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Out of Pocket Expenditure and its Impact in Pakistan

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Abstract:
Health care in Pakistan is divided into two major portions: public and private. Though government owned, public sector on multiple occasions fails to provide adequate health services to Pakistani citizens; whereas private sector, since well equipped and maintained, provide expensive health care in Pakistan. With numerous citizens availing the private health care organizations, the financial implications of these costs on families is immense as much of the payment is through Out of pocket. Out of pocket expenditure has outlasting financial and monetary effects on individuals and families. It not only leads to economic loss but also affects the productivity of a country. This review narrates the catastrophic and impoverishment impacts of Out of Pocket expenditure on Pakistan and its citizens.

Keywords: *Pakistan and Out of pocket expenditure, impact of OOP on Pakistan*

1. Introduction

Health care services are essential, but its utilization could have devastating cost implications on economies. Pakistan healthcare system, though has undergone an increase in total health care expenditure per capita from 26% in 2008 to 30% in 2011 (World Bank data); but the total health expenditure per GDP has decreased from 2.9% in 2009 to 2.5% in 2011 (World Bank data). Like other developing countries, Healthcare financing in Pakistan is conducted via multiple modes of insurance, private company support, government funds but Out of Pocket (OOP) expenditure by households dominates all. This review will focus on Out of Pocket expenditures in Pakistan, its impacts and solutions.

2. Out of Pocket Expenditure

Health care expenditure is dependent on the perception of illness and understanding the need for utilizing healthcare services (Australian Aid, 2012). According to World Health Organization, OOP expenditure is payment by households directly to health practitioners, pharmaceuticals and other medical aid with the objective of refurbishment of health. OOP, according to National Health Accounts (NHA, 2009-2010) accounts for 61% (Figure 1) of the healthcare financing in Pakistan.

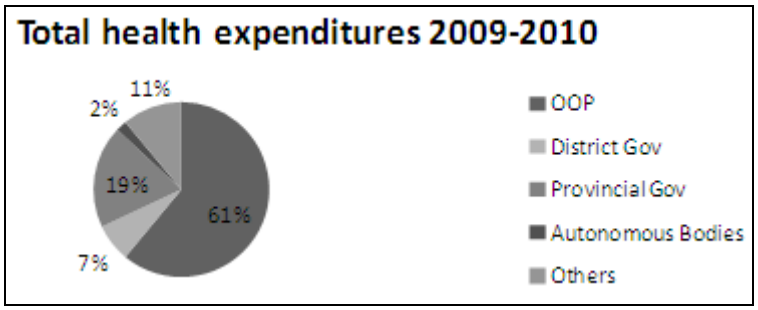

Figure 1: NHA, 2009 – 2010

In Pakistan, OOP percentage out of total health expenditures in 2009-2010 has declined by 5% since 2007-2008; but the amount in currency has increased from Rs 227,316 to Rs 271,757 indicating the decline in the GDP contribution to health (NHA, 2009). Supporting, OOP as a percentage of private expenditures has also declined from 88.2% in 2009 to 86.3% in 2011 (Australian Aid, 2012) – the major reason could be families pulled into severe poverty lack resources to access health care facilities (Tomini, Packard, Tomini, 2012).

A further dissection of data appreciating the division of OOP among socioeconomic groups reveals the maximum utilization of health care services by rich people as compared to poor (Garg & Karan, 2005). The main explanation preceding this variation could be awareness and information which is easily accessible to rich. Since utilization of health services is more among the rich people of Pakistani society, health expenditures (36%) are also maximized at Quintile 5 – the richest level (Figure 2).

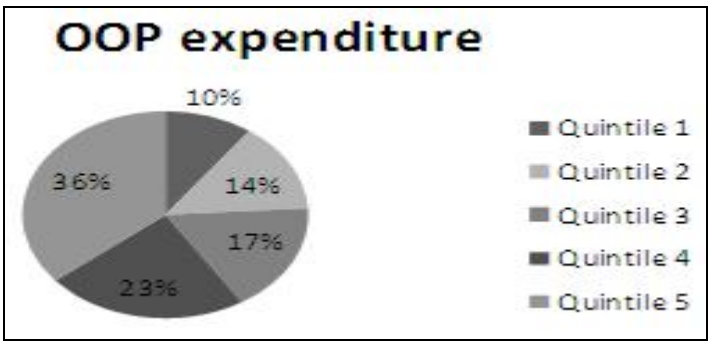

Figure 2: PSLSWS data, Country Brief 2012

Another reason supporting this idea could be unavailability of funds and financial instability which refrains the poorest Quintile 1 population to spend only 10% on health. However, the financial impacts of OOP are more prevalent in lowest Quintiles of population as they do not have enough reserves and savings for support (Garg & Karan, 2005).

OOP is calculated as the expenditure from the non-food spending and is mainly focused on medicines, hospitals and private practitioners (Tomini, Packard, & Tomini, 2012). A provincial distribution of OOP reveals remarkable variation explained by PSLSWS data (Figure 3) analyzed in a Country brief by Australian Aid (2012)

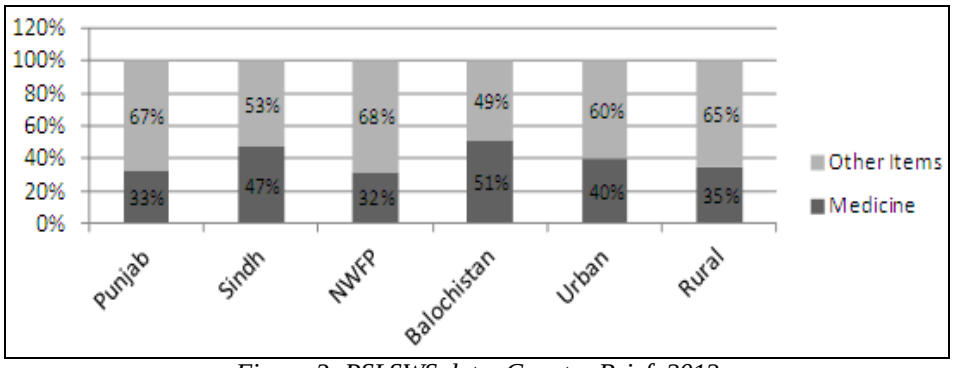

Figure 3: PSLSWS data, Country Brief, 2012

Increased amount of OOP can lead to both deteriorating and devastating aftermaths on societies incurring it. Due to unstable healthcare systems, increased OOP could force households into catastrophic payments leading them towards poverty – thus further deteriorating health and increasing barriers to medical care.

3. Catastrophic Impacts

Catastrophic payments in healthcare are spending which exceeds the significant portion of non-food expenditures of households (Doorslaer, Donnell, Rannan-Elliya, Somanathan, Adhikari, Akkazeiva et al, 2005). Catastrophic payments have alarming effects on living standards of households as these payments are paid by compensating spending on essential commodities (Doorslaer et al, 2005). Globally, 150 million people suffer financial catastrophe post OOP on healthcare (Tomini, Packard, tomini, 2012). Furthermore, a 1% increase in the proportion of total expenditure by OOP expenditure leads to a 2.2% increase in the share of households encountering catastrophic payments (Xu, Evans, Kawabata, Zeramidini, Klavus, Murray, 2003). Interestingly, catastrophic impacts of OOP are independent of medical care becoming expensive; rather depend on the household's capacity to pay after the basic subsistence needs have been fulfilled (Xu et al, 2003). Such income dependant payments have long term impacts as exhausted assets lead to a struggling life for restoration of resources for financial stability (Lorenz, 2009).

There is no specific standard for decision of catastrophic payments as the threshold is associated with the income of households. However, any healthcare spending exceeding 10% of the household costs and 40% of the non-food overheads could be considered catastrophic (Xu, 2003). According to NHA (2005-2006) of Pakistan, almost 10.3% families spent more than 10% of the savings on healthcare needs and 1% had to allocate more than 40% of the earnings on the healthcare (Australian Aid, 2012). In Pakistan, though the richest Quintile spends more on OOP but a division on income basis reveals rich spending 5.9% of the non-subsistence expenses on health while poor quintile spending 8.9% - indicating the debilitating impacts of OOP on poor population group (Australian Aid, 2012, Figure 4).

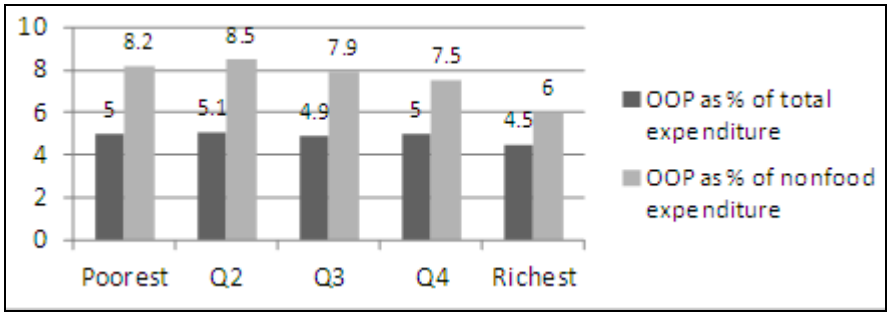

Figure 4: PSLSWS data as analyzed in Country Brief, 2012

Catastrophic payments have severe financial impacts on households and economy. Households incurring this cost are driven into poverty, further diminished incomes; escalated disability adjusted life years and lessened productivity due to inadequate reinstated health.

4. Impoverishment Impact

Impoverishment Impact is the stimulating strength of OOP forcing households below poverty line post healthcare expenditure (Anonymous, 2012). According to NHA, as stated in Country brief (Australian Aid, 2012), 7.5 million people (4.7%) in Pakistan were forced below the poverty line in 2005-2006. Households affected by poverty has increased by Rs 275.07 over 8 years as indicative in the table

Pakistan Poverty Line in Historical Perspective (Rs)	
Year	**Poverty Line**
1998 – 99	673.40
2000 – 01	723.40
2004 – 05	878.64
2005 – 06	948.47

Table 1: Economic Survey, 2009-2010

Impoverishment impact is calculated on the basis of three criteria: Poverty headcount denoting to the number of households lower than poverty line, poverty gap which is a cumulative of the total households subsiding into poverty and normalized poverty gap which is a ratio of poverty gap and poverty line (Chuma & Maina, 2012). Figure 5 below shows an increase in overall poverty headcount by approximately 10% over the span of 5 years (Arif & Farooq, 2011).

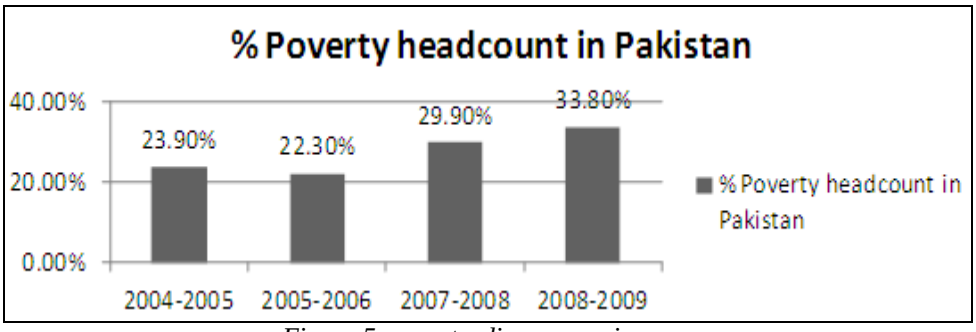

Figure 5: www.tradingeconomics.com

Despite an increase in the poverty headcount, there has been a decrease in Poverty gap from 4.19% to 3.49% over the last 16 years (Figure 6)

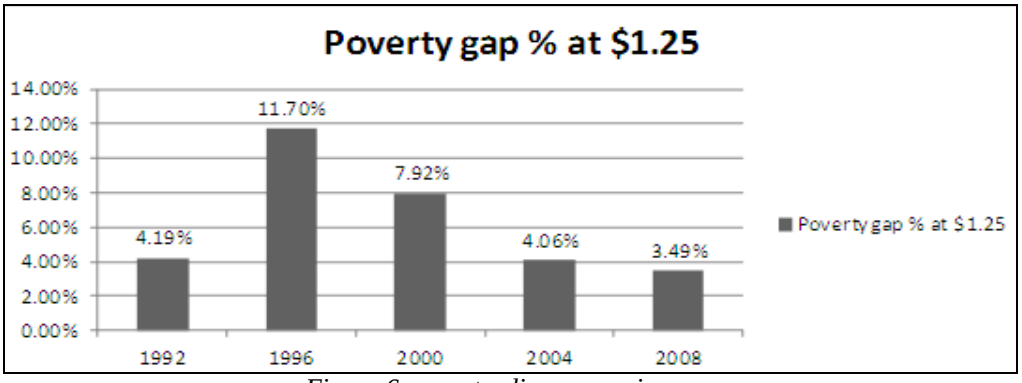

Figure 6: www.tradingeconomics.com

This decrease could be indicative of an improved economic situation of Pakistan but underreporting of current poverty situation should also be considered. Moreover, this decline could be associated with households re-establishing the financial status after being thrashed into poverty post OOP. Nonetheless, a reduction in GDP contribution towards health and immense catastrophic payments by households over the years may have amplified the poverty percentage in Pakistan.

5. Solution to Out of Pocket Expenditure

Financial implications of OOP expenditure require intensive measures and policies for maintaining economic stability and equity in the country. Prepayments via taxation, insurance or other specific modes could be considered as an effective means of healthcare financing (Xu et al, 2007).Since the input towards prepayments and their contribution is dependent on the economic status of a country; hence, catastrophic payments are insignificantly related to prepayments ($p>0.001$) in middle income countries (Xu et al, 2007). Analysis also magnifies the significant relationship of social insurance with decrease OOP as compared to taxation in middle income countries (Xu et al, 2007). In Pakistan, though Insurance agencies cover almost 2% of the healthcare expenditure, the reliability of these insurance agencies is questionable. With increasingly prevailing corruption and inequality in Pakistan, distribution of money earned via taxation and insurance could be unequal and not according to the equity needs of population. Thus a thorough and accountable healthcare system is required for implementation and appropriate distribution of funds to reduce OOP in Pakistan.

6. Conclusion

Out of Pocket expenditures on health create severe financial loss to households incurring it. Households bearing the catastrophic payments descend into the vicious cycle of poverty hampering the economic growth and productivity of an economy. Since health in Pakistan is majorly funded by OOP, economic stability can be achieved through implying taxation, social insurance and equitable allotment of funds among the different socioeconomic groups of population.

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