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## **Technical paper**

### **The impact of health expenditure on households and options for alternative financing**

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## **Executive summary**

Total health expenditure as a share of world gross domestic product increased from 3% in 1948 to over 8% today. The world spent US\$ 3.8 trillion on health in 2001. However, there is wide variation in per capita health expenditure between and within the different countries of the world and the Eastern Mediterranean Region. Most governments of the Region have had to cut the real per capita budget for health because of poor economic performance. In order to maintain the integrity of the public health system, public health policy-makers have introduced cost containment and cost recovery strategies, including indiscriminate user fees. As a result, households have increasingly been facing financial difficulties in paying for necessary health services. Some households, especially poor households, have to pay such a substantial proportion of their income for health services that they are pushed into poverty. Many households, overburdened by disproportionately high health expenditures relative to their income, have to borrow, sell their assets or forgo the health services needed and to live (or die) with their illness and suffer the consequences. Moreover, as a result of the dynamic dual interlink between health and poverty, many households will not be able to escape the trap of ill-health and poverty once they fall into it.

Empirical results strongly suggest that direct payment for health services is the main culprit behind disproportionately high health expenditures. In most poor and middle-income countries of the Region direct, or out-of-pocket, payment accounts for more than 50% of total health expenditure. Prepayment schemes provide a clear route to elimination of disproportionately high health expenditures that overburden households. There are several alternative health care financing options in order to develop prepayment schemes and universal coverage, including tax-funded government-sponsored schemes and social, private and community-based health insurance schemes. There is no unique prepayment scheme appropriate for all countries of the Region.

The experience of the countries of the world that have achieved universal coverage shows that they all go through a transition. During the transition, the share of public spending through taxation and/or social health insurance increases, while the share of direct payment decreases. The transition period and exact pathway is determined by many factors, including the political will of policy-makers and the economic performance of the country.



## 1. Introduction

The economic growth rate of the Eastern Mediterranean Region has been modest for the past decade and is projected to be low for the next decade. Most governments have had to cut the real per capita budget for social services, including health. In order to maintain the integrity of the public health system, public health policy-makers have introduced cost containment and cost recovery strategies, including indiscriminate user fees. As a result, households have increasingly been financially overburdened by paying for necessary health services. Some households, especially poor households, have to pay such a substantial proportion of their income for health services that they are pushed into poverty. The goals of health for all, equity and fairness in financing the health system, which Member States are striving to attain, are thus compromised. The purpose of this paper is to:

- review the most recent global and regional evidence concerning health expenditure patterns and their impact on households;
- analyse the determinants of household health expenditure that is disproportionately high relative to the household's ability to pay;
- suggest alternative financing options for health care, which can reduce the financial barriers to access to health services, improve financial equity and fairness, and protect households against overburdensome health care expenditure.

The paper makes use of the available global and regional data and studies, such as national health accounts, and household and public health expenditure reviews. In the first part of the paper health care expenditure patterns in the world and the Region and the relationship between health and poverty are reviewed. Disproportionately high health care expenditure and its determinants are discussed in the second part of the paper, while in the third part, options for alternative financing are presented. Finally, conclusions and recommendations are presented.

## 2. Health care expenditure patterns and the relationship between health and poverty

### 2.1 Health determinants

Health has many determinants. Empirical studies have shown that factors other than expenditure on health services, such as genetic endowment, environment, nutrition, education and income influence health outcomes. This section looks at health expenditure patterns and the relationship between health and income.

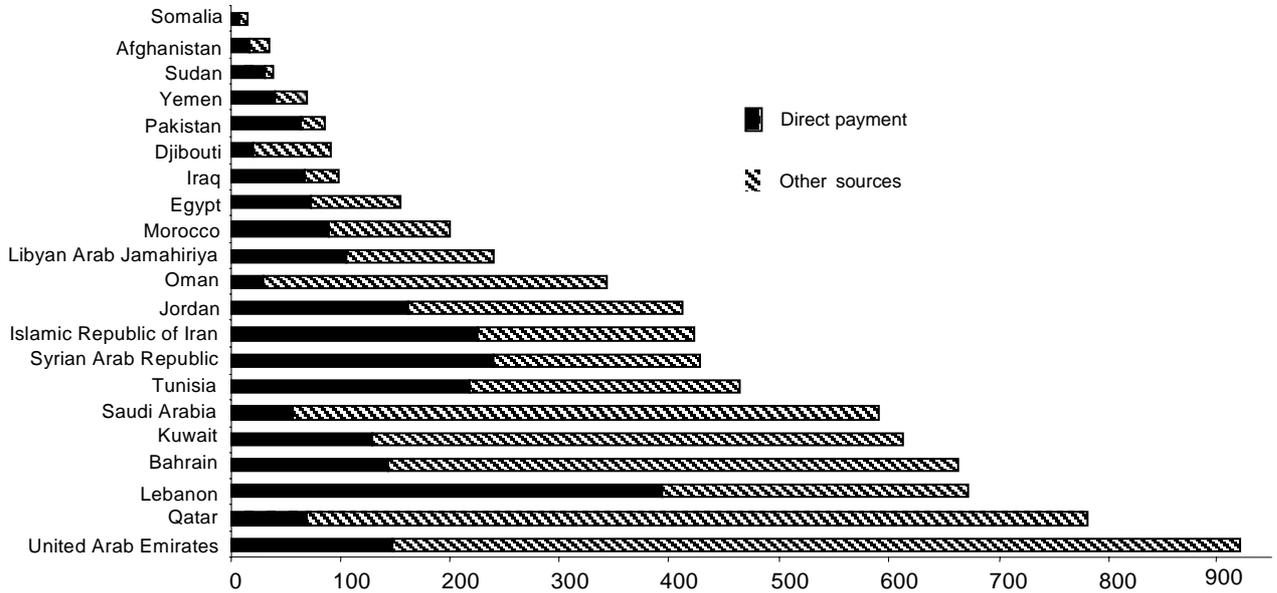
### 2.2 Health expenditure pattern

Total health expenditure as a share of world gross domestic product (GDP) increased from 3% in 1948 to over 8% today. The world spent US\$ 3.8 trillion on health in 2001, over US\$ 600 per capita. However, there is wide variation in the per capita health expenditure among the different countries of the world and of the Eastern Mediterranean Region. The per capita health expenditure in the Eastern Mediterranean Region ranges from less than US\$ 30 to over US\$ 900 (Figure 1), compared with over US\$ 2500 in member countries of the Organisation for Economic Co-operation and Development (OECD).

Large variation in per capita health expenditure is also observed within different socioeconomic groups of countries of the world and the Eastern Mediterranean Region. Differences in households' income explain most of the variations observed in household health expenditure. For example, households in the top income decile on average spend much more on health (in some countries, over 20 times more) than households in the lowest income decile. The difference is much more pronounced in countries where the provision of health services by the public sector is weak.

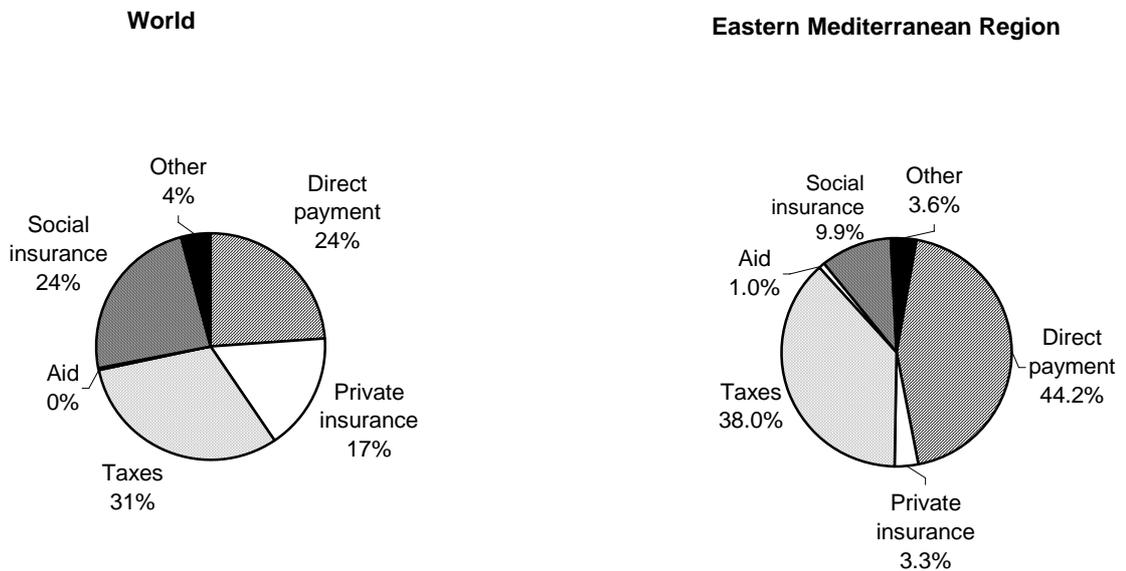
Figure 2 shows and compares composition of health spending in the world and in the Eastern Mediterranean Region. While the percentage of direct, or out-of-pocket, payments (payments made by households at the point they receive health services) is 24% on average for the world, it is much higher, and in many cases is over 50%, of total health spending in the middle-income and low-income

countries of the Eastern Mediterranean Region. In addition, the share of social health insurance is only 9.9% for the Region, compared to 23.9% for the world. These figures indicate that prepayment schemes have not developed in the Region and that a large percentage of households is exposed to uncertain, and on occasion, high health expenditure.



Source: [1,2]

**Figure 1. Total health expenditure per capita in countries of the Eastern Mediterranean Region 2001 (international dollars)**



Source: [2]

**Figure 2. Composition of health spending in the world and the Eastern Mediterranean Region 2001**

## 2.3 Health and poverty: a dual relationship

There is ample evidence of a quantitatively large association between measures of economic status, such as income and wealth, and health outcomes, including mortality and morbidity, in both industrialized and developing countries. However, the full explanation on the direction of causation and on why the association arises has been the subject of heated debate among researchers.

Some researchers argue that poverty leads to ill health because poor households do not have access to quality health care and/or have a stronger pattern of deleterious personal behaviour that affects their health status. Therefore, income and economic development are the main determinants of health [3]. At least for industrialized countries, this hypothesis has been rejected [4]. An alternative hypothesis has developed in recent years that emphasizes the long-term impacts of early childhood environmental factors, prolonged exposure to stressful events and reaction to social injustice, such as rising income inequality, as the main culprits behind the low health status of the poor. Both hypotheses have a common aim which is to establish a link between physiological processes through which poverty leads to poorer health.

In recent years, economists have argued the opposite, that it is ill health that leads to poverty, and have shown that poor health has a negative impact on households' income and economic growth rate [5,6,7]. Poor health would reduce a household's capacity to earn income and accumulate wealth by limiting work, raising medical expenses and reducing savings. Individuals affected by certain diseases, such as malaria, tuberculosis, and HIV/AIDS, may never develop the capacity to earn enough income to get out of the illness-poverty trap. This point was well recognized by the Commission on Macroeconomics and Health [8]. Moreover, economists, especially those who work in sustainable economic growth theory, have increasingly recognized health as a form of human capital. As such, better health increases the productivity of other forms of capital and it contributes to economic growth. Healthier children have higher rates of school attendance and improved cognitive development which lead to a higher rate of return on education and makes investment in education more attractive. The thought of planning for retirement also occurs only when individuals expect to live long enough for retirement to be a realistic prospect. Rising longevity motivates the current generation to save—an incentive that has dramatic effects on national saving and subsequent economic growth [9]. It is estimated that a 10% increase in life expectancy at birth leads to a 0.35% increase in annual growth rate of per capita income [10]. The impact of such an incremental economic growth rate due to better health over time is quite large.

The interplay between health and poverty and economic growth runs much deeper. There are many channels, such as stability of labour supply and the political system, through which health can affect income, and vice versa [4]. The dynamic dual relationship between health and poverty provides new arguments for policy-makers to make a case for more investment in health.

## 3. Disproportionately high health expenditure

### 3.1 Definition

A well functioning health system provides good health, is responsive to people's needs and adheres to the principle of fairness in financial contribution. Fairness in financial contribution is based on the notion that every household pays a "fair" share of its income for health. What constitutes fair share depends on individuals' normative view as to how health systems should be financed. Nevertheless, fairness in financial contribution embraces two critical aspects: that the contribution of individuals to financing of the health system depends on their income and that it is independent of the state of individuals' health.

Degree of fairness in financial contribution varies from one health system to another. However, accessing health services costs money and it can lead to some households having to pay such a large share of their income on health services that it has catastrophic consequences, pushing some into poverty, and others into even deeper poverty than they were already in. As discussed in the last

section, poverty itself can lead to ill health and households may find themselves caught in an ill health–poverty trap.

In most middle-income and low-income countries, including countries in the Eastern Mediterranean Region, households seeking health services are often forced to borrow money, sometimes at very high interest rates, or to sell their assets, in order to pay for health services. The alternative for such households is to forgo health services and live with their illness and suffer the short-term and long-term consequences.

It is worth noting that disproportionately high health expenditure is not always synonymous with hospitalization or high-tech medical treatment. For some households, medication can represent disproportionately high expenditure relative to their ability to pay. Households' ability to pay depends on the relative size of the cost of health services in relation to their income.

Health care spending is taken to be “disproportionately high” when a household must reduce its expenditure on basic items, such as food, in order to cope with health costs. Xu et al [11] defined health expenditure as disproportionately high, or “catastrophic”, if the proportion of the household's direct payments for health compared to the remaining income after basic subsistence needs have been met is at least 40%. That is:

$$\frac{\text{Direct payments for health}}{\text{Total household expenditure – subsistence expenditure}} \geq 0.40$$

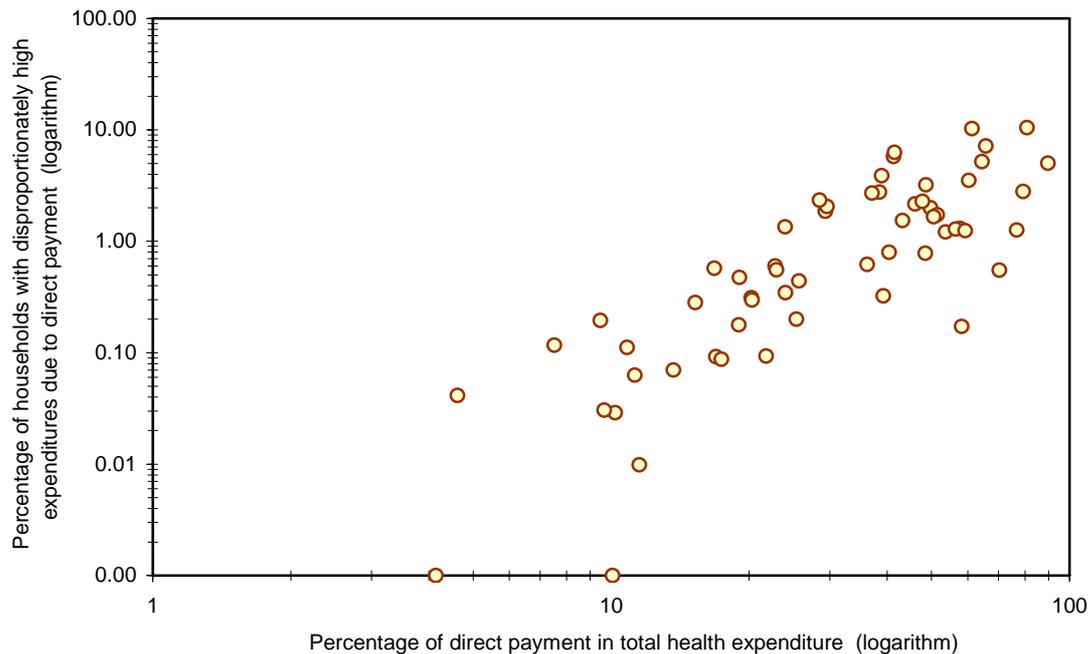
Direct payments for health include all types of health-related expenses incurred at the point of receiving service, such as consultation fee, purchase of medicine, laboratory services, diagnostic services and hospitalization. All reimbursements from third-party payers are deducted. Indirect costs of seeking health care, such as transport and lost earning, are not included. Therefore, the percentage of households exposed to disproportionately high spending will probably be underestimated. A household's subsistence level for each society is calculated based on the total expenditure on food adjusted for household's size.

### 3.2 Pattern and determinants

Xu et al [11] used household expenditure surveys and national health account information from 59 countries for which the necessary data were available to calculate the percentage of households exposed to disproportionately high health spending and to analyse its determinants.

The percentage of households facing disproportionately high spending from direct health payments varied widely between countries, from less than 0.01% in the Czech Republic and Slovakia to 10.5% in Viet Nam. With the exception of Greece, Portugal, Switzerland and the United States of America (USA), the percentage of such households in countries that have well developed social health insurance or tax-funded health systems was less than 0.5%. There were five countries from the Eastern Mediterranean Region in the sample: Djibouti, Egypt, Lebanon, Morocco and Yemen. The percentage of households facing disproportionately high spending ranged from 0.17% in Morocco to 5.17% in Lebanon.

The figures indicate that there is a positive association between the percentage of households facing disproportionately high health spending and the share of direct payments in total health expenditure (Figure 3). The results also show that at any given share of direct payment, the percentage of households facing disproportionately high spending varies substantially. These findings suggest that, first, in some countries the impact of overburdensome health spending is on selected households. Second, there are other contributing factors that explain the observed pattern of disproportionately high health spending.



Source: WHO headquarters in collaboration with country analysts

**Figure 3. Direct payment share of total health expenditure compared with percentage of households with disproportionately high health expenditure**

Disproportionately high health spending may push some households over into impoverishment. The percentage of impoverished households attributed to direct payments for health in the sample ranges from 0.1% to 5%. For some countries, including Egypt, Lebanon and Yemen, such an observation is a major concern for health care financing policies. It is also important to note that some households may choose not to seek health care in order not to become impoverished.

Economic growth and increase in per capita income will make more resources available for the health system. However, the problem of disproportionately high health spending may persist. There is a need for development of alternative health financing options to deal with the problem.

Xu et al [11] used multivariate regression in order to identify the determinants of disproportionately high health spending. The results indicate that of direct payment share of total health expenditure, total health expenditure share of GDP and percentage of households below the poverty line significantly affect the percentage of households overburdened by health spending.

There are good justifications to explain the impact of share of GDP spent on health on percentage of households exposed to disproportionately high health spending. First, once services become available as a result of investment in capacity-building in health services, households will try to utilize them, sometimes to the extent that they become impoverished. Second, the capacity to provide service creates its own demand, causing higher overall health expenditure; the so called “induced demand” hypothesis. Therefore, countries need to consider not only how much they spend on health but also what that money is spent on. In other words, availability of, and paying for, certain expensive services may result in a higher percentage of households facing disproportionately high health spending.

The results of Xu’s study proved to be robust to changes in the cut-off points used to define poverty line and disproportionately high payments. According to the findings, a 1% increase in the direct payment share of total health expenditure leads to an average 2.2% increase in the percentage of

households facing disproportionately high payments. Furthermore, a 1% increase in the total health expenditure share of GDP or a 1% increase in percentage of households below the poverty line are associated with a 1.6% and a 0.2% increase in the percentage of households exposed to disproportionately high spending, respectively.

The results strongly suggest that direct payment is the main cause of households' exposure to disproportionately high health spending. The development of prepayment schemes provides a direct route to reduce overburdensome health spending. However, there are alternative strategies. Programmes that subsidize highly expensive health services, or provision of certain services for the poor would protect the largest segment of the population against disproportionately high health spending.

## **4. Alternative health care financing options**

### **4.1 Introduction**

Health may be priceless but health care costs money and too many households either cannot pay for health services or become impoverished in doing so. While direct payment is not the only factor that contributes to disproportionately high health spending, it is the main culprit and health systems must protect households against overburdensome health spending. Financing (and its sub-components, collection, pooling and purchasing) is one of the main functions of the health system. Health care financing policies determine who will have access to basic health services, what services are offered and at what quality, and who pays for services. A well functioning health system provides a basic package of health services that is affordable, sustainable and is based on ability of households to pay regardless of their need or risk.

The development of prepayment schemes provides a direct route to reduce disproportionately high health spending. However, there are alternative health care financing options that can protect households against paying a disproportionate share of their income for health services. Some are more limited in the scope of coverage than others. There is no single system that is most appropriate for all countries in the Eastern Mediterranean Region. The choice of the system is determined by factors such as the government's ability to raise funds, the size of the formal sector, as well as by political considerations. It also depends on the history, culture and current health institutions in the country. In this section alternative health care financing options and their merits are outlined.

### **4.2 Government funded programmes**

Governments can raise revenue from a variety of sources, including taxes, sales of natural resources and state-owned enterprises. The government can also borrow money from domestic and/or international sources, or can simply run a deficit. The revenue is used to finance a large number of government activities and programmes, including health-related programmes.

Direct taxes (income tax) and indirect taxes (sales tax, customs, etc.) are the main sources of government revenue in the countries of the Region with the notable exception of the members of the Organization of the Petroleum Exporting Countries (OPEC). But the capacity of governments to raise taxes is limited in most developing countries. The International Monetary Fund (IMF) reported that the median percentage of national income collected as taxes was 18% in developing countries compared to 48% for developed countries [12]. Moreover, indirect taxes, which are regressive and distortional compared to direct income taxes, account for a large share of government tax revenues in developing countries.

Earmarked taxes (sometimes called "sin" taxes), such as taxes imposed on cigarettes or alcohol, are other potential sources of government revenue. The public often assumes that such taxes will be used for predetermined programmes, such as health programmes, and therefore is less reluctant to pay them.

No matter what the source of the government revenue, it can be used to finance a variety of public health programmes, including plans to protect households against disproportionately high health expenditure.

a) *Targeted programmes for individuals with special disease(s)*

A health plan can be developed to cover individuals with special diseases, such as renal failure, who face high and, in some cases disproportionately high, health expenditure. The plan is largely financed through government resources.

**Advantages**

- Individuals (patients) can be easily identified.
- The plan can be easily managed.
- The required resources are limited.

**Disadvantages**

- The scope of the coverage is limited and the patient may face other high health expenditures.

b) *Targeted programmes for selected population groups*

Health plans can be developed to cover specific segments of the population perceived to be vulnerable, for example, a plan to cover the elderly or the poor. In the case of the plan for the poor a “means test” is used to identify those eligible for inclusion in the plan. A basic package is defined to be offered to the plan members. The plan may offer the covered services for free or may include minimal user fee charges to deter over-utilization of services.

**Advantages**

- An acceptable primary health care package can be offered.
- In the case of the elderly, those eligible can be easily identified and the number of members in the plan is predictable.

**Disadvantages**

- The basic package often does not include exceptionally high health care expenditures.
- In the case of the poor, the means test could be degrading and costly.
- The funding is dependent on government revenue which can fluctuate.
- There are people outside the targeted group who might face disproportionately high health spending.
- The cut-off point is arbitrary.

c) *Comprehensive national or provincial public health plans*

The government can provide universal and comprehensive coverage for all citizens and/or residents of the country funded through general government revenues. There are 80 countries in the world that have universal coverage policy, of which 50 countries use general government revenues to finance the system. Some have a single national pool (plan), such as the National Health Service (NHS) in the United Kingdom (UK), while others have provincial pools coordinated at national level, such as Canada. The defined package of services covered under the plan is either delivered through a network of public facilities or is contracted out to private providers. Given the size of the programme, the health infrastructure (both physical and human) needs to be well developed to ensure delivery of the package of services to all.

**Advantages**

- The pool allows cross-subsidy from the healthy to the sick and from the rich to the poor.
- An acceptable primary health care package can be offered.
- The plan is very much in line with the goal of health for all.
- Equity and access concerns are met.
- In the absence of large user fees all types of health spending are covered.
- Administrative costs are reasonable.
- Health policies and regulations are uniform and easier to enforce.

- As a national or provincial programme it helps the cause of political unification at national or provincial level.
- Adverse selection is not a problem.

### **Disadvantages**

- The government may not be able to raise sufficient taxes to fund the plan.
- Cost containment is a real challenge in view of advances in medical technology and people's expectations.
- The existing management capacity of most countries of the Region would need to be upgraded to ensure efficient operation of the plan.
- The legal system is not well developed in most developing countries and so where provision of health services is contracted out, enforcement of contracts is a potential problem.
- Given the funding that may reasonably be expected to be available in middle-income and low-income countries of the Region, households in the middle-income and upper-income groups would probably seek health care outside of the public system. This would lead to a two-tier system. A "low" quality health system for the poor and a "high" quality health system for the rest. The long-term dynamic of such a two-tier system would be problematic.
- Patients' rights may not be fully observed.
- Moving to a national health system creates anxiety among some stakeholders, especially the medical professions who might feel that their independence will be compromised.

### **4.3 Health insurance**

Individuals over a normal life cycle are expected to have episodes of illness and in old age to face more such episodes. However, there can be no certainty about the occurrence and duration of an illness and the size of the related health costs. It is the uncertainty of health care needs, the high cost of medical care and the risk-averse nature of individuals that give rise to demand for health insurance and that place risk pooling at the centre of health care financing reforms in many health systems.

Health insurance organizations pool the financial resources of the members and share the risks of medical expenditures among their members. Pooling of funds means that the financial resources available in the pool are not tied to a particular contributor. Pooling allows cross-subsidy from the healthy to the sick and from the rich to the poor, in addition to protecting every member against disproportionately high health expenditures.

All health insurance schemes are perceived as a measure to raise new funds for the health system. It is generally believed that people are less reluctant to pay a part of their income to any organization if they are convinced that the money will go directly towards protecting their health. This is an important advantage of health insurance schemes compared to tax-funded public programmes. The overhead and administrative costs of social and private health insurance organizations, such as registration, collection of premiums, contracting, claims processing and reimbursement, are a concern. The percentage of total funds allocated for administrative costs is a potential deterrent in the usefulness of social health insurance in poor countries.

#### *a) Social health insurance*

Social health insurance is a compulsory form of health insurance created through the legislative process. It is primarily directed at civil servants and formal sector workers because of the ease with which contributions can be collected and the higher level of income of these groups compared to informal workers. Every eligible person must enrol and pay a predetermined percentage of his/her wage or salary as a premium. In many cases, employers and sometimes the government are also required to contribute to the social health insurance funds. The members of social health insurance funds and sometimes their immediate family members are entitled to a benefit package. The benefit package is provided through either social health insurance own-provider networks, public and private providers, or a combination of both.

In the Bismarckian model of social health insurance, individuals are required to join one of the several pools in the system. Each pool (or sickness fund) covers a different package of health services and charges a different premium.

There are 30 countries in the world that rely on social health insurance in order to achieve universal coverage [13]. Social health insurance organizations are expected to be financially independent and self-reliant. However, the long-term solvency of social health insurance organizations is an important concern. In some cases governments have had to bail out such organizations.

There is a large variation in the quality of health facilities and health professionals in most middle income and poor countries of the Region. This in itself indicates the existence of a higher quality private providers' sector outside the social health insurance system. In such cases, either some members of the social health insurance system are not fully insured or there is a need for a complementary private health insurance system.

#### **Advantages**

- Because individuals' contributions go directly to financing their health plans they have a stronger incentive to pay. As a result, the health system can mobilize more resources.
- The pool allows cross-subsidy from the healthy to the sick and from the rich to the poor.
- Adverse selection is not a problem.
- Social health insurance organizations are less prone to executive government decisions.
- The long-term concern of the contributors with regard to the solvency of the organization can be expected to bring accountability and transparency.
- In the absence of large deductibles and/or co-payments, all types of disproportionately high spending are covered.

#### **Disadvantages**

- The culture of health insurance is not well developed in many middle-income countries.
- Overhead and administrative costs restrict the use of social health insurance in poor countries.
- The proportion of formal workers in the total labour force determines, to a large extent, the use of social health insurance as a means to move towards universal coverage.
- Social health insurance is, in many cases, tied to other entitlement programmes, such as retirement, disability, unemployment and death. In such cases, not only does the management of the system become problematic but resources can be shifted from health to other programmes.
- There will be a need to develop certain skills, including managerial and actuarial skills, to run the system.

#### *b) Private health insurance*

For-profit and non-profit firms offer private health insurance on individual and group basis. Premiums are based on actuarial analysis and are calculated using individual's and groups' risk characteristics and underwriting rules to select the risk. Risk selection to avoid adverse selection is a major concern for private health insurance firms. Individual plans are more expensive than group plans and usually require the buyer to pass a medical examination. Administrative costs and profit margin account for a large share of the premium, and may be as much as 40%–50% of the premium in the case of for-profit firms [12].

Private health insurance schemes have the potential to help improve the financing function of the health system [12]. They can also help to reduce the burden of large direct payments. In many countries, private health insurance schemes provide “complementary” coverage for social health insurance schemes.

National health accounts results and country specific studies indicate that private health insurance is more widespread than previously thought. In the Eastern Mediterranean Region, Lebanon and Morocco are the only two countries with sizable private health insurance markets but many countries

in the Region are entertaining the idea of opening up their health insurance market to both domestic and international firms.

However, the private health insurance market needs to be regulated and monitored from the outset if it is expected to play a role in the general scheme of health financing of the system. The real challenge is how to do it right.

#### **Advantages**

- People have a choice.
- Private health insurance helps to develop the “health insurance” culture in the society.
- It helps to improve the financing function of the health system (collection, pooling, purchasing).
- It reduces the burden of expenditure by direct payment.
- The development of private health insurance can lead to the development of more widespread systems, such as social health insurance, or more efficient organizations, such as health maintenance organizations (HMO).

#### **Disadvantages**

- The premium is much higher than the actuarially fair premium.
- Premiums are risk-based. Sick individuals are not allowed to join or there are severe limitations on their coverage.
- Private health insurance firms are not concerned with fairness in financing.
- Private health insurance competes with social health insurance schemes and can limit the cross-subsidy from rich to poor and healthy to sick in social health insurance as they have a comparative advantage to take away the healthy and the rich clients.

#### *c) Community-based health insurance*

When the concept of risk sharing is limited to family or village and health care is recognized as a basic necessity, there may be a chance for a community to come together in order to organize, finance and manage a limited-scale health plan under what is known as “community-based health insurance”. In fact, the Declaration of Alma-Ata encouraged community participation in all organizational aspects of primary health care, including health financing [15]. The government may, perhaps should, provide technical and/or financial support to a community-based health insurance scheme, but not to run it. Community-based health insurance is expected to be based on community cooperation and to be self-reliant.

The development of community-based health insurance schemes is a response to public sector financial and organizational constraints on reaching, and covering the health needs of, some communities, especially in the rural areas and informal sector. They are short-term and medium-term solutions to a long-term problem.

#### **Advantages**

- It is easy to identify the contributing population and collect the contribution.
- It is a way to reach and cover self-employed and informal workers.
- Overhead and administrative costs are expected to be modest.
- Community-based health insurance can be tailored to meet each community’s specific needs and the capacity of its members to contribute.
- It is a step forward in the development of democratic organization in the society.
- It can easily be linked to community-based initiatives (CBI) in the Region.

#### **Disadvantages**

- Risk pooling and adverse selection is a major problem.
- An epidemic, or exceptionally high health expenditure for a few members, could wipe out the financial resources of the scheme.

- Evidence shows that community-based health insurance schemes are successful in building physical facilities but not in management of the scheme.
- Both financial and service coverage is modest.
- Simple book-keeping can be a problem and can lead to allegations, and may cause some members to stop contributing to the plan.
- It requires some degree of social mobilization.

## 5. Conclusion and recommendations

Disproportionately high health expenditure is closely linked to direct payments and is not unique to under-funded health systems. High-tech care in affluent countries or medicine in poor countries can both expose households to disproportionately high expenditure relative to their income. Health systems need to protect households against such expenditures through risk pooling and prepayment schemes, to the extent that such protection can be financed and sustained. Even so, households cannot be protected against the financial burden of all that health technology has to offer. The level of exposure has to be in line with the resources available. Obviously, the health system must try to mobilize as many resources as possible. Health must be perceived as an investment in human capital that promotes economic growth. Investment in health interventions is just like any other investment in development projects. It is also important that health systems become more efficient than they currently are, in order to justify allocation of new resources. This requires reliance on the use of new analytical tools, such as national health accounts and burden of disease and cost-effectiveness analysis. Health policies need to become evidence-based.

Universal coverage is the ultimate goal and will protect all households against overburdensome health expenditures. There is no unique pathway towards universal coverage that is appropriate for all countries in the Region, and certain public programmes must remain the sole responsibility of the government regardless of the choice of health financing options. These include “public goods” and programmes that generate measurable externalities, such as clean water, sanitation, health promotion and immunization. In addition, governments’ responsibilities to ensure that poor and vulnerable groups receive quality health services through a well-functioning primary health care network should not be undermined. These programmes are financed by the government through taxes and other sources of revenue and, often but not always, are provided through state-owned facilities. Finally, regulation of the private sector will always be the responsibility of the government.

The experience of the countries of the world that have achieved universal coverage shows that they all go through a transition, as shown in Figure 4. During the transition, the share of public spending through taxation and/or social health insurance increases, while the share of direct payments decreases. The transition period and exact pathway is determined by many factors, including the political will of policy-makers and the economic performance of the country.

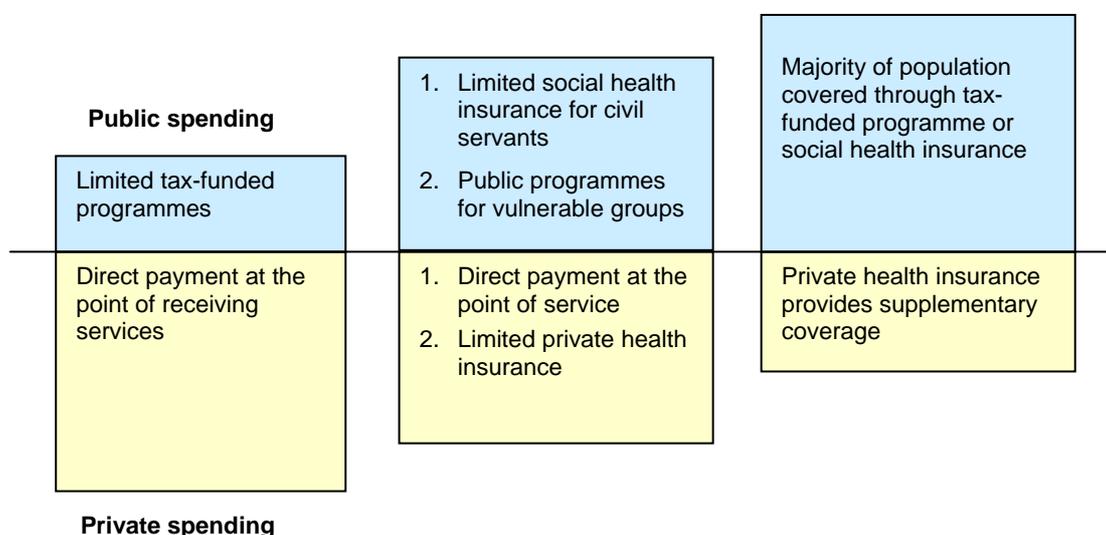


Figure 4. Transition towards universal coverage

Based on economic performance, the countries of the Region can be divided into three groups: low-income, middle-income and high-income. The optimal health-care financing option to protect households against disproportionately high spending would be different for each group.

For low-income countries, a free, basic, primary health care package for all, financed by government tax revenue and donors is the only viable alternative. Health care that is provided through a network of state-owned facilities or outsourced to nongovernmental organizations represents the basic structure of the system. Community-based health insurance can supplement the basic structure to the extent that communities can be organized efficiently to play their part. A limited number of diseases can also be targeted for government financial support to the extent that public resources permit.

For middle-income countries, a comprehensive primary health care package financed by government tax revenue with minimal user fees for some services and medicines to curb over-utilization should be available to all. Health care that is provided through a network of state-owned facilities or outsourced to nongovernmental organizations represents the basic structure of the system. Compulsory social health insurance should be launched to provide comprehensive coverage for civil servants, formal sector workers, workers in large institutions, and their family members. Special schemes need to be supported by governments to provide coverage for poor and vulnerable groups and to target selected diseases for all. Private health insurance organizations could offer coverage, including supplementary coverage, to cover the gap not covered by social health insurance. Over time, social health insurance coverage should become compulsory for all and social health insurance schemes need to be consolidated. The government needs to pay the premium for the poor and vulnerable groups out of general tax revenue.

For high-income countries, the existing government funded programmes have protected citizens and expatriates against disproportionately high payments. However, in the move towards development of compulsory health insurance schemes for expatriates, countries need to adhere to the principles of fairness and equity. Moreover, the administrative cost of launching a new system and its impact on the existing system needs to be studied carefully.

The private sector, in all countries of the Region, must be regulated but it must also be regarded as a partner that has the potential to improve the performance of the health system. The role and size of the private sector depends on the extent to which the public sector fails to provide the necessary coverage at an acceptable level of quality.

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The impact of health on education is an important factor that plays a role in healthcare expenditure and economic performance (30, 33). Children who enjoy good health can attend school regularly and have the potential of high learning ability and cognitive development. Also, if good health continues through adulthood, it will enable the population to recover the investments in education (30, 33, 39). Another significant dimension in the relationship that healthcare spending has with economic development is the impact of health on savings. health expenditures, there remains a significant challenge in balancing the need for promoting public health, controlling noncommunicable diseases, and improving population health in these emerging economies. BRICS nations have a great potential for embracing a public health agenda aimed at promoting physical activity and healthy lifestyles as part of the BRICS public health policies in order to improve population health and reduce the. Purpose: The goal of this study was to assess the effectiveness of healthcare spending among the leading Asian economies. Methods: We have selected a total of nine Asian nations, based on the strength of their economic output and long-term real GDP growth rates. An analysis of the financing and organization of health care in foreign countries has allowed probation to identify three basic models of the economic healthcare mechanism. The first is mostly state free healthcare, as in England, Denmark and Ireland. The second is the financing of basic health care by the private insurance companies, as, for example, in the United States. Over the last 40 years there has been a significant shift in the direction of growth of state expenditure on health care. Currently the US government pays over 40 % of health expenditure in the country (and in 1960 21 %). This is due to the fact that since 1965 the US has a Federal system of social insurance for the elderly called «Medicare». Financing health care has evolved from personal payment at the time of service delivery to financing through health insurance (prepayment) by the employer and employee at the workplace. This has progressed in most industrialized countries towards governmental financing through social security or general taxation, supplemented by private and non-governmental organizations (NGOs) (Table 11.3), and personal out-of-pocket expenditures. Per capita health expenditures also vary widely. The total per capita expenditure on health, whether as a percentage of GDP or as dollars per capita, does not reflect the efficiency with which the resources are used. Where financing of health care is centralized, a potential exists for rational allocation of resources.