Financing Healthcare

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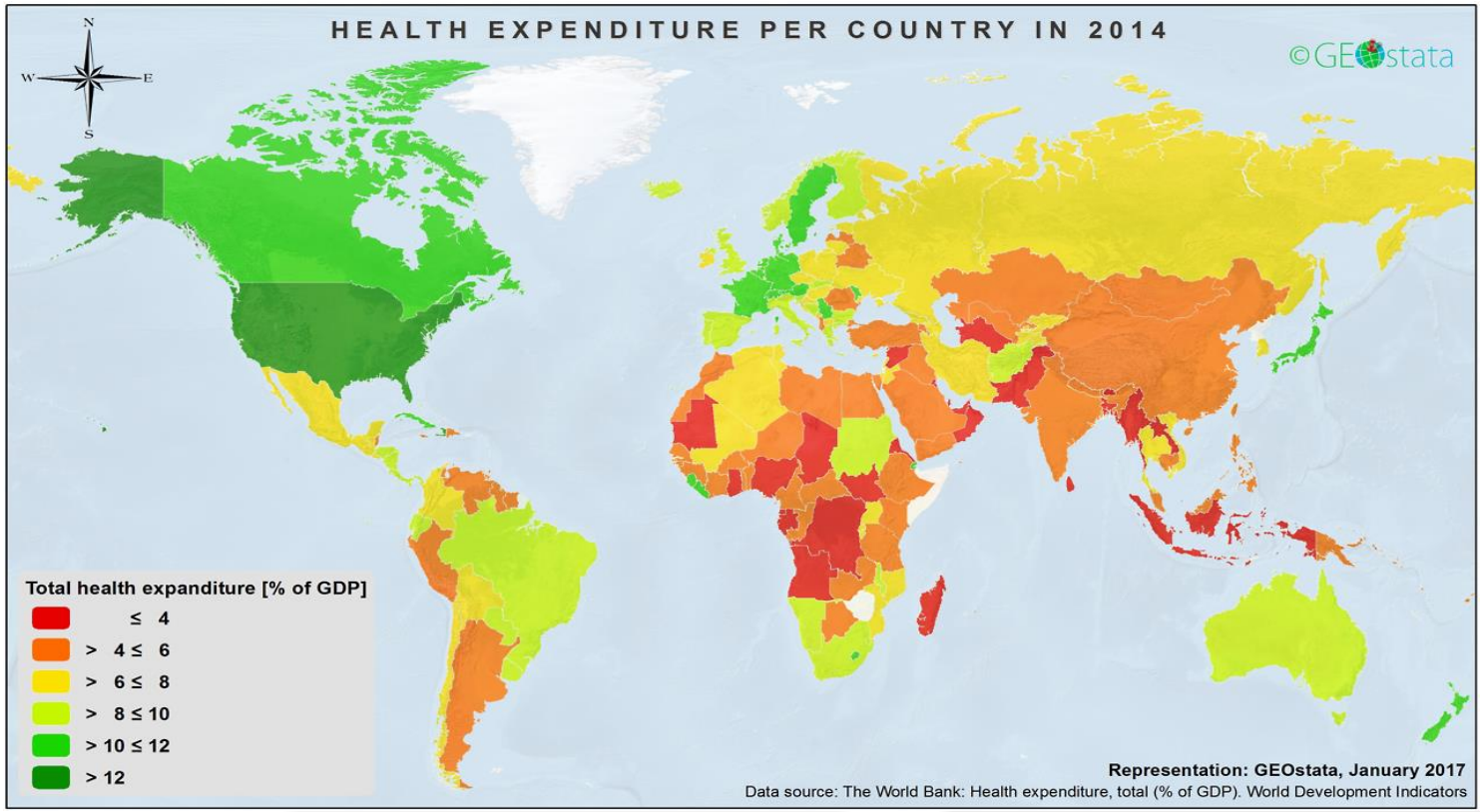
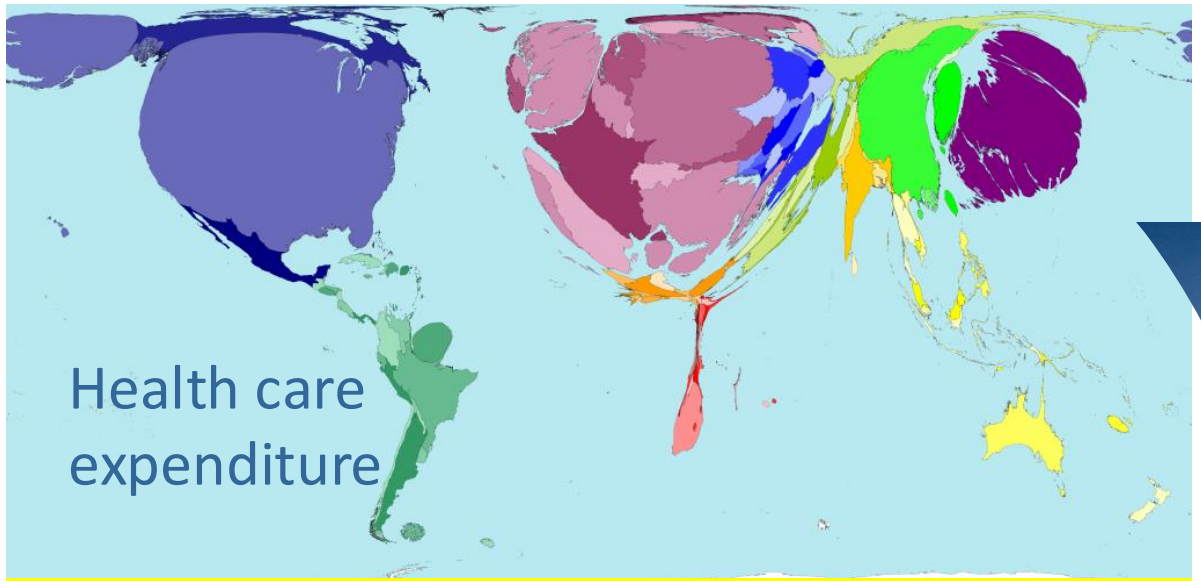
Introduction

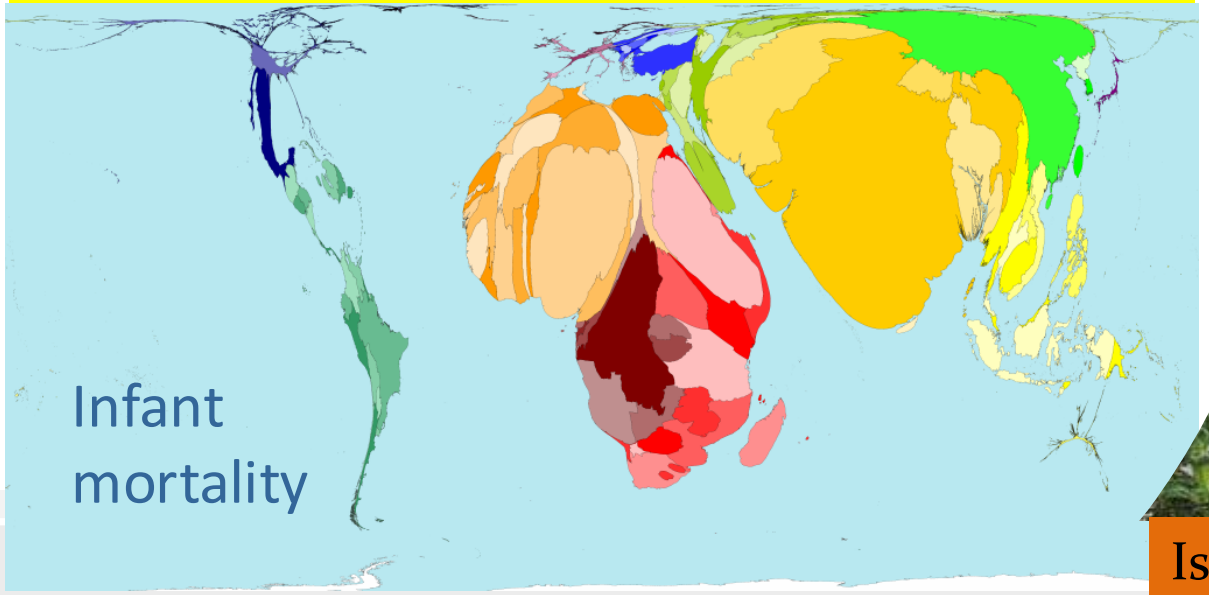
- **Health financing is a core function of health systems.**
- **Health financing = one of WHO building blocks**
- **Expenditure levels vary between countries.**
- **The amount spent on healthcare depends on wealth.**
- **In developing countries, financing is a major barrier to health care delivery.**





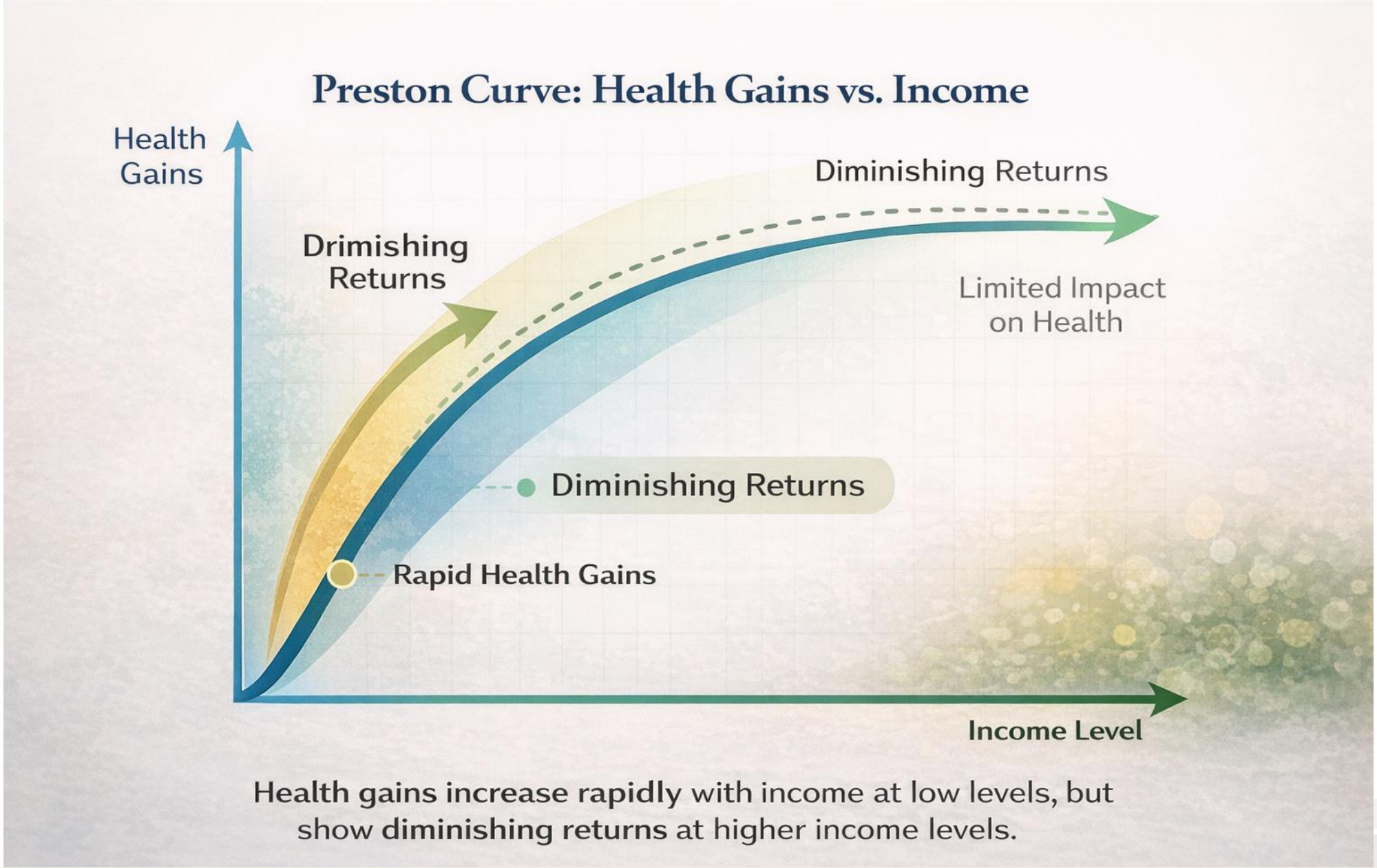
“wealthier countries are healthier countries”

WHAT DO YOU THINK??



Is wealth the cause or just a correlation?

www.worldmapper.org



In low-income countries, financing is critical; in high-income countries, efficiency and equity matter more than additional spending.

Why Healthcare Financing Matters

- **Health systems face growing financial pressures:**
- **Aging Populations**: increase the burden of chronic diseases (e.g., Jordan's elderly projected to reach 8% of population by 2025).
- **Pandemics & Climate Crises**: COVID-19 showed gaps in emergency funding; climate-related health costs are incraesing.
- **Technological Advancements**: (AI, telemedicine, precision medicine) require continous financing.
- **Equity Gaps**: 30% of Jordanians lack health insurance (DOS 2023); OOP payments increase poverty.

Without financing, health systems fail.

Objectives when funding healthcare

- **1. Equity :** Ensure access to care for all(regardless of income, location, or social status).
- **2. Efficiency :** Best use of resources (cost-effective, evidence-based, minimal waste)
- **3. Financial Protection :** Prevent Catastrophic Health Expenditure (CHE) from healthcare costs through risk pooling and government support for vulnerable groups.

Health should be a right, not a privilege

CHE: when healthcare costs exceed 10–25% of household income (WHO).

Definitions

Financing:

- *The process of obtaining and managing funds to pay for health services and systems.*

Revenues (إيرادات/عائدات):

- Funds received or expected by a healthcare facility, primarily from:
- **Patient services** (e.g. consultations, procedures)
- **Third-party payers** (e.g. insurance reimbursements)
- **Other sources** (e.g. government subsidizations, donations)

Expenditure: spending on healthcare services

Business structure

- **For Profit:**
- A for-profit organization objective is to **maximize profit** by generating revenue that exceeds costs.

Profit = Total Revenue - Total Expenditures

- Once the amount of revenue exceeds expenditures, this is called **profit**.
- **Revenue > Expenditures**:
  - Must cover expenses (salaries, equipment, taxes) **and** generate excess.
- **Breaking Even**:
  - Revenue = Expenditures (no profit/loss).
- **Investor Returns**:
  - Profits distributed to shareholders/owners.

Business structure

- **Not-for-Profit:**

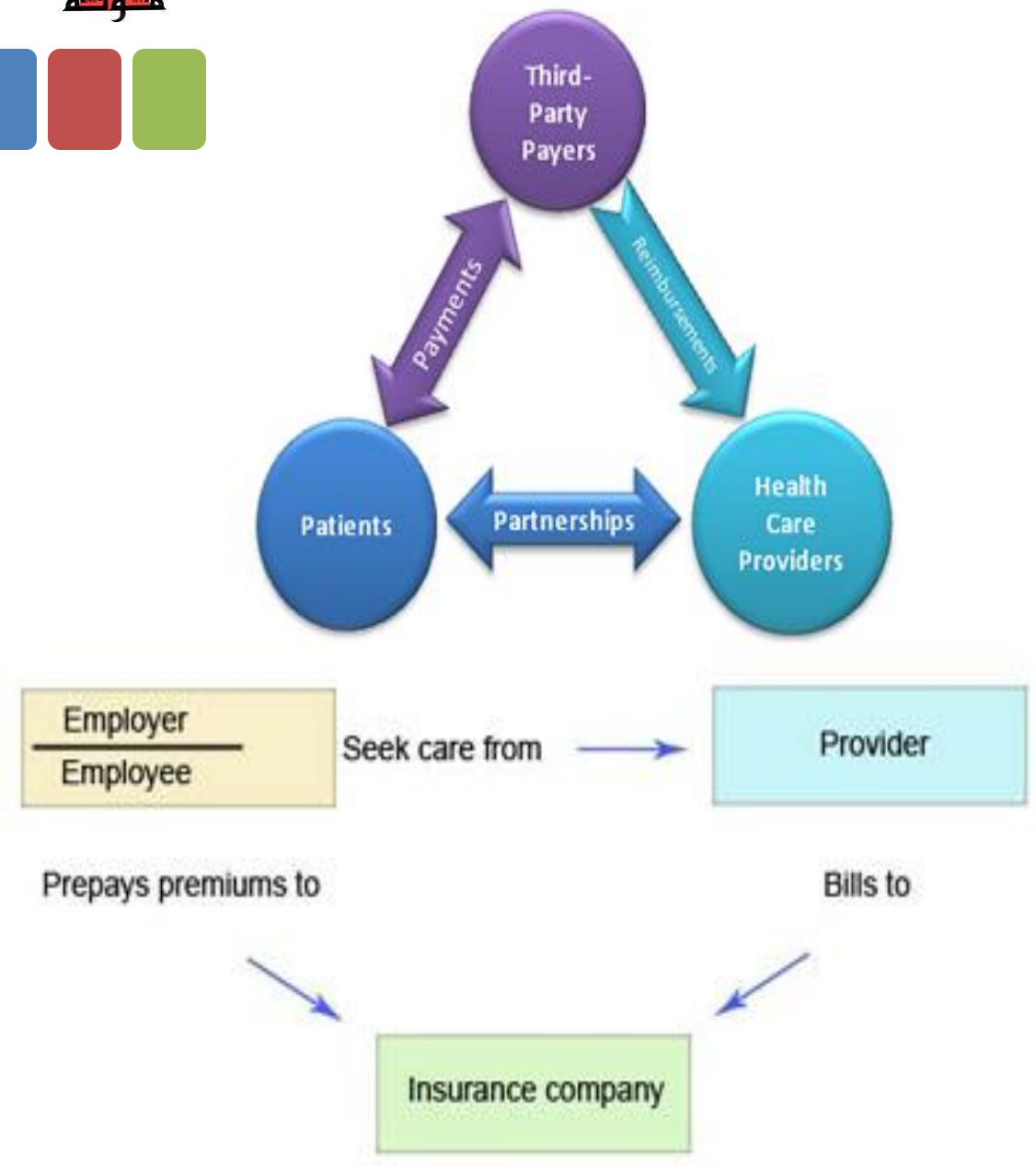
- Break even while reinvesting all excess to improve services and expand access.

The difference between a **not-for-profit** and a **for-profit** is :

1. **Profits are reinvested, not distributed.**
2. **A not-for-profit** establishments are tax-exempt (do not pay taxes).
3. **Fund sources** :Patient fees (if applicable), Grants, government subsidies, and charitable donations.

Donations are often tax-deductible for the donor.

Business structure



- **Third-Party Payers:**

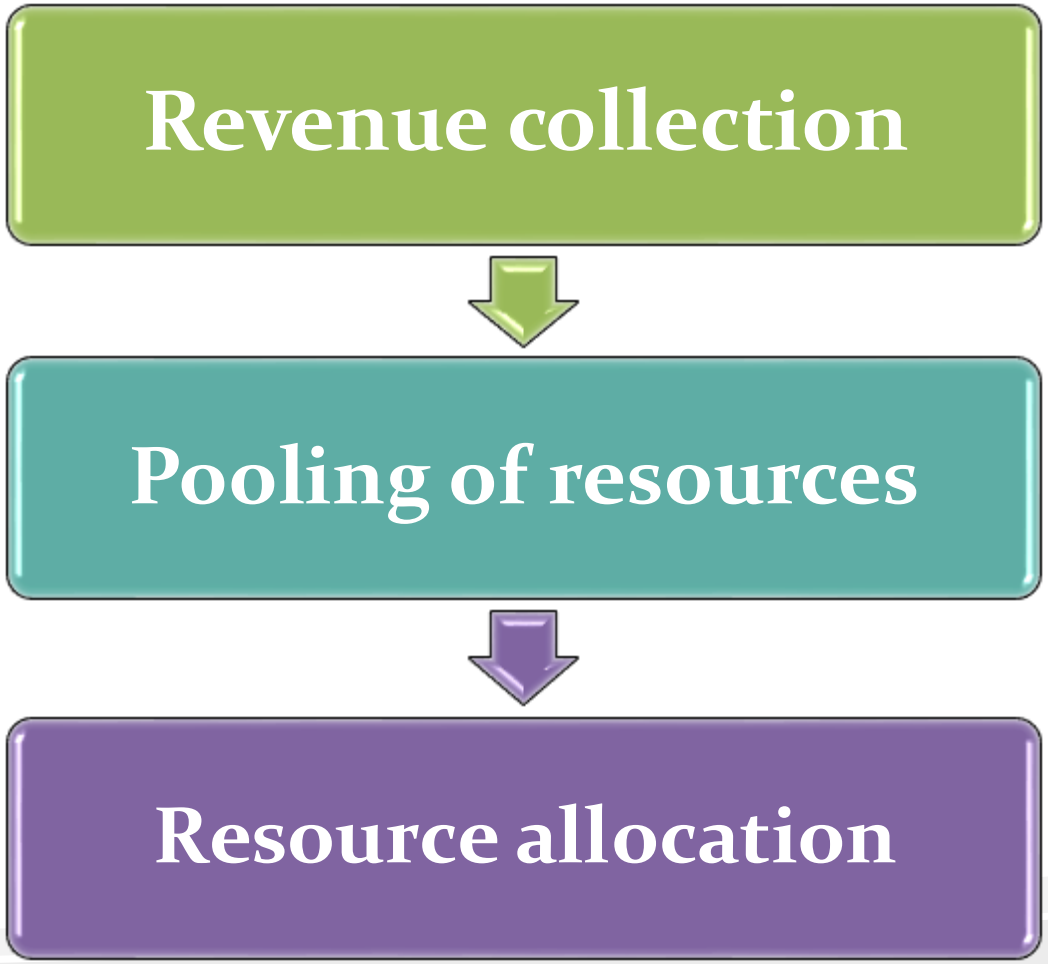
Organizations (other than patients) that finance healthcare services by:

- **Covering costs directly** (pre-payment)
- **Reimbursing costs** (post-service payment)

Types of Third-Party Payers:

- **Public Payers**
  - Government programs (e.g., Jordan's Ministry of Health)
  - Social health insurance systems
- **Private Payers**
  - Commercial insurance companies
  - Employer-sponsored health plans
- **Hybrid/Other**
  - Non-governmental organizations (NGOs)
  - International donors (e.g., WHO, UNICEF)

Flow of finances



1. Revenue collection

- **Revenue collection:** How health systems gather funds from various sources.
- Revenue collection concerned with the *sources of revenue (who pays)* for health care, *the type of payment (what are the contribution mechanism?),* and *the agents that collect these revenues (who collects?).*

1. Revenue Collection

Who Pays?

- General population (taxes)
- Subgroups (insurance premiums)
- External sources (e.g., World Bank loans)
- *Donor contributions *often treated separately*

How is it collected?

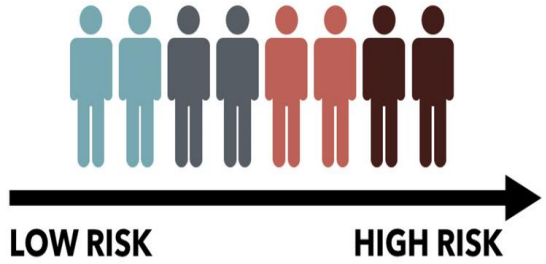
- **Taxation** (income tax)
- **Social insurance** (payroll deductions)
- Private insurance premiums
- Out-of-pocket payments

Who collects?

- Governments / public agencies
- Insurance funds
- Healthcare providers

Collection agents often also pool funds and purchase services.

Pooling of resources



Pooling: Combining prepaid funds to share financial risk across populations

When pooling resources:

- **Prepayment contribution:** Funds are collected **before illness occurs**
- **Risk Sharing:**
  - Healthy subsidize the sick
  - Wealthy subsidize the poor
- **Equity:**

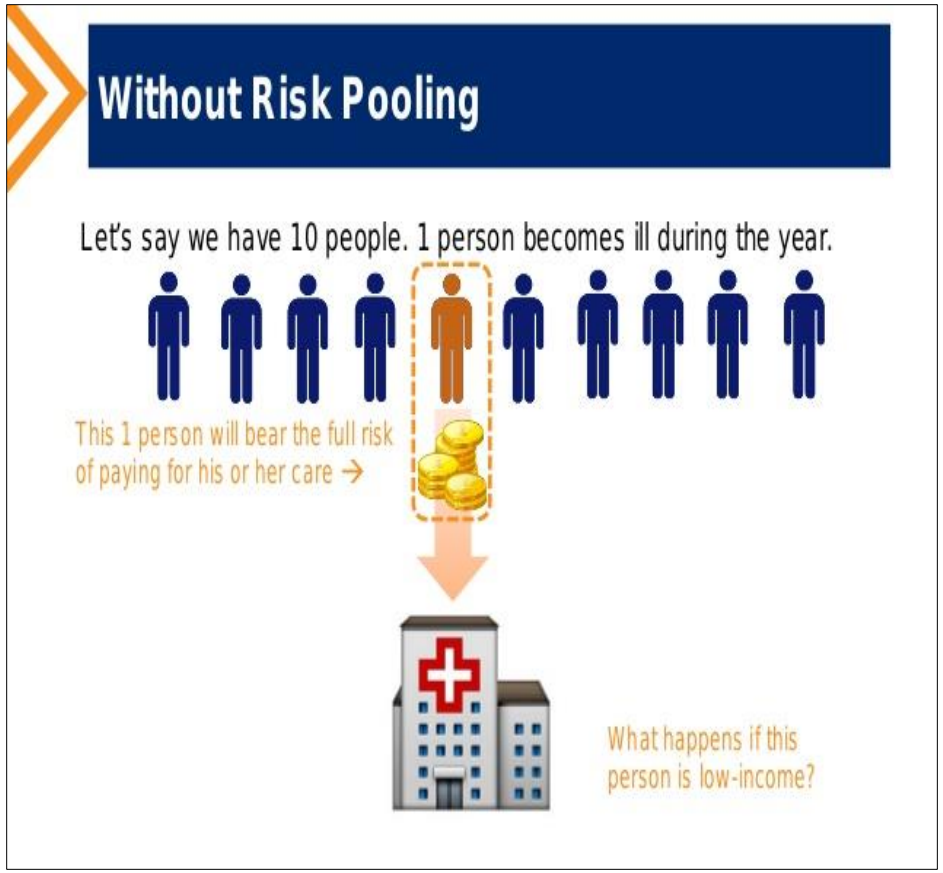
- Contributions based on **ability to pay**
- Access based on **health needs**

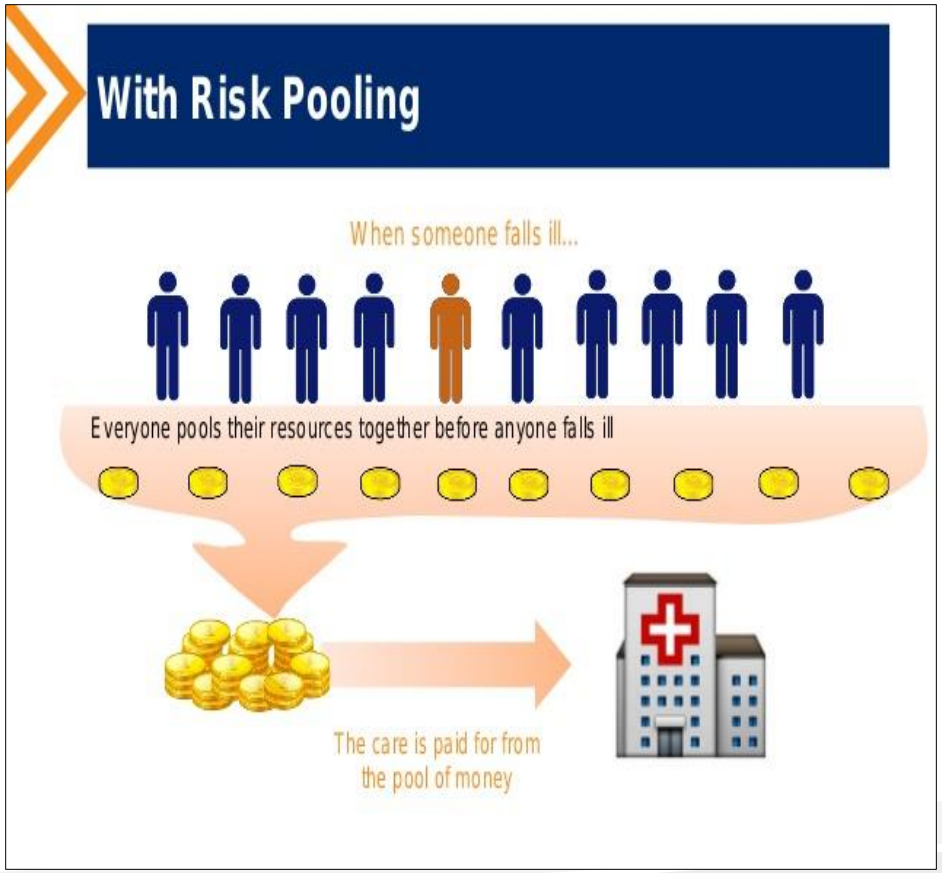
Pooling combines two elements: funds and risk

A mix of contributors is essential:
(contribution > need, = need, < need, or no contribution with need)

Pooling of resources

Sharing financial risk between contributors.



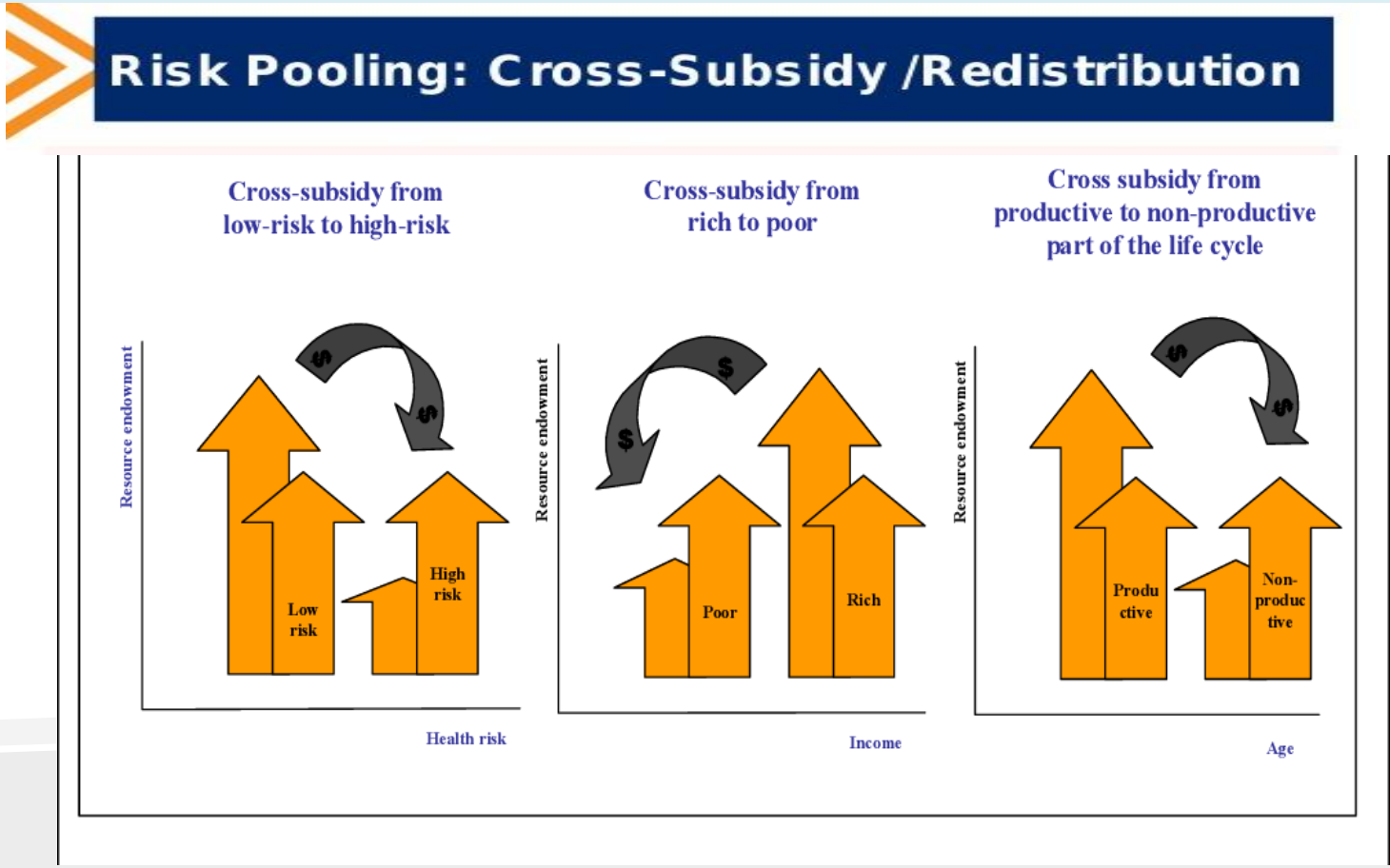


Pooling and Cross-Subsidization

- Tax-based financing and health insurance involve pooling
- Out-of-pocket (fee-for-service) does not involve pooling (each individual pays for their own care)

How Pooling Works:

- Pooling enables **cross-subsidization**:
  - Low-risk → high-risk
  - Healthy → sick
  - Wealthy → poor
- This allows:
  - Some services/groups to pay **more than cost**
  - Others to receive care at **lower than cost**



3. Resource allocation (Purchasing of health services)

- **Distributing pooled funds** to healthcare providers
- **Purchasing of Health Services**
- Carried out by **public or private agencies**
- Funds are used to:
  - **Provide services directly**
  - **Purchase services for beneficiaries**
- In many systems, the **purchaser is also the pooling agent**

3. Resource allocation (Purchasing of health services)

- **Who are the purchasers?**
- Ministry of Health (MOH)
- Social security agencies
- Insurance organizations
- Individuals / households (out-of-pocket)

Types of Purchasing:

Passive purchasing:

Follows predetermined budgets or pays bills as they are presented (Paying for services as they are provided, with little planning or control) Example: Hospital sends bill → government pays

Strategic purchasing:

Uses **value-based payments** and **negotiates quality and price** (Actively selecting services based on cost, quality, and value) Example: Government chooses best provider at set price

Patient Cost-Sharing Mechanisms

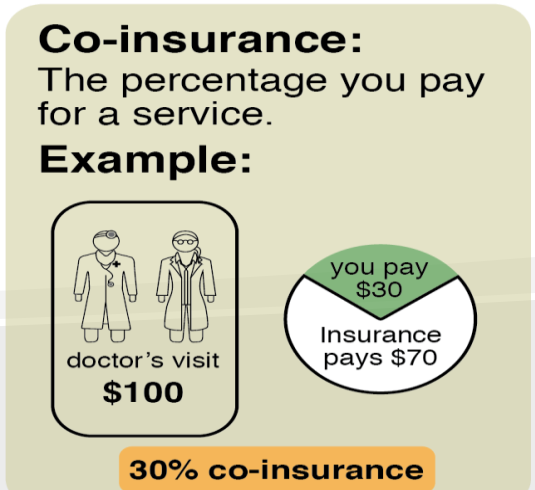
1. Co-payment

- A **fixed amount** paid by the patient per visit
- Paid **regardless of the services provided**
- *Example: Patient pays $20 per visit*

2. Coinsurance:

The patient pays a **percentage of the cost**, while the insurer pays the rest

- *Example: 80/20 policy → patient pays 20%, insurer pays 80%*

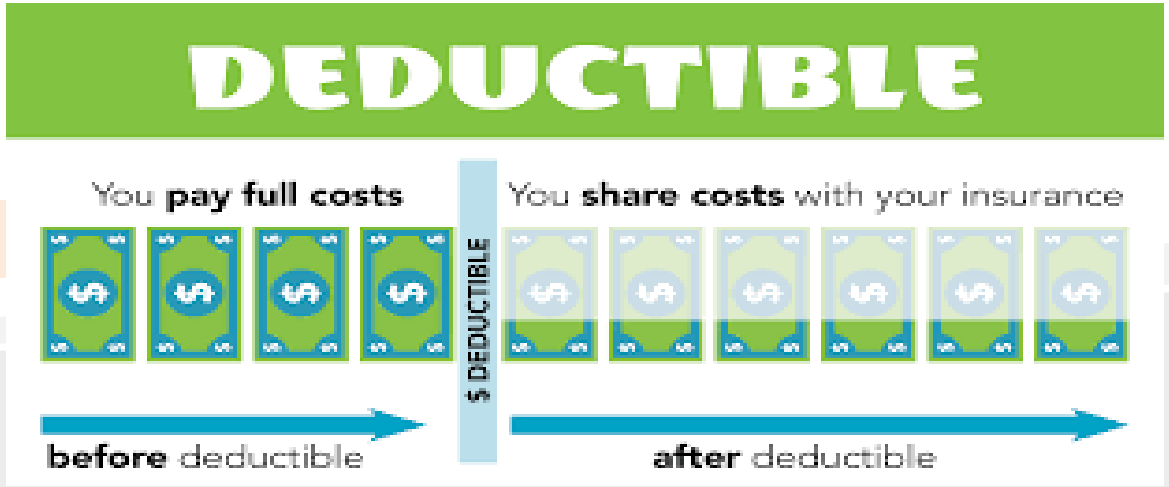


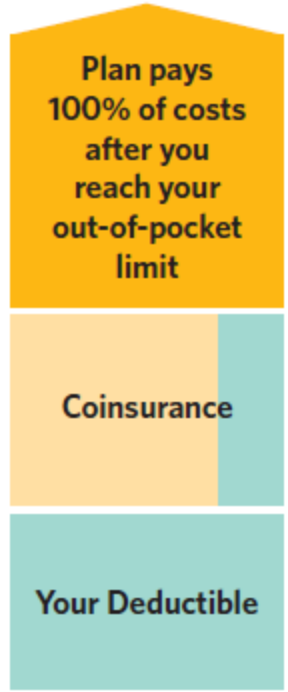
Patient Cost-Sharing Mechanisms

3. Deductible

- The amount the patient must pay **out of pocket each year**
- Paid **before insurance coverage begins**
- Example: Patient pays first $500 → then insurance starts covering costs

Deductible = pay first, then insurance pays

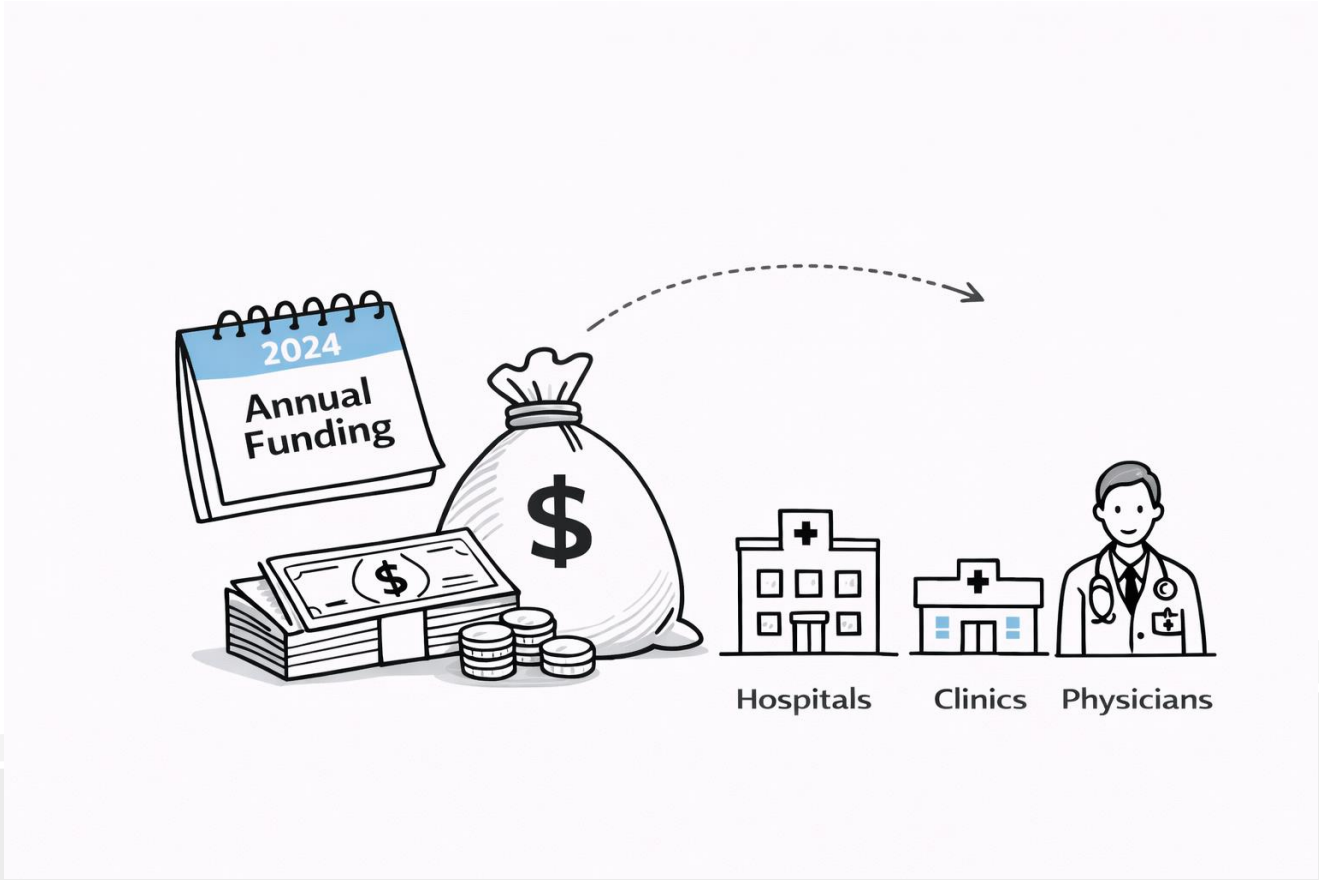




Payment Methods

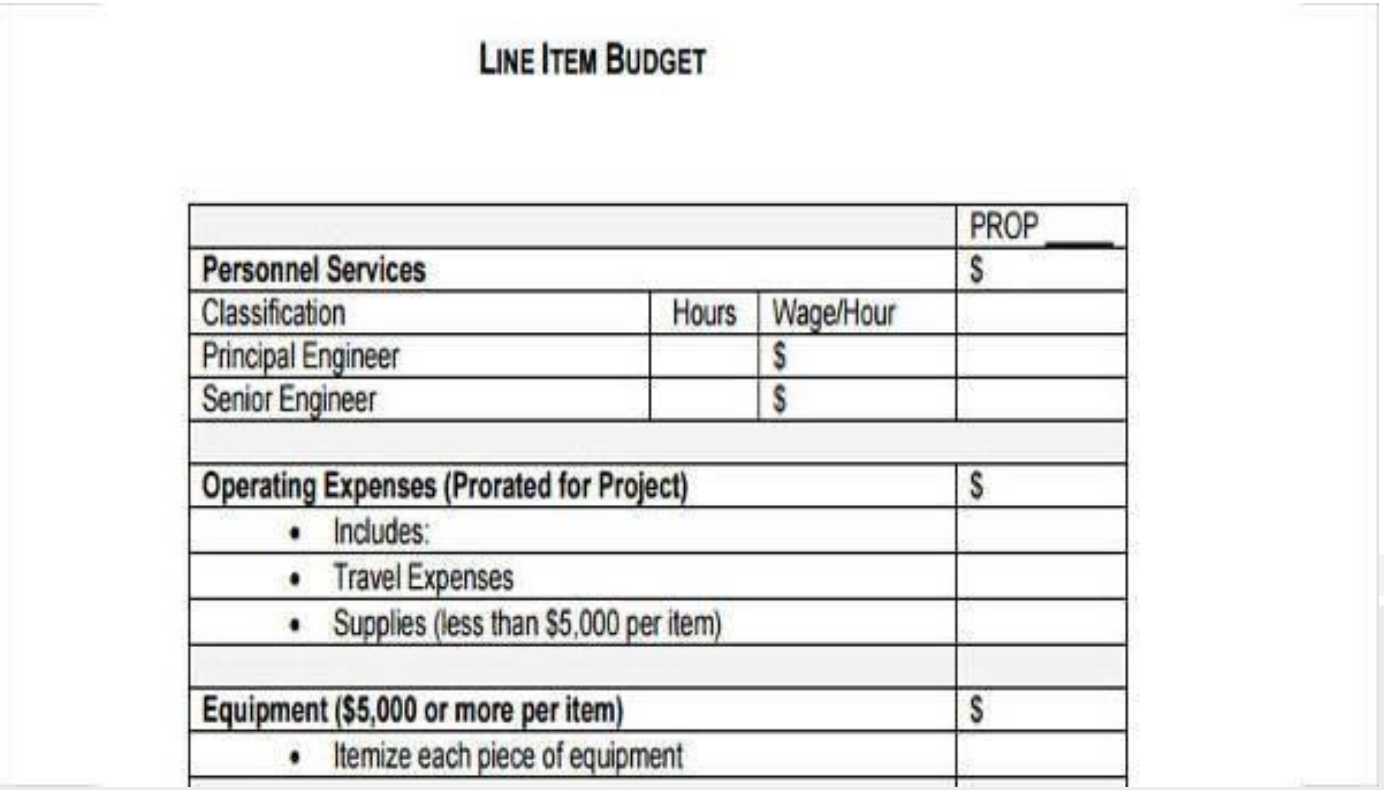
Global Budgets

- A **fixed annual amount** allocated to healthcare providers
- **Covers:**
- Hospitals
- Clinics
- Physicians
- **Based on:**
- Type of facility
- Historical budget
- Number of beds (hospitals)
- Per capita or utilization rates



Payment Methods

- **Line-item budgets** A detailed budgeting method where funds are **allocated to specific expense categories**
- **Includes:**
- Salaries (personnel)
- Equipment
- Supplies
- Operating expenses



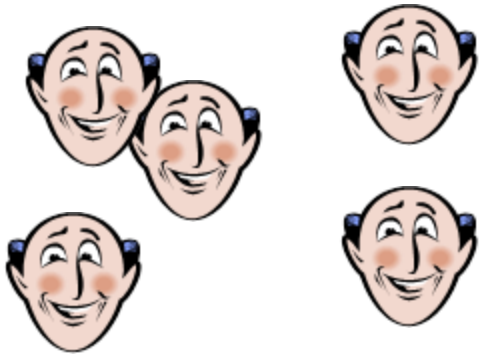
LINE ITEM BUDGET

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

Payment Methods

Capitation

- **Fixed annual payment per patient**
- Paid to **primary care providers**
- **Regardless of service use**
- *Example: $200 per patient/year*
- 200/year×1,000patients=200,000 annual budget



Per diem payment

- **Fixed daily rate per patient stay**
- Paid to **hospitals**
- *Example: $500 per day*

Rates vary by:

✓Department (ICU vs. general ward)

✓Hospital type (public vs. private)

Payment Methods

Case-based payment Fixed payment per case/condition

- Covers **all standard services** for that episode
- *Example: Knee replacement → fixed cost*

Fee for service

Payment per service provided

- Each service is charged separately
- *Example: Consultation, tests, X-ray*

Paid by:

- Patients (**out-of-pocket**)
- Insurers (**reimbursement**)

Key Trend: Jordan mixes global budgets (public) + fee-for-service (private).

Key Health Financing Indicators

Total Health Expenditure (THE) per Capita

- **Average health spending per person**

Calculation:

- (Government + Private + Donor + Household spending) ÷ Population

Purpose:

- Compare spending across countries
- Track changes over time

Example:
Jordan: $327
Saudi Arabia: $1,045
Egypt: $150
Turkey: $480

Higher spending does not always mean better health outcomes

National Income Metrics

GDP vs. GNI		
Metric	Definition	Key Difference
GDP (Gross Domestic Product)	Value of goods and services **produced within a country**	Measures **domestic production**
GNI (Gross National Income)	GDP + net income **from abroad**	Reflects **citizens' income**

Jordan Health Financing Overview

Jordan Health Financing (2023–2024)

- **Key Indicators**
- GDP: **8%** Health spending in Jordan is relatively high compared to countries at a similar income level.
- Per capita spending: **~$300**
- Total health expenditure: ~ (JD 2.85B / $4B)
- Government health budget: **~10%**

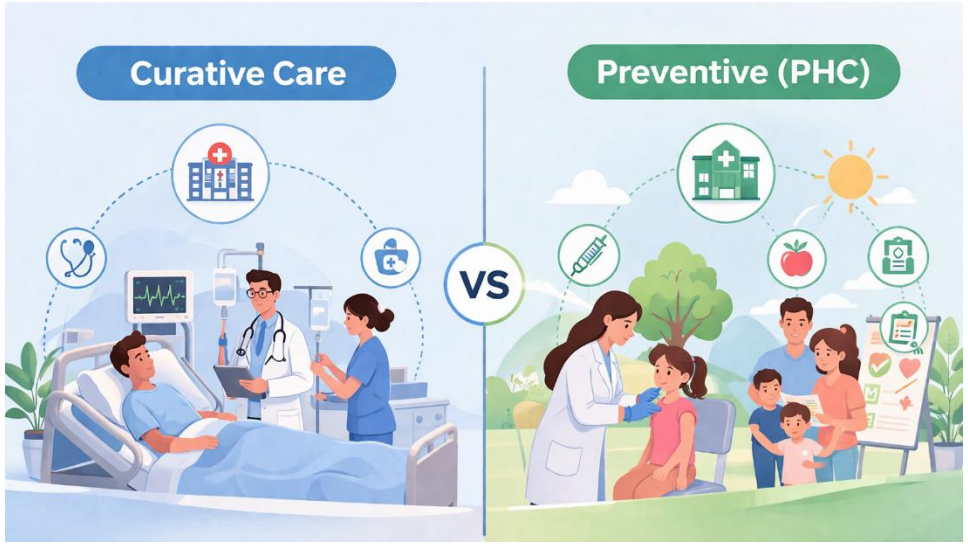
Funding Sources

- Public: **68.2%** (**Ministry of Finance** (**40.1%**), **Social Security** (**18.3%**))
- Private: **29.4%** (**Household OOP** (**30.5%**), **Private Insurance** (**15.8%**))
- Donors: **2.4% Excludes UNRWA (0.6%)**

Spending & Coverage

Spending Allocation

- Curative care: **72%**
- Preventive (PHC): **19%** *(below WHO target 30%)*
- Drugs: **24.1%**
- Digital health: **1.9%**
- *The rest spent on* administrative activities, training, and other activities.



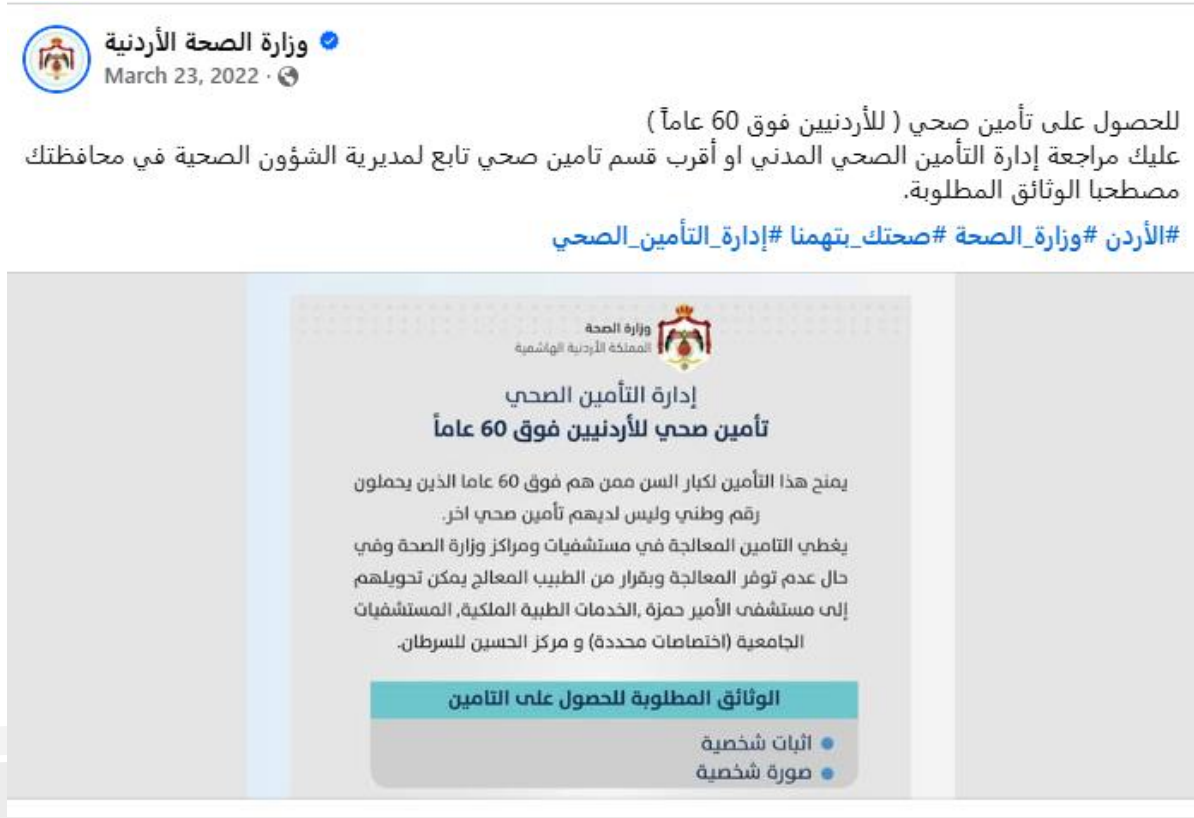
Insurance Coverage

- Total coverage: **62%**
- Jordanians: **75%**
- **Exclusions**: ~5% (Royal Court exemptions)

Health Insurance Coverage in Jordan

Eligible Groups:

- Public sector employees & their dependents
- Free coverage is provided to citizens aged 60+ and children under 6.
- Low-income groups (Ministry of Social Development)
- Residents of remote and less fortunate areas
- Organ donor family member (valid for 5 years)
- Blood donors (valid for 6 months)
- Patients with specific conditions:(infectious diseases, cancer insurance is available for Jordanians under 19 and over 60 not covered by other insurance, kidney diseases, tuberculosis, AIDS, addiction)



Readings:

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