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Are we doing justice to our citizens? Public financing of healthcare in developing countries with special reference to India

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ABSTRACT

Public expenditure in health care has accounted for a rising proportion of national income in the current and previous centuries and this is regardless of their level of economic development. In this context, the central idea of the paper is to analyze the degree and volume of public health financing systems in developing countries [lower and middle-income countries (LMICs)] with a focus on India. Indicators selected include per capita income of the country (in PPP USD terms), life expectancy at birth (LEB) of the total population, infant mortality rate (IMR), the share of total health care expenditure (THE) as a proportion of GDP, government health expenditure (GHE) as a proportion of total health care expenditure (THE), private health expenditure (PHE) as a proportion of total health care expenditure (THE), etc. A positive relationship is found between per capita income of a country and its corresponding health care resource commitment. In average terms, public sources contribute 45 percent of health financing, while the rest is by private means. Countries like Afghanistan, Bangladesh, India, Nepal, Seira Leone spend relatively less from public sources. Life expectancy is having a positive relationship with total health care spending in the countries analyzed. Given the context of serious market failures and government failures, the low-income country populace are in a vicious cycle of ill-health and poverty. Public spending is a major way of removing the clutches of deprivation.

Keywords: Public financing; health outcomes; LMICs

INTRODUCTION

Despite being debated, it has been more or less confirmed that public expenditure has a positive correlation with economic growth because protection (both internal and external peace and security) and provision of public goods have a positive cyclical impact on economic progress. Economic development is widely being seen as a powerful instrument for progressive social transformation. One of the most visible concomitants of economic development is a fall in mortality rates and a rise in the general level of health. Good health and longevity are not only highly desired in themselves but are also important because of their potential contribution to economic welfare. And so, the high-income societies tend to attain greater level of health and social development. In short, their basic capabilities tend to be greater than those of people living in poor countries (Anand & Ravallion 1993). It also means that health outcomes are both the determinants and outcome of poverty.

Every sovereign society which assumed the pedals of policy making have had to encounter some fundamental questions on the organization of its health care systems. Initially, political ideologies determined the approach. As a consequence, two major polar structures emerged: the free-market enterprise system and the centrally planned structure. Central planning relies on ability of government to advance welfare of all people efficiently and equitably, while free market stands on the sovereign consumer who can make informed and rational choices and a laissez-faire market will ensure efficiency in outcomes and satisfaction to its participants. However, presence of market failure and inability of the socialist system to rise up to the expectations of the population led to mixed economic framework in policy making. In modern health economics too, such questions cropped up; which include "the appropriate role of government in health service provision and finance?" (Culyer 1983). As is fairly well-known, beliefs, perceptions and theories have to be empirically tested as far as possible as a decision taken by a public policy maker is for a divergent population and multiple generations.

Who would finance, provide and regulate and the need for them have been debated for long? Should health care financing be tax-based, social insurance oriented, rely on private or voluntary insurance, out-of-pocket based, community-based pre-payment route etc are questions of perennial interest. Is a single payer mechanism more efficient and equitable? Is a multi-payer approach more

sustainable and pragmatic in a diverse society like India? In any economy, the ultimate burden on financing health care lies with the households except donor funding. However, the way health care is financed has implications for equity and efficiency in health outcomes and social health.

The central idea of the paper is to analyze, in macro terms, the degree and volume of public health financing systems in developing countries [lower- and middle-income countries (LMICs)]. The paper is organized into a theoretical part (Section I) that basically describes the conceptual features of the system called health and health care and its attributes so as to establish that health care market requires a different treatment than the standard goods and services market in economics. It also discusses briefly the characteristics of different financing mechanisms in the health sector. The succeeding part (Section II) is an empirical analysis of how different countries are financing their health care systems and the returns they receive. Since the basis of analysis is laid on a set of data, a brief methodology and some caveats are presented within the Section II. This is followed by brief discussion (Section III) of the issues raised.

Section I – In Theory

Let me clarify at the outset that what is being attempted is an analysis of financing health care and not health. The reason is that health is an unusually complex entity as the health (status) of a population is determined by a multiplicity of factors like nutrition, clean drinking water, personal hygiene, housing, environment, health-enhancing behaviour etc (what is called the social determinants of health) besides health care. Health care is meant to include all goods and services which go in the improvement in health status or sustaining a certain level of health status, curing/preventing the health level from declining or even gives a painless death. We normally call them preventive and promotive care, curative care and palliative care respectively. How health care is being financed in these countries is the topic of discussion.

Health care – an abnormal commodity

Health care constitute a heterogeneous category of goods and services beginning with control of infectious diseases, maintaining clean water and sanitation to medical research, cosmetic surgery and organ transplants. The major characteristics of the product (if it can be called so) are the following.

Firstly, an obvious distinguishing character of an individual's demand for medical services is that it is not steady in origin as, for example, for food or clothing, but irregular and unpredictable. The risks are not by themselves unique; food is also a necessity, but avoidance of deprivation of food can be guaranteed with sufficient income, where the same cannot be said of avoidance of illness (Arrow 1963).

Secondly, uncertainty as to the quality of the product is more intense here than in any other important commodity (ibid). Recovery from disease is as unpredictable as is its incidence and so, the associated costs. Under uncertainty, the patient and the family may not be in a position to take an economically rational decision as in the case of purchase of automobiles, refrigerator etc. Here, the consumer (though it is unethical to draw a parallel between a patient and a standard consumer) is neither sovereign in most cases nor the preconditions of sovereignty present.

Thirdly, the behavior expected of health care professional is different from that of business men in general. These expectations are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of highest trust in the relation. The degree of relationship is so strong that an individual would be willing to even open his/her physical and psychological properties to a medical man.

Fourthly, as medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is necessarily very much greater than that of the patient, or at least so it is believed by both parties (information asymmetry) which is less relevant issue in most competitive markets. This applies to the case of voluntary (private) insurance as well.

Fifthly, diffusion of communicable diseases provides an obvious example of nonmarket interactions. The classical free-rider problem would emerge because vaccination of one individual would prevent the disease from infecting the other.

Sixthly, in insurance hypothetically, insurance requires for its full social benefit a maximum possible discrimination of risks and those groups of higher incidences of illness should pay higher premiums – a point of inequity.

Thanks to economic theory, we can classify commodities into three major categories: public, merit and private. According to economic theory, it is socially optimal for non-market agents (say, government) to finance and possibly provide the first two types of services; while it may be more efficient for the free market to finance and provide the third (Samuelson 1954). Public goods are non-exclusive and/or non-rival in consumption. In the health sector, most of public health and preventive measures are public goods (Hsiao 1995). Examples include programs to provide clean water, sanitation, vector control, road safety, air- and water-pollution control, fluoridation of water, and mass health education etc. Several types of merit goods are also present in the health sector (ibid). One type consists of services whose consumption produces greater social benefit than private benefit, such as family planning and some primary-care services. Another type produces positive externalities such as vaccination and control of sexually transmitted diseases. A third type of merit goods includes services possessing significant interpersonal utility values (e.g. altruism) such as emergency services for trauma patients and medical services to relieve acute pain and basic health services for vulnerable people. Every society has a vulnerable population such as children and possibly women and minorities, who may be

powerless to make consumption choices to pursue private benefit (Atkinson & Stiglitz 1980). Finally, merit goods include services where individuals lack sufficient education or rationality to make rational consumption decisions. For example, many people significantly discount preventive services that produce future benefits and helps others from contracting illnesses (Diamond & Hausman 1984). Private goods are those services that exclusively benefit the persons who consume them and due to their exclusivity, the market can produce and distribute them efficiently. Some of the curative medical services and drugs fall into this category.

The World Development Report 1993 (World Bank 1993) succinctly puts the following on the importance of a well functioning public health care system: The poor cannot always afford healthcare that would improve their productivity and well-being. Publicly financed healthcare services would help the poor to reduce poverty or alleviate its consequences. Some actions that promote health are pure public goods or create large positive externalities. Private markets would not produce them at all or would produce too little. Market failures in health care mean that government intervention can raise welfare by improving how the markets function. Based on the conceptual background, how a health system needs to be organized is clearer. A health system includes: Health care provision (who would provide health services, public-private partnerships, contracting etc), health care financing (who would fund the health care provision, how it is done etc) and health care organization (how the relationship between different players are organized, the regulatory framework, etc)

Since our focus is on the second question, we could now turn exclusively into it alone, notwithstanding the other two components' significance. Historically, health sector have been in the realm of non-profit sector or with the state or the community. As indicated elsewhere, in any economy, the ultimate burden on financing health care lies with the households except donor funding. However, the way it is paid has implications for equity and efficiency in health outcomes and social health. The following self explanatory box briefs the major properties of different health care financing tools. The analysis based on equity and efficiency effects of health financing suggests that due to the complex character of health care, a free-market based financing instrument is likely to fail on several counts as is visible here.

	Tax revenue	Social Insurance	Private insurance	User fees/OOP
Net revenue generating ability	Depends on the tax base. Few marginal costs of collection	Depends on the size and income of the labour force in the formal sector	Depends on the extent to which demand will increase or decrease in response to change in cost. If steep decline in demand, revenue generated would be limited. Costs of collection and billing may be substantial	
Effect on supply and demand	More amenable to needs-based planning and provision of appropriate services. Effect on demand depends on whether services are provided free or there is a cost involved.		May have high incentives for service providers to provide unnecessary services and tests and lead also to an emphasis on curative services	
Equity effect	Dependent on whether the taxation is 'progressive' – i.e. the poor pay a smaller share of their income	Inequity between those who are in the formal labour force and those not in it.	The poor pay a greater share of their income, and may often not be able to afford. If included, then health risks pooled and could be useful.	Poor pay a greater share of their income
Structural effect	Easier to provide for funding promotive and preventive health services		May be a barrier to providing for funding of promotive and preventive health services	
Viability and ease of use	Requires adequate tax base	Difficult unless there is a large pool of formal labour force	Easy unless co-payments are part of the system	Easy if flat rate is charged from all. Costly if exemptions are to be made, for e.g. for the poor

Adapted from Sundari Ravindran (2004)

Section II

Methodology of analysis

The analysis relies on the data set called World Health Statistics 2015 provided by the World Health Organisation (WHO 2016). A sample of twenty lower and middle-income WHO member countries have been selected taking representing Asia, Africa and South America where the developing countries predominate. The indicators selected include per capita income of the country (in PPP USD terms), child mortality rate (U5DR) of total populationⁱ, access to improved sanitation facilitiesⁱⁱ, share of total health care expenditure (THE) as a proportion of GDP, government health expenditure (GHE) as a proportion of total health care expenditure (THE), private health expenditure (PHE) as a proportion of total health care expenditure (THE), external health expenditure (EHE) as a proportion of government health care expenditure (GHE), per capita total and government health expenditure in PPP terms. Though health care is only one among the components in influencing the health status of a population, it is considered a proxy for health sector attainments. As a proxy for the social determinants of health, access to improved sanitation facilities is taken as an indicator. Compared to many other health indicators (say life expectancy at birth), mortality at the youngest ages could be substantially influenced more by health care interventions and social determinants of health. That is the reason why we have taken under 5 mortality rate as an indicator of health status/outcome.

The WHO collects the data from the member countries as reported in their National Health Accounts (NHA). The most comprehensive and consistent data on health financing are generated from national health accounts (NHAs) that collect expenditure information within an internationally recognized framework. NHAs trace financing as it flows from funding sources to decision-makers (who decide upon the use of the funds) and then to the providers and beneficiaries of health services. Not all countries maintain or update NHAs in such cases data are obtained through technical contacts in the country or from publicly available documents and reports. WHO sends all such estimates to the respective ministries of health every year for validation. All the indicators shown are measured as financing agents except “external resources for health” which is measured as a financing source. The regional, income and global figures are calculated using Purchasing Power Parity (PPP) terms. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2014 data will cover the fiscal year 2013–14) unless otherwise stated for the country. For 2014, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis. In some cases, especially of the OECD countries the sum of government and private expenditures on health may not add up to 100% because of rounding. Care needs to be taken in interpreting external resource figures. Most are taken from the OECD DAC/CRS database except where a reliable full national health account study has been conducted. These are disbursements to recipient countries as reported by donors, lagged one year to account for the delay between disbursement and expenditure. A PPP series resulting from the 2005 *International comparison project* (ICP) estimated by the World Bank has been used. In countries where this is not available, PPPs are estimated by WHO. Non-profit institutions (such as nongovernmental organizations) serving households are accounted for in “external assistance” and recorded under government expenditure. Government expenditures include external assistance (external budget).

Limitation of the analysis

The major limitation of the present analysis is that the results derived are very preliminary as no advance statistical tools have been used to reach any definite conclusions. Secondly, since the analysis is country-wide the context of development issues and reasons vary far and wide, so the conclusions reached may be biased to the extent.

Section III

What do the statistics tell?

Table 1: GDP, U5 Mortality and Sources of Financing in LMICs (2015)

Country	GDP Per Capita (PPPUS\$)	U5 mortality rate	THE as % of GDP	Tax-GDP ratio	GHE as % of THE	PHE as % of THE	GHE as % of GTE	EHE as % of THE	PCHE at PPP \$	OOP as % of THE	Access to improved sanitation
Argentina	14090	12.5	5	37.2	55	45	13.7	0.1	1062	31	96.4
Bangladesh	3123	37.6	3	8.5	28	72	7.4	5.8	44	67	60.6
Brazil	15893	16.4	8	34.4	46	54	6	0	875	25	82.8
Burkina Faso	1620	88.6	5	11.5	52	48	16.3	29.2	82	39	19.7
China	13206	10.7	6	22	56	44	10.3	0.2	265	32	76.5
Costa Rica	14918	9.7	9	21	73	37	26.1	0.1	1059	25	94.5
Cuba	10200	5.5	11	44.8	96	4	18	0	2475	4	93.2
Egypt	10533	24	6	15.8	38	62	5.9	0.6	261	56	94.7
Ethiopia	1500	59.2	5	11.6	59	41	11.5	40.7	37	32	28
Ghana	4082	61.6	4	20.8	60	40	8.5	14	114	27	14.9
India	6020	47.7	5	17.7	30	70	4.4	1.6	122	62	39.6
Kenya	2954	49.4	6	18.4	61	39	5.8	26.8	66	26	30.1
Mexico	17315	13.2	6	19.7	52	48	15	0	837	44	85.2
Nepal	2374	35.8	6	10.9	40	60	11.3	11	66	42	45.8
Nigeria	5911	108.8	4	6.1	25	75	6.4	4.6	113	48	29
Seira Leone	1966	120.4	11	10.5	17	83	4.2	17	104	7	13.3
Sri Lanka	11110	9.8	4	11.6	56	44	7.9	1.8	187	82	95.1
Thailand	15735	12.3	7	17	86	14	14.2	0.3	328	24	93
Vietnam	5629	21.7	7	13.8	54	46	9.3	1.7	201	77	78

Sources: World Bank 2016, WHO 2016

In table (Table 1), information about GDP per capita, U5 Mortality Rate (U5M), total expenditure on health care (THE) which includes both public and private sources of financing health care, government health expenditure (GHE) includes all expenses by different levels of government and government agencies, private health expenditure (PHE) meaning health expenses made by households and private firms, government health expenditure relative to total government expenditure (GTE), external health expenditure (EHE): all resources committed by donor agencies outside the country in kind and cash, per capita health expenditure (PCHE) and per capita government health expenditure (PCGHE) and access to improved sanitation facilities are given. The highest and lowest are marked in bold.

As expected, it is clear that the countries having higher per capita income tends to have a lower under 5 mortality rate. This is because a higher average individual income permits to purchase almost all essential elements of survival. However, one would not find a linear relationship between per capita income and health outcomes as measured by U5M. This indicates that income alone cannot explain all variations in child mortality. Analysis relating to countries like Seira Leone, Kenya, Ethiopia would need to

take into account the widespread HIV/AIDS epidemic had on their disease pattern, mortality rates, health expenses, and magnitude of donor funding. Bangladesh is one country which commits very low amount of resources for health care but gets better returns.

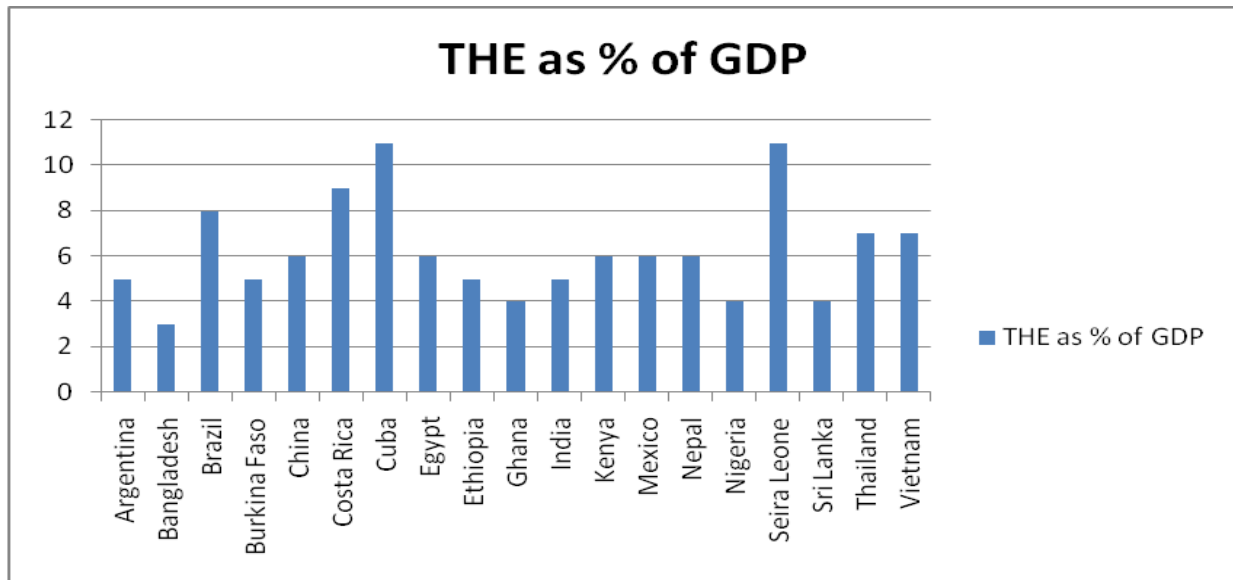


Figure 1: Total health care spending and GDP (LMICs- 2015)

On average, 6.8 per cent is the average amount committed by these 19 countries with a range of 3.3 for Bangladesh and 13.3 for Sierra Leone in 2015 (Figure 1). One interesting fact here is that though Cuba and Sierra Leone spend almost same proportion of their GDP on health care, the level of economic and social development attained and volume of resources in Cuba are so many times higher than the Sierra Leone. There are at least 8 countries including India which spend between 4-5 per cent of their GDP on health care. This is in contrast to the world average of 9 percent.

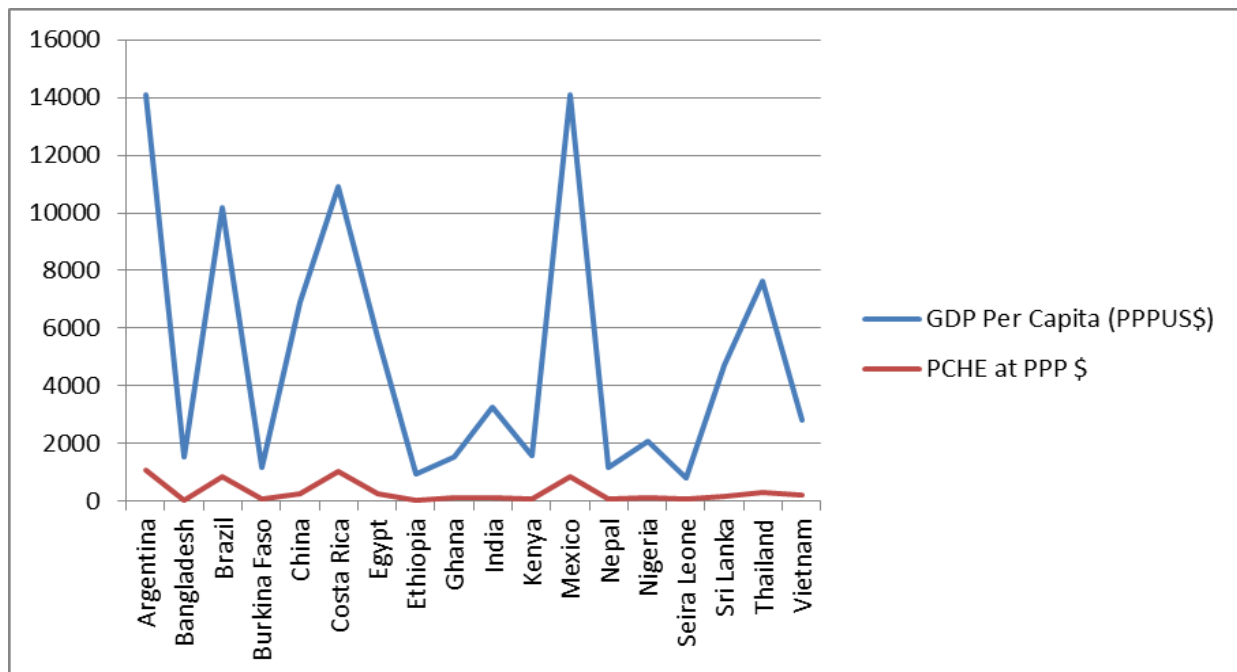


Figure 2: Per capita health expenditure in select LMICs (2015)

It is seen here that there is a positive relationship between per capita income of the country and its corresponding health care resource commitment (Figure 2). However, interestingly, this is always not true as some countries despite having comparatively higher per capita GDP spend less on health care. India is a case in point.

A break-up of public and private sources of financing in health care in the selected countries (Figure 3). The lower part of the chart indicates the public contribution and the rest the private financing. In average terms, public sources contribute 45 per cent of health financing, while the rest is by private means. There are a number of countries that spend a relatively high proportion of public resources including Cuba, Costa Rica, Thailand, Sri Lanka. However, countries like Afghanistan, Bangladesh, India, Nepal, Seira Leone spend relatively low from public sources.

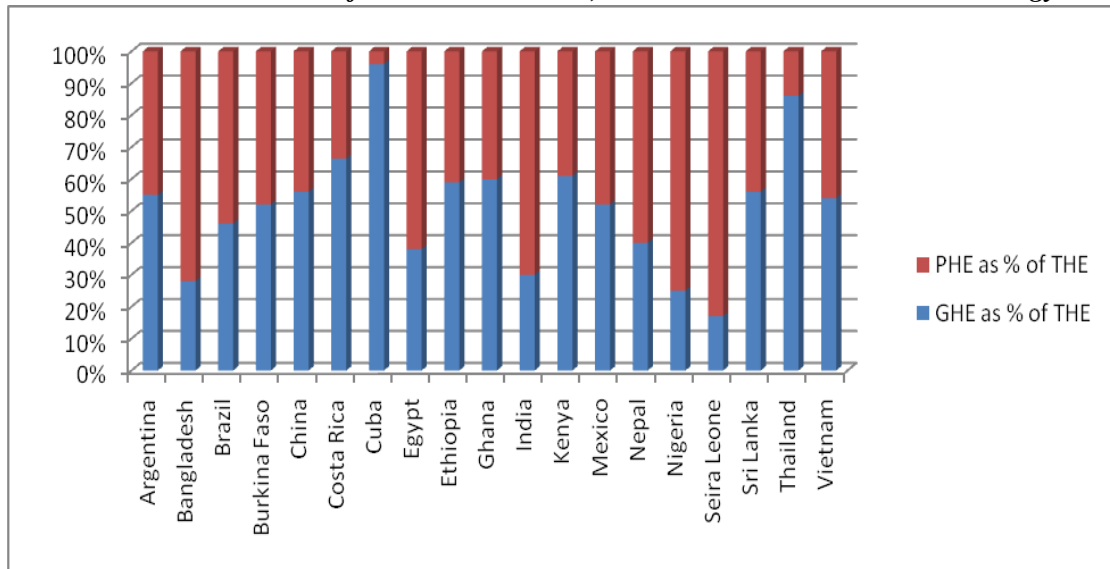


Figure 3: Relative contribution of public and private sources of financing

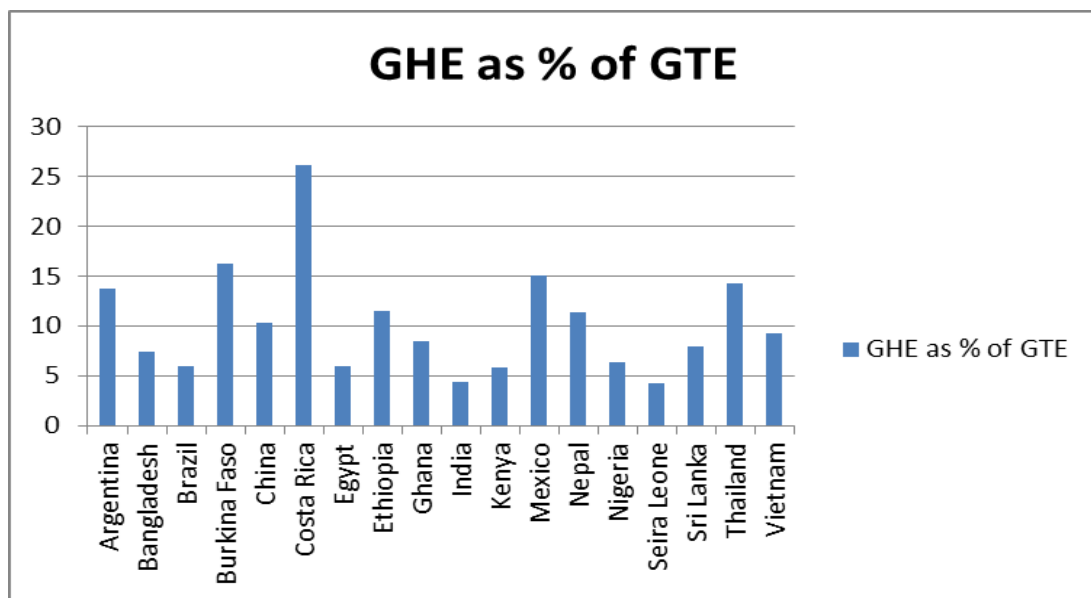


Figure 4: Government's Health Expenditure and Government Total Expenditure

Figure 4 shows the relationship between total available resources with the government and the amount earmarked for health sector. It ranges from a low of 4.2 per cent (Sierra Leone) to 26.1 per cent for Costa Rica. India is one the serious publicly underfunded health care systems with 4.4 per cent from the total budgetary expenses (combined Centre and States). This is reflective of the commitment of the respective governments towards health sector.

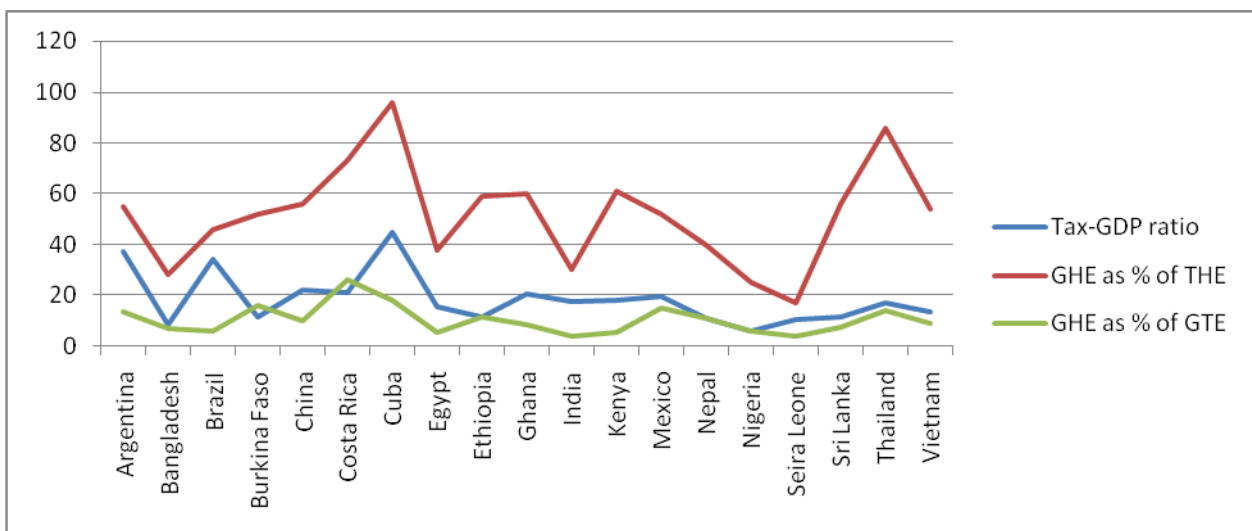
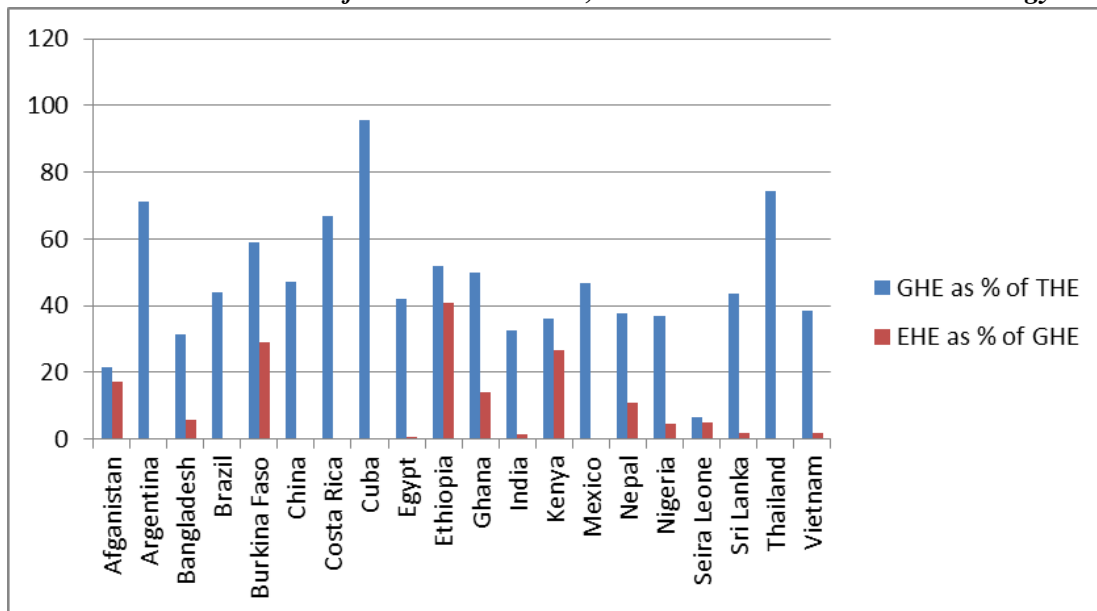


Figure 5: External resources and health care expenditure



The figure (5) is an instructive one which highlights the importance of external assistance in the developing country health budgets. As is seen, countries like Burkina Faso, Ethiopia, Kenya, Sierra Leone in Africa depend heavily on external assistance to sustain their government budget expenses on health care. In Asia, Afghanistan, Bangladesh and Nepal depend foreign sources to some extent. The foreign dependence is as high as 95 per cent in the budget for Sierra Leone.

Public spending on health care is found to have a positive relationship with health outcome in the countries analyzed (Figure 6). When public expenditure and private expenditure is broken down, the public expenditure is found to have stronger positive impact on reduction in child mortality. This is possible if we take the relative distance between the three lines in the diagram. In other words, in countries where public expenditure share is higher, they tend to have a very low child mortality, say, Cuba, Costa Rica, Thailand among others. The finding clearly shows the magnitude of avoidable mortality of children in these low-income countries and the inequity in health attainment is expected to widen across countries if adequate measures are not taken.

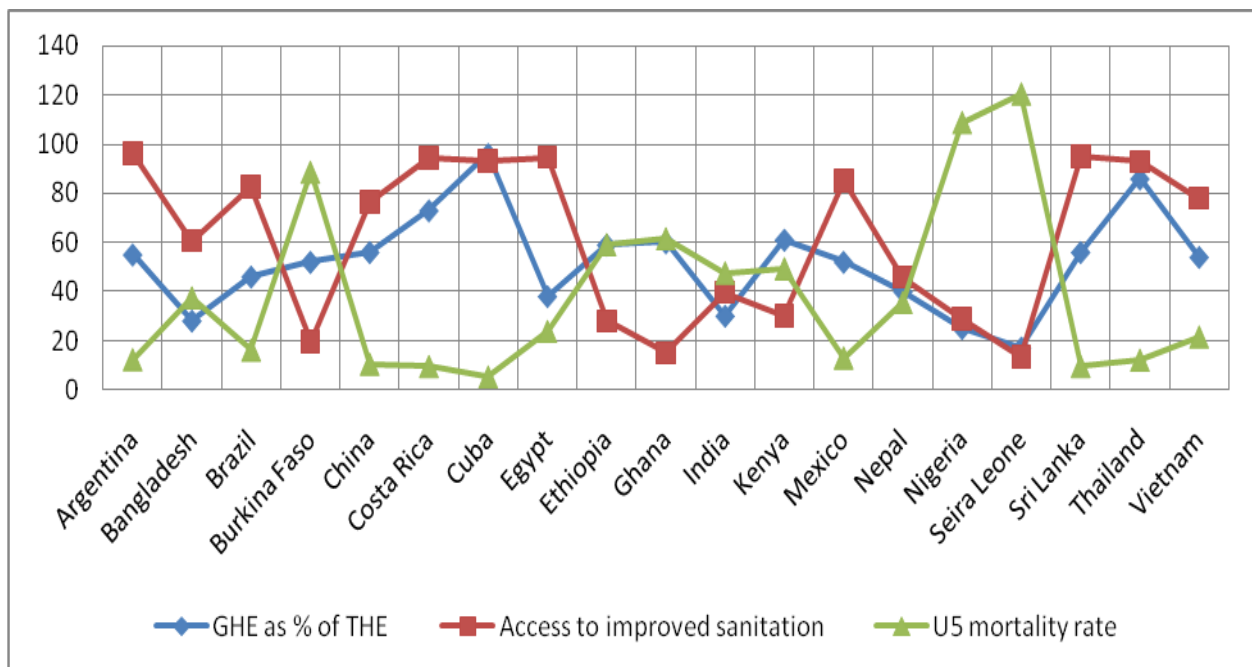


Figure 6: Public health spending, Access to Improved Sanitation and Under5 Mortality Rate (2015)

There is an unambiguous negative association between public investment in health and under 5 mortalities. The hypothesis is that higher the public spending better the health outcomes, assuming the resources are spent efficiently. We attempted to further run the relationship between access to improved sanitation and under 5 mortality and found that there is a consistent negative relationship between access to improved sanitation facilities and child mortality. Both access to improved sanitation and public spending on health care play a very complementary association. In many countries, a major social determinant of health such as access to improved sanitation facilities has more descriptive power the public health expenditure in explaining variations in under 5 mortalities. It also shows that access to better sanitation is a merit good and countries' spending on such social determinants reap better health returns. Besides, countries like Bangladesh, India and Nepal show that they get proportionate health gains as reflected by the minimum gap between public spending and under 5 mortality.

Section IV

Discussion

Public budget revenues are central to financing progress towards universal health coverage (UHC) in low- and middle-income countries (LMICs). Given the relatively small size of the formal sector in most LMICs, it is general budget revenues (mainly sourced from indirect taxes) rather than direct contributions for health coverage that must play the leading role. This is reflected in the growing number of cases of budget-funded coverage expansions in which the government either fully or largely covers the cost of contribution in LMICs such as Thailand, Mexico, Rwanda, China, Kyrgyzstan. Access to affordable and reasonable quality health care has been an unquestioned objective of all health systems irrespective of the social-political systems (WHO 2000). In case of health, there is a strong association between government spending and health status (World Bank 2004). Given the context of serious market failures and government failures, the low-income country populations are in a vicious cycle of ill-health and poverty. Public spending is a major way of removing the clutches of deprivation. Many low-income countries spend optimal amounts compared to their level of income. As mentioned elsewhere, public sources of financing possess substantial efficiency and equity properties compared to privatized means of financing.

Since this is a macro analysis involving about 19 LMICs, some broad context specific comments are warranted. One fundamental feature of all these countries is that almost all of them have been under early or new colonies of imperialist forces. While Latin America was dominated by the Spanish and the French, Asia and Africa had been under the rule of the English, the French and other Western European forces. Much of the Latin American countries attained Independence during late 19th century and all of them had highly unequal societies. During 1950s, countries in South America like Argentina, Brazil, Chile, Cuba, Mexico etc had restructured their social sector resulting in substantial increase in funding of health, education and other social overheads. Some countries stand out. For example, Cuba and Costa Rica have a very strong and vibrant public health delivery system based on concept of family physician with emphasis on preventive and promotive care. Cuba is also one of the very few countries in the developing block where health care is a fundamental right. Though Cuba has addressed the first order problem of ensuring access to health care, sustaining the health gains and containment of cost is a challenge. Sri Lanka has a fairly well-developed public health system with focus on preventive care and fairly accessible curative services. Due to a well laid public orientation and limited competition, Sri Lanka gets more than optimum returns to its health sector investment from a macro perspective.

Countries in the African block still seriously suffer from the new generation of colonial dependence (neo-Colonialism) where majority of the poor economies in Africa act as both the input and output of the OECD (Organisation of Economic Development and Cooperation). Countries in Sub-Saharan Africa still receive huge amount of donor aid which, in turn, determines the level of resource availability and health care planning in these countries. When HIV/AIDS pandemic run through the length and breadth of Africa, majority of the African health systems collapsed further. The aid given by the West goes back to the West themselves in multiple forms like repayment of debt, brain drain, intellectual property rights etc.

Specifically, like many African countries, India is spending far less than the optimum for any economy (market, command or mixed); governments in India's 'social economy' contribute only 24% to the country's health care resources whereas those of European 'market economy' allocate 75% (Dreze and Sen 2002). Government spending in India is fifth poorest in the world; only Cambodia, Congo, Georgia and Sierra Leone rank below India [WHO 2015]. Per capita government spending too falls below the minimum financial requirement to cover essential health care needs of an individual in a developing country [WHO 2014]. The low level of public spending is compounded by (a) a highly inefficient use of available resources, and (b) sharp inequalities in access to health care based on region, class, caste and gender [GoI 2002, 1997 & 1996]. Majority of the primary care and infectious diseases are having a high degree of externality and possess public good character, as economists say. Positive externalities occur when one person is protected or cured from an illness. In India, communicable diseases account for about 52% of the disease burden in the country and government is able to meet only 19% of India's demand in this regard [NSSO 2015].

India is one of the very few countries which has a comparatively higher per capita income similarly placed countries. It has a moderate tax-GDP ratio and the missing aspect is the lack of commitment towards health sector and it has not been a political priority. One, the tax-GDP ratio actually permits a higher potential spending as visible from the experience of many LMICs. Secondly, even as a proportion of gross government expenditure, the amount earmarked for health spending is substantially lower. How efficient are subsidies in reaching the target is another fundamental question to be asked? Scholars suggest that rich people gain more from public subsidies in education and health than do poor people for four sets of reasons: private costs, differential costs and benefits, patterns of government expenditure, and rationing (Anand & Ravallion 1993). However, in areas where the non-monetary capital of the population tends to be higher like better literacy rates, social security measures, inequity is minimized. For example, the poorest 40 percent of the population in Colombia, Malaysia, and Sri Lanka have received a relatively proportional share largely because of the progressive effect of public spending on rural health care (ibid).

Poverty effects of out-of-pocket spending is so heavy on low- and middle-income populations who constitute roughly 70 percent of the population in these countries. The economic catastrophe (WHO defines health care payments as catastrophic if it crosses a threshold of non-food spending by households, say 5 or 10 percent) created by direct financing of health care expenses by households is unacceptably high. It is only when the reliance on direct payments falls to less than 15–20% of total health expenditures that the incidence of financial catastrophe routinely falls to negligible levels (WHO 2010) and this is very rare in low income countries. Most studies on health care payments confirm that almost all households paying out-of-pocket for hospitalised care (whether in public or private) tend to have experienced catastrophic payments and a large majority gets indebted (some for a shorter period and the rest perpetually) (NSSO 2015, Godwin 2009).

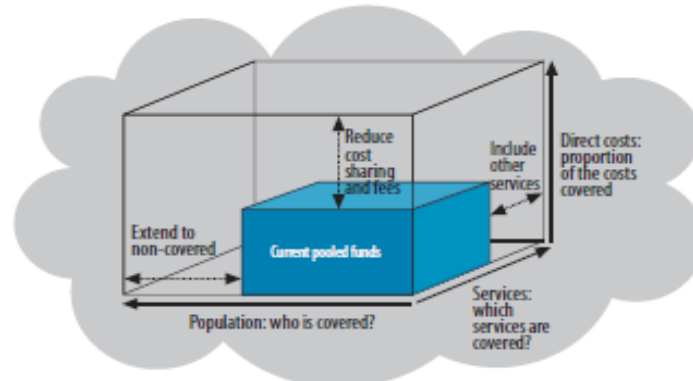


Figure 7: Existing level of health care coverage
Source: Source: Directly adapted from WHO 2010

This is one of the most viewed WHO figures in the last five years on the discussion of financing health care globally. The figure shows the existing level of universal coverage (depicted as the blue box) and the uncovered area represents the road to be travelled which is tough but possible. Literature have adequately shown that expansion of universal coverage through private and social insurance is a difficult proposition, but a substantial increase in health funding coupled with governance changes in health services is an equitable, efficient and sustainable way of universalizing health care protection.

To conclude, the statistics on the pattern of health care financing across low and middle income countries clearly brings out some definite directions and messages. It hints at the following: one, countries having a socialised health care delivery system tends to fare better in terms of health outcomes. Two, while certain countries commit more resources towards health and social sector while some seriously underspend on them despite the resource flexibility they have. Three, more than the average income of a country, it is the magnitude of public financing as reflected by tax-GDP ratio is more important in explaining the differences in the ability of a nation to spend in social sector (health included). Even wasting a minute in addressing the unfinished agenda of universal access (health for all) will amount to a criminal injustice to the ailing and readily avoidable mortality. Collectively, do we have the will? This is a trillion dollar question.

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ⁱ Under-five mortality rate is the probability per 1,000 that a newborn baby will die before reaching age five, if subject to age-specific mortality rates of the specified year.

ⁱⁱ Access to improved sanitation facilities refers to the percentage of the population using improved sanitation facilities. Improved sanitation facilities are likely to ensure hygienic separation of human excreta from human contact. They include flush/pour flush (to piped sewer system, septic tank, pit latrine), ventilated improved pit (VIP) latrine, pit latrine with slab, and composting toilet.