Health spending, macroeconomics and fiscal space in countries of the World Health Organization South-East Asia Region

Indrani Gupta,1 Swadhin Mondal2

ABSTRACT

The paper examines the issues around mobilization of resources for the 11 countries of the South-East Asia Region of the World Health Organization (WHO), by analysing their macroeconomic situation, health spending, fiscal space and other determinants of health. With the exception of a few, most of these countries have made fair progress on their own Millennium Development Goal (MDG) targets of maternal mortality ratio and mortality rate in children aged under 5 years. However, the achieved targets have been very modest – with the exception of Thailand and Sri Lanka – indicating the continued need for additional efforts to improve these indicators. The paper discusses the need for investment, by looking at evidence on economic growth, the availability of fiscal space, and improvements in “macroeconomic-plus” factors like poverty, female literacy, governance and efficiency of the health sector. The analysis indicates that, overall, the countries of the WHO South-East Asia Region are collectively in a position to make the transition from low public spending to moderate or even high health spending, which is required, in turn, for transition from low coverage–high out-of-pocket spending (OOPS) to high coverage–low OOPS. However, explicit prioritization for health within the overall government budget for low spenders would require political will and champions who can argue the case of the health sector. Additional innovative avenues of raising resources, such as earmarked taxes or a health levy can be considered in countries with good macroeconomic fundamentals. With the exception of Thailand, this is applicable for all the countries of the region. However, countries with adverse macroeconomic-plus factors, as well as inefficient health systems, need to be alert to the possibility of overinvesting – and thereby wasting – resources for modest health gains, making the challenge of increasing health sector spending alongside competing demands for spending on other areas of the social sector difficult.

Key words: health, macroeconomic factor, resource mobilization for health, South-East Asia

INTRODUCTION

The link between public spending on health and health outcomes is no longer under debate and countries are now increasingly concerned with different ways of raising additional spending and spending such finances efficiently.1–4 The two main justifications for raising additional resources are to improve directly health outcomes via provision of public health services, and to be able to reduce the financial burden on households via extending health coverage, especially in countries where out-of-pocket spending (OOPS) as a proportion of gross domestic product (GDP) is very high.5,6

The ability of countries to raise resources for social sector spending, including health, is, in turn, closely related to the availability of fiscal space and the macroeconomic situation in the country, as has been discussed and analysed by a number of researchers,7,8 after the World Health Organization (WHO) Commission on Macroeconomics and Health published its recommendations.2 While the 2010 World Health Report: Health systems financing: the path to universal coverage was
a comprehensive account of health-systems financing with a global perspective; country-specific analytical research on public financing of health remains relatively sparse, especially for the WHO South-East Asia Region. Finally, the importance of other factors, such as literacy and poverty, which might impact on health outcomes and the quality or effectiveness of spending, is an area that is even less explored for countries of this Region. For example, one study found that 95% of cross-national variation in mortality can be explained by a country’s income per capita, inequality of income distribution, extent of female education, level of ethnic fragmentation and predominant religion. Such results can be interpreted to mean that adverse social determinants actually reduce the effectiveness of spending, raising concerns about wastage of scarce health sector resources.

Finally, fiscal space generally refers to a country’s ability to increase health spending without affecting other expenditures necessary for development and its own long-term solvency; any analysis of fiscal space generally includes an analysis of the macroeconomic situation of a country – mainly economic growth and its prospects – and increases in government revenue; a re-prioritization of health within the government budget; an increase in health-specific resources, grants and foreign aid for the health sector; and improved efficiency of spending.

This paper starts with a brief overview of the role of public financing for health, based on the global literature and some quantitative analysis. It then goes on to assess the current situation regarding health outcomes, for the countries of the WHO South-East Asia Region, based on the Millennium Development Goals (MDGs), as well as the overall disease patterns for these countries. Next, an analysis of the current level of health spending, the macroeconomic situation and availability of fiscal space is undertaken, to aid understanding of the ability of these countries to allocate greater resources to the health sector. Finally, the paper discusses some of the other factors that might prevent effective spending and improved health outcomes in the region.

Centrality of public health spending

Globally, there have been many analyses of the determinants of health outcomes, such as infant mortality rate (IMR), mortality rate in children aged under 5 years (U5MR) and maternal mortality ratio (MMR). The role of health expenditure has been central to such analyses, as have variables such as the level and growth of income, poverty, inequality and female literacy rate, as well as health service variables such as immunization and utilization of antenatal care. Recent evidence also indicates that higher spending via universal health coverage (UHC) impacts health outcomes positively, with larger benefits for poorer countries.

However, many of these studies and others argue that merely raising public spending is unlikely to achieve the desired levels of health outcomes. Other key variables that impact on health outcomes are poverty and income; female participation in the labour force; per capita gross national product; primary school enrolment; diphtheria, pertussis, tetanus (DPT) vaccination; female literacy; and income equality rates. Even UHC is unlikely to achieve health goals in the face of adverse values of these variables, especially among vulnerable sections of the population.

For example, an analysis of the relationship between health, poverty and economic growth in India showed that per capita public health expenditure positively influences health status, that poverty declines with better health and that growth and health have a positive two-way relationship. The study also found that public spending on health care matters more to the poor than the non-poor, and that merely increasing public spending will not be sufficient to improve health status significantly. This is also corroborated with studies by King and Bidani, and Ravallion. Houweling et al. also demonstrated that higher national incomes were associated with lower mortality rates among children aged under 5 years, though this association was significantly weaker for the poor than for the rich. However, the association between public spending on health and mortality in children aged under 5 years was stronger for the poor.

The link between public spending on health and health outcomes comes via the health system, with a strongly funded well-functioning health system being a key to better health outcomes. However, the preceding literature review indicates that adequate health spending is a necessary but not a sufficient condition for improving outcomes if the other social determinants of health are not addressed. While short-term gains might be in evidence, uneven development of these factors may create barriers to achieving sustainable health outcomes, despite a higher level of spending. Figure 1 plots per capita public spending on health against IMR for 182 countries for 2011, and indicates that while there is a negative relationship between the two, there are countries that are able to achieve the same health outcomes with lower spending, indicating different levels spending efficiency. This could be due to different efficiency levels of health services, as well as the presence of other adverse correlates of health outcomes (social determinants), such as poverty and lack of education.

Despite the different levels of spending efficiency, any proposed move towards UHC would require a higher level of spending, especially for low- and middle-income countries. Improving efficiency of spending would remain a critical strategy in financing for UHC, but may take a longer time horizon to implement and show results. In the meantime, funding would remain an important concern. Irrespective of whether countries opt for tax-funded UHC or scheme-based UHC, funds would be required for the UHC, which would presumably have a large component of subsidy for the poor and vulnerable; for health-system strengthening; for monitoring and evaluation; and for administration and management. All the countries of the South-East Asia Region have been part of this global trend towards UHC, and while countries like Thailand have actually transited to a well-functioning system of UHC, other countries such as Nepal and India are debating the best approach.

The ability of these countries to raise sufficient resources would depend to a great extent on robust and sustainable economic health of the countries, and the availability of fiscal...
space. Needless to say, mere availability of fiscal space may not always lead to the use of that space, unless health is prioritized in public spending, particularly as an important component of social sector spending. A very recent analysis indicates that factors such as democratization, lower levels of corruption, ethnolinguistic homogeneity, and more women in public office are correlated with higher shares of public spending on health. Case studies from this analysis indicate that country-specific political economy considerations are key, and instead of focusing only on government budgetary targets, countries need to focus on the breadth and depth of health coverage. The centrality of public health spending can also be gleaned from its association with OOPS, which is an indicator of the extent of financial protection households have from catastrophic health spending. There are only a few variables that would impact on how much people spend out-of-pocket on health as a proportion of their country’s GDP. While it is expected that a rise in national income might see a rise in this ratio because of the pure income effect, this should taper off with increasing coverage. The increasing health coverage would, in turn, be driven by increases in public spending, which should exert a downward pressure on OOPS. Finally, a well-functioning public health infrastructure would also help reduce OOPS by making people choose public – rather than private – health facilities. A recent cross-country estimate used a simple regression to test whether income, public health spending and a well-functioning infrastructure have any impact on OOPS. The results confirmed that public health spending has a significant impact on a country’s average OOPS: the higher the spending by the government, the lower will be the OOPS. Thus, while health outcomes might be impacted by other social determinants as well, OOPS has a direct link with public health spending, which acts via greater investment in public health infrastructure as well as UHC.

### Millennium Development Goals and disease burden in countries of the WHO South-East Asia Region

How have the countries fared in their health outcomes? Table 1 examines the progress in the indicators for MDG 4 (“reduce child mortality”) and MDG 5 (“improve maternal health”), but it also includes IMR, which is often used as an additional indicator of child health outcomes.

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**Figure 1**: Infant mortality rate and public health spending per capita

Sources: Authors’ calculation from World Bank World Development Indicators for 2011.

\[
\text{Per capita public health expenditure} = \frac{\text{Public health expenditure total}}{\text{Total population}}
\]

Where public health expenditure as % of GDP \( (X) = \frac{\text{Public health expenditure total}}{\text{GDP (Y)}} \times 100\)

Therefore, Public health expenditure total \( = \frac{(X \times Y)}{100} \).

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*Scaling up health expenditure for universal health coverage: prospects and challenges,* India Infrastructure Report 2013/14, IDFC Foundation, New Delhi.
Indicators under this goal. Almost all the countries of the Region except India, DPR Korea and Myanmar have done quite well in terms of their own MDG targets for IMR. However, there remains considerable scope to improve beyond the MDGs in these cases, since the levels remain high in countries such as Nepal and Timor-Leste.

For U5MR, Bhutan, Maldives and Nepal have already achieved this goal and most other countries are close to achieving their targets. Here again, India, DPR Korea and Myanmar have been lagging behind the most.

For MMR, Bhutan and Maldives have achieved their targets. Thailand, Nepal and Sri Lanka are closer to their targets than other countries. Significant gaps remain in all other countries. Also, even when close to targets, countries such as Nepal still have high absolute level requiring them to hasten further improvements in this indicator. Overall, the MDGs indicate that, as far as these goals go, most countries except a few, such as India, DPR Korea and Myanmar, seem to be on track. However, the challenges may not only come from the diseases of reproductive and child health. The changing epidemiological profile of most of these countries poses the real challenge in terms of priorities and resources.

Noncommunicable diseases (NCDs) are the leading cause of death in the WHO South-East Asia Region. As Figure 2 indicates, NCDs now form a great share of total disease burden. Indonesia, the Democratic People’s Republic of Korea, Maldives, Sri Lanka and Thailand are dealing with very high NCD burdens.

Table 1 presents further evidence compiled from the Global Burden of Diseases, Injuries and Risk Factors Study 2010 country profiles on the highest-ranking causes of premature deaths in terms of number of life-years lost, the biggest change in causes, and the leading risk factor for deaths in each of these countries. This gives a more nuanced picture of the epidemiological challenges the countries are facing, the areas where they have made significant progress, and where they might see the most change. While NCDs are increasing across the board, Bangladesh, Bhutan, India, Myanmar, Nepal and Timor-Leste are still dealing with avoidable diseases relating to pregnancy, birth and infectious diseases. However, they have also been able to address infectious and communicable diseases effectively, as can be seen from the second column of Table 2, raising the hope for further spending effectiveness. In terms of risk factors, for Bangladesh and the Democratic People’s Republic of Korea, smoking is the leading risk factor, while for Nepal it is air pollution from solid fuels. For all the other countries of the Region, dietary risks are the leading factor, indicating the possibility of rapid change in their disease profile in the years to come.

The evidence presented indicates that the countries of the South-East Asia Region are facing the dual burden of communicable and noncommunicable diseases, and countries that are yet to effectively arrest infectious, vaccine-preventable diseases will also have to contend with an increasing burden of NCDs. Countries that have yet to meet their MDG targets will clearly have the greatest challenge in terms of resource needs and prioritization. The issue of sufficiency of resources is closely related to the disease profile of countries, and each

**Table 1: Millennium Development Goal (MDG) progress for infant mortality rate (IMR), maternal mortality ratio (MMR) and mortality rate in children aged under 5 years (U5MR) in the World Health Organization South-East Asia Region**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>37</td>
<td>33</td>
<td>4</td>
<td>200</td>
<td>138</td>
<td>62</td>
<td>46</td>
<td>48</td>
<td>-2</td>
</tr>
<tr>
<td>Bhutan</td>
<td>33</td>
<td>31</td>
<td>2</td>
<td>140</td>
<td>225</td>
<td>-85</td>
<td>40</td>
<td>45</td>
<td>-5</td>
</tr>
<tr>
<td>India</td>
<td>45</td>
<td>29</td>
<td>16</td>
<td>220</td>
<td>140</td>
<td>80</td>
<td>58</td>
<td>42</td>
<td>16</td>
</tr>
<tr>
<td>Indonesia</td>
<td>26</td>
<td>21</td>
<td>5</td>
<td>210</td>
<td>108</td>
<td>102</td>
<td>32</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>24</td>
<td>11</td>
<td>13</td>
<td>98</td>
<td>21</td>
<td>77</td>
<td>30</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Maldives</td>
<td>10</td>
<td>23</td>
<td>-13</td>
<td>38</td>
<td>108</td>
<td>-70</td>
<td>12</td>
<td>31</td>
<td>-19</td>
</tr>
<tr>
<td>Myanmar</td>
<td>42</td>
<td>26</td>
<td>16</td>
<td>220</td>
<td>145</td>
<td>75</td>
<td>54</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Nepal</td>
<td>35</td>
<td>33</td>
<td>2</td>
<td>220</td>
<td>198</td>
<td>22</td>
<td>43</td>
<td>47</td>
<td>-4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>32</td>
<td>12</td>
<td>20</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Thailand</td>
<td>12</td>
<td>10</td>
<td>2</td>
<td>28</td>
<td>11</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>50</td>
<td>43</td>
<td>7</td>
<td>330</td>
<td>300</td>
<td>30</td>
<td>59</td>
<td>57</td>
<td>2</td>
</tr>
</tbody>
</table>

Notes: the MDG indicator target for IMR, MMR and U5MR was calculated from the World Bank 1990s figure for each indicator. Targets for 2015 are: IMR – reduced by two-thirds between 1990 and 2015; MMR – reduced by three-quarters between 1990 and 2015; U5MR – reduced by two-thirds between 1990 and 2015.

Figure 2: Burden of communicable and noncommunicable diseases in the World Health Organization South-East Asia Region

DPR Korea: Democratic People’s Republic of Korea. Percentages indicate the relative burden of disability-adjusted life years for communicable and noncommunicable diseases (injuries excluded).

Source: Authors’ calculation from WHO, Measurement and Health Information, February 2009.

Table 2: Leading causes of premature death, change in causes and leading risk factor

<table>
<thead>
<tr>
<th>Country</th>
<th>Highest ranking causes of premature death in terms of number of years of life lost, 2010</th>
<th>Largest decrease among the 25 most important causes of burden of disease (DALYs) from 1990 to 2010</th>
<th>Leading risk factor</th>
<th>Source: Compiled from Global Burden of Diseases, Injuries and Risk Factors Study 2010, Country Profiles database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Preterm birth complications, lower respiratory tract infections, neonatal encephalopathy (birth asphyxia and birth trauma)</td>
<td>Diarrhoeal disease, by 85%.</td>
<td>Tobacco smoking</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>Lower respiratory tract infections, preterm birth complications, poisonings</td>
<td>Diarrhoeal disease, by 85%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>Cerebrovascular disease, ischaemic heart disease, chronic obstructive pulmonary disease</td>
<td>Congenital anomalies, by 41%</td>
<td>Tobacco smoking</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Preterm birth complications, lower respiratory tract infections, diarrhoea</td>
<td>Measles, by 63%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>Cerebrovascular disease, tuberculosis, road injury</td>
<td>Lower respiratory tract infections, by 81%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>Ischaemic heart disease, cerebrovascular disease, neonatal encephalopathy (birth asphyxia and birth trauma)</td>
<td>Lower respiratory tract infections, by 89%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>Lower respiratory tract infections, cerebrovascular disease, HIV/AIDS</td>
<td>Diarrhoeal disease, by 73%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>Lower respiratory tract infections, cerebrovascular disease, neonatal encephalopathy (birth asphyxia and birth trauma)</td>
<td>Congenital anomalies, by 66%</td>
<td>Air pollution from solid fuels</td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Ischaemic heart disease, self harm, cerebrovascular disease</td>
<td>Interpersonal violence, by 68%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>HIV/AIDS, ischaemic heart disease, road injury</td>
<td>Preterm birth complications, by 56%</td>
<td>Dietary risks</td>
<td></td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Lower respiratory tract infections, diarrhoea, preterm birth complications</td>
<td>Measles, by 85%</td>
<td>Childhood underweight</td>
<td></td>
</tr>
</tbody>
</table>

DALY: disability-adjusted life year
country will need to do its own calculations of how many resources are needed under UHC to effectively address their patterns of disease.

**Macroeconomic scenario and fiscal space**

The main concern in the context of UHC is whether countries can spend more on health than current levels. Examination of the macroeconomic and fiscal space indicators in Table 3 for 2005 and 2011 and also Figs 4 and 5 enables an assessment of the countries in the WHO South-East Asia Region that would be able to do that.

In Table 3, the last two columns report public health spending as a percentage of GDP for 2005 and 2011. While the share of public health spending in GDP is often used as a summary indicator of prioritization, this gives only a partial – and sometimes incorrect – picture of priorities. A better indicator is the share of health expenditure in total government expenditure, which is presented in Fig. 3. Looking at this share first, it can be seen that, in 2011, it was highest in Thailand (14.5%) and lowest in Myanmar (1.3%). In 2005, Timor-Leste had the highest share of health expenditure in terms in total government expenditure (38%) but had a very sharp decline to 2.9% in 2011. However, for almost all the countries of the region, this share dropped between 2005 and 2011. For Thailand, there was an increase from 2005 to 2011 and India too was able to increase the share somewhat after 2010. As a share in GDP, public health spending has noticeably increased only in Thailand. For others, it either remained the same or showed a marginal increase, and fell for Maldives, Sri Lanka and Timor-Leste (see Table 3). Together, these two indicators seem to suggest that many of the countries of the region are struggling to accord health a reasonable priority in total government spending.

Bhutan needs to reprioritize its health spending, to prevent a decline in the gains it has been able to make in its health outcomes. Timor-Leste clearly needs to seriously tackle its decline in health spending – especially since its other determinants are rather poor. Sri Lanka has done well but with modest resources, confirming that effectiveness of spending is an important source for health gains.

While high economic growth helps open up additional fiscal space, growth that is too rapid can lead to overheating, leading to inflation, which can effectively erode a country’s capacity to maintain high growth and development. A high level of debt also narrows fiscal space. Domestic resources comprise the most stable source of funding, especially for the social sector, which needs continuous and stable funding. Countries that depend on outside funding like Official Development Assistance (ODA) are less able to sustain their social sector spending than others. Finally, the willingness of countries to set aside an increasing proportion of resources for the social sector is an indication of prioritization within countries.

The first thing to note is that growth has been rather good in all the countries of the Region and higher in 2011 than 2005, with the exception of India and Thailand. This is good, since high growth is a key to expansion of the fiscal space. India’s growth was robust until recently but currently it is seeing a plunge in its growth rate, which some argue may pick up only slowly.\(^\text{38}\) India has been also dealing with inflationary pressures for a while now.

For Bangladesh, growth has been more or less stable, though inflation has been quite high. Bhutan has seen substantial

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**Table 3: Macroeconomic situation in the World Health Organization South-East Asia Region**

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP growth (% of GDP)</th>
<th>Inflation (%)</th>
<th>Tax revenue (% of GDP)</th>
<th>Debt (% of GDP)</th>
<th>Net ODA (% of GNI)</th>
<th>SSS (% of government expenditure)</th>
<th>Public spending on health (% of GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>5.96</td>
<td>6.71</td>
<td>7.05</td>
<td>10.71</td>
<td>8.22</td>
<td>9.98</td>
<td>33.9</td>
</tr>
<tr>
<td>India</td>
<td>9.28</td>
<td>6.33</td>
<td>4.25</td>
<td>8.86</td>
<td>9.91</td>
<td>10.39</td>
<td>61.19</td>
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<td>Indonesia</td>
<td>5.69</td>
<td>6.49</td>
<td>10.45</td>
<td>5.36</td>
<td>12.5</td>
<td>11.77</td>
<td>47.34</td>
</tr>
<tr>
<td>Maldives</td>
<td>–8.68</td>
<td>7.05</td>
<td>2.30</td>
<td>14.85</td>
<td>13.56</td>
<td>17.0</td>
<td>39.77</td>
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<td>Myanmar</td>
<td>13.64</td>
<td>5.60</td>
<td>9.37</td>
<td>5.02</td>
<td>4.30</td>
<td>3.70</td>
<td>NA</td>
</tr>
<tr>
<td>Nepal</td>
<td>3.48</td>
<td>3.88</td>
<td>6.84</td>
<td>9.55</td>
<td>9.18</td>
<td>13.25</td>
<td>51.76</td>
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<td>Sri Lanka</td>
<td>6.24</td>
<td>8.25</td>
<td>11.64</td>
<td>6.72</td>
<td>13.73</td>
<td>12.42</td>
<td>90.6</td>
</tr>
<tr>
<td>Thailand</td>
<td>4.60</td>
<td>0.08</td>
<td>4.54</td>
<td>3.81</td>
<td>17.24</td>
<td>17.55</td>
<td>27.33</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>6.22</td>
<td>10.81</td>
<td>1.11</td>
<td>13.5</td>
<td>1.50</td>
<td>1.10</td>
<td>0.00</td>
</tr>
</tbody>
</table>

GDP: gross domestic product; GNI: gross national income; NA: not available; ODA: Official Development Assistance; SSS: social sector spending (health and education)

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**Figure 3:** Public health expenditure as % of total government expenditure, 2005–2011

Source: World Bank World Development Indicators.39

**Figure 4:** Relative position of nine countries of the WHO South-East Asia Region, in terms of ratios of fiscal deficit to gross domestic product (GDP) and public debt to GDP

Source: World Bank World Development Indicators for 2012.39
growth in the recent past, driven by the hydropower sector developments. The International Monetary Fund (IMF) predicts a favourable medium-term outlook, with growth remaining between 8% and 9%. Inflation has risen, however, and Bhutan may need to watch out for possible overheating. There is some indication that inflation has recently been brought under control. Maldives has recently seeing a slowdown in growth, owing to global conditions and slowdown in tourism, on which it depends heavily. Given its recent-found stability, Myanmar – a resource-rich country – had done rather well. Policy reforms have stimulated economic growth in the recent past and are expected to drive further development in the near future, and inflation has been moderate.

Nepal’s political situation hampers a faster macroeconomic turnaround, despite the fact that recent economic performance has picked up somewhat. The country depends heavily on the monsoon, service sector growth and foreign remittances, making predictions somewhat difficult. Inflation was high, but is currently moderate. Sri Lanka continues to experience strong economic growth, despite a long history of internal conflict. The government has been stimulating economic growth by pursuing large-scale reconstruction and development projects supplemented with private investment, especially in war-torn and disadvantaged areas.

Although the Thai economy has been severely affected by the global financial crisis over the past few years, supply-chain disruptions following the tsunami in Japan, and the devastating 2011 floods, the economy has rebounded recently, with modest GDP growth (GDP rose by 6.4% in 2012 compared with just 0.1% in the previous year) and a modest inflation rate. After a long history of internal conflict (1999–2006), Timor-Leste has made significant economic progress towards stable economic growth. The country has initiated a new development phase that is pursuing a high rate of sustainable economic growth through the conversion of petroleum wealth into human and physical capital. However, inflation has been a worry, owing to too rapid a growth.

An earlier paper analysed constraints in fiscal space for countries of the WHO South-East Asia Region. The current paper uses revised estimates in Figs 4 and 5 to demonstrate four key dimensions of fiscal space for these countries: fiscal-deficit-to-GDP ratio, government debt as a proportion of GDP, tax revenues, and ODA.

Figure 4 shows the ratios of fiscal deficit to GDP and government debt to GDP in nine countries of the region. The two benchmarks shown are those laid down in the Treaty on European Union (Maastricht Treaty), as indicators of sound fiscal policies, namely: a fiscal-deficit-to-GDP ratio of no more than 3% and government debt no greater than 60% of GDP. While these benchmarks have been discussed and often critiqued, they remain widely used. The lower the values of these parameters, the better is the fiscal position of the country. The best position to be in is in the top left quadrant and only Indonesia and Thailand are here. Bangladesh and Myanmar are also doing well. Bhutan’s fiscal situation is favourable but it faces a high public debt ratio. India, Sri Lanka and Maldives are not performing very well on these two parameters.
In Figure 5, the inverse values of revenue-to-GDP and aid-to-GDP ratios are plotted, with the threshold values indicated with solid lines: revenue-to-GDP 13% or more, and aid-to-GDP 5% or less. The best quadrant to be in is the lower left one. Maldives is in the most favourable situation with respect to both these parameters. Thailand, Indonesia, Nepal and Timor-Leste are also comfortable. Bangladesh, India and Myanmar need to seriously focus on their revenue situations. Overall, most of the countries of the WHO South-East Asia Region have manageable aid-to-GDP ratios, but their revenue-to-GDP ratios are not very favourable.

Bangladesh does not depend too much on ODA and has also been able to increase tax revenue somewhat, though it can probably be raised further. Given these mostly positive scenarios, it does seem possible for Bangladesh to increase its social sector spending substantially, by exploiting the available fiscal space; it is among the lowest spenders on health among countries of the South-East Asia Region.

Maldives has had a high fiscal deficit for a while now and been experiencing robust growth. As one possible source of funding, given that the country has modest tax effort, it has been able to spend substantially on the social sector. However, health spending has been rather low, or external dependence issue. Its fiscal deficit, however, has been high, and inflationary pressures continue. Despite its high public debt ratio. Maldives has relatively strong tax revenues overall and has already been able to increase social sector spending substantially. Government spending on health is the highest among the countries of the WHO South-East Asia Region. It may not have a lot more fiscal space at this point, and needs to focus on reprioritization and improved efficiency of health spending. Nevertheless, tourism remains an avenue for additional resources, if necessary.

While some teething problems remain in areas such as government controls, economic policies and governance, recently Myanmar made a major policy reform for stimulating economic growth and it is expected to drive further development. Growth is accelerating, external balances remain stable and fiscal policy has been wisely encouraging fiscal prudence, while at the same time helping boost investment and social spending, and supporting macroeconomic stability. Myanmar has substantial potential to use the existing GDP growth for increasing social sector spending significantly.

For Nepal, the major concern is the high level of poverty and unemployment (46%) in the country. Despite this, Nepal has managed to raise its social sector spending by garnering additional revenues from its GDP. It spends more than India and Sri Lanka on health, but can possibly raise additional resources from domestic funds, if necessary.

In Sri Lanka, the government’s high debt payments and historically high budget deficits have been controlled to a certain extent by recent economic reforms in line with IMF recommendations. Inflation has also been under control to a certain extent. Sri Lanka has been able to sustain favourable health outcomes despite low health spending as a percentage of GDP. There remains enough fiscal space for it to try and increase health spending to deal with changing disease patterns.

In the WHO South-East Asia Region, Thailand has been leading in health outcomes and UHC. It has the highest ratio of social sector spending and highest percentage of tax revenue from GDP among all the countries of the Region. The country can consolidate its gains by reprioritization and improving allocative efficiency, while trying to raise its public health spending by a modest amount.

As will be seen in the next section, in Timor-Leste, poverty, illiteracy and unemployment remain causes of concern. Despite this, Timor-Leste has met its MDG targets already, but sustainability and further improvements cannot be guaranteed, owing to its adverse social indicators and the somewhat lopsided growth model that it has pursued. It will have to reduce dependence on external funds and use more of its domestic resources, which it can easily do given the high growth rates.

Macroeconomic-plus factors in the WHO South-East Asia Region

Finally, Table 4 presents selected indicators besides the ones pertaining to health outcomes and fiscal space, to aid understanding of how countries have fared based on these indicators. Selected parameters such as GDP per capita, poverty, female literacy, inequality and extent of immunization are used and these have been called “macroeconomic-plus” factors. A last column has been added for per capita health spending, to contextualize the discussion.

Table 4 shows that, while each country is at a different point with respect to some of these selected macroeconomic-plus factors, countries with high GDP per capita are also countries with low poverty head count ratio and high female literacy. Thus, for example, Indonesia, Maldives, Sri Lanka and Thailand have relatively high GDP per capita, but also low poverty. These are also countries with high female literacy rates.
From earlier discussions, it is known that these countries also have favourable health outcomes. For the other countries, one or the other of these social determinants would slow down the improvements in health outcomes. Thus, for example, Bangladesh, Bhutan, India, Nepal and Timor-Leste need to improve either poverty or literacy rates, or both. Clearly, a confluence of these various determinants coupled with moderate to high health spending would ensure sustainable and improved health outcomes.

Maldives leads for per capita health spending, with Thailand following in the second place, followed by Bhutan, Indonesia and Sri Lanka. For this group of countries, there seems to be a positive association between per capita spending, health outcomes and macroeconomic-plus factors generally.

Table 4: Macroeconomic-plus indicators in 10 countries of the World Health Organization South-East Asia Region (selected variables)

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP per capita (current US$)</th>
<th>Poverty headcount ratio at US$ 1.25 a day (PPP) (% of population)</th>
<th>GINI index</th>
<th>Literacy rate, adult female (% of females aged 15 and above)</th>
<th>Immunization, DPT (% of children aged 12–23 months)</th>
<th>Public health expenditure per capita (current US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>664.1</td>
<td>43.3</td>
<td>32.1</td>
<td>52.2</td>
<td>95</td>
<td>9.0</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2211.2</td>
<td>10.2</td>
<td>38.1</td>
<td>38.7</td>
<td>91</td>
<td>79.8</td>
</tr>
<tr>
<td>India</td>
<td>1419.1</td>
<td>32.7</td>
<td>33.9</td>
<td>50.8</td>
<td>72</td>
<td>15.0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2946.7</td>
<td>18.1</td>
<td>35.6</td>
<td>89.1</td>
<td>63</td>
<td>30.3</td>
</tr>
<tr>
<td>Maldives</td>
<td>6552.5</td>
<td>16.0</td>
<td>37.4</td>
<td>98.4</td>
<td>96</td>
<td>248.1</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1400.0</td>
<td>32.7</td>
<td>NA</td>
<td>89.9</td>
<td>99</td>
<td>NA</td>
</tr>
<tr>
<td>Nepal</td>
<td>594.3</td>
<td>24.8</td>
<td>32.8</td>
<td>48.3</td>
<td>82</td>
<td>11.3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2399.9</td>
<td>4.1</td>
<td>36.4</td>
<td>90.0</td>
<td>99</td>
<td>37.8</td>
</tr>
<tr>
<td>Thailand</td>
<td>4802.7</td>
<td>0.4</td>
<td>39.4</td>
<td>91.5</td>
<td>99</td>
<td>139.9</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>766.0</td>
<td>41.0</td>
<td>31.9</td>
<td>53.0</td>
<td>72</td>
<td>32.9</td>
</tr>
</tbody>
</table>

DPT: diphtheria, polio, tetanus; GDP: gross domestic product; NA: not available; PPP: purchasing power parity

Source: World Bank World Development Indicators for 2010; sources of GINI indices are Index Mundi Country Economic Profiles 2013 (www.indexmundi.com). For each country, the coefficient is for the most recent year for which data are available.

The remaining countries are spending much less on health per capita; given their fairly positive growth and macroeconomic scenario, raising resources should not be a problem in countries such as Bangladesh, India, Indonesia and Nepal that currently have a low revenue-to-GDP ratio. Indonesia is progressing well in its plan for UHC and it seems entirely possible for it to give health a higher priority. India has been discussing UHC internally and needs to show commitment to the health sector by increasing spending significantly, which it can do despite its current growth problems. For India, the question is of prioritizing health. India is lagging behind in its MDGs in any case, but adverse socioeconomic indicators would further affect the efficiency of spending, and increase the need for even higher resources. Also, Bangladesh and Nepal need to take care to sustain their health gains, unless their macroeconomic-plus factors improve.

Myanmar’s economic history is relatively new, but it has shown remarkable results in a short time in terms of economic policy. While it might take longer for it to reach an equilibrium level of health spending, its growth and macroeconomic situation indicate that fiscal space will expand further. However, it has to seriously tackle its socioeconomic indicators, to prevent erosion of efficiency in spending.
Timor-Leste would have to reprioritize health and social sector spending by using a much greater slice of its oil revenue right away, to tackle health and other social determinants of health.

Overall, countries of the WHO South-East Asia Region are collectively in a position to make the transition from low average spending to moderate or even high health spending, which will be required, in turn, for transition from low coverage-high OOPS to high coverage-low OOPS. However, explicit prioritization for health within the overall government budget for low spenders would require political will and champions who can argue the case of the health sector. Additional innovative avenues of raising resources such as earmarked taxes or a health levy can be considered in countries with good macroeconomic fundamentals. With the exception of Thailand, this is applicable for all the countries of the Region. However, countries with adverse macroeconomic-plus factors, including an inefficient health system, need to be alert to the possibility of overinvesting – and thereby wasting – resources for modest health gains, making the challenge of increasing health sector spending alongside competing demands for spending on other areas of the social sector a difficult one.

REFERENCES