TO THE CREATION OF FISCAL SPACE FOR HEALTH

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Introduction

- This paper deals with the **fiscal space for healthcare and the resources we can use to build it.**
- The aim is to map the possibilities of creating the fiscal space for healthcare, to grasp it in theory and to use a triangle graph to perform basic quantifications.
- To achieve this, we shall also classify the sources of health care financing in the universal and optional part so that we know their basic typology and socioeconomic properties.

Fiscal space for health

- Useful concept of fiscal and health policy
- Introduced by Heller (2006), can be defined as government’s ability to mobilise and allocate resources to healthcare without compromising the balance and sustainability of public budgets (Cashin & Tandon, 2010) (Wolfe & Powell-Jackson, 2013).
- There are **two basic ways to provide and pay for health care.** The first of them works with the link between **the need for health care** (given that people do not choose their diseases usually) and the **objectively recognized entitlement of the patient** financed using the principle of solidarity. The second is based on the **client's decision-making** in relation to the health care provider and **the subjective benefit** financed for private money on the principle of equivalence.
- From this, universal and optional (voluntary) part of the system emerge

Universal system financing

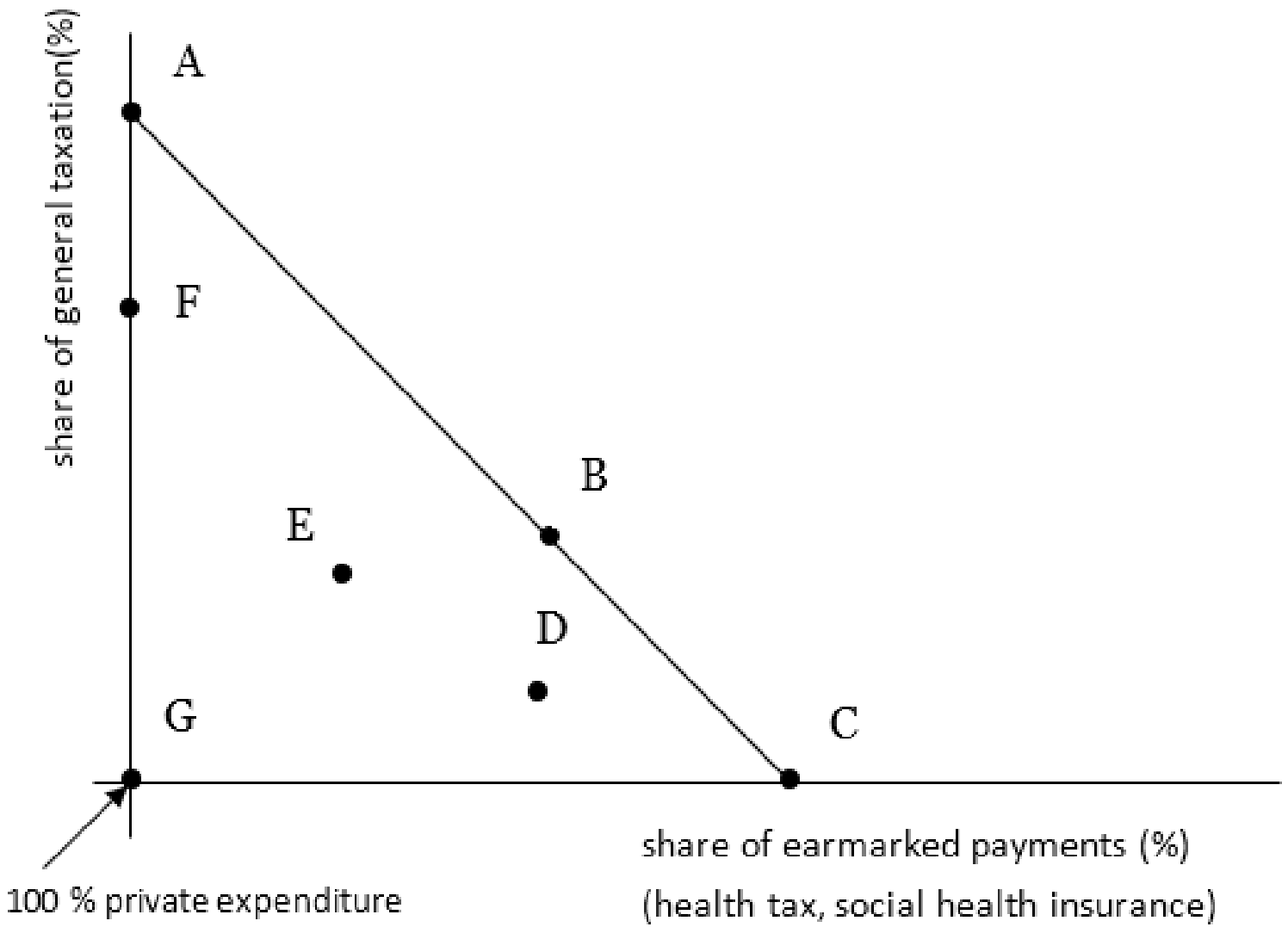
1. General taxes
2. Hypothecated (earmarked) health tax
3. Social insurance
4. Nominal health insurance
5. Fees and surcharges (co-payments)

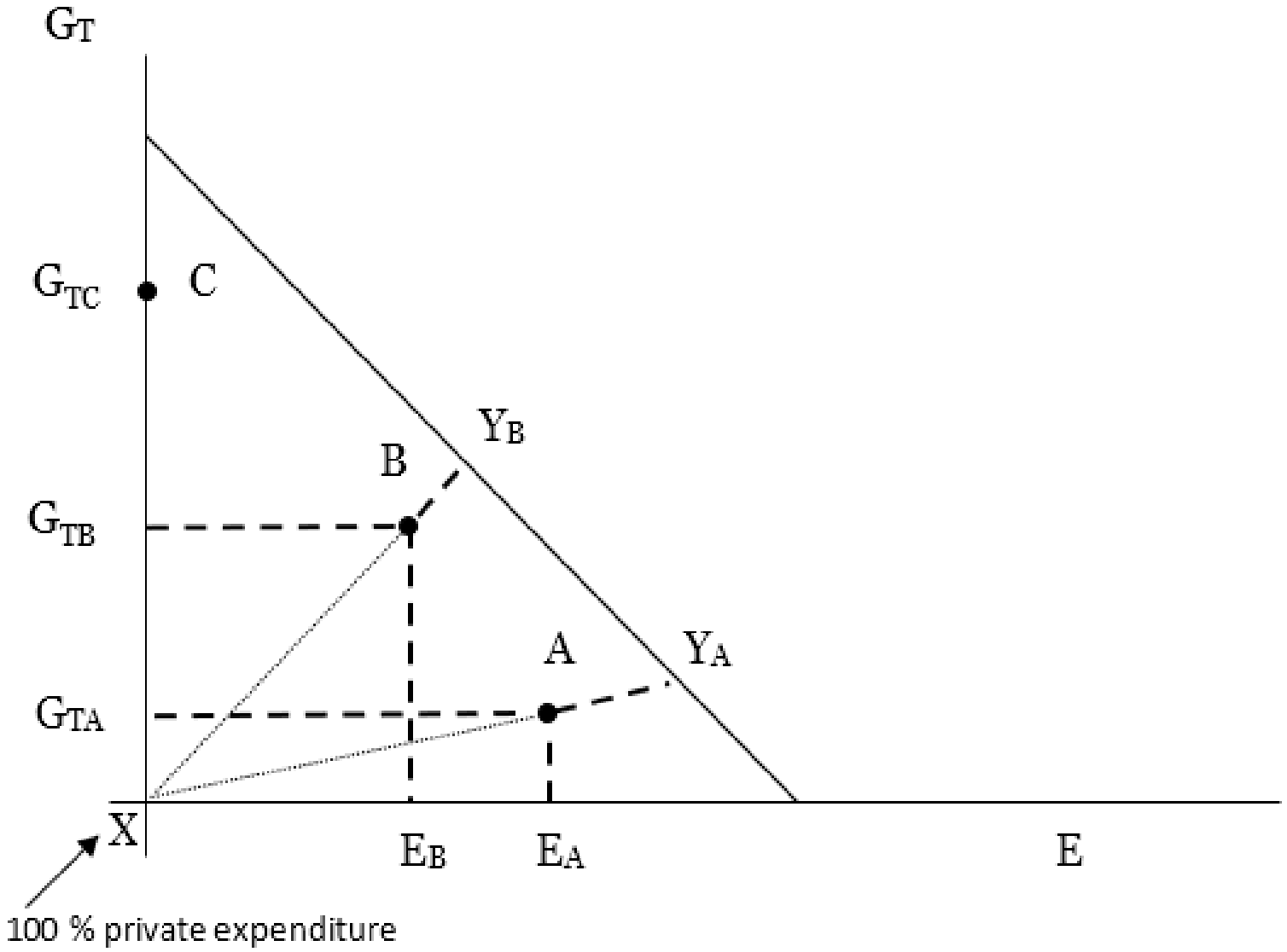
2-4 can be seen as earmarked compulsory payments into the system

Optional part financing

1. Private insurance
2. Health savings
3. Direct payments (out-of pocket)

Their usage depends on the overall system configuration. When official optional part is small, we can reduce the financing to universal with co-payments (or when we want to statistically analyse the universal part only), when optional part is large methods above become more significant or even transform to soft-or-hard compulsion to buy products based on them. We can show it both theoretically and empirically.


share of general taxation(%)
A
F
B
E
D
G
C
100 % private expenditure
share of earmarked payments (%)
(health tax, social health insurance)


G_T
G_{TC}
C
Y_B
B
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A
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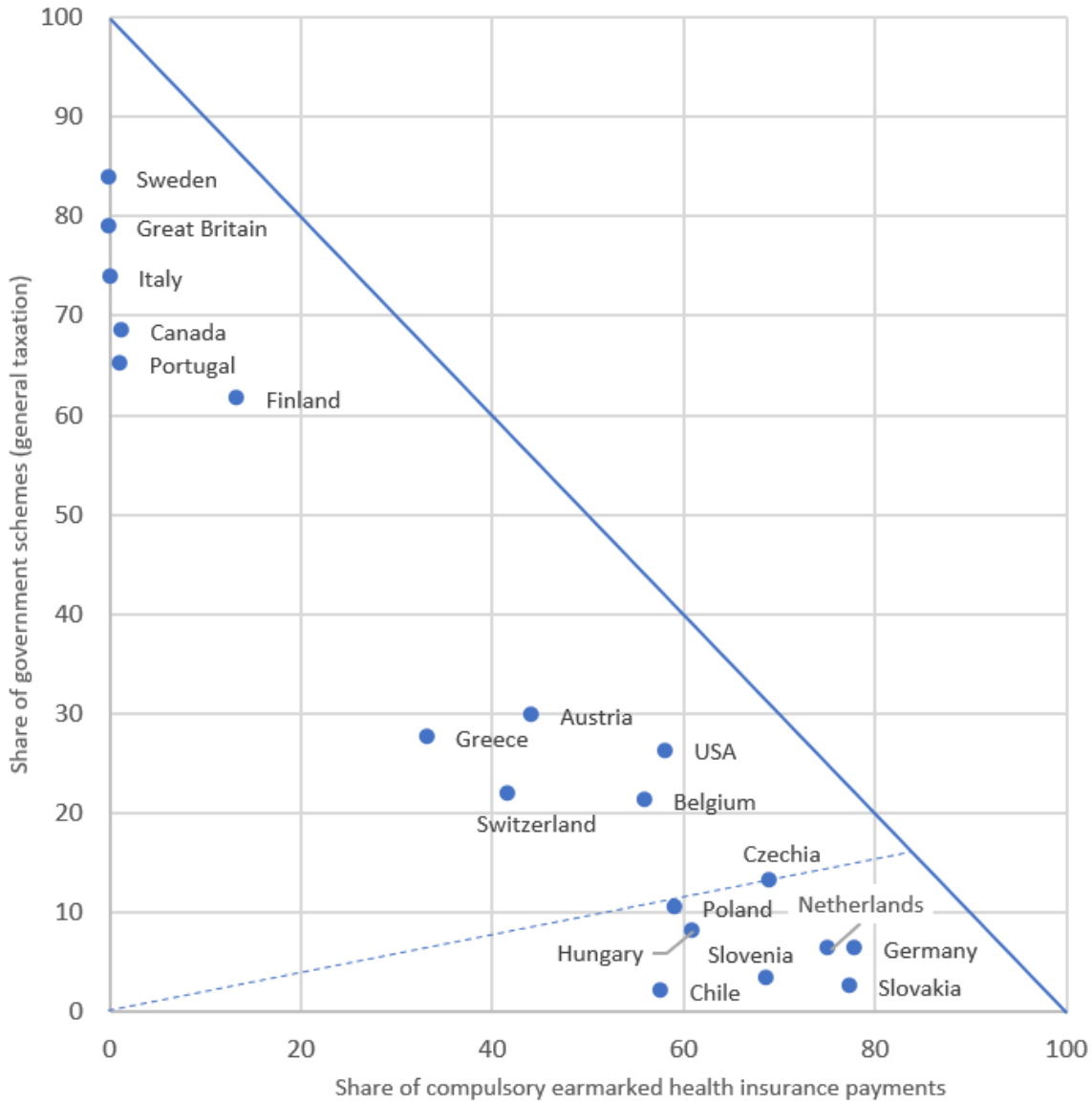
X
E_B
E_A
E
100 % private expenditure

Figure 3: Triangular diagram of government, compulsory and voluntary health expenditures, OECD 2017, %



Source: author, data (OECD, 2019)

Conclusions 1/2

- The resources for financing health care can be divided according to the character of health care they finance and the earmarking at the time of collection. While private resources and social health insurance are earmarked by nature, financing from taxation can be general or earmarked based on public choice and the health policy goals.

- The design of fiscal space for health for particular country corresponds to the sources used. We have provided a general overview of possible financing resources and pointed out their principal socioeconomic characteristics.

- We recognize if the resources are obligatorily or voluntarily allocated, used for universal or optional part of care, utilize primarily principle of solidarity or equivalency, are earmarked or not. Then we moved into the concept of fiscal space for health where these sources are mixed into financing schemes that together create the annual health budgets.

Conclusions 2/2

- The application of a triangular graph clearly showing the share of the three variables (government expenditure, compulsory earmarked payments, voluntary private expenditure) in the creation of the fiscal space in healthcare has shown that the share of individual sources of financing differs fundamentally between countries. Three basic variants of dominant sources of healthcare financing can be traced: from general taxes, from compulsory solidarity-based payments (earmarked taxes, social health insurance) and from compulsory private payments (private insurance); in all cases supplemented by an appropriate share of optional private expenditure. The specific nature of compulsorily collected resources is important for building the fiscal space, from general taxes through health tax and variations of social insurance premiums collected as a percentage to nominal insurance premiums in the form of an absolute amount. From the general taxation various health schemes can be directly or indirectly subsidized or in case of private schemes, tax exemptions and special regimes can exist.

- The triangular graph tells us that considering earmarking resources for health, we can observe three main groups of countries. The first one, including e.g. Canada, Great Britain, Sweden, which relies mainly or solely on general taxation as a resource for healthcare. And the second group, including e.g. Slovakia, Germany, Netherlands, Slovenia and also Czechia, that relies mainly on earmarked payments. Few countries fall into the third group (like USA, Switzerland or Austria) that combines resources with no major preference.