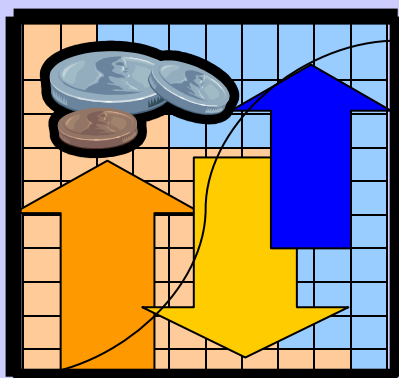




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Financing health promotion

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Financing health promotion

by

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**World Health
Organization**
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Executive Summary

Health promotion is a complex, multi-sector activity. Within the health system, it is organized vertically in the form of public health campaigns or integrated in other health care interactions. Furthermore, health promotion can be encouraged on the health care market, for example through the introduction of financial incentives. This paper advocates for health promotion in any form as a necessary intervention for improving and maintaining population health. It is considered equally relevant for developed and developing countries, although different countries may want to employ different strategies. While still under-funded in many high-income countries the lack of funding for health promotion is generally most notorious in middle and low-income countries. In many of the latter groups, health promotion is also not included in health system financing arrangements.

This paper explores how health promotion can be integrated in health system financing schemes. The analysis departs from the health systems financing framework and is based on the health financing functions: revenue collection, pooling and purchasing. Examples from different countries are presented to illustrate a number of innovative financing options for health promotion. Countries that aim to achieve universal access to cost-effective programs of this kind are recommended to exert efforts in securing adequate funds for health promotion. Furthermore, they are advised to develop multifaceted financing strategies, including ways to encourage efficient behaviour on the health care market.

1. Introduction

Health promotion is a multi-sector activity: only part of it is organized within the health system. Broadly spoken, it refers to public policies and campaigns about hygiene, nutrition and safe sex, the signalization of mined areas, measures on accident prevention, and programs that lobby for better living conditions in slum-like urbanizations. It comprises governmental and non-governmental programs that are disease specific or focused on healthy life-styles in general. It also relates to global, national and local efforts to address the social determinants of health, including human rights, the redistribution of wealth and resources, as well as environmental issues. Health promotion programs are implemented in various environments and at different levels, including the population, community, workplace, school, hospital and clinic. The programs are generally distinguished in population-level and individual-based interventions (DCPP, 2006). To date, the basic principles of health promotion programs remain consistent with the 1986 Ottawa Charter that prioritized building healthy public policy, creating a supportive environment, strengthening community action, developing personal skills and reorienting health services (WHO, 1995).

Health promotion is widely recognized as a cost-effective way to reduce the burden of disease and to improve population health. It also has proven to result, sooner or later, in cost savings for the health system (WHO, 2005; DCPP, 2006). Health promotion programs may contribute to controlling health problems associated with ageing, non-communicable diseases across age groups, HIV/AIDS, injuries caused by accidents and violence, communicable diseases, global epidemic influenzas, and others. In a global

report on preventing chronic disease, it was confirmed that while 60% of all deaths in the world are due to chronic disease and 80% of these occur in low middle income countries, a major part of it is preventable: 'Adopting a pessimistic attitude, some people believe that there is nothing that can be done, anyway. In reality, the major causes of chronic diseases are known, and if these risk factors (unhealthy diet, physical inactivity, tobacco use) were eliminated, at least 80% of all heart disease, stroke and type 2 diabetes would be prevented; over 40% of cancer would be prevented'. The report confirms that 'comprehensive and integrated approaches that encompass interventions directed at both the whole population and individuals ...', made death rates fall by up to 70% in the last three decades in Australia, Canada, the United Kingdom, the United States, and have also had significant results in middle income countries, like Poland (WHO, 2005).

Similarly, evidence is mounting about effective programs to reduce HIV transmission through the promotion of condom-use (Weller and Davis, 2004), or to control the alcohol-related burden of disease. In the latter case, the Disease Control Priorities Project found that even a combination of interventions is cost-effective: '...the most efficient strategies for reducing high-risk alcohol use would be tax increases (additional gains are obtained at virtually no extra cost because the costs of tax administration and enforcement remain relatively constant whatever the rate of tax), followed by the introduction or escalation of comprehensive advertising bans on alcohol products, reduced access to retail outlets, and the provision of brief interventions such as physician advice in primary care. Even a multifaceted strategy made up of an increase in taxation plus full implementation of the other interventions considered here has a favorable ratio of costs to health benefits (DCPP, 2006)'. In addition, as argued in this paper, a multifaceted strategy may increase the capacity of health systems to achieve universal coverage of health promotion programs.

In August 2005, WHO member states signed the Bangkok Charter for Health Promotion in a Globalized World (WHO, 2006). The charter identifies actions, commitments and funds that are needed to address health determinants through health promotion. It follows up on the Ottawa Charter establishing a firmer commitment to close the so-called implementation gap. The Bangkok Charter mainly focuses on the need to convince people to make other lifestyle choices. In this respect, the Commission of Social Determinants of Health goes one step further: it pinpoints to the socio-economic factors that determine such choices and emphasizes that these are '... conditioned by patterns of material deprivation and social exclusion': 'Health-compromising behaviors are disproportionately concentrated in socially disadvantaged groups, both in developed and in developing countries. Effective policy to tackle health challenges must address the underlying social conditions that make people who are disadvantaged more vulnerable' (Irwin et al., 2006). The recognition of the social determinants of health as the cause of health inequalities between and within countries has contributed to making health promotion in the broadest sense a key responsibility for merely any national ministry.

The need for multi-sector strategies to promote health is endorsed in this paper, but the analysis here focuses on health promotion as a function of the health system. It is argued that in addition to multi-sector approaches, health promotion must be enhanced within the

health system and incorporated in health financing arrangements, subject to evidence about the cost-effectiveness of interventions and the available technical and institutional capacity in a country. This paper departs from the thesis that even though it has been proven that most health system and financing reforms are inextricably related to health promotion it is still not readily visible in many health systems. This may be due, among other things, to too rigid, historic allocation mechanisms and a perceived lack of funding. Both issues are addressed in this paper by exploring innovative options to raise funds for health promotion as well as to incorporate incentives to encourage efficient behaviour (promoting health) on the health care market.

2. Health promotion framework

Improved health is the defining objective for any health system. Together with fair financing and responsiveness it represents the broader health system goals (WHO, 2000). Successful health system performance is related to the degree population health is maximized within the constraints of the available human, capital and financial resources in a specific country. From this perspective, health promotion programs play an important role to produce health gain and to control costs. But although health promotion is advocated as a cost-effective method to improve and maintain population health, health promotion financing is still inadequate both in developed and developing countries. Only 3% of total health expenditure on average is dedicated to prevention and health promotion programs in OECD countries (OECD, 2005). Furthermore, in many countries the limited financial resources that are available for health care are often disproportionately spent on hospital based curative services. In Asia and the Pacific more than 70% of essential interventions require primary care including prevention and promotion, but countries spend on average less than 10% of their health care resources on primary care and public health services (Asian Development Bank, 1999).

Disease prevention and health promotion are two closely related functions, but they are not same; their respective focus is different and both make use of different instruments. While prevention generally refers to clinical interventions, health promotion aims to increase people's awareness about improving and maintaining their own health. The two functions have been distinguished as follows:

- Health promotion refers to population-based strategies that target major risk factors of disease, mostly through efforts to change health-related behavior
- Preventive care refers to organized population-directed services in areas such as vaccination, screening and prenatal care (OECD, 2004).

As mentioned earlier, in this paper individual-based health promotion interventions are also considered.

Integrating health promotion in the health system requires the identification of the major health problems in a country. It means increasing public awareness about these health risks and changing allocation and utilization patterns to control these. As this refers to processes rather than end-states, health promotion programs need to be continuously assessed and monitored in terms of their relevance. Additionally, health system performance should be monitored in view of the pursued health promotion outcomes

(controlled health risks). To address the main health issues of today's world, the OECD identified the following set of health promotion performance indicators (OECD, 2004):

- Obesity prevalence (nutrition)
- Physical activity
- Smoking rate
- Diabetes prevalence (preventable through a healthier life-style)
- Gonorrhoea/Chlamydia rates (reproductive behavior)
- Abortion rates (reproductive behavior)

These indicators are drawn from experiences in OECD countries. However, additional or other indicators are needed in the context of non-OECD countries, like the use of condoms, bed-nets, seat-belts and helmets, or, for example, weight monitoring in countries with high levels of malnutrition. Adequately funded health promotion programs are assumed to raise the awareness about health, the main causes of illness and disability, and the predominant risk factors in a society, and thus to influence health-related behaviour of individuals and populations. Therefore, health promotion performance indicators should be developed at the country level (or even at levels below that) in view of the major health risks that are found on a certain moment in a specific place.

Financing health promotion programs is complicated, among other things due to their economic behaviour. Firstly, many programs do not behave as normal, but as public goods. This means that the total costs of production do not increase with the number of consumers, as they are non-rival (the amount that one person consumes does not influence the amount available for another consumer) and non-excludable (once the good is produced it is impossible to stop anyone else from consuming it). Health promotion programs, like a radio message or a bill board text, for example, are once produced beneficial to an unidentifiable and uncontrollable number of consumers. As a consequence, no one consumer will be willing to pay for the programs, or in other words, no market exists for them. Secondly, the programs, like preventive services, have externalities: their social benefit is larger than their private benefit. For example, encouraging one person to stop smoking may have a snowball effect within the family or community, and it reduces the risk of other people to suffer from passive smoking. Similarly, convincing one family member to use a bed net reduces the risk of infection in that person but also in others, and it may encourage other household or community members to do the same. This characteristic makes the market price of health promotion programs higher than what private households would be willing or able to pay for them; the price would reflect the social benefit, which is larger than the private benefit. Thirdly, health promotion and prevention are bound by the problem of time preference, i.e. consumers tend to value benefits more highly if they are more immediate (buy an aspirin to kill a headache) and prefer costs to be postponed. Health promotion programs do the opposite (pay (or 'suffer') now to avoid lung disease in the future), which makes them unattractive to consumers. In addition, time-preference affects the willingness of third party payers, like insurers, to finance health promotion programs. Where they would seem interested to invest in health promotion programs as a way to make cost savings in the future, insurers are also aware of the following: 1. the expected cost savings are statistic and are not necessarily produced in each individual person; 2. if produced, it may

occur only after many years; 3. the result may be beneficial to another financing agent rather than themselves, for example, another health insurer or a disability fund. This problem is particularly important in health financing systems that are based on competition between insurers. As consumers in such systems are allowed to change between insurers periodically, the latter have no guarantee that their investments in health promotion programs will effectively pay off to them (Belot, 2006). Competition between insurers may thus function as a disincentive for insurers to invest in health promotion programs, unless they are given opportunities to retain their clients.

Since the production and consumption of health promotion programs are subject to market failure, these are traditionally financed from public funds. In most countries, the Ministry of Health implements health promotion programs financed from general government revenues. Therefore, health promotion services are regarded as free to the consumer and often not included in contributory third party benefit packages. However, the impact of population-level programs on consumer behaviour is not always clear and there is now an increasing focus on individual-based strategies. Following the Innovative Care for Chronic Conditions (ICCC) Framework (WHO, 2002), health promotion activity levels need to be rationed and programs structurally integrated in all health care interactions. As argued in this paper, health promotion programs should pursue universal coverage. This can be done, among other things, by ensuring necessary financial resources through different financing mechanisms and developing diversified programs adjusted to local needs and capacities. In terms of health promotion financing, innovative fund raising mechanisms need to be encouraged. Furthermore, (financial) incentives should be incorporated in health financing schemes that target all the health market actors, including insurers, providers and consumers. Such incentives should also take into account the opportunity costs associated with producing and consuming health promotion.

3. Health systems financing and health promotion

Health systems financing has been subdivided into three sub-functions: revenue collection, pooling and purchasing (WHO, 2000). The strategic design of each of these functions has an immediate effect on coverage, delivery and access to health services. The health financing functions together have the following targets:

- to generate sufficient and sustainable resources for health
- to use these resources optimally (by modifying incentives and through appropriate use of these resources)
- to ensure that everyone has financial accessibility of health services

These targets are valid for health promotion, irrespective whether this is developed as an independent intervention or integrated at certain health service delivery levels. In order to monitor the performance of health financing schemes (including health promotion) in terms of coverage, access, equity and effectiveness, a number of key indicators have been identified for each of the three health financing sub-functions. This set of indicators aims to help policy makers develop, monitor and eventually improve their health financing scheme (Carrin and James, 2004). The analysis presented below departs from this framework referring to experiences in various countries. This way, a number of

innovative options are discussed for revenue collection and for the incorporation of financial incentives at the levels of pooling and purchasing.

3.1 The revenue collection function (performance indicators: population coverage and method of finance)

Population coverage

The population is the primary source of health care financing. Public financing refers to prepayment schemes, like social health insurance or tax-based schemes that offer financial protection against the risk of ill health. This is done by collecting and pooling regular and predictable contributions. It is contrary to out-of-pocket or direct payment schemes that require people to pay at the moment of service utilization. These schemes exclude people who cannot afford to pay when illness occurs, or may impoverish them due to unexpected, relatively high health care costs.

Population coverage is an important indicator for revenue collection: the more people covered by a public financing scheme, the more people contribute and the more funds are collected. At the same time, the more people enjoy good access and utilization of health services, and the more are protected against the financial risks associated with the services included in the benefit package. As illustrated below, health promotion programs are often not included in the benefit packages covered by social health insurance schemes.

Method of financing

As mentioned above, the method of financing (prepayment vs. out-of-pocket payment schemes) is an important indicator for revenue collection. To collect revenue for health services, countries often use a combination of the following instruments: general government tax and revenues (e.g. from international trade), including external aid, provincial and local taxes, corporate taxes, earmarked taxes, excise taxes, income-related tax payments, contributions to social health insurance, contributions to private or voluntary health insurance, co-payments, direct payments and grants. Rather than from health insurance contributions, health promotion is traditionally financed from general government revenue or external sources, due to its public goods nature. Many governments finance public health campaigns, for example, to influence their population's health-related behaviour. Such campaigns are more and more organized both at the central and at lower, devolved authority levels.

Mexico has a mixed financing scheme (social security, tax-based payments and private health insurance). The social security scheme primarily focuses on personal care services, but the Ministry of Health, both at the level of the nation and the states, is responsible to provide public health services (OECD, 2004d). Likewise in Mongolia, health promotion and prevention activities are funded by central and local government budgets, while social health insurance and private financing focuses on curative care (Ministry of Health, Mongolia, 2005). Denmark has a decentralized tax-based health financing system. Curative care is financed and provided at the county level; health promotion and prevention programs are financed through national and local taxation schemes, and implemented by the counties and municipalities. The latter employ people to promote

prevention activities, work within the multi-sector 'Healthy Cities' and 'health promoting hospital' networks, and implement disease specific campaigns (e.g. focused on heart disease). There are also requirements for counties and municipalities to regularly present plans and report on these activities. (Health Systems in Transition, Denmark, 2001).

An alternative way for governments to implement health promotion programs is by financing specialized institutions. Denmark has two institutions of this kind. Northern Ireland founded the Health Promotion Agency (HPA) in 1990 as a special agency of the Department of Health, Social Services and Public Safety (HPA, 2006). In the Netherlands, where health financing is based on social health insurance, public health services are carried out by special institutions (GGD) at the municipal level that are financed from national and local taxation (similar to Denmark), while the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ, 200x) is a semi-governmental organization that develops and implements health promotion programs across the country.

It should be noted, that achieving universal coverage of health promotion through public health campaigns, may have an important caveat: the campaigns may seem to provide universal coverage, but exclusion occurs, for example, in countries with a weak socio-economic infrastructure, with a high number of illiterate population groups or groups that cannot read or understand the (formal) language used, or where in certain areas radio signals are not captured. Therefore, in countries with a risk of exclusion, health promotion programs should also be integrated in primary care interactions, for example, or organized in the form of targeted out-reach programs, e.g. by mobile theatre groups. Similarly, health promotion should not be exclusively integrated in primary care interactions in countries where financial and geographical access to these services is not universal. This paper therefore argues that the best way to achieve universal coverage of health promotion programs is by implementing cost-effective, multifaceted strategies.

In the following paragraphs a number of revenue collection tools are discussed used by countries to finance health promotion programs. The aim of these tools is to increase available funding for health promotion, independent of the type of program that is implemented.

Earmarked or dedicated taxes (sin-taxes)

Earmarked or dedicated taxes has been shown a successful tool to finance health promotion. The taxes, also called 'sin-taxes', are levied on health damaging products, like alcohol and tobacco, or on activities like gambling. The instrument was already promoted by the WHO Framework Convention for Tobacco Control (WHO, 1996). During a follow-up meeting on the 6th Global Conference on Health Promotion, experiences from different countries were presented. Evidence showed that earmarked taxes are effective in reducing the consumption of harmful products: a 10% price increase of harmful products reduces overall consumption by 4% in developed and 8% in developing countries (SEA, 2006). Currently, a number of countries in Asia and the Pacific such as Fiji, French Polynesia, Malaysia, Philippines and Vanuatu are considering the use of tobacco tax as a way to increase funds for health promotion activities (WPRO, 2003).

Dedicated taxes are collected with the immediate aim to finance health promotion programs. The advantage of this instrument is that the funds can not be taken away easily by competing programs. In several countries the resources are used to finance (semi-) autonomous institutions that implement health promotion programs at the national or local level (see Box 1).

Box 1: Countries with special laws to levy earmarked taxes for health promotion		
State Government of Western Australia	1983: Tobacco Tax 1990: Tobacco Control Act	1991: Western Australian Health Promotion Foundation Healthway; 15% increase in tobacco tax resulted in 10% additional fund for health promotion. Total revenue is AU\$ 17 million; 30% is spent on health promotion, research and sports, the rest on promotion of arts
State Government of Victoria (Australia)	1987: Tobacco Act	The Victorian Health Promotion Foundation VicHealth (independent statutory body), funded by a 5% dedicated tax levied on tobacco products. Total revenue is USD 25 million. (40% for promotion of community and school health, 30% for sponsoring sports, 20% for health research, balance for administration)
USA: various States	As of 1988: Tobacco Tax through legislation	Used for tobacco control programs
New Zealand	1976: levy on alcohol produced or imported for sales in the country	Used to reduce harm from alcohol use, mainly through education and research
Republic of Korea	1995: National Health Promotion Act (tobacco tax)	National Health Promotion Fund: health education, anti-smoking campaigns, limited advertisement of cigarettes and alcohol. Total revenue UD`SD 1.5 million used to promote health education and anti-smoking campaigns and to limit advertisements of cigarettes and alcohol.
Thailand	2001: Thai Health Promotion Act (2% tax on tobacco and alcohol products)	Thai Health Promotion Fund (Thai Health), an autonomous State Agency aiming to advocate, support and finance organizations active in health promotion, incl. tobacco and alcohol control, traffic accident prevention, health promotion at various levels in communities across the country.

Source: SEA (2006)

However, earmarked taxes may have some disadvantages as well. The funds can formally not be used for other programs, even when prioritized, and when separate institutions are founded, health system fragmentation and duplication of efforts may occur. Furthermore, to give an example, in 1997 the Australian High Court ruled that the dedicated tobacco tax was unconstitutional. Since then, health promotion activities are funded from general government revenue and the level of funding available for health promotion increased. Another problem of earmarked taxes is that these may send out a contradictory message: the more health damaging products are consumed, the more revenue is collected. Furthermore, theoretically, if consumption indeed decreases, the funds will ultimately dry up. If the taxes are used to finance health promotion programs associated with other risk

factors as well (not exclusively related to the health damaging product they are levied on), or a health promotion institution, such activities may not be sustained. Finally, earmarked taxes may have opportunity costs. For example, in the Netherlands, a majority in parliament last year supported a decrease in taxes levied on alcohol products (against a proposal from the Minister of Health to increase these) in order to protect the commercial sector. Consumers, particularly in the border areas, had started to purchase alcohol products abroad (Elsevier, 2005). Losing a market share to neighbouring countries because of earmarked taxes may thus become an unintended incentive provided by the scheme. In summary, earmarked taxes have succeeded in reducing the use of health damaging products and in raising additional funds for health promotion programs in various countries, but eventual limitations of the scheme must be closely monitored.

Excise tax, corporate tax and sponsorship

Instead of earmarked taxes, a number of countries levy excise taxes, for example on tobacco, like New Zealand, or on a variety of products, including motor vehicles, energy, spirits and tobacco products, like Denmark. The latter also introduced green excise duty in the 1990s on the consumption of polluting or scarce goods such as water, oil, petrol and electricity (Health Systems in Transition, Denmark, 2001). Excise taxes are levied because of a concern for health. Their aim is to increase general government revenue but their use is not strictly earmarked. The opportunity costs related to earmarked taxes, as mentioned above, apply to excise taxes all the same, but the funds collected may be used for any government program that is prioritized. Alternatively, taxes can be levied on tobacco company profits, like in Canada. But governments can also, rather than sanctioning private companies that sell health damaging products, choose to encourage those that sell 'healthy products'. For example, they can allow companies that work in the field of leisure products and services to join in partnerships and sponsor health promotion activities (WHO, 1996).

'Earmarked' premiums

Social health insurance schemes also have the potential to support health promotion policy and activities and to free up public resources for health promotion programs. Since 1998, Switzerland applies an earmarked premium to finance the activities of the Swiss Health Promotion Foundation. The annual contributions collected as part of the health insurance premium are CHF 2.40 per person, yielding a total of around CHF 17 million per year. The amount is set by the Federal Department of the Interior at the request of the Foundation (Health Promotion Switzerland, 2006). Current activities are: health and workplace, adolescents and young adults, healthy life styles. A similar scheme is implemented in Estonia, where 0.3 to 1% from the budget of the Estonian Health Insurance Fund is earmarked for health promotion. In 2002, a total of Euros 865,400 (= Euros 0.62 per capita) was collected. Priority activities of the Fund depend on the disease burden; the current focus is on cancer, injuries, STD and mental health (Carrin, 2006). In 2004, WHO and the International Social Security Association launched an initiative to assist countries with social security schemes to develop health promotion activities (WHO and ISSA, 2004). The initiative has facilitated technical discussions, but it should be noted that up to date in most countries, social health insurance remains restricted to formal sector employees. Therefore, the capacity to collect funds through earmarked

premiums is often limited. Furthermore, as illustrated above, in most countries social health insurance is focused on curative personal care rather than on health promotion among the larger population.

External aid

Finally, health promotion programs can be financed from external sources. In Central America, for example, the Central America Diabetes Initiative (CAMDI) was founded as the outcome of a regional workshop on diabetes in 2000 (financed by PAHO and DOTA). CAMDI focuses on a better quality of care for people with diabetes, including training programs for providers and patients, but also on the provision of education and information to the general public (CAMDI, 2006). There are also many private initiatives, including subsidized and voluntary programs, at the global (regional), national and local levels that finance and/or implement mostly vertical health promotion programs.

3.2 The pooling function (performance indicators: composition of risk pool(s) and the quality of risk equalization)

The composition of risk pool(s)

As mentioned earlier, health promotion can be organized in the form of public health campaigns (vertical programs), individual counselling sessions or, for example, through financial incentives that encourage efficient behaviour on the health care market. This paragraph discusses the pooling function and explores ways to influence the behaviour of insurers in this respect.

Country experiences show that risk pools are either a single fund or consist in multiple funds. In the case of a single fund, like in Costa Rica, the level of redistribution (equity) is generally high depending on the composition of the covered population¹, but there is little or no consumer choice for insurers. As mentioned earlier, single funds can finance health promotion programs by allocating a fixed proportion of revenue (earmarked premiums), but no other incentives can be incorporated in the scheme to increase the activity level of the fund-holder.

Contrarily, in a health insurance scheme with multiple insurance funds, like in Slovakia or the Netherlands, the development of health promotion programs can be encouraged through the incorporation of financial incentives in the health financing scheme. The requirement is that open competition exists between insurers. In the following paragraph, in order to explain this mechanism, the 2006 reforms in the Netherlands are briefly described.

Multiple funds can also exist in countries where the health financing scheme is tax-based, for example after a process of decentralization. In Denmark, counties and municipalities collect county and local taxation for social care programs. Within these systems, however, competition between funds is not possible, as these are all geographically restricted. Redistribution of funds may occur to address the risk of inequitable service

¹ The composition of the risk pools refers for example to questions like whether the scheme is mandatory, whether dependents are automatically covered and what socio-economic groups are eventually excluded.

provision, but in tax-based systems efficient behaviour and the implementation of health promotion programs are generally encouraged through target setting.

The quality of risk equalization

As discussed above, in an insurance based system with multiple funds, health promotion programs may be under-produced due to the problem of time preference; insurance funds prefer to apply risk selection than to make extra costs implementing health promotion programs. However, in multiple fund schemes where risk selection is prohibited, and consequential cost imbalances addressed through a risk equalization scheme, insurers are assumed to be interested in producing health promotion as a way to increase their efficiency.

Risk equalization means that health insurers who operate on a market with open enrolment (where risk selection is prohibited and funds are obliged to accept all applicants), are compensated for differences in health care costs due to differences in the characteristics of their membership: insurance funds with a high number of high risk members are compensated by funds with a high number of low risk members.

Risk equalization can be implemented in two ways: on the basis of *ex ante* or *ex post* adjustment mechanisms. The former is called prospective risk adjustment, the latter retrospective risk adjustment. Retrospective risk adjustment means that health insurance funds are compensated afterwards for all or most of the costs they have made to serve their clients. In fact, if administrative costs are included, this mechanism turns a multiple fund scheme merely into a single fund (Carrin and James, 2004). As such, it does not provide incentives for insurance funds to behave efficiently.

Prospective risk adjustment, on the contrary, compensates health insurers in advance on the basis of previously agreed risk adjusters. Insurers receive or make compensation payments for their members on the basis of their age, sex and health status (the latter can be increasingly refined). Prospective risk adjustment gives insurers an incentive to behave efficiently by constituting a level playing field (within the legal boundaries set by the government in terms of the quality and quantity of the benefit package) on which they can operate 'freely' pursuing value for money as well as attracting and retaining their clients. Those who succeed in terms of the latter are able to control the problem of time preference. Consequently, prospective risk adjustment provides sickness funds with more incentives for effective preventive care (including health promotion) than retrospective models (Van de Ven et al., 2003).

In 2006, the Netherlands introduced a health financing scheme based on the principals of regulated competition. It implies that insurers are allowed to make profit as private companies, but operate within the boundaries of a legal framework. With the reforms, social health insurance has been made mandatory for all and enrolment open (insurers are prohibited to apply risk selection). Consumer choice is enhanced by allowing fund members to change insurer once every year. The benefit package that used to be formulated in the form of concrete health products is re-defined in broad, functional terms and insurers are allowed to contract providers selectively. They can even hire them

directly. Furthermore, insurers may design a variety of benefit packages in addition to the basic package (defined by the government) and thus pursue good value for money to attract and retain their clients.

To monitor whether insurers properly follow the rules of the game, the Dutch government created the Dutch Care Authority. It also started to empower consumers to properly exercise their choice on the health care market, to be sufficiently informed to do so, and to claim their legal rights. Both the government and patient and consumer organizations also monitor the quality of services provided by insurers and providers who are obliged by law to employ full transparency. One of the expectations of the scheme was that with a reasonably refined prospective risk equalization scheme in place, health insurers would be interested in designing cost-effective benefit packages, including health promotion. And in fact, since the introduction of the new scheme, insurers and providers increased the provision of health promotion activities, both at the individual and population level. Websites and brochures are being developed to inform clients and patients about health risks and how to prevent these; they also design disease specific benefit packages, including targeted health promotion, and some insurers now cover participation in weight control programs, for example (Zorg en Zekerheid, 2007).

3.3 The purchasing function (performance indicators: provider payment mechanisms and consumer incentives)

In this paragraph, the purchasing function is discussed. It involves the production and consumption of health care services, including health promotion. Ways are explored to influence the behaviour of providers and consumers in this respect, for example by introducing specific financial incentives.

Purchasing of health services is the process by which the most needed and effective health interventions are selected and provided to the population. Because of its cost-effectiveness, it is important to ensure that health promotion, for example in the form of individual counselling, is prioritized and integrated in the benefit package. To date this has not been the case in many countries. But the situation is slowly changing. Primary health care providers and hospitals are increasingly encouraged to increase their focus on health promotion with the aim to control costs in the longer term. In Thailand, for example, as a follow-up on the 6th Global Conference on Health Promotion, there is a movement focusing on the integration of health promotion at the primary care level through targeted training programs for primary health care providers (non-financial incentive). Furthermore, a reform of provider payment mechanisms is foreseen to include performance-based payments (financial incentive) for the provision of health promotion services (Jongudomsuk, 2005).

Provider payment mechanisms

Provider payment mechanisms imply, whether on purpose or not, incentives for a certain type of provider behaviour. Over the last few years, a number of overviews has been published that explore the effects of different payment mechanisms (Carrin and Honvoravongchai, 2003; Liu, 2003). In this paragraph payment mechanisms are

discussed that countries use to encourage the provision of health promotion services at the primary care level, as well as those that are problematic in this respect.

Fee-for-services (FFS)

Fee-for-service (FFS) payments are associated with over-production and supplier induced demand. The mechanism provides an incentive to increase income at the cost of quality. Furthermore, FFS requires direct, out-of-pocket payments from consumers; the increased risk of catastrophic health expenditure and impoverishment due to such payments is largely documented. Due to this, FFS is considered one of the least efficient and effective payment mechanisms. However, FFS is increasingly used in countries of the European Union, among others, as a tool to motivate the provision of cost-effective services, like prevention and health promotion, e.g. child immunization and counselling. In these cases, FFS is generally combined with other payment mechanisms, for example, capitation payments for curative services (Liu, 2003) or salaries.

Capitation payments

Various studies indicate that providers who receive a fixed payment per patient are more encouraged to behave efficiently than those who receive FFS. Capitation payments thus provide incentives, in principle, for the production of health promotion services, like counselling, life-style advice and preventive services (Liu, 2003)². Furthermore, the payments are associated with increased allocative efficiency as they do not give incentives for the provision of unnecessary care. On the other hand, capitation payments may provide incentives for underproduction; they may encourage a reduction in the provision of necessary care and an increase in the selection of low-risk patients. These problems can be addressed respectively by introducing FFS for selected services, and a proper risk adjustment scheme to compensate providers for the extra costs of high cost patients.

Salary payments

Salary payments are referred to as neutral in terms of the provision of incentives. The payments neither motivate over-production, like FFS, nor under-production, like capitation payments. Furthermore, salaries show an increase in the provision of preventive services compared to FFS. However, salary payments are also associated with low morale (as there is no reward for harder or better work) and do not provide incentives for doctors to recommend the most cost-effective interventions, decrease costs, and increase health outcome. Salary payments may therefore cause low productivity, and low quality of care, and allocative efficiency may be lower than under capitation payments. Salaries may also encourage providers to ask for informal payments, particularly when those are low (Liu, 2003). On the other hand, since salary payments are widely practised in many countries, these can be combined with other payment mechanisms, like FFS, for example, to encourage the provision of health promotion services.

Performance-related payments (PRP)

Performance-related pay means that payment is directly linked to performance. On the health care market, PRP is as of yet controversial. Advantages are that PRP can be used

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to reward good results, it forces payers to evaluate their payees and it motivates people to perform better. However, PRP is also associated with a number of problems: firstly, there must be funds available to effectively pay out rewards; secondly, in high income countries there may be little interest in receiving a reward; thirdly, the choice for policy makers between giving high rewards to a few or low rewards to many is not always obvious; fourthly, rewarded performance must be measurable and contradicts with the fact that team work is important in health care (managers may not want to single out individuals); finally, if the reward only focuses on quantity of services, it is hard to control supplier induced demand and to ensure quality. To address the latter, patient satisfaction is often included as a condition for rewards (Liu, 2003). PRP is used by GAVI, among others, as a tool to encourage the production of preventive services, like immunizations (GAVI, 2003). Similarly, it could be applied to health promotion activities.

It should be noted, that where providers of prevention and health promotion programs are paid on the basis of FFS or PRP, they may induce the demand for such services (overproduction). This can be the case with respect to preventive interventions, like laboratory tests, x-rays, mammographies and scans, as well as health promotion activities, like dietary and life-style related programs, or programs that promote liposuction or surgery, for example. In the Netherlands, the government recently increased the inspection of commercial providers of medical check-ups, which require accreditation, to protect consumers against unnecessary interventions (NRC, 2007).

Consumer incentives

Consumers can be encouraged to engage in health promotion through financial and non-financial incentives. Free health education gives consumers a non-financial incentive to behave in support of the health promotion goals. Such programs have proven to be effective, although some have also failed, due to socio-cultural factors, for example. The programs should always be closely monitored and evaluated, which adds to their implementation costs.

Consumers can also be given financial incentives to behave cost-consciously (in line with the health system goals) and live without illness and health related sufferings that reduce their household income. Furthermore, consumers who are allowed to exercise choice on the health care market are empowered to force insurers and providers into the provision of value for money. They are encouraged to maintain their good health and encourage providers and insurers to offer quality health care for a reasonable price. Generally speaking, consumer behaviour in support of health promotion is expressed by appropriate knowledge and awareness about health and health related risks, a rational choice and utilization of services and taking good care of one's own health and that of one's family and community members. Countries use the following financial incentives to encourage efficient consumer behaviour.

Co-payments

Efficient consumer behaviour with respect to curative services is sometimes encouraged through co-payments or co-insurance, also called cost sharing. It is widely used in US

commercial health insurance. The tool, however, is disputed because it may stop consumers from utilizing necessary and cost-effective care as well. It has shown to reduce total utilization and is not considered an effective tool to encourage the right or desired mix of health interventions: 'The reduction of total utilization does not mean an improvement in allocative efficiency, unless the reduction is mainly the result of a decrease in utilization of less cost-effective interventions. Research shows that cost sharing has resulted in a reduction of both cost-effective and cost-ineffective services and both essential and non-essential drugs (Liu, 2003).

No-claim bonus

Another controversial instrument to encourage rational consumer behaviour is the no-claim bonus. It is used in social health insurance schemes applying nominal premiums next to income-related contributions. It allows insurers to pay back part of the nominal premium to members who, at the end of the calendar year, have not or hardly used certain services. The incentive encourages rationale service utilization, but may give unintended incentives as well. Particularly lower income groups may choose to under-utilize health care services, also when these are really necessary, and use the reimbursed money for other purposes. The measure is considered inequitable as well because people with chronic illnesses are generally not able to benefit from it.

A relatively high nominal premium (in addition to a lower proportional premium)

Another financial incentive used to influence consumer behaviour within social health insurance schemes is the introduction of a relatively high nominal premium, corrected for lower income groups through a tax credit. This tool has been implemented in the Netherlands in 2006 with the aim to make consumers more cost-conscious. The high nominal premiums are assumed to reflect the real costs of health care and consumers are expected to 'help' insurers to keep them low by rational utilization. The effects of the tool are not yet fully known: the high premium may become unaffordable for lower-income groups that use their tax credit for other purposes, and insurers may find room to link their premium level to other factors (e.g. through inappropriate deals) than rational consumer use.

Deductibles

The incorporation of choice for consumers between various levels of own risk or deductibles, associated with lower or higher nominal premium levels, is also used as an incentive for consumers to think and behave cost-consciously. Again, this instrument is used in social health insurance schemes. Low-risk groups may be encouraged to take out a higher own risk, while benefiting from a lower monthly premium, and take good care of their health with the aim to rationalize utilization. This tool is also implemented in the Netherlands, but only a relatively small proportion of the population (5%) purchased an own risk polis, probably because insurers did not offer sufficiently attractive premium reductions.

Insuree bonus

In Germany, a financial incentive, the so-called '*insuree bonus*' is implemented to encourage patients 'to take an active role in protecting their health and put the services of

the health care system to good use' (BMGS, 2004; Expatica, 2004). Patients who sign up for the family doctor system and take part in prevention programmes or special programmes for the chronically ill, can qualify for a bonus from their health insurance fund. In order to enhance competition between insurers, the latter are allowed designing their own bonus package, which may consist, for example, in a reduction of co-payments, consultation fees or insurance contributions. Insurance companies are also allowed to give out prizes to consumers with exemplar behaviour.

Sin-premium

Across the world, discussions are taking place about the need to sanction people who behave 'badly' in view of the health system goals. The focus is mainly on smokers who, according to some opinion-makers should pay a higher premium than non-smokers. In the United States it is found in private health insurance schemes (Associated Press, 2006), but it seems unlikely for social schemes to follow suit. The measure has several equity concerns, as various other risk factors are not controlled this way (obesity, alcohol overuse) and because supposed healthy behaviour, like exercising sports, implies increased risks and costs for the health system as well. But there are also efficiency concerns, as there is no evidence whether smokers are finally more or less expensive for the health system than non-smokers: as they generally live shorter, they may ironically be cheaper. Furthermore, evidence is increasing about a potential genetic preposition in (some) smokers, which would imply that for equity reasons their increased risks should be covered by public funds (Worldpress, 2006).

Health credit

The consumer incentives listed above are mostly associated with insurance based health financing schemes. However, similar to the options described rewarding health insurance members for 'good behaviour', tax payers can be rewarded through the introduction of a 'health credit' applicable to their annual tax statements. The instrument can be based on the health coverage tax credits applied in the US and the Netherlands, which compensate lower income groups for their participation in voluntary or mandatory insurance scheme respectively (IRS, 2006).

4. Conclusion

Health promotion activities need to be increased in health systems across the world. Governments should pursue universal coverage of programs that address the most important risk factors in their countries. In order to achieve this, they should secure adequate funding and focus on the implementation of cost-effective, multifaceted strategies.

To support the outlined approach, this paper explored existing and innovative financing options for health promotion. The analysis was based on the health systems financing framework. Except for general taxation and subsidies, other options were discussed to raise funds for health promotion. Furthermore, examples were provided of financial incentives that encourage the incorporation of health promotion within the health system. These include incentives that encourage insurers to finance health promotion, providers

to deliver cost effective services and consumers to increase their awareness about health risks, care for their health and behave cost-consciously on the health care market.

In terms of strategy, it can be concluded that governments that want to ensure an adequate level of health promotion in their country are advised to examine eventual funding gaps and to study the effects of the incentives that are provided, on purpose or not, by their health financing scheme. They should redefine health promotion as a specific health system function taking into account public health services as well as personal health care, like counselling and behavior change support activities. In order to pursue universal coverage, policy makers should be aware of the importance of multifaceted strategies and of the various options available to them. There is no single financing scheme most appropriate across countries. Therefore, careful analysis by all stakeholders is required to find the most cost-effectiveness scheme for each country. This depends on the political, socio-economic and cultural context of the country, the technical and institutional capacity in place, as well as the existing health (financing) scheme.

Finally, while there is growing evidence about the cost-effectiveness of health promotion in general, further research is required, particularly into the impact on consumer behaviour of each of the financial and non-financial incentives described in this paper. With respect to financial incentives, it should be noted that whenever efficient consumer behaviour (rational use) is pursued, unintended incentives for under-utilization are also provided, particularly for lower income groups. Such schemes should therefore always be rigorously monitored. In the case of non-financial incentives, monitoring and evaluation are also important in order to better understand their actual impact and eventually identify opportunities for improvement.

5. References

- Asian Development Bank (1999), *Health Sector Reform in Asia and the Pacific. Options for Developing Countries*, Manila, Philippines,
- Associated Press (2006), 16 February 2006, <http://msnbc.msn.com/id/11394043/>
- Belot M (2006), *Prevention in the curative sector*, CPB Memorandum, CPB Netherlands Bureau for Economic Policy Analysis, 20 January 2006, <http://www.cpb.nl/nl/pub/cpbreeksen/memorandum/142/memo142.pdf>
- BMGS (2004), *The Healthcare Reform: A healthy choice for everyone*, January 2004, Federal Ministry of Health and Social Security
- CAMDI (2006), *The Central America Diabetes Initiative (CAMDI): Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua* <http://www.paho.org/english/ad/dpc/nc/camdi.htm>
- Carrin G, Hanvoravongchai P (2003), Provider payments and patient charges as policy tools for cost-containment: how successful are they in high-income countries? *Human resources for health*, 1(6):1-10.
- Carrin and James (2004), *Reaching universal coverage via social health insurance: key design features in the transition period*, Discussion Paper Number 2, Department Health System Financing, Expenditure and Resource Allocation (FER), Cluster Evidence and Information for Policy (EIP), WHO Geneva
- Carrin and James (2005), *Key Performance Indicators for the Implementation of Social Health Insurance*, *Appl Health Econ Health Policy*: 4(1): 15-22
- Carrin (2006), *Innovative financing for HIV/AIDS*, Workshop on the 5-country study on universal access to HIV/AIDS care and treatment and innovative financing methods, Maputo, Mozambique (31 May - 2 June 2006)
- DCPP (2006), *Disease Control Priorities in Developing Countries* (2nd Edition), Editors: Jamison D, Breman J, Measham A, Alleyne G, Claeson M, Evans D, Jha P, Mills A, Musgrove P., The World Bank Group, <http://www.dcp2.org/pubs/DCP>
- Elsevier (2005), *Kamer wil verlaging accijns sterke drank*, 2 November 2005, <http://www.elsevier.nl/nieuws/politiek/nieuwsbericht/asp/artnr/71428/index.html>
- Expatica (2004), *Health Reforms Pay Off*, http://www.expatica.com/actual/article.asp?subchannel_id=38&story_id=11904
- GAVI (2003), *Eight Developing Countries to be paid \$15M for Imminuzing more Children* http://www.gavialliance.org/Media_Center/Press_Releases/Press_111203.php
- Health Promotion Switzerland (2006), *For improved quality of life* www.gesundheitsfoerderung.ch/en/about/mission/default.asp
- Health Systems in Transition, Denmark (2001), *European Observatory on Health Systems and Policies, HIT Country Profiles* <http://www.euro.who.int/observatory/Hits/TopPage>
- HPA (2006), Health Promotion Agency, Mission: To make health a top priority for everyone in Northern Ireland. <http://www.healthpromotionagency.org.uk/AboutHPA/hpa.htm>
- IRS (2006), *Health Coverage Tax Credit*, <http://www.irs.gov/individuals/article/0,,id=109960,00.html>
- Irwin et al. (2006), *The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities*, Irwin A, Valentine N, Brown C, Loewenson R,

- Solar O, Brown H, Koller T, Vega J, PLOS Medicine, Volume 3, Issue 6, June 2006 Published online 2006 May 23. doi: 10.1371/journal.pmed.0030106.
- Jongudomsuk P (2005) *Health care systems in Thailand: reforms towards health promotion*. Bangkok, Bureau of Policy and Planning, National Health Security Office, http://www.anamai.moph.go.th/6thglobal/09_HCSsystem.pdf
- Liu X (2003) *Policy tools for allocative efficiency of health services*. Geneva, World, Health Organization.
- Ministry of Health, Mongolia (2005), *National Health Account Mongolian* <http://www.whoindia.org/EIP/NHA/CountryExperience/Mongolia.pdf>
- NIGZ (200x), *Netherlands Institute for Health Promotion and Disease Prevention*, http://www.nigz.nl/index_en.cfm?act=esite.tonen&a=6&b=51
- NRC (2007), NRC Handelsblad, Web- en weekeditie voor het Buitenland, 9 Februari 2007, p.3, <http://buitenland.nrc.nl>
- OECD (2004), *Selecting Indicators for the Quality of Health Promotion, Prevention and Primary Care at the Health Systems Level in OECD Countries*, Marshall M, Leatherman S, Mattke S and the Members of the OECD Health Promotion, Prevention and Primary Care Panel, *OECD Health Technical Papers 16*, DELSA/ELSA/WD/HTP(2004)16
- OECD (2004d), *SHA-Based Health Accounts in 13 OECD Countries: Country Studies Mexico, National Health Accounts 2001*, María-Fernanda Merino-Juárez, Maluin-Gabriela Alarcón-Gómez and Rafael Lozano-Ascencio, DELSA/ELSA/WD/HTP(2004)8, <http://www.oecd.org/dataoecd/33/15/33733586.pdf>
- OECD (2005), *Health at a Glance - OECD Indicators 2005*, http://www.oecd.org/document/11/0,2340,en_2649_34631_16502667_1_1_1_1,0_0.html, *OECD countries spend only 3% of healthcare budgets on prevention, public awareness*, http://www.oecd.org/document/0/0,2340,en_2649_34631_35625856_1_1_1_1,0_0.html
- SEA (2006), *Regional Strategy for Health Promotion: Follow-up to the Sixth Global Conference on Health Promotion, Health Promotion and Dedicated Taxes*, SEA7RC59/Inf.xx (draft) 18 April 2006
- Ven van de W. et al. (2003), *Risk adjustment and risk selection on the sickness fund insurance market in five European countries*, Health Policy Volume 65, Number 1, July 2003: 75-98, www.elsevier.com/locate/healthpol, <http://www.ingentaconnect.com/content/els/01688510/2003/00000065/00000001/art00118>
- Weller S and Davis K (2004), *Condom effectiveness in reducing heterosexual HIV transmission*, Cochrane Review, The Cochrane Library, Issue 4, Chichester, UK, John Wiley and Sons, Ltd.
- Worldpress (2006), *Two Models of Health Insurance*, <http://insurance.viaden.com/2006/06/24/two-models-of-health-insurance/>
- WHO (1995), *Ottawa Charter for Health Promotion*, First International Conference on Health Promotion, Ottawa, 21 November 1986, WHO/HPR/HEP/95.1, http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

- WHO (1996), *Financing Health Promotion through Sport and Arts Sponsorship*,
http://www.who.int/docstore/tobacco/ntday/ntday96/pk96_8.htm
- WHO (2000) *The World Health Report 2000. Health systems: improving performance*.
Geneva, World Health Organization, Chapter 5: Who pays health systems?
<http://www.who.int/whr/en/>
- WHO (2002), *Innovative care for chronic conditions: building blocks for action: global report*, <http://www.who.int/diabetesactiononline/about/iccreport/en/index.html>
- WHO (2005), *Preventing chronic diseases: a vital investment*, WHO Global Report,
http://www.who.int/chp/chronic_disease_report/contents/foreword.pdf
- WHO (2006), *The Bangkok Charter for Health Promotion in a Globalized World*,
http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/
- WHO and ISSA (2004), *Report of International Consultation on Social Insurance and Health Promotion*, International Social Security Association Helsinki, Finland.
- WPRO (2003), *Health promotion financing opportunities in the Western Pacific Region*,
<http://www.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=52&codcch=36>
- Zorg en Zekerheid (2007),
http://www.zorgenzekerheid.nl/portal/page?_pageid=501,1569976&_dad=portal&_schema=PORTAL&_p_channel_id=1#10111