International Journal of Psychosocial Rehabilitation, Vol. 24, Issue 05, 2020
ISSN: 1475-7192

High out-of-pocket expenditure: making healthcare out-of-reach for lower income countries

[1]Neha Goel

ABSTRACT:

Health care costs are rising worldwide. As per the WHO fact file, every year about 25 million households are pushed into poverty due to direct, out-of-pocket health payments. Key financing issue for low- and middle-income countries is how to provide increased financial protection for households. Reduction of economic and social inequality also has instrumental relevance for good health. Gross inequalities harm the health of the underdogs of society, both by undermining their lifestyles and by making them prone to harmful behavior patterns, such as smoking and excessive drinking. Lower income countries are prone to non-communicable diseases (NCDs) and growing aging population. Non-communicable diseases may be a result of globalization and urbanization which exposes them to risk-factors likeobesity, unhealthy lifestyle, consumption of alcohol or tobacco use. Public expenditure oh health is low in lower income countries and out-of-pocket expenditure is very high in these countries.Thus, people are pushed into poverty due to high health care costs in lower income countries.

Models like integrated public healthcare or universal social health insurance system is the need of the hour. Well-designed policies and strategies are required to reduce OOP and its negative impacts. A healthy population can in turn help the economy to grow through increased efficiency and better pay. It is therefore a matter of urgency.

KEYWORDS: health expenditure, out-of-pocket expenditure, poverty, low income countries, universal health coverage, integrated health care

ABBREVIATIONS:

WHO: World Health Organization

OOP: Out-Of-Pocket

NCDs: Non-Communicable Diseases

UHC: Universal Health Coverage

SEAR: South East Asian Region

[1] *PhD Scholar, Faculty of Management Studies, University of Delhi*

GDP: Gross Domestic Product

IPCHS:Integrated People Centred Health System

I. INTRODUCTION:

High health care cost is global cause of concern. As per the WHO report, every year more than100 million people are pushed into poverty due to direct, out-of-pocket (OOP) health payments[1]. OOP costs are those expenses that are not reimbursed by the insurance companies.Countries are focusing on providing Universal Health coverage to reduce OOP. Achieving UHC requires that every individual should have access to promotive, preventive, curative and rehabilitative health services such that there are no financial hardships faced by the people while paying for those services. Thus, the key financing issue for low- and middle-income countries is how to provide increased financial protection for households.However, high OOP expenditure is a huge constraint on this target

As per WHO Global Health Expenditure database in 2016, OOP expenditure (as a % of current expenditure on health) of South-East Asian region was much higher than the world average of 18%. Among the South-East Asian countries, Myanmar ranks the highest with about 74% Out-Of-Pocket (OOP) health expenditure and Timor-Leste ranks the lowest with about 9%, followed by Thailand with 12% Out-Of-Pocket (OOP) health expenditure. However, an exceptional example is Cuba with 10%Out-Of-Pocket (OOP) health expenditure. It is a third-world economy with impressive first-world indicators such as literacy, healthcare quality and coverage, life expectancy, education access and infant mortality rate[2].

Lower- and middle-income countries have experienced globalization and liberalization in the past which resulted in rising inequalities among people in these countries along with unhealthy lifestyles. Gross inequalities harm the health of the underdogs of society, both by undermining their lifestyles and by making them prone to harmful behavior patterns, such as smoking and excessive drinking. This has also resulted in rise of non-communicable and other cardiovascular diseases in such countries. While Universal health coverage might ensure an equitable and efficient health care to people, integrated care requires health systems to be designed in such a way that centre of care is people and their needs.

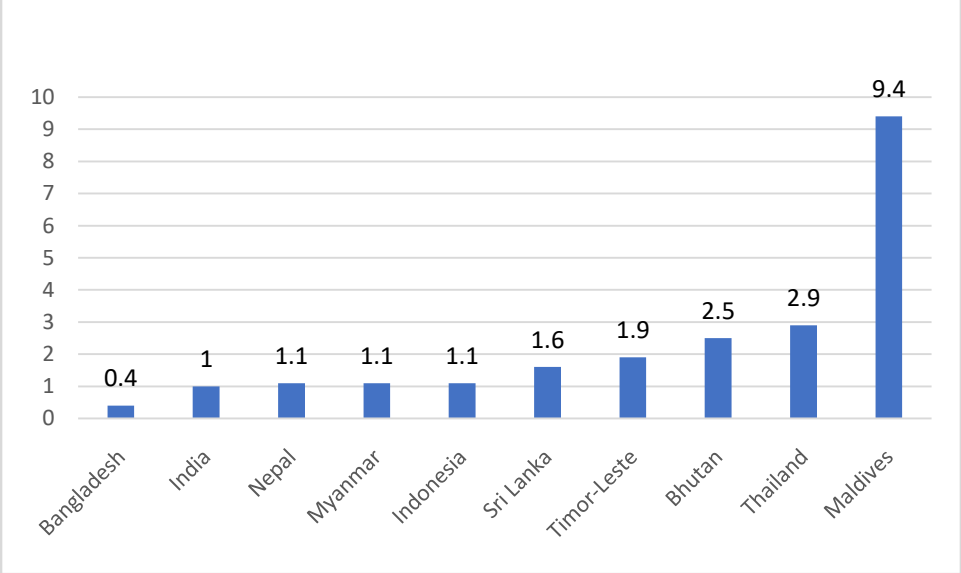
II. RATIONALE OF STUDY:

Today's health care services are not fit for 21st century challenges. Thinking about development and human welfare, improvements in health is as important as improvements in income. Having limited access to effective and equitable healthcare services, population in low and middle-income countries tend to spend a greater proportion of their household income on increased healthcare cost leading to catastrophic expenditure and thus being pushed into poverty. Expenditure on health care is leading to impoverishment, and the hospitalization costs, whether public or private, results in catastrophic payments. WHO has proposed that health expenses become catastrophic if the total

out-of-pocket (OOP) health payment is greater than or equal to 40% of a household's capacity to pay i.e. available income after meeting the basic subsistence needs[3].

Data shows that government participation in the healthcare sector has been declining over the years. We can see from the graph below that the lower income SEAR nations also have low government expenditure on health as percentage of GDP[4]. This may be due to poor infrastructure and lower healthcare workforce in lower income countries. Voluntary private insurance suffers from serious market failures, characterized by cost escalation, moral hazard, adverse selection etc. Private healthcare facilities are more expensive than public facilities on an average. Thus, well designed policies and strategies are required to reduce OOP and its negative impacts. Higher OOP means higher burden on consumer pockets which makes the healthcare market ripe for the insurance companies and global players.

Fig. 1: PUBLIC EXPENDITURE ON HEALTH AS % OF GDP- SEAR NATIONS IN 2015



Source ***:***

Global Health Expenditure Database, World Health Organization

: national health profile 2018

Public expenditure on health as percentage of GDP in India is very low (1.12 in 2009-10 and 1.02 in 2015-16)[4]. South East Asian region has wide social, economic and political diversity. The region has poor health infrastructure along with increasing burden of non-communicable diseases (NCDs). Non-communicable diseases are caused due to impact of globalization, urbanization and economic and demographic transition and many natural calamities occurring in such economies. For example, physical inactivity, tobacco and alcohol consumption, and unhealthy diet are some of the risk-factors to which people are exposed to in lower income countries. These risk factors may lead to diseases like diabetes, cancer and cardiovascular diseases. All these factors may result in loss of

household income for population in low- and middle-income countries. Natural calamities like floods, earthquakes and cyclones are common in these countries due to climate change and this may result in mental illness of the people along with displacements and destructions. People living in lower- and middle-income countries have limited access to effective and equitable healthcare services and have to pay mostly from out-of-pocket due to low health insurance coverage. High health care costs may lead to loss of income for poor people and push them further into poverty.

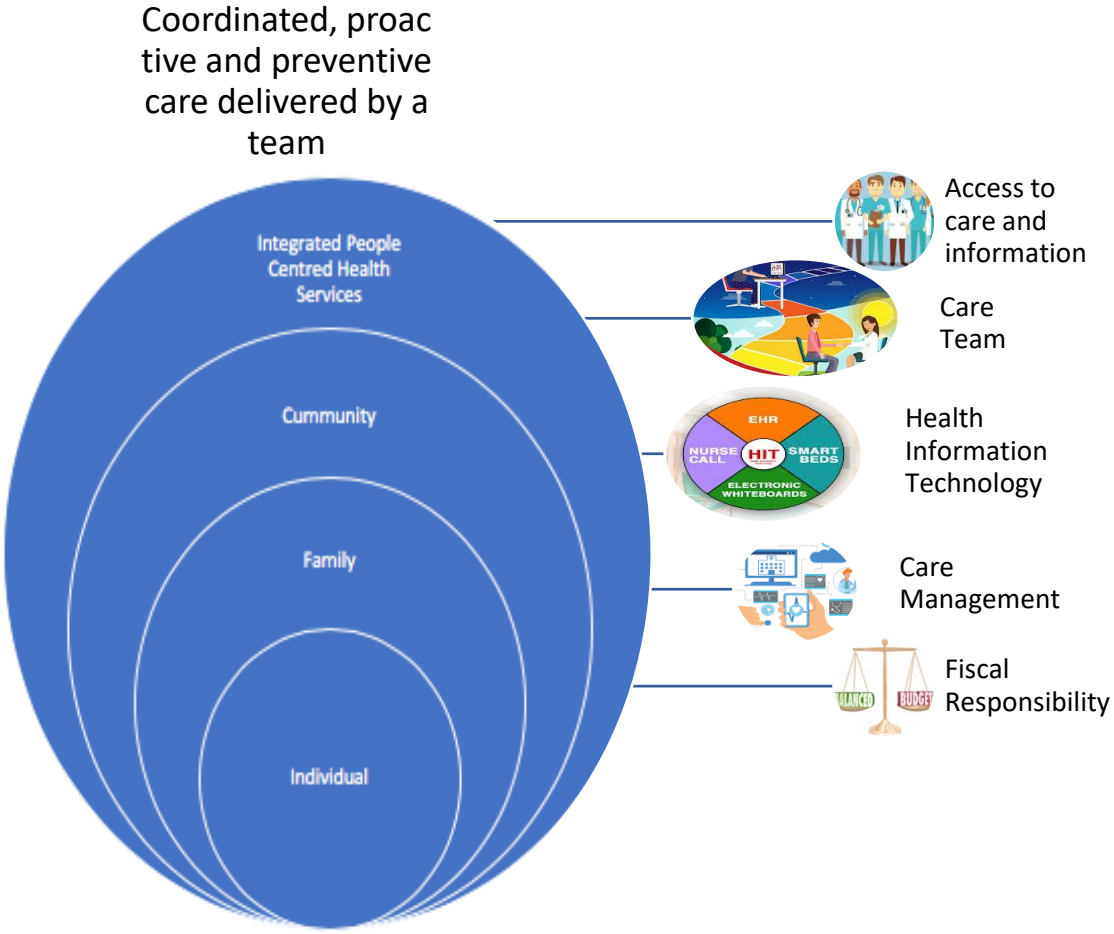
III. SOLUTION/MODEL:

1. INTEGRATED HEALTHCARE MODEL:

Lower income countries have a growing aging population and a growing burden of patients with chronic conditions which requires an efficient health system with integrated care. For example, as per census report, share of the aged to total population (per 1000) in India have increased from 68 person (per 1000) in census 1981 to 88 person (per 1000) in census 2011[15]. Integrated care may be defined as high degree of communication and collaboration among health professionals. In integrated health care model there is a unique sharing of patient's health information among team membersand establishment of comprehensive treatment plan to meet the social, biological and psychological needs of the patients. Integrated care is an approach that keeps people and community in the centre and also call Integrated People Centred Health System (IPCHS). WHO recommends five key strategies to implement integrated care i.e. Engage and empower individuals and communities, reorientation of the model of care, strengthen governance and accountability, coordination of health care services within and across different sectors and creation of an enabling environment.

Integrated People Centred Health System (IPCHS) argues that all types of care such as nursing homes, hospitals, sub-specialty care, home health centres and stakeholders (e.g. individual, family, community, private and public community-based services), should be brought together with the help of real or virtual integration. This model is a gate-opener to care – offering personalized care to patients by assigning them to primary care physicians. This implies that most of the care is delivered by multidisciplinary teams in primary care, but this team may purchase specialist care services if needed, on behalf of the patients. IPCHS adapts shared responsibility for a patient's health where the patients know who is responsible for their health and the providers are aware of the patients they are responsible for. This is enabled by a coherent provider payment mechanism. Patient registries along with information technology and health information exchanges, plays a crucial role in the success of patient-centred care. In this way, the patients receive the indicated services as and when needed by them in a culturally and linguistically appropriate manner. The framework on integrated people-centred health services supports countries progress towards Universal health coverage by shifting the health systems designed around diseases and health institutions to system designed around people and their needs.

Fig. 2: INTEGRATED HEALTH CARE MODEL:



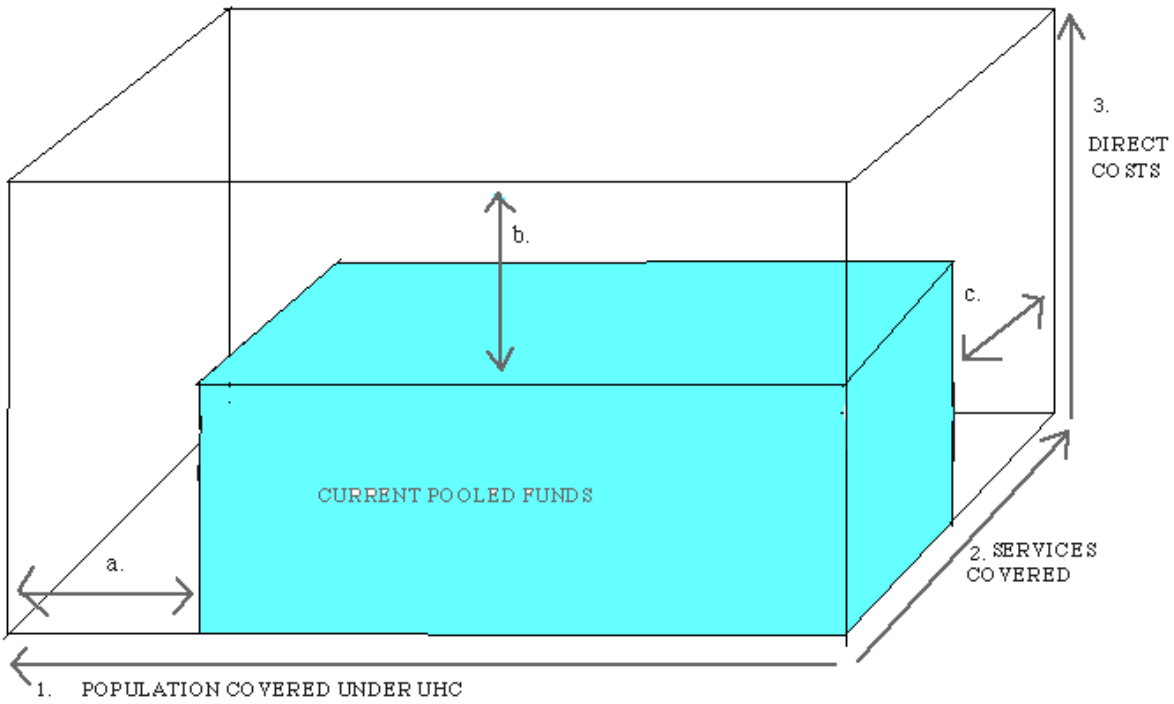
2. UNIVERSAL HEALTH COVERAGE MODEL:

The 2030 agenda for sustainable development recognizes that poverty and other deprivations goes hand-in-hand along with improvement in health and education, higher economic growth and reduction in inequality. UHC ensures provision of qualitative, essential, preventive, palliative and rehabilitative health services to all the individuals and communities without facing any financial hardship. Recently, in the UN assembly held in USA, in September 2019, a high-level united nations political declaration on UHC was adopted. It is the most comprehensive landmark on global health and development ever adopted. Universal Health Coverage is one of the main sustainable goals which most of the countries aspire to attain. The key to achieving Sustainable Development Goals by 2030 is universal health coverage[1]. This financial protection reduces people's risk of being pushed into poverty after paying for unexpected illness out of their own pockets. Universal Health Coverage can be measured by the proportion of

population accessing essential quality health services and the proportion of population spending large amount (as per WHO, more than 40% of household income) of household income on health[3].

Movement towards UHC has three dimensions: Proportion of population who are covered, health services which are provided and proportion of the costs covered under UHC, as depicted in the figure 3 below. The population axis represents the people who need health services. The region marked by (a) in the figure shows that moving towards UHC will help the services reach the uncovered population. The services axis represents all the services mentioned to achieve universal health coverage due to various diseases. Such services should be of good quality with equitable access to population. The region marked by (b) in the figure below shows that moving towards UHC will help in the inclusion of other services not covered otherwise. The vertical axis that represents direct costs is the total cost for obtaining the services needed by the population. The region marked by (c) in the figure shows that moving towards UHC will help in the reduction of cost and fees as people won't be paying the entire costs of health services from their own pocket. Financial risk protection can be provided by pooling of funds (through taxes, other government revenues and/or insurance contributions) as shown by the colored area in the figure below.

Fig. 3: UNIVERSAL HEALTH COVERAGE



IV. CONCLUSION:

Low- and middle-income countries must take necessary steps to allocate and increase government health care expenditures. The main focus should be provision and betterment of primary health care, which includes developing a robust system of health information and promotion systems at the local level, and the provision of free curative services at the primary level. For accommodating maximum number of people in the screening of the general population, there is also a strong need to develop local health system. The development of local health system would imply a focus on a preventive-promotive approach, the provision of free essential drugs, diagnostics and strengthening the tertiary tier.Public and private sector should come together to ensure a standard pricing system to bring parity on service cost across the country.Investment in technology and research on public health must be prioritized. An adequate number of health care providers and technical rural health workers are required to be hired at different levels, increasing the human resources density to achieve WHO norms of at least 23 health workers (including doctors, nurses and midwives) per 10,000 people[3]. Proper health insurance schemes and well-designed policies should be implemented with the involvement of both central and local government. This will significantly reduce out-of-pocket expenditure among poor populations.

V. SCOPE FOR FUTURE RESEARCH:

Climate change in lower income countries is a threat to health security as well as food, economic and energy security. For example, floods in Thailand and Vietnam, volcanic eruptions in Indonesia, typhoons and cyclones in Bangladesh, Myanmar and Philippines, have caused a lot of destruction and displacement. There is a gap in understanding the impact of climate change on natural calamities. There is a gap in understanding how we can reduce the implication of climate change on healthand its long-term health implication, even for high income countries. Further research needs to be conducted to see the impact of such natural calamities on mental health of the people. This will encourage policy makers and health personnel to provide counselling and continued care long after a calamity has occurred. It may help in achieving long-term health capacity development.

REFERENCES:

1. WHO: Health financing. See https://www.who.int/health_financing/topics/financial-protection/en/. (accessed 1st December2019)
2. WHO: Global health expenditure database. See http://apps.who.int/nha/database/ViewData/Indicators/en. (accessed 1st December2019)
3. World Health Organization. Designing health financing systems to reduce catastrophic health expenditure. Geneva: World Health Organization; 2005.
4. National health profile 2018. See https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEw

ivksrvxYzmAhUSIKwKHeIZC7EQFjAAegQIBRAC&url=http%3A%2F%2Fwww.cbhidghs.nic.in%2FEbook%2FNational%2520Health%2520Profile-2018%2520(e-Book)%2Ffiles%2Fassets%2Fcommon%2Fdownloads%2Ffiles%2FNHP%25202018.pdf&usg=AOvVaw1hx3wCFrR5JdEvQuMsMI7-. (accessed 1st December2019).

5. Dela Cruz AM, Nuevo CE, Haw NJ, Tang VA. Stories from Around the Globe: Financing Catastrophic Health Expenditures in Selected Countries. PIDS Discussion Paper Series; 2014.
6. Mills A. Health care systems in low-and middle-income countries. New England Journal of Medicine. 2014 Feb 6;370(6):552-7.
7. Campion EW, Morrissey S. A different model—medical care in Cuba. New England journal of medicine. 2013 Jan 24;368(4):297-9.
8. See https://www.who.int/servicedeliverysafety/areas/people-centred-care/en/. (accessed 1st December2019).
9. Murray CJ. Understanding Household Catastrophic Health Expenditures: a Multi-country Analysis. Health Systems Performance Assessment.:565.
10. See http://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/. (accessed 1st December2019).
11. World Health Organization. People-centred and integrated health services: an overview of the evidence: interim report. World Health Organization; 2015.
12. World Health Organization. WHO global strategy on people-centred and integrated health services: interim report. World Health Organization; 2015.
13. World Health Organization. Integrated care models: an overview. Health Service Delivery Program, Division of Health System and Public Health. 2016.
14. World Health Organization. Tracking universal health coverage: 2017 global monitoring report.
15. National Sample Survey Organisation. Social consumption: health—NSS 71st round (2014) New Delhi: Ministry of Statistics and Programme Implementation, Government of India; 2016 [cited 2018 April 4]. Available from: http://mospi.nic.in/sites/default/files/publication_reports/nss_71st_ki_health_30june15.pdf. (accessed 1st December2019).
16. See WHO framework on integrated people-centred health-services. https://www.who.int/servicedeliverysafety/areas/people-centred-care/en/. (accessed 1st December 2019).
17. Universal health coverage: supporting country needs: See https://www.who.int/contracting/UHC_Country_Support.pdf (accessed 1st December2019).
18. Tsunami wreaks mental health havoc: See https://www.who.int/bulletin/volumes/83/6/infocus0605/en/Tsunami (accessed 1st December2019).
19. Escap UN. Overview of natural disasters and their impacts in Asia and the Pacific, 1970–2014. ESACP Technical paper information paper and communications technology and disaster risk reduction division. 2015 Mar 7:1-8.