International Experience of Healthcare Financing with Special Focus on India

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Abstract:
Good health is one of the most precious assets of human resource in the country. According to WHO (2005) "a good healthcare system would be one that raises the status of the people and promotes their well being by enabling them to access quality and affordable healthcare."World Health Organization (WHO) states that 'Health is a state of complete physical, mental and social well being. It is not merely the absence of disease or infirmity'. Good health is one of the most precious assets of human resource in the country. A good healthcare system would be one that raises the status of the people and promotes their well being by enabling them to access quality and affordable healthcare. The author wants to highlight via this reviewed article; titled 'International Experience of Healthcare Financing with special focus on India' that the healthcare financial experiences with special reference to India.

Keywords: *Finance, Health care, International experience, WHO*

1. Introduction

The 58th session of the World Health Assembly in 2005 defined universal health care as providing access to key preventive, curative and rehabilitative health interventions for all at an affordable cost (World Health Organisation,2005). The Alma Ata Declaration (1978) which emerged from the international conference on primary healthcare argued that health is essential to social and economic development. It identified primary health care as the key to the attainment by the year 2000,by all people, of a level of health that will permit them to lead a socially and economically productive life (WHO,1978). Amartya Sen in his study also focused on health as an important component of human development. Empowerment of people comes from the freedom they enjoy and this includes, among others, freedom from poverty, hunger, malnutrition, freedom to work and lead a healthy life. (Sen, 1999). World Health Organization (WHO) states that 'Health is a state of complete physical, mental and social well being. It is not merely the absence of disease or infirmity'. Good health is one of the most precious assets of human resource in the country. A good healthcare system would be one that raises the status of the people and promotes their well being by enabling them to access quality and affordable healthcare.(World Health Organisation,2005). Investment in the health of the poor raises their educational ability and productivity. It gives them both the assets they need to lift themselves from poverty and the immediate welfare gains of relief from physical sufferings (Wuensch & Poteat, 1998).

Inspite of the fact that health is a very essential component for development of the country, healthcare expenditure is highly unequal across the globe. As is to be expected, developed countries spend the most on health per person. In the year 2000 developed countries accounted for less than 20 per cent of the world's population but were responsible for almost 90 per cent of the world's health spending. While less developed countries accounts for 80 per cent of world's population and spent only 10 per cent of the total expenditure on health. This includes people in the Asia-Pacific as well

as African and Latin American countries. Africa accounts for about 25 per cent of the global burden of disease but only about 2 per cent of global health spending (WHO, 2003).

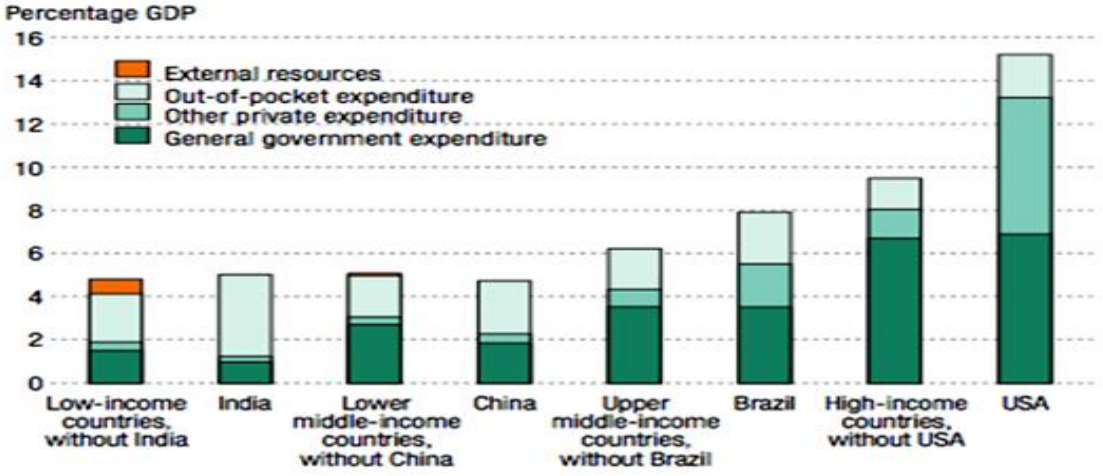
The total health expenditure of a country consists of sum of public and private health expenditures on healthcare. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health.(WHO, 2011). Health expenditure, public (% of total health expenditure) consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and non-governmental organizations), and social (or compulsory) health insurance funds while private expenditure on health is largely in form of out-of-pocket health expenditure which is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure. (WHO, 2011).

Most of the low and middle income countries find financing healthcare as a major challenge, as it would require substantial increases in public spending and productivity increases in an environment of severely strained resources. Of course, there has been considerable success in achieving universal health coverage in some middle-income countries, including Thailand and some Latin American countries, while other countries, such as China, Indonesia and Vietnam are focusing their attention on improving access. In Africa countries like Ghana and Rwanda have recorded remarkable success in expanding coverage, which has inspired other countries in that continent to embark on health sector reforms.(WHO,2011). Improvements in the health indicators of the country have a positive influence on economic growth. For instance rapid improvement in health in East Asia in 1940s created conditions for a favourable demographic transition. An initial reduction in infant mortality swelled the youth population and after a time lag, the working age population began growing faster than the dependent population. This change in demographic structure of the population intern created an opportunity for higher rates of economic growth and can explain perhaps a 1/3 to 1/2 the "Economic Miracle", experienced by East Asia during 1965 to 1999.(Bloom and Williamson 1998).

2. Comparison of Healthcare Spending in Different Economies of World

There is high discrepancy in expenditure on healthcare services among different countries of the world. The expenditure on health is very high in developed countries while it is very low in lower income countries. At the same time there is also large difference in the share of public and private expenditure on healthcare in the world as shown below in the table.

Figure 1. Showing comparison of healthcare Spending in Different Economies of World



(Percentage of GDP used for health, 2005)
Source: United Nation Development Report, Human Development Report

Table 1. World Health Organization: National Health Accounts, report on expenditure on health in different countries of the world for 2011

HDI Rank 2011	Country name	Health expenditure, total (% of GDP)	Health expenditure percapita (current US$)	Health expenditure, public (% of total health expenditure)	Out-of-pocket health expenditure (% of private expenditure on health)
1	Norway	9.5	8091	83.9	95.2
2	Australia	8.7	4775	68	64.1
4	United states	17.9	8362	53.1	25.1
5	New Zealand	10.1	3279	83.2	62.6
9	Germany	11.6	4668	77.1	56.6
14	Iceland	9.4	3722	80.7	92.9
16	Denmark	11.4	6422	85.1	88.1
23	Spain	9.5	2883	72.8	76.1
26	Singapore	4	1733	36.3	84.8
28	UK	9.6	3503	83.9	62
30	UAE	3.7	1450	74.4	73.3
39	Poland	7.5	917	72.6	80.6
41	Portugal	11	2367	68.1	77.8
61	Malaysia	4.4	368	55.5	76.8
66	Russia Federation	5.1	525	62.1	82.8
77	Mauritius	6	43	41.7	88.8
97	Sri Lanka	2.9	70	44.7	81.2
101	India	4.1	54	29.2	86.4
123	South Africa	8.9	649	44.1	29.6
128	Vietnam	6.8	83	37.8	92.7
134	India	4.1	54	29.2	86.4
146	Bangladesh	3.5	23	96.5	3.5

Source: World Health Organization National Health Account database: 2011.

The table shows health expenditure, both in terms of percentage of GDP spent on health and per capita health expenditure, is much higher in the developed countries and extremely low in developing countries. Table also shows that there is much higher ratio of public health spending to private spending in the developed countries. By contrast, in middle developed and low developed countries, either private expenditure dominates or there is very little difference between the shares of private and public expenditure, although in general both tend to be low. It is notable that India has the lowest ratio of public to private health expenditure among all the countries described in this table, including the poorest countries. Further, all the private expenditure in India is mainly constituted by out-of-pocket expenses. This is inherently regressive and puts a disproportionate burden for healthcare on poor households. (WHO,2011)

Table 2. Public and Private Expenditure on Health in Selected Countries, 2007

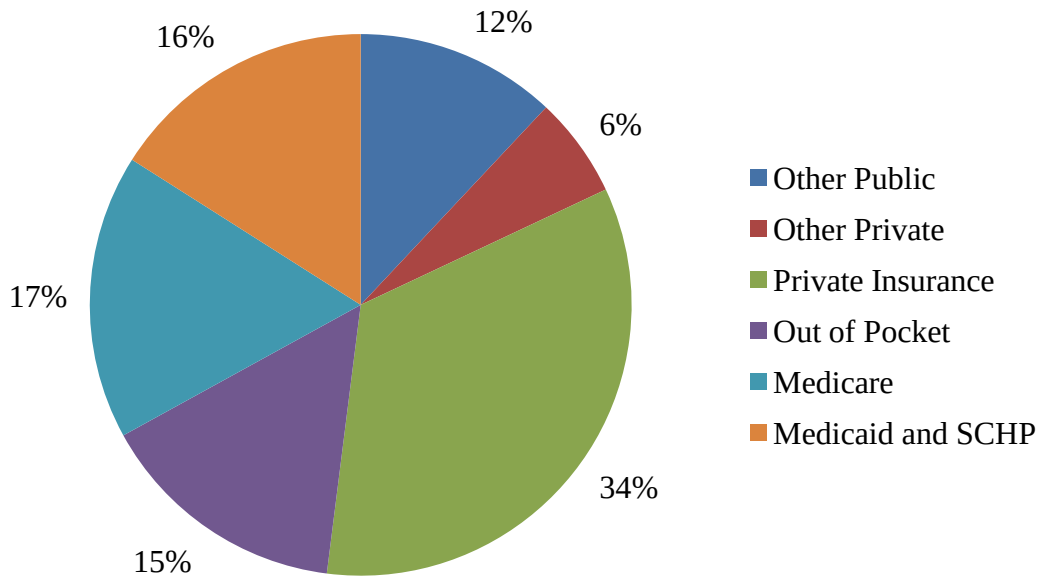
Country	Public spending %	Private spending%
India	26.2	73.8
Bangladesh	33.6	66.4
Sri Lanka	47.5	52.5
Canada	70	30
Thailand	73.2	26.8
U.K.	81.7	18.3

Source: World Health Statistics, 2010, WHO

2. Healthcare Expenditure in America

United States of America is one of the major economies of the world. Its healthcare expenditure has been the highest among the other countries in the world. America has highest health expenditure as percentage of Gross Domestic Product. Its level of per capita public expenditure on health is $8362 which is highest among major economies of the world. In America 60% of the total healthcare dollar comes directly or indirectly from citizens pockets, i.e., directly from their pockets or indirectly paid through taxes. (WHO, 2011).

Figure 2. Healthcare Expenditure in America



Source: Centre for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (NHSG)

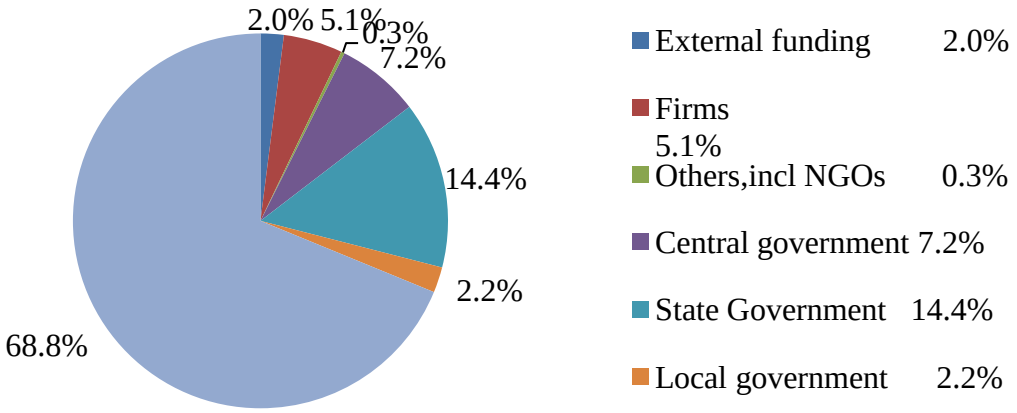
In United States of America, in the year 2000, financing healthcare expenditure from private insurance comprised nearly 34% of the total expenditure while 15% was the out-of-pocket costs came directly from the people's check books or pockets. This Out-of-pocket costs include paying for services not covered by health plan or insurer.(NHSG,2000).

3. Health expenditure in India

In 2007, according to WHO's World Health Statistics, India ranked 184 among 191 countries in terms of public expenditure on health as a percent of GDP. In per capita terms, India rank 164 in the sample of 191 countries, spending just about $29 of purchasing power parity (PPP). This level of per capita public expenditure on health was around a third of Sri Lanka's, less than 30 percent of China's and 14 percent of Thailand's (WHO, 2010). India constituted nearly 74 percent of the total spending on health in contrast to 18 percent in the United Kingdom. Nearly 90 percent of this private expenditure in India was in the form of out-of- pocket expenditure on health by households which is one of the highest in Asia (Doorslaer, 2007).

The first systematic analysis of the distribution of health spending in India by source of funds was published in the National Health Accounts of India, 2001-02. The results are shown in pie-Chart and confirm the widespread perception that private households account for the bulk of health expenditure in India.(Report of the National Commission on Macroeconomics and Health, 2005).

Figure 3. Healthcare Expenditure in India



According to the Report of the National Commission on Macroeconomics and Health (2005), estimated households accounted for more than two-thirds of health spending in the country and around three times the amount of all government expenditure taken together, by the Central, State and local governments(22%). Employers (firms) account for only 5 %, but what is especially notable is the negligible role played by both external sources and others, including NGOs. Despite the reported increase in foreign aid for dealing with HIV/AIDS and similar issues, all external sources taken together accounted for only 2% of total health spending, while NGOs accounted for only 0.3%. More recent estimates suggest that the role of households has increased even more substantially in the most recent period. (Report of the National Commission on Macroeconomics and Health 2005).

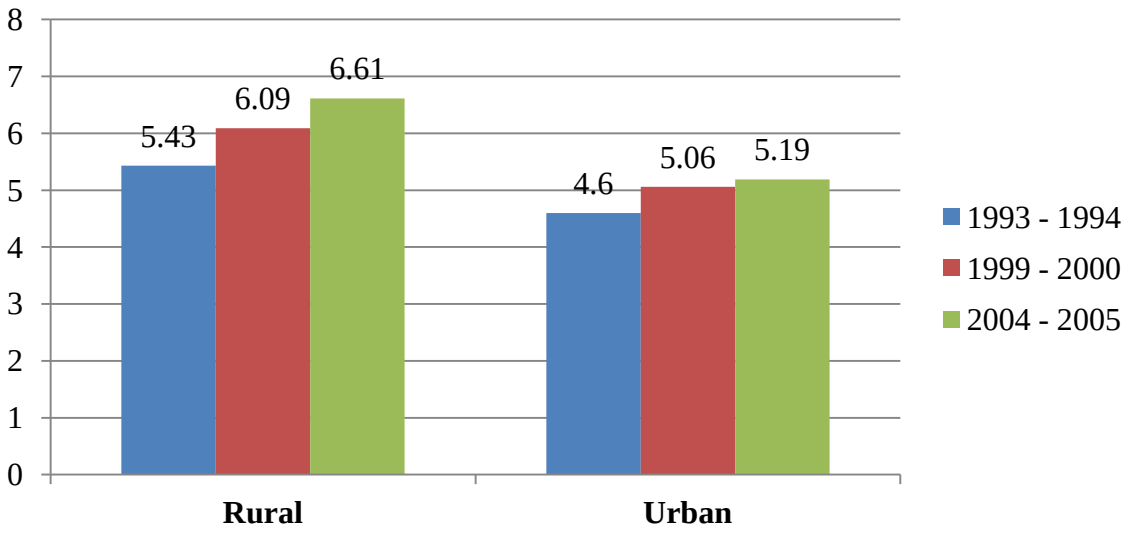
In India Public health expenditure has increased substantially since independence, but this has not been enough to secure a minimum decent standard of healthcare services in the country. As a consequence, the private health sector has seized the opportunity and established its market in the profitable sub sector of health, namely, curative care and drug manufacturing and distribution. The public healthcare sector has been saddled with preventive and primitive services, medical education and urban hospital services; the former mainly in rural areas and the latter in urban areas. (Duggal, et al.,1993). The ratio of Central Government spending to total State Government spending is currently around 1:2. In the past decade, Central Government expenditure on health and related areas has been relatively flat at around 0.35 per cent of GDP. It is also significant that a greater proportion is taken up by revenue expenditure (essentially, the payment of salaries) rather than capital expenditure for creating much-needed basic physical infrastructure. (Mahal, Srivastav and Sanan, 2000). This in turn resulted in increasing household expenditure on healthcare.

At present, Government of India is spending only 1.2 percent of the total budget on healthcare. However, the Planning Commission of India has recommended the government to increase public spending on health by central and state governments from the current level to 2.5 % of GDP in 12th Five-Year Plan and to 3% of GDP by the next 13th Five Year Plan(2017-2022).(12th Five Year Plan of India).

In 2009, India's total expenditure on health was 4.13% of GDP (out of which 1.10% was public). Two-third of healthcare expenditure is on out-patient and the rest one-third is on hospitalization (Selvaraj, 2009).Government is only spending one-fifth, rest 70 per cent is being spent by the households as their out of pocket expenditure on healthcare. Out-of-pocket expenditure on health reached as much as 80% of personal expenses, mostly for outpatient treatment (74%) and drugs (72%) (Ministry of Health and Family Welfare, 2009).

Another study conducted by World Bank in 2012 stated that out-of-pocket health expenditure in India was reported at 86.35 in 2010. India ranked 42nd in the list of countries with highest average of out of pocket expenditure. It holds third rank in the South-East Asia region in the latest list of countries with highest out-of-pocket expenditure on health (World Health Organization, 2012). Chart below reveals that spending on health in India has been gradually increasing as a proportion of total household consumption.(WHO,2011).

Figure 4. Health spending as % of household consumption expenditure



Source: NSSO Surveys of consumption expenditure, 50th, 55th and 61st rounds.

The increase has been especially notable in rural areas, where health now accounts for nearly 7 per cent of total household consumption expenditure. This reflects three separate trends: the greater valuation placed on health such that even poor households are willing to spend and incur debt to ensure minimal healthcare. The reduced access to reliable public health services, the increase in user charges and other effective charges upon consumers even in the public health system has been increasing. Government-run hospitals and clinics that are starved of public funds as a result citizens are made to pay more for medicines, diagnostic procedures and surgical aids. Instances of accident or severe illness requiring hospitalisation have drastic effects upon the households of the affected persons, even among poor households. This is equally true of urban and rural households but the effects may be particularly sharp among the rural population because of the relative paucity of any publicly provided treatment. (Ghosh and Chandershakher, 2011).

Analysis of the spending showed that 82%of primary health care spending was out-of-pocket, as was 92% of primary curative spending. In other words, primary healthcare spending is more private than overall spending, despite government's stated priority for such services. The study also showed that primary healthcare spending was proportionately more private in rural areas and for lower income population, implying a significant burden on the rural poor.(World Bank,1995). Data from the National Sample Survey Organization (NSSO) in India indicate that between 1986-87 and 2004, the share of ailments not treated due to financial reasons has increased from around 15 percent to 28 percent in the rural areas. Part of this increased financial burden arises from the fact that the share of visits to private health facilities has increased in recent years. According to the NSSO data, the share of outpatient visits to public facilities has dropped from 25 to 20 percent and for inpatient visits from 60 to 40 percent (Selvaraj and Karan, 2009; Shahrawat and Rao, 2011). Notably, outpatient treatments account for nearly three-fourths of out-of-pocket expenditure by households. (NSSO, 2007).

4. Medical poverty trap phenomenon

"If a household spends more than 10 per cent of household expenditure on health care, then it is termed as a catastrophic expenditure. In India, 13.68 per cent of household expenditure is spent on health care." (Selvaraj,2009).

Many other studies have shown that out of pocket spending on health care is one of the major reasons for pushing households into poverty (Selvaraj, 2011). The high medical bills cause 3.2 percent Indians to fall below poverty line (WHO,1999). Another study states that the out of pocket expenditure accounts for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively (Gupta, 2009). There are about 70 percent Indians who spent their whole income on healthcare and medicines. The Planning commission also agrees that high out of pocket expenditure on health leads to poverty. It is recognized as a growing issue since 39 million Indians are pushed to poverty due to ill health every year. In 2004 around 30 percent people in rural India were unable to go for any treatments, restrained by financial difficulties while 20 percent of diseases were untreated in urban areas because of the same reason (WHO, 2011).

Out of pocket spending is inefficient and inequitable for the poor who are more susceptible to disease and likely to be pushed into the poverty trap. Out of pocket has been identified to generate four major effects namely untreated morbidity, reduced access to health care, long term impoverishment, irrational drug use. This reinforces the well known vicious circle of poverty (Whitehead, et al., 2001).

5. Suggestions to reduce the financial burden of healthcare expenditure in India

Reducing the burden of healthcare cost remains a big challenge for India at present. Keeping in view the State's constitutional obligation and its inability to fulfil the health care needs of the disadvantaged section (due to resource crunch, lack of political will etc), inefficient public health care system, problem of inflation in healthcare services, shrinking budgetary allocations for health and heavy out of pocket expenditure on health have created a strong need and desire for various reforms in healthcare.

Firstly, India's national health goals cannot be achieved without greatly expanding public financing in the health sector. There is a need for policy reliance on the strengthening of the public health structure for the attainment of improved health outcomes on an equitable basis by allocating additional financial resources. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.(Kumar,et al.,2011)

Secondly, spread of medical insurance can play an important role in household's access to healthcare, it turns the unexpected health expenditures into predictable payment in the form of insurance which in turn encourages households to further invest in the wellbeing and further reduces the crunching effects of poverty(Asgary, et al., 2010). Medical insurance aims at converting heavy out of pocket expenditure into prepayment schemes through insurance on the basis of their willingness to pay so that they do not have to live with the risk of large and unpredictable health care bills. Premiums are paid voluntarily and often depend on the risk category of the buyer of health insurance.(Rexford,et al.,2001). Thus, health insurance increases the likelihood that those who need health care will be able to obtain it in an affordable and timely way. Justification for promoting-health insurance is to assume protection of the poor from bankruptcy, upgrade quantity of healthcare and open avenues for resources required to sustain the system (WHO,2000).

Thirdly, such a medical insurance scheme for healthcare could be supported by public financing from a combination of tax revenues, private insurance (mandatory for all employers), and income-indexed compulsory personal insurance payments integrated to provide funds for a universal healthcare fund. Existing government sponsored insurance schemes will, however, need to be integrated into the universal medical insurance scheme for health care.(Reddy,et al.,2011)

Fourthly, increased spending on health, alone is insufficient to improve the health status of Indian people. Simultaneous steps are needed to improve performance, efficiency, and accountability in the public and private sectors. Introduction and reinforcement of health management information systems, third-party assessments of service guarantee and quality, community supervision, public disclosure, social audits and accreditation of facilities could help to improve effectiveness and accountability. (Kumar,et al.,2011)

Fifthly, need to establish uniform national standards for payment, and regulate quality and cost by use of appropriate information technologies. Universal financial protection is necessary to guarantee health as a right of all citizens. Financial protection should be offered to all citizens, not just those who are poor, against inpatient and outpatient care. In such a system, the government would collect and pool revenues to purchase health-care services for the entire population from the public and private sectors. The state would enlist public and private providers of allopathic and non-allopathic systems of medicine for the people.(Kumar,et al.,2011)

Lastly, Legislative and other policy changes will also be needed to contain the rising costs of medical care and to ensure quality of care. The government would need to fill gaps and deficiencies in drug policies, registration of health practitioners, and guidelines for health-care. The coverage of price regulation of commonly used drugs would need to be strengthened and increased. Standardised protocols and costs of various treatments would have to be developed and monitored; particularly when private providers are called on to provide services to fill gaps in public provisioning. The central and state governments would need to introduce more effective ways of ensuring consumer protection and information disclosure about quality, pricing, equity, and efficiency of health services provided by the public and private sectors in India.

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