The Financial Burden of Healthcare

Neave O'Clery & Kajaluxy Ananthan, Imperial College London
Walaiporn Patcharanarumol, Thai Ministry of Public Health

Healthcare is expensive. Annual health expenditure globally is $5.3 trillion yet this is uneven with OECD countries representing only 18% of the world's population yet 86% of the total spend in 2007[1]. However, it is not always true that poorer countries necessarily have poorer health coverage and outcomes.

Thailand has led the way in developing a model for universal healthcare at reasonable cost. With life expectancy of 70 years comparable to many high-income countries, Thailand has successfully expanded health provision and ensured accessibility for all – for a mere $173 annual per capita spend (2008)[2]. Can lessons from the Thai experience be useful elsewhere?

Traditional infectious diseases such as HIV/AIDS, malaria and TB, together with the emergence of non-communicable diseases such as heart disease and cancer, are the main causes of morbidity and mortality in developing countries. The development and purchase of new medicines and treatments, as well as preventative methods and screening, is very expensive. With an average annual per capita spend of $3,881, the cost of universal treatment afforded by some OECD states is well out of reach of the majority of the world's nations.

In recent years there has been a concerted attempt by the global health community to examine and quantify the effects of healthcare financing, and understand existing models with a view to establishing what really works, and under which conditions. Two recent major reports from the WHO (2010)[3] and the World Bank (2008)[4] respectively attempt to draw conclusions about how low and middle income countries might move towards this elusive universal coverage.

Broadly speaking, there are three models of payment for healthcare from a consumer perspective: direct payment, meaning payment at the point of use, some form of insurance and universal coverage, although in practice most countries combine several approaches. Here we ask how we assess a healthcare system in terms of financing and outcomes. We examine the need to avoid direct payment models in favour of pooled funds, and assess the role of the state and private providers in financing, taxation and insurance.

To aid this study, we will look at three upper middle-income countries: Chile, South Africa and Thailand. Thailand mainly runs a National Health Service-type model funded by general taxation while Chile relies primarily on a mixed public/private compulsory insurance model. South Africa, on the other hand, depends on crippling direct payment and expensive private insurance. With comparable per capita GDP, Thailand and Chile have impressive life expectancies in the 70's compared to South Africa at just 54 years, see Table 1. Yet South Africa spends twice the % GDP on health than Thailand at just 4.3%.

Health, Wealth and Happiness

So what defines the healthcare status of a country? There are many indicators including life expectancy, adult, infant and maternal mortality rates, available hospital beds and number of doctors.

1 WHO (2010) National Health Accounts Report.
2 Working group on Thai NHA (2009) Thai National Health Account 1994-2008. International Health Policy Program.
3 WHO (2010) Health Systems Financing.
4 World Bank (2008) Good Practices in Health Financing (Chapter 12, Thailand: Good Practice in Expanding Health Coverage – Lessons from the Thai Health Care Reforms).