

HEALTH EXPENDITURES DURING THE COVID-19 PANDEMIC

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ARTICLE INFO	ABSTRACT
<p>Article Type: Research Paper</p> <p>Keywords: health-care management, health expenditures, COVID-19, pandemic.</p> <p>Corresponding Author(s) Sevinç Elif ŞEN</p> <p>Adress: Riga Stradins University</p> <p>E-mail: sevincelifalkan@ gmail.com</p>	<p>The first Covid-19 case had been detected in Wuhan city which is located in China. Then the virus spread to other countries and the incidence rate increased fastly all over the world. As a result of all of this uncontrollable situation WHO announced the pandemic. Turkish Ministry of Health announced the first official covid case on 11th March 2020 in İstanbul Turkey. After the first recorded case, the virus spread rapidly to the other cities. The aim of this study is to examine the health expenditures effect by Covid 19 during the pandemic. To understand clearly how the pandemic affected the health expenditures it is also important to compare to the previous periods. With this study, we are aiming to put a light on the researchers using case study methods that are related to the management of the expenditure for health care. Every country has to devote a part of their economy to health. Through their investment in health, they will improve the well-being of the communities living in it. This budget allocated varies according to the level of the country and various factors. There has been great variability in the level of health expenditure per capita in Turkey over the years. When comparing the health spending before the pandemic and the during pandemic it seems slighlth difference between the periods in Turkey.</p>

INTRODUCTION

Every person has a right to reach the healthcare system in an equal and basic way. For that reason based on the WHO report that is published in 2000, for the healthcare systems, equality, and productivity is important issues. The ratio of health expenditures to general expenditures is rapidly increasing from year to year. But this ratio is also variable in every country depends on their economic growth. In response to the ever-increasing population and the consequent increasing demand, limited resources cause some problems. Based on the basic economics terminology, however, supply is less than demand. The definition of “efficiency” is also becoming very important because of the limited resources dedicated to health care.

General government expenditure on health as a percentage of total government expenditure - This indicator is defined as the level of general government expenditure on health (GGHE) expressed as a percentage of total government expenditure. It shows the weight of public spending on health within the total value of public sector operations. This indicator includes not just the resources channeled through government budgets, but also the expenditures channeled through government entities for health by parastatals, extrabudgetary entities, and, notably, compulsory health insurance. The indicator refers to resources collected and pooled by public agencies, including all revenue modalities.

Total expenditure on health as a percentage of gross domestic product (GDP) - This indicator is defined as the level of total expenditure on health expressed as a percentage of GDP, where GDP is the value of all final goods and services produced within a nation in a given year. It provides information on the level of resources channeled to health, relative to a country's wealth.

Per capita total expenditure on health - This indicator is defined as the per capita total expenditure on health, expressed at the average exchange rate for that year in US\$. It shows the total expenditure on health relative to the beneficiary population, expressed in US\$ to facilitate international comparisons. (WHO/<https://www.who.int/data/nutrition/nlis/info/health-expenditure>)

1. HEALTH SPENDING

Expenditure is a monetary payment made to individuals, institutions or companies in exchange for a product or service needed to access a product or service. Expenditures made to meet individual and social needs are financed by households or public authorities in various ways. Expenditures made to meet a specific need are conceptualized with the place where the expenditure is made. Expenditures made to meet nutritional needs are called food expenditures, expenditures to meet educational needs are called education expenditures and expenditures to meet health needs are called health expenditures (TUİK,2020).

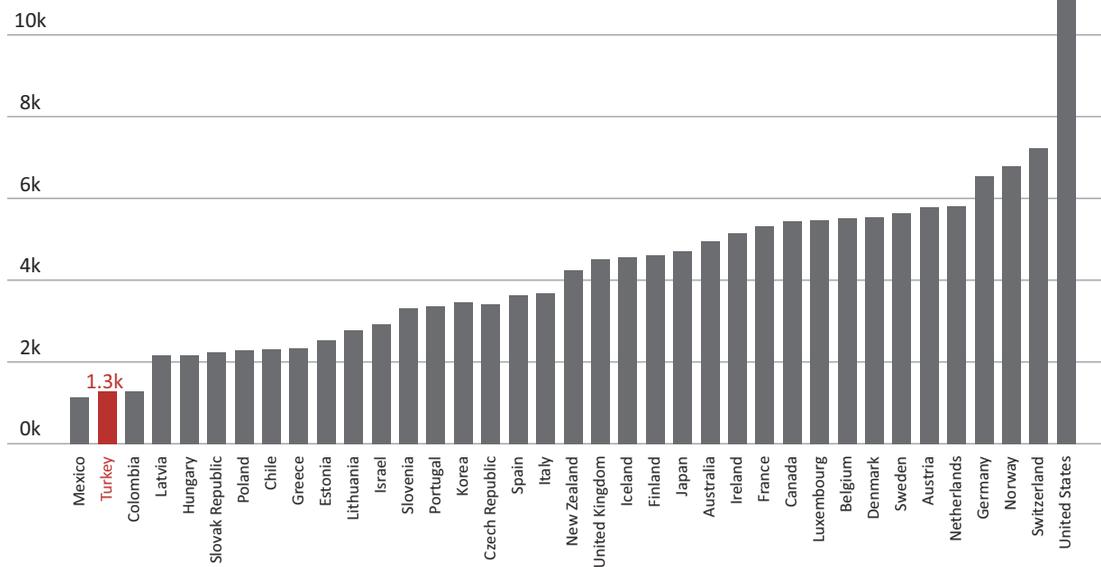
Based on the WHO's definition on health spending: health expenditure, preventive and curative health services for individuals, community-based public health programs, and expenditures for programs that have a direct impact on health status are included in this scope. Programs that indirectly affect health, such as food and environmental programs, should be excluded (Murray, 1994).

According to OECD (2020) It is the final monetary value of spending on services to individuals and services to society. Investment in health care is the final monetary value of expenditure. Investment expenditures for health services are excluded from this total. Health Service; It is financed by a combination of government expenditure and the central budget, compulsory or voluntary contributions and insurance, out-of-pocket payments by households, donations made through non-governmental organizations, and funds generated by private companies (Akyürek and Aydın, 2021:287)

The scope of health expenditure, classified under consumption expenditures by the Turkish Statistical Institute (TUİK, 2020), is as follows; Medicines, health products, therapeutic tools and materials (glasses, lenses, neck braces, hearing aids, walkers, etc.) hospital and non-hospital medical services (doctor examination fee, dental services, x-ray, ultrasound, tomography, analysis, hospital bed etc...). It covers expenses related to surgery, delivery, physical therapy, ambulance etc. (Akyürek and Aydın, 2021:287)

Based on the definitions given, the health expenditure incurred in a certain year for individuals and society; It can be defined as the monetary value of all expenditures on products and services for the execution and management of all preventive, curative, rehabilitative and health-promoting activities (Akyürek and Aydın, 2021:287).

Figure 1.1. Health Spending Total US dollars/capita, 2020 or latest available

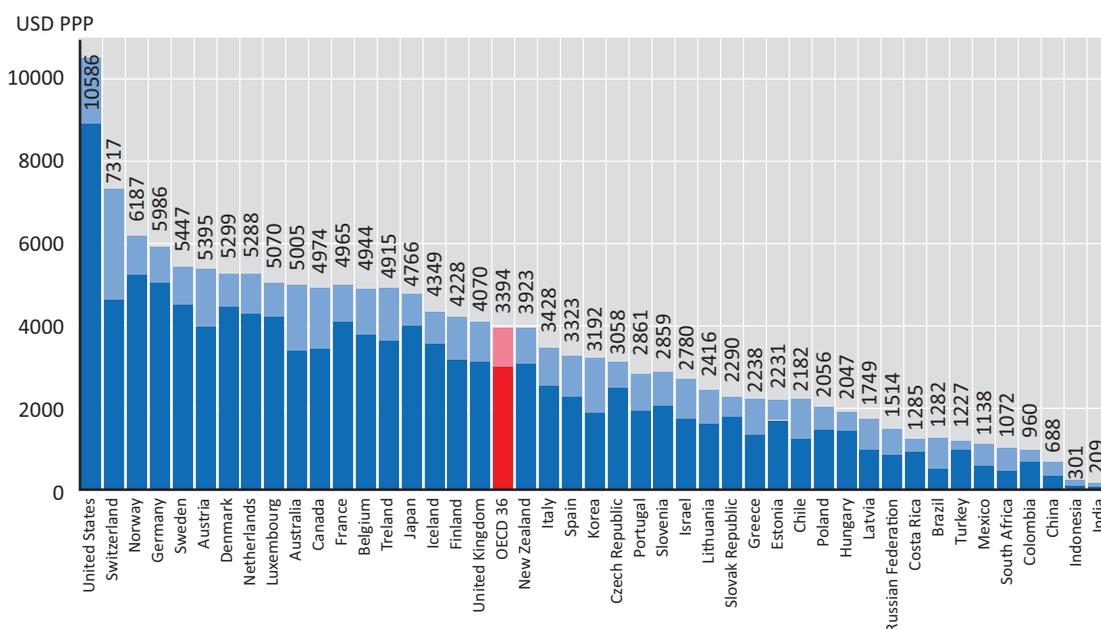


Source: (OECD, 2021), Health spending indicator,

Figure 1.1 shows the data on health expenditures per capita in 2020 for OECD countries. Health expenditure per capita in the USA is seen as approximately 11,000 dollars and is the only country with the highest expenditure in this regard. Switzerland (\$7138) is the second largest spender after the USA. After Switzerland, other developed countries; Countries such as Norway, the Netherlands, Germany and Sweden, on the other hand, spend almost half of the health expenditures of the USA. Of course, the population may be a factor on to these expenditures here cause for this ratio. Respectively, Turkey, Colombia, Mexico and Latvia are the top four OECD countries with the lowest per capita health expenditures, with \$1267, \$1276, \$1133 and \$2,074.

Turkey is geographically located between Europe, Central Asia and the Middle East countries. It is useful to state that health problems are similar, although not always linear, and that the level of health expenditure is very important in shaping the level of health expenditure. In addition, it is seen that Turkey has a similar average per capita health expenditure level with countries that are geographically closer to it, as well as developing Latin American countries that are much more distant geographically.

Figure 1.1.2. Health Expenditures per capita, 2018 (or nearest year)



Source: OECD Health Statistics 2019, WHO Global Health Expenditure Data

Overall in 2018 spending on health care in the United States was seem to be the equivalent of more than 10 000 dollars for each US resident. This amount of expenditure (when adjusted for different purchasing power in countries) was higher than all other OECD countries by a considerable margin. Switzerland, the next highest spender in the OECD, spent (7317\$), while the overall average of all OECD countries was less than 40% of the US figure (USD 3 994) Many high-income OECD countries, such as Germany, France, Norway, Sweden spend only around a half or less of the US per capita spending on health. Lowest per capita spenders on health in the OECD were Mexico and Turkey with health expenditure at around a quarter of the OECD average.

1.1. Analysing Health Spending Of Turkey

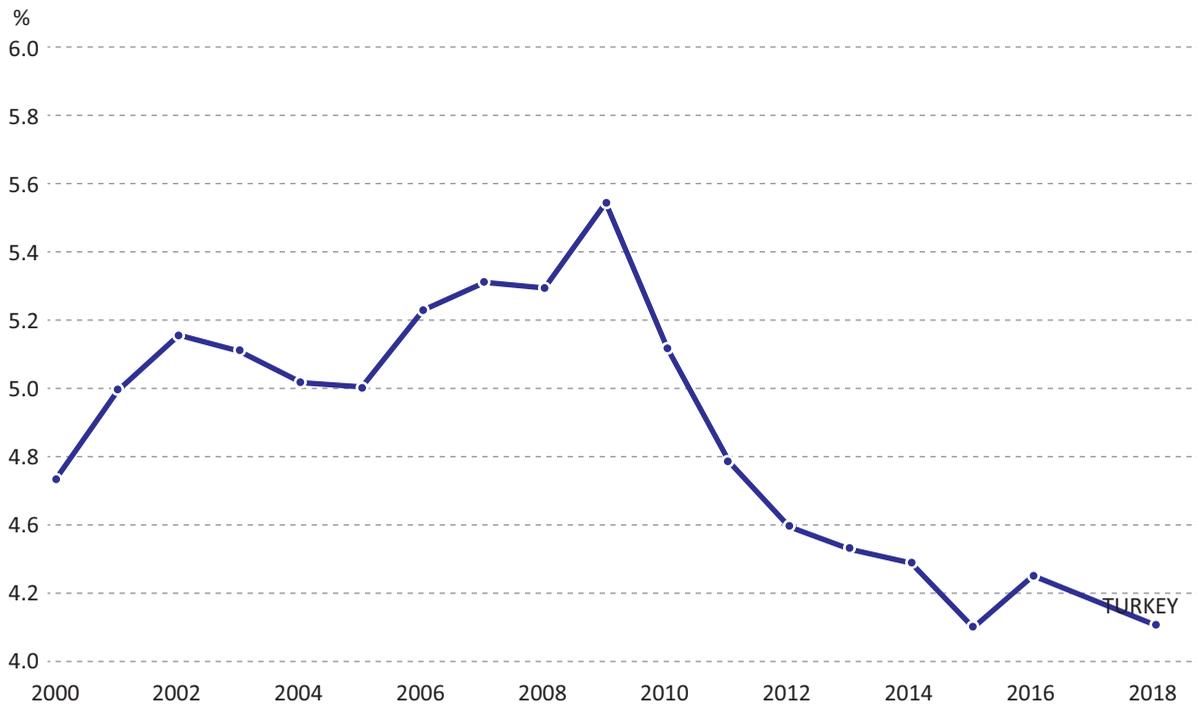
Due to the different methods used at different times in data collection in Turkey, it is not easy to compare health expenditures over time and with other countries. In addition, discussions on what health expenditures are and the comparison of results obtained from different sources continue for many years in Turkey. To address these controversies, At first National Health Accounts study was conducted for 1999 and 2000. With this study, the Health Accounts System methodology, which is also used by other OECD member countries, has been used and it has been an important study to ensure both the real level of health expenditures and the comparison of Turkey and other countries in terms of health expenditures. Turkish health expenditures in 2001 and the following years are collected and reported by the Turkish Statistical Institute (TUIK). In addition, the Ministry of Development has been collecting and publishing data on this subject for many years.

1.1.1. The Development of Health Spending in Turkey

Health is one of the most crucial factors for the economic growth and development of households, nations, and even all over the world which was emphasized in the report of Sustainable Development Goals published by the United Nations. These goals are key factors for a sustainable and better future. One of these goals is good health and well-being. The health system succeeded with a noticeable improvement with the Health Transformation Program (HTP) in Turkey. The most comprehensive reforms were carried out after implementing this program in 2003. Before 2003, health insurance system funds were organized by various regulations. In 1965, The Active Civil Servant Scheme was created and funded by government budget and allocated to civil servants who work actively. In 1992, The Green Card Scheme financed by the Ministry of Health was established to support people who earn lower than one-third of the minimum wage level. The Government Employees Retirement Fund was founded in 1949, and civil servants who are retired financed this system. The Social Insurance Agency of Merchants, Artisans, and Self Employed (BAĞ-KUR) provided health services to self-employed workers and are financed by earnings gained by these people since 1987. In 1964, the Social Insurance Organization established and covered the biggest part of the population such as white-blue collar workers in private and public sectors and these workers were financed by payroll wages (Yıldırım and Yıldırım, 2011).

Radical differences also have taken place in healthcare finance since 2003. Health services that serve the population such as the private and public sectors are financed by the social security scheme. The Ministry of Health in Turkey is responsible for providing care systems through facilities. The total current healthcare expenditure of GDP rises from 4.6% in 2000 to 5% in 2010 (World Bank, 2021). The HTP provided a decrease in restrictions, reaching health facilities. These improvements have a big role in this rise. The health insurance system, financial easiness during illness, and access to healthcare facilities provided the impact of the HTP to be improved especially for poorer citizens. (Esen and Keçili, 2021)

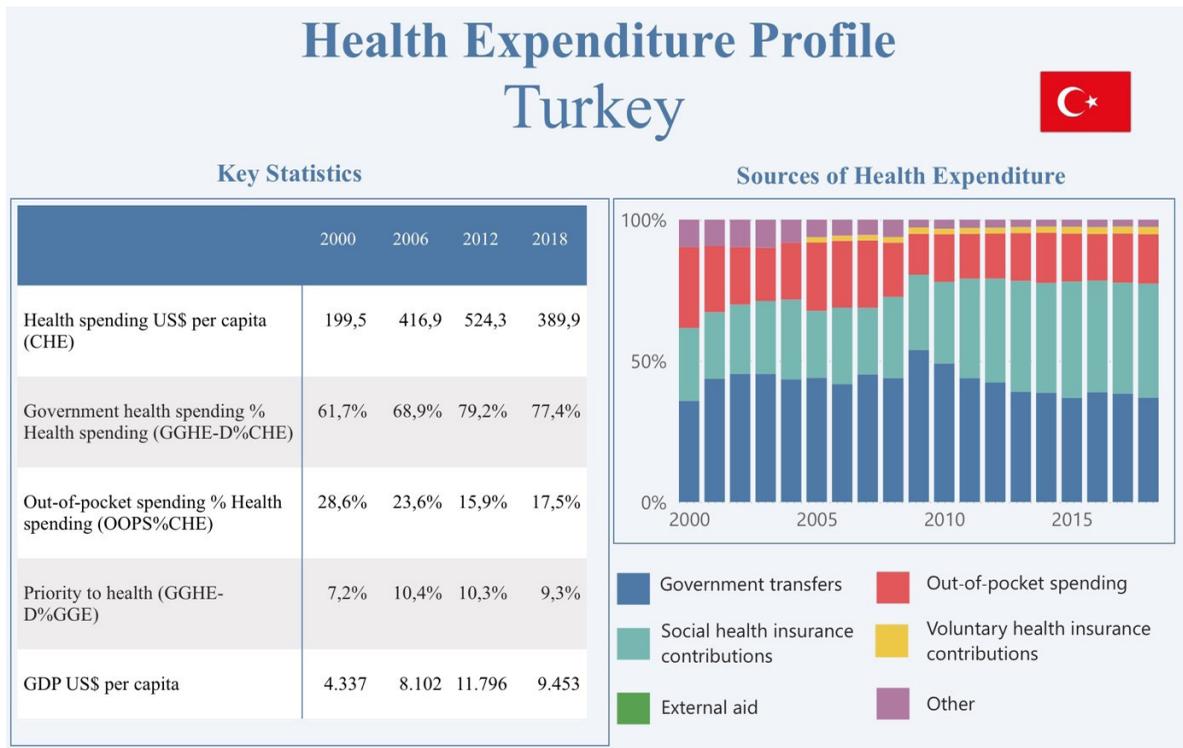
Figure 1.2.2. Current health expenditure (% of GDP) - Turkey



Source: World Health Organization Global Health Expenditure database (apps.who.int/nha/database)

Figure 1.2.2. illustrates the health expenditures ratios of Turkey between the years 2000 – 2018 years. It is clear that this expenditures ratio is not predictable. There are sharp fluctuations during these years. In 2010 the spending reaches the up (over 5.4%). Until 2010 there is a systematic increase. From that year as we can see on the figure, the spending ratio is remaining to decrease until 2018.

Figure 1.2.3. Health Expenditure Profile Turkey between 2000 – 2018 years



Source: WHO Global Health Expenditure Database/ Country Profiles (https://apps.who.int/nha/database/country_profile/index/en)

Health expenditure per capita for 2017 worldwide has been determined as 1080\$. While the average per capita health expenditure of low-income countries is 41\$, this rate has increased to 2931\$ in developed countries. (WHO,2019) If we consider this situation-specific to Turkey, as can be seen in the figure, the highest was realized in 2012 (\$524.3). Almost all parameters were measured as the highest values reached in 2012. The ratio of resources in health expenditures, on the other hand, shows that out-of-pocket expenditures and government-supported expenditures are almost parallel to each other.

2. HEALTH EXPENDITURES DURING THE PANDEMIC

Failure to control COVID-19 has led to the deepest economic shock in decades. It has not only hit countries harder than the global financial crisis but also affects a much wider group of countries in the European Region. Without urgent and substantial policy intervention, the economic recovery may take longer and be more uneven than forecasts predict, exacerbating socioeconomic inequalities within and between countries.

Countries were quick to mobilize additional funds for the health system in 2020. This higher level of public investment will need to be sustained in the years ahead to treat and prevent COVID-19, address the backlog created by widespread disruption to health services, mitigate the negative health effects of foregone care, unemployment and poverty and strengthen preparedness for future shocks.

Health financing policy is less resilient to economic shocks in countries where levels of public spending on health are low as a share of GDP and out-of-pocket payments are high, implying significant gaps in health coverage. Health systems are also vulnerable to economic shocks if public spending on health relies heavily on employment (SHI schemes), entitlement to health services is linked to health insurance status, and countercyclical mechanisms to mitigate the effects of rising unemployment and falling wages are lacking or weak.

Well-designed public policy can mitigate the negative effects of COVID-19 and build health system resilience. Key steps countries can take include: broadening the public revenue base for the health system; introducing and strengthening automatic stabilizers; de-linking access to health services from health insurance status; re-designing co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions; reprioritizing the government budget to ensure sustained increases in public spending on health; and using priority- setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals.

Countries, government revenue falls may find it difficult to make health care more public investment, but austerity is not a viable option. Austerity in the health sector in response to the global financial crisis slowed public spending on health, undermined progress towards UHC and increased socioeconomic inequalities. Two factors offer support to governments willing to put improving people's lives and livelihoods at the heart of the recovery from COVID-19. First, international financial institutions strongly encourage countries to continue to invest in health systems now, recognizing the damage austerity has caused and the importance of the health sector to societal well-being, economic development and resilience to future shocks; they should continue to support careful investment in health and well-being in the longer-term. Second, this shift in thinking is closely aligned with public preferences. Survey after survey carried out in the last 10 years has shown the extent to which people value good access to health care. (WHO, 2021)

2.1. Health Spending During the Pandemic in Turkey

Covid-19 has been affecting all over the world in a negative way many people lost their lives and lost their loved ones. Turkey is also affected too. But to overcome with less loss the support of the authority's immediate response helped contain some of the more negative effects of COVID-19 though emerging economic imbalances have required policy tightening.

The authority put some early regulations such as social distancing, mobility restrictions, testing, and health capacity enhancements helped contain the spread of the virus and the number of fatalities. The economy came to a near sudden halt during the second quarter of 2020. Fiscal, monetary, and financial measures however extended support to some of the most affected parts of the economy. Leading indicators suggest that both supply and demand are making up for lost ground. At the same time, monetary expansion on the back of already negative real interest rates contributed to macroeconomic imbalances and erosion of external buffers, eventually prompting a reversal in monetary easing (Brookings,2021).

3. CONCLUSION

This paper analyzed the relationship between economic growth and health expenditure for Turkey and OECD countries. Considering the effects of the COVID-19 pandemic on health expenditures in Turkey and around the world, it is seen that there is an increase in every country. The ratio of health expenditures, especially in developed and high-income countries, is above the world average. The health expenditures of these countries show more than 50%. The source of most of the high level of expenditure is financed by public resources. However, no evidence or studies have been found to prove its sustainability. In underdeveloped and low-income countries, the rate of expenditures for health is quite low and government support is low in these expenditures. The source of these expenditures is generally private insurance and out-of-pocket per capita payments. As can be understood, this makes it difficult for people with low income levels to access health care.

In Turkey, health expenditure per capita has changed a lot over the years. The graph is in an upward trend. In order to maintain this upward trend, public resources must be used effectively and efficiently.

When we compare Turkey's health expenditures with other OECD countries, Turkey has the lowest level of health expenditure in GDP per capita. However high spending may not always indicate the welfare of the country. It is important to make inferences in terms of health expenditures. Nevertheless, it is also known that there is an important relationship between health expenditures and positive health indicators.

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