simple classification of pooling arrangements, the specific ways that fragmentation manifests and the challenges of pooling in achieving universal health coverage objectives should be explored. It is important to recognize that pooling arrangements will set the potential for redistributing health spending. The extent to which the potential redistributive and efficiency gains established by a particular pooling arrangement that are realized in practice depends on its interaction and alignment with the other health financing functions of revenue raising and purchasing, as well as the service benefits and populations they cover.

The extent to which a health financing system effectively achieves the risk pooling objective is affected by the following: amount of revenues raised, how well health services are purchased, and the design of pooling arrangements. As such, pooling is a distinct policy instrument, because a health system's pooling arrangement greatly influences the extent to which progress can be achieved independent of the overall level of prepaid funding available. Pooling arrangements influence risk pooling in financial protection and equity in service use, and also the UHC objectives of efficiency and equity in the distribution of a health system's resources. However, fragmentation in pooling is of a particular challenge in the realization of UHC objectives. Pools are fragmented when there are barriers in the redistribution of available prepaid funds. Fragmentation in pooling also contributes to inefficiency in the health systems because of the duplication or multiplication in the number of agencies required to manage the pools and the purchasing as well. There are two reasons to show how fragmentation contributes to efficiency.

1 First, there are higher administrative costs in having multiple pooling/purchasing agencies rather than one. This can result in raised system-wide costs. Multiple funds will imply multiple information systems linked to each pool/purchaser that can give rise to more administrative staff and more spending at the level of providers. The administrative costs are greater when there are different service providers that are associated with each financing arrangement. This duplication of functions is the major driver of inefficiency in the entire health system.

2 Second, fragmentation can enhance efficiency by weakening the potential gains of using purchasing as an instrument of influencing provider behavior in countries where multiple purchasers use different payment methods and rates to pay the same providers in an uncoordinated way. This will encourage the providers to alter the costs between patients that are covered by different schemes thereby reduce the system's impact on purchasing reforms.

3.3.1 Designs of Pooling Arrangements

According to the World Health Report of 2010, there are two designs of pooling arrangements. These are:

1 the nature of pooling and
2 the structure of pooling.

For any prepaid funds in a health system, these two designs will determine the redistributive capacity of the funds to support access to health care services for financial protection, and efficiency. The combinations of the structure and the nature of pooling will determine the classification of pooling arrangements.

From these two designs, the level of prepaid funding will be determined. Determining the extent of reliance of the health system on the prepaid funds against out-of-pocket payments (OOP) is an important driver to achieve the UHC goals. However, the extent of prepaid funds arises from how a health system raises revenues, and not how it organizes pooling arrangements. Of course, fragmented pool structures will yield more dependence on OOP expenditure and thus decrease the share of prepaid funds in overall health spending. Hence, the primary policy action is to influence the level of prepaid and pooled funds in revenue raising and not pooling. The classification helps to assess the pooling setup and contribute to identifying policy options that will address fragmentation and mitigate its consequences.

3.3.2 Pooling as Objective and Policy Instrument

The goals of UHC are equity in service use, quality, and financial protection. Equity in the distribution of resources and efficiency in their overall use constitute the immediate objective of UHC. Improved equity in service use and financial protection involve expanding risk pooling, and as such, pooling becomes a policy objective in itself. Risk pooling means that the

healthy will subsidize the sick, and by implication due to their lower health risks, the young will subsidize the old. In the absence of risk pooling, payments made for health services will be directly related to the health needs of the consumer. This means that sicker individuals will pay more because they will need more health care services than those who are not sick. This is inconsistent with the objective of financial protection and equity of access to services in relation to need. Therefore, maximizing the potential to redistribute from lower-need to higher-need individuals by not linking contributions such as taxes or insurance premiums with health risk is the central objective for pooling. This may indirectly contribute to pro-poor equity as well, to the extent that poorer persons have greater health needs.

3.3.3 Nature of Pooling

Pools can be compulsory, automatic or voluntary participation. Compulsory participation refers to the legal requirement that someone should be included for coverage that goes hand-in-hand with contributory-based entitlement. This means that there must be a specific contribution made by or on behalf of the covered persons. The "on behalf" contribution may come from public budgets for specific groups of individuals whose participation is fully or partially subsidized, or it may come from traditional insurance contributions that cover individuals beyond the contributor. For example the contributions that are made by family members. Automatic participation is typically based on legal or constitutional obligations, and the basis for entitlement is non-contributory. This is derived from citizenship, residence or other factors such as poverty status and so on . As such, automatic entitlement is typically solely funded from general budget revenues. Many of those with non-contributory entitlement are paying taxes in some forms, but the distinction is the absence of direct linkage between explicit contribution and entitlement. Because the individuals benefiting from either compulsory or automatic coverage do not have the option of not being covered, they have important similarities, and they are grouped together under the label "compulsory".

In contrast, voluntary participation means that an individual or firm makes a voluntary pre-payment and enrolls on a voluntary basis in a health coverage scheme. This is the voluntary

health insurance. It is voluntary because there is no legal obligation to join a scheme, and therefore, the person or the employer can choose not to be part of a pool for the coverage. However, mandatory coverage is often not implemented because it is difficult to enforce, especially for people working in the informal economy. The result is that even where it is legally mandatory for the entire population; it is de facto voluntary coverage.

The nature of pooling that individuals are included in pools has important implications for the redistributive capacity. When coverage is compulsory or automatic for all population groups, the pool(s) have a more diverse mix of health risks. People who have higher risks are just as covered as people who have lower risks. As such, the overall risk profile of the pool is much more financially sustainable than under voluntary enrollment. Conversely, schemes that have voluntary membership, i.e. voluntary contributions from beneficiaries, are prone to adverse selection because people with higher risks are more likely to enroll than people with lower health risks. As a result of inadequate diversity of healthier and sicker people, the costs of care for a pool based on voluntary coverage are in principle higher than for the average in the population. This limits the potential for risk pooling, as there are not enough healthy members from whom to redistribute. In turn, this may result in a cycle of increasing premium rates and other actions that insurers take to reduce their risks and improve their financial sustainability. Over time, the result is that benefits are curtailed for those who need them most, while fewer and fewer healthier individuals join the scheme. This is called “death spiral” of voluntary health insurance

3.3.4 Structure of Pooling

3.3.4.1 Single Versus Multiple Pools

Prepaid health revenues can be pooled in one or several pools. At one extreme, it becomes a single pool of all funds for health services covering the entire population in a country. A single pool will maximize the potential for risk pooling in the whole population. However, no country has only a single pool even in countries with highly centralized pooling. There are

usually several pools of funds used in paying for health services like occupational health programs, and supply-side funding for other government services like those delivered through vertical programs or voluntary health insurance. Multiple pools imply fragmentation and this takes many forms with different implications and challenges.

3.3 .4.2 Competing Versus Non-competing pools

There is competition across pools. Agencies that manage pools with typically insurance schemes compete for members. Alternatively, in a non-competitive arrangement, people could be assigned to specific pools, with enrollment based on some criteria, so that the different pools cannot compete for beneficiaries.

On one hand, a multiple competitive fund setup offers to beneficiaries incentives for innovations, especially for purchasing. However, the efficiency in the improvement with increased market competition among purchasers is weak. Alternatively, competition among insurance pools creates an incentive for pool managers to **cream skim**, that is, to enroll members with low health risks relative to their contributions in order to incur lower health costs and thereby reach a larger margin between revenues and expected expenditures. The investments that competing insurers select to avoid high health risks are inefficient from a social welfare perspective because the resources meant for risk selection will not contribute to progress towards UHC, and in fact, may weaken it. Risk selection affects the redistributive capacity negatively, as healthier and wealthier individuals and their contributions end up in a different pool than poorer and sicker members with usually lower contributions. In many cases, pools with richer and healthier members offer benefit packages. Conversely, pools with higher health risks are more likely to restrict benefits if legally allowed but can face financial difficulties or deficits. Risk selection practices can be addressed with risk adjustment mechanisms such as:

3.3.4.3 Population Segmentation Versus no Population Segmentation

A multiple pool setup is based on population segmentation, that is, there are different funds for different population groups, with the affiliation based on socio-economic or socio-demographic criteria. In countries where, for example, a contributory scheme with statutory enrolment exists for various groups of individuals such as formal sector employees, and separate health coverage schemes for other population groups, the elderly outside the formal sector and other defined population groups. Again, segmentation can occur between higher-income people with health lower risks and higher income people with health higher risks. Also contributions may be in a different pool from people in low-income groups with higher and lower contributions. Such a pool setup will create large scope for inequity, as it will allow enormous differences in available resources per capita across pools. Conversely, there is no population segmentation when coverage and participation in a pool is independent of people's socio-economic or socio-demographic criteria.

3.3.4.4 Territorially Distinct Versus Territorially Overlapping Pools in Service and Population Coverage

Pools may be organized as territorially distinct. A territorially distinct pool serves the people living in that territory. Pools are not divided according to population groups. Instead, they follow a country's territorial structure that is a sub-national pool per state, province or district. When government in a decentralized setting pools for a distinct level of health services, then it is organized in a territorially distinct way. For example, district governments only pool for ambulatory care and district level hospitals, provinces for provincial hospitals, and the national government for high-level tertiary services. But where territorially distinct pools are too small in terms of the number of people, their risk profile can be financially precarious and there could be efficiency and capacity concerns. Likewise, when their sizes differ across the country, they can have unequal redistributive capacities.

However, pooling set up may only be territorially distinct on paper. When pooling follows the country's administrative structure, the mandates for service coverage and hence population coverage of different government level pools may overlap, thus creating an additional layer of fragmentation. For example, the pool from which the national capital city funds its "**city hospitals**", and the pool from which the central government funds national tertiary facilities are not territorially distinct, particularly when the national tertiary hospital is also an important provider of more basic services for the local population. This overlap turns into duplication of service coverage particularly in big cities, with the main policy consequence being large inefficiencies in the form of excess provider capacity.

3.3.4.5 Classification of the Pooling Arrangements in Health Care Financing Systems

To have the classification, the different features in the structure and the nature of pooling are combined to examine the extent of pooling among some income groups. Based on this, eight broad types of pooling arrangements reflect particular challenges due to the nature and consequences of fragmentation. Let us now discuss the eight common types of pooling arrangements such as :

3.3.4.6 Unified Single Pool with Compulsory or Automatic Coverage

Some countries rely predominantly on a single national pool funded from general government revenues. Such a pool provides compulsory or automatic coverage for the entire population, usually for a particular package of services. There are two forms of this pooling arrangement.

Under the first form, the ministry of health pools the funds into the "health budget" and allocates them to service providers. Here, there is no explicit purchaser-provider split. In principle, everyone will have access to the same benefits. In practice, only very few countries have this pooling arrangement alongside a low share of out-of-pocket expenditure (OOP) < 20% of total health spending.

Under the second form, countries establish a single national fund that will be managed by a separate pooling and purchasing agency, with a purchaser-provider split. The agency will be labeled as a national health insurance fund and constitute an autonomous public entity. This entity pools public funding, in form of general tax revenues or a combination of the revenues and social insurance contributions from employers and employees. This type of pooling arrangement is common in countries with small populations.

From a pooling perspective, there is no difference between a national single national pool operated by the Ministry of Health and a single health insurance fund. Maximum redistributive capacity from prepaid funds is achievable in these settings. Further pooling reforms may not be needed, but other health financing reforms in the areas of revenue raising or purchasing can serve to preserve or realize the potential set by this pooling arrangement so as to maximize financial protection, equitable access and efficiency.

3.3.4.7 Territorially Distinct Pools with Compulsory or Automatic Coverage

Territorially distinct pools are related to a single national pool. But in contrast to having just one pool, residents of a particular region of the country are served by a regional pool, that is, one fund is meant for the population in that territory. Here the pooling function lies with a state, province, or district if managed by a level of public administration or another entity, such as a health insurance fund, with defined responsibility for the entire population of that territory. Systems relying on territorially distinct pools which are a product of a wider political context of federalism or devolution. The resources allocated to these different pools come from a mix of centrally and sub-nationally raised revenues, with allocations often based on a consistent formula applied across the country.

But a system with territorially distinct pools can suffer from fragmentation, if the population size or the territorial areas are too small to ensure redistributive capacity, or when there are different levels of average per capita expenditure on health. Therefore, resource allocations from the central to states should be risk-adjusted to account for differences in population size, the health risk profiles of people as well as factors like poverty which will affect the health needs or costs of serving the population density of a specific region. Resource allocations also need to take into account differences in sub-national revenue raising capacity across the different territorial units.

Territorially, distinct pools are found among high-income countries as well as among low- and middle-income countries. Sometimes, the arrangements include a purchaser-provider split. For example, some countries have a national health insurance scheme, which is territorially divided up along states LGAs and others.

3.3.4.8 Territorially Overlapping Pools in Service and Population Coverage

Decentralized countries often have pools organized at government administrative levels. Here, service provision is integrated with pooling and purchasing at government level. Different horizontally organized pools overlap and effectively serve the same population. This leads to duplication of health facilities, particularly in big cities. This, in some places, remains one of the main drivers of large inefficiencies in the health systems.

3.3.4.9 Population segmentation through different pools for different socio-economic groups

In some countries, different pools exist for different socio-economic groups, thereby, creating a highly fragmented system with population segmentation. This is the consequence of policy decisions that emphasize "starting insurance" with formal sector employees because of the ease of collecting contributions from them. The compulsory social health insurance system for the formal sector tends to be small and comparatively well-funded. In contrast, public budget through the Ministry of Health offers free health services for the rest of the population. But services are grossly underfunded and often unavailable, thus resulting in implicit benefits. Fragmentation is further aggravated, as a small part of the better-off population is often enrolled in commercial voluntary health insurance, whilst a small share of people in the informal sector may enroll in voluntary community-based health insurance schemes. There are specific coverage schemes for defined population groups, such as the poor and the rich.

Such pooling setups create unequal financing arrangements and the population segmentation is further linked with separate purchasing and service provision arrangements. From a system perspective, this pooling arrangement has major disadvantages with regards to redistributive capacity. The better-off groups, those in formal employment with higher per capita funding will get more benefits when compared with the rest of the population with lower financial protection. These arrangements when put in place for health financing will exacerbate existing inequalities rather than compensate them. The issue of segmentation as found in several low- and middle-income countries has limited social health insurance for formal sector employees like civil servants.

In some other countries that have managed to overcome different schemes for different population groups and established a unified pool for contributors and non-contributors, fragmentation remains active because much of the informal sector population is defined as non-poor and must contribute so as to be part of the pool. As a consequence of this de facto voluntary arrangement, individuals still experience inequities between the insured and uninsured population.

3.3.4.10 Different Pools for Different Population Groups, with Explicit Coverage for All

Some countries developed policy responses and pooling reforms due to concerns about the previous type of arrangement where different schemes for different population groups persist. This gave rise to the critical modification to the previous section, and this is why it is a separate pooling arrangement.

The main difference to the previous pooling arrangement is the explicit coverage schemes for the poor and the entire population outside the formal sector. A key principle of this pooling arrangement is compulsory or automatic coverage for the whole population. The explicit nature of the coverage schemes focuses on the equally explicit inequities in the levels of public funding per capita for the formal and informal sector populations. This mitigates some of the effects of segmentation, though the remains are incomplete due to the power of the initially insured population groups. That is, some countries have scheme for civil servants and another scheme for private sector employees.

Some have schemes for the low-income population and the elderly and a subsidized voluntary insurance program for the rest of the population. These schemes were latter replaced by the universal health coverage scheme. as a response to concerns about the differences in funding per capita across the schemes and the coverage gap due to the failure of the voluntary insurance to reach the informal sector. The UHC is expected to pool together all the revenues including increased budget allocations.

Common to these low- and middle-income countries is the inability to merge all coverage schemes into one pool due to the resistance of the formal sector employees for a unified national scheme. These countries have therefore created explicit coverage program for people outside the formal sector, whilst increasing the level of funding to narrow the gap in per capita expenditure across the different schemes. Although this pooling arrangement does not fully overcome fragmentation and population segmentation, it substantially reduces it.

3.3.4.11 Multiple Competing Pools with Compulsory Coverage

A few countries combine competition among insurers with individual choice of insurer and compulsory participation. This is commonly referred to as a competitive social health insurance arrangement. Each of the insurance schemes constitutes a separate pooling agency. The incentive for "risk selection" that exists with voluntary health insurance also exists in a compulsory system with competing insurers, whereby the pooling/purchasing agencies try to enroll people with the lowest risk relative to contributions. This has an adverse impact on equity in resources across pools.

3.3.4.12 **Risk Adjustment Across the Pools**

A critical requirement of this pooling arrangement is the risk adjustment of the revenues to each insurer as a means to limit segmentation of the population into different pools based on the health risks and to address inequities in resources available across different pools. Risk adjustment can be organized in two ways: funds are either allocated from a national level fund holder to the various pools through risk-adjusted allocations. Criteria like age, sex, poverty and disease burdens are utilized. Here, funds are transferred from pools with lower health risks, or with higher incomes to those with higher health risks, or lower incomes.

3.3.4.13 **Virtual Single Pool**

This is a type of pooling arrangement with an effective risk adjustment mechanism that will prevent risk selection efforts and act as a virtual single pool due to the flows between the pools. This has important similarities with the territorially distinct pools. The aim of this is to match per capita funding of each pool with the relative health risk of the population affiliated to each pool.

4.0 CONCLUSION

Universal health coverage (UHC) is an important agenda to policymakers around the world, and health financing has been recognized as a key area for health system actions that will positively impact on UHC. Health financing for UHC consists of three core functions: revenue raising, which is the mobilization of resources for the health sector; pooling, which implies the accumulation and management of prepaid financial resources for some or all of the population; and purchasing, which is the allocation of pooled funds to health service providers. Revenue raising, and purchasing are of strong policy interest in pooling arrangements and have the potential of contributing to the progress of UHC. The function of pooling as well as the different ways that pooling is organize is of critical

importance to the progress of UHC. Risk pooling is the spreading of the financial risk associated with the need to use and pay for health services, rather than to be fully borne by the individual who falls ill. There is need to encourage pooling as a health financing policy instrument that will provide a simple classification of the country's pooling arrangements through which the challenges associated with fragmentation will manifests in each setting.

5.0 SUMMARY

Countries can assess their pooling arrangements so as to identify the policy options that will address fragmentation

and mitigate the consequences in health systems. However, classifications are useful, because they do not substitute for the detailed work that is needed to fully understand pooling arrangements, the links to other health financing , the system functions and the implications for policy. The cost of Social Health Insurance through employment contributions rises with medical costs and affects the competitiveness of the economy. Spreading health care cost to all factors of production through comprehensive National Health Insurance financed by progressive taxation of income from all sources, instead of employer-

employee contributions, will protect health system objectives, especially during economic recessions, and will ensures health system sustainability.

6.0 TUTOR-MARKED ASSIGNMENTS

1. Explain why the systemic view of health financing is necessary?

2. Explain how population ageing will lead to uncontrolled health expenditure growth?

3 Explain how the sustainability of health financing can be achieved in health systems?

4. Use two reasons and explain how fragmentation in pooling can contribute to inefficiency in the health care financing

5. State the three qualities of a good financing system

6. Explain the central objective for pooling

7. Explain how pooling occurs in the health care financing systems

8 Differentiate the functions of compulsory, automatic and voluntary pool participation.

7.0 REFERENCES/FURTHER READINGS

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