Sources of health care financing

In all OECD countries, the various schemes that pay for the health care goods and services rely on a mix of different sources of revenues. Government schemes, for example, typically receive budget allocations out of the overall government revenues (e.g. from income and corporate taxation, value-added tax, etc.). Social health insurance is usually financed out of social contributions payable by employees and employers. However, these schemes may also receive a varying proportion of their revenues from governmental transfers. The main sources of revenue for private health insurance are either compulsory or voluntary prepayments, which typically take the form of regular premium payments as part of an insurance contract. Out-of-pocket payments are exclusively financed from households' own revenues. Some health financing schemes (e.g. non-profit or enterprise schemes) may also receive donations or additional income from investments or rental. Resident financing schemes can also receive transfers from abroad as part of bilateral co-operations with foreign governments or other development partners. However, these transfers play no role in the vast majority of OECD countries.

The composition of revenues is strongly correlated with a country's system of health care financing. Hence, when analysing the overall revenue structure in, say, Denmark – where health care activities are predominantly financed through local government schemes (see indicator on "Financing of health care") – governmental transfers are the most important revenue (Figure 7.9). Comparing the structure of financing schemes with the types of revenues that these schemes receive can give important insights into how financing works in different health systems: in many countries, the government's role is typically larger than as just a simple purchaser of health services (Mueller and Morgan, 2017). In Japan, for example, the government is directly responsible for only 9% of all health spending but government transfers to the different schemes existing in the country constitute 42% of all revenues for health care financing.

The role governments play as a financing source can be highlighted more clearly when only analysing the composition of revenues for compulsory health insurance, which in most OECD countries consists of social health insurance (SHI) (Figure 7.10). In the countries analysed, governmental transfers are a source of revenue in each case but the importance differs significantly. In Japan, more than 40% of the revenues of SHI stems from governmental transfers. The shares are similar in Chile and Finland but account for less than 5% in Estonia, Poland and Slovenia. In those countries, SHI funds finance their outlays nearly exclusively via social contributions. Yet, even here, substantial variations exist when analysing this stream of revenues in more detail. In Poland, employees bear the brunt of social contributions, whereas in Estonia the financing responsibility falls on employers.

Some countries are planning to reduce their reliance on wage-based contributions in the face of shrinking labour markets and financial shocks, and are increasingly looking for ways to diversify their revenue base (OECD, 2015). While there is little year-to-year change in the health financing structure and composition of revenues, some trends can be discerned over a longer time horizon (Figure 7.11). In Belgium, for example, the share of social contributions in all revenues has fallen from over 50% to around 43% over the last decade. At the same time, governmental transfers have gained importance. The latter is also true for the United States where the share from government transfers increased from 34% to 41% over the same time period. In Korea, on the other hand, government transfers have stagnated while the share through social contributions has increased.

Definition and comparability

Health financing schemes have to raise revenues in order to pay for health care goods and service for the population they are covering. There are different types of revenues which can however be closely correlated with the financing scheme. In general, financing schemes can receive transfers from the government, social insurance contributions, voluntary or compulsory prepayments (e.g. insurance premiums), other domestic revenues and revenues from abroad as part of development aid.

In reality, the revenues of a health financing scheme are typically not identical to its expenses in a given year leading to a surplus or deficit of funds. In practice, most countries only analyse the composition of revenues per scheme and apply the resulting shares on a pro-rata basis to the expense of each financing scheme thus equating revenues with its expenses.

References

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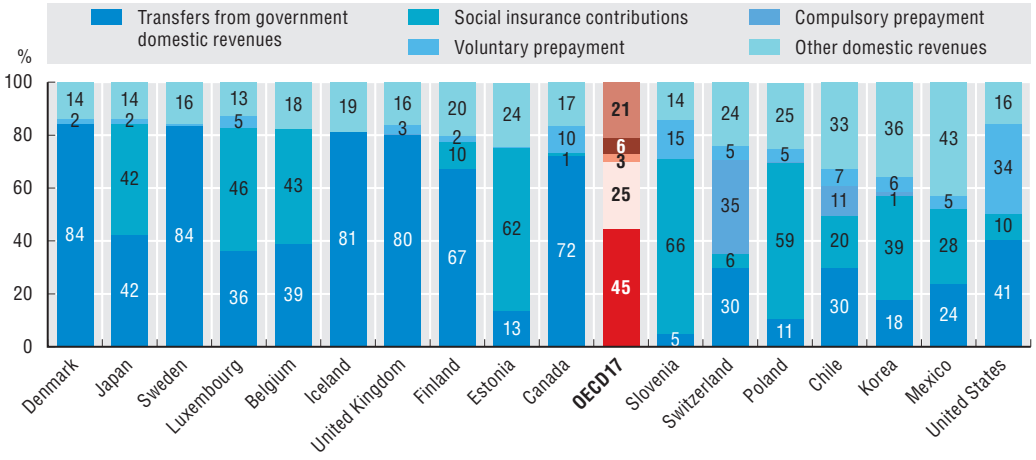
OECD (2015), *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264233386-en*.

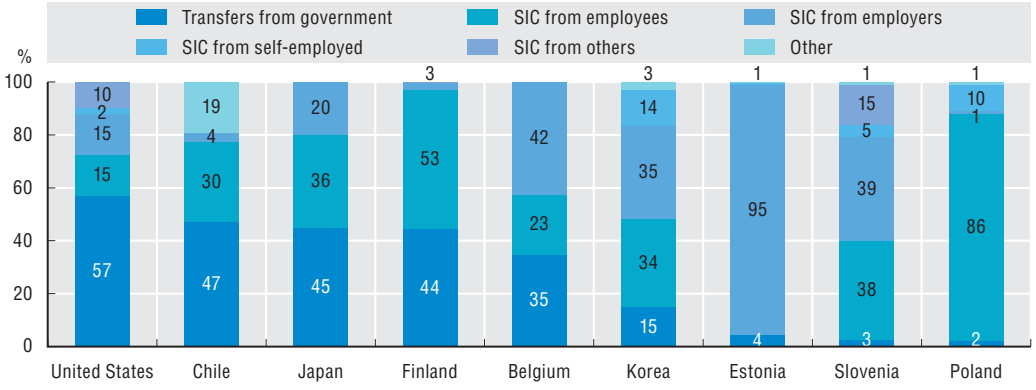
7.9. Health financing sources by type of revenue, 2015 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933604343

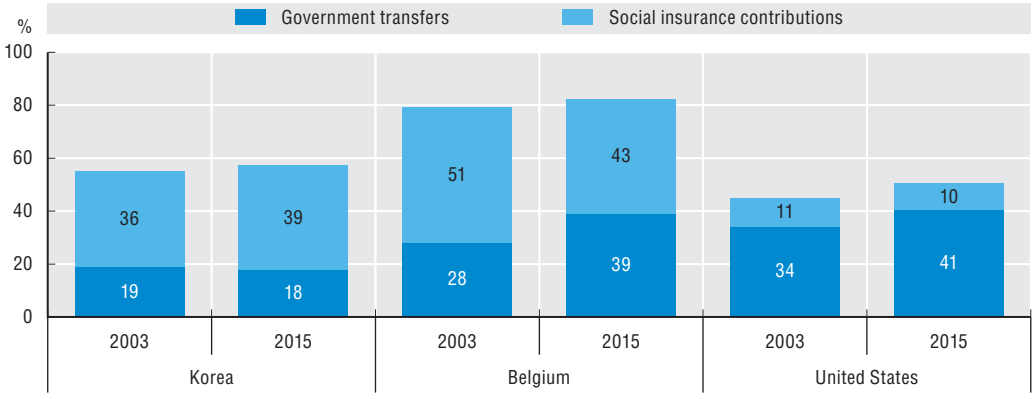
7.10. Financing sources of compulsory insurance by type of revenue, selected countries, 2015 (or nearest year)



Note: SIC stands for social insurance contributions. "Other" includes compulsory prepayment and other domestic revenues.
Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933604362

7.11. Share of government transfers and social insurance contributions in all revenues of financing schemes, selected countries, 2003-15



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933604381