Past and Future of Health Financing Worldwide and in Argentina

Pasado y futuro del financiamiento de la salud en el mundo y en la Argentina

The most complete approach is to identify the desired health status changes and determine what needs to be purchased to achieve those goals.
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INTRODUCTION

The relationship between economic development and health financing has been recently described, with particular emphasis on the evolution of world health financing over the recent past (20 years) and the near future (25 years). Moreover, subsequent articles have tried to characterize the access to healthcare and the quality of care for the causes of preventable death in personal healthcare.

Considering the global health financing of all the healthcare systems worldwide (184 countries), in 2014 the average health expenditure per capita across all countries was $ (USD) 1,279, similar to the average health expenditure per capita of $1,322 in Argentina. But this expenditure is concentrated in high-income countries and ranges from $33 in Somalia to $9,237 in the USA. These extremes, which are reported using 2015 PPP (purchasing-power-parity) in USD to account for inflation and different prices across countries, highlight the huge variation in how much is spent on health around the world. (2)

"In 2014, health expenditure across low-income countries was $120 per capita, but ranged from $33 (Somalia) to $347 (Uganda). Expenditure per capita across lower-middle-income countries was $267, but ranged from $92 (Bangladesh) to $791 (Tunisia), while expenditure per capita in upper-middle-income countries was $914, but ranged from $228 (Angola) to $1,980 (Maldives). Finally, health expenditure per capita was $5,221 in high-income countries, and ranged from $853 (Seychelles) to $9,237 (USA). Geographic variation is also present when examined using the aggregated gross domestic product (GDP) by regions" (2) (Table 1).

WHO PAYS HEALTHCARE EXPENDITURE?

Total healthcare expenditure was considered as the sum of government expenditure (direct expenditure through taxes or indirect expenditure through salaries), prepaid volunteer private insurance and out-of-pocket payments (these data were extracted from the WHO Global Health Observatory, and 964 National Health Account reports). International "development agency expenditures were also considered (based on data from all publicly available databases tracking development assistance).

Globally, governments provided 59.2% of health expenditure, while 17.4% of total health financing was prepaid private healthcare, 22.8% was out-of-pocket, and only 0.6% was development assistance for health.

But these averages covered up deep inequalities. For example, state health expenditure increased from 18% in low-income countries to 63.4% in high income countries. Conversely, in low-income countries, health expenditure was predominately financed by development assistance for health (35.7%) and out-of-pocket payments (29.1%), constituting between both almost 65% of the total healthcare expenditure (Table 2).

The share of health financing obtained from out-of-pocket payments was largest in lower-middle-income countries (58%), followed by government expenditure (35.9%), while the incidence of prepaid private or development assistance expenditures was negligible (see Table 2).

Government expenditure in upper-middle-income and high-income countries, by contrast, were the highest and predominant in the bulk of healthcare and the related activities were, at 57.2% and 63.4%, respectively.

Countries (2014)	Mean expenditure	Range of expenditure
Low income	$120	$33 (Somalia) - $347 (Uganda)
Middle-low-income	$267	$92 (Bangladesh) - $791 (Tunisia)
Middle-high-income	$914	$228 (Angola) - $1,980 (Maldives)
High-income	$5,221	$853 (Seychelles) - $9,237 (EEUU)
Total (2014)	$1,279	$33 (Somalia) - $9,237 (USA)

* PPP: Purchasing-power-parity

Table 1. Income by inflation adjusted by 2015 PPP*, in US dollars

Across all income groups, prepaid private health expenditure remained quite low, being about 17% at the extremes of wealth (low-income and high-income countries).

In Argentina, health expenditure remains predominantly financed by the state (government and workers' health insurance, 55.8%), followed by out-of-pocket expenditures (30.9%), constituting between both 86.8% of total healthcare expenditure. Prepaid volunteer private insurance only finances 13.2% of healthcare expenditure (see Table 2).

HOW TOTAL HEALTH EXPENDITURE PER CAPITA CHANGED BETWEEN 1995 AND 2014

It is important to know how total health expenditure per capita has changed over the past 20 years (1995-2014). Upper-middle and lower-middle-income country groups have increased faster their per capita health expenditure, with annualized growth rates of 5.9% and 5.0%, respectively. Over the course of these 20 years, this led to near tripling the health expenditure per capita in upper-middle-income countries, from $309 to $914 per capita. In lower-middle-income countries health expenditure per capita increased 2.5 times.

Expenditure in low-income countries grew less, at 4.6%, while the slowest growth was observed in high-income countries, which grew collectively at 3.0% per year.

Despite this slower rate, the largest health expenditure increase in absolute terms of dollars per capita was in high-income countries, which added $2244 per capita in expenditure. Upper-middle income and lower-middle-income countries added $605 and $162 per capita, respectively. Low-income countries, which spent very little in 1995, increased health expenditure by only $69 per capita between 1995 and 2014.

However, the source of growth in expenditure was different according to the countries' wealth. For high-income and middle-income countries, the growth in expenditure was driven by increases in government expenditure. For example, in high-income countries, 64.5% of the $2,244 increase was due to increase in government expenditure. Conversely, the growth in low income countries was driven by increase in development assistance for health (51.0% of absolute increase).

When the increase in health expenditure was compared with the increase GDP of the countries, there was essentially no change in the percent GDP health expenditure across time.

Total health expenditure increases with economic development, while the share of out-of-pocket financing decreases. Across countries, growth in GDP per capita was associated with exponential growth in total health expenditure per capita. Thus, when measured as a share (percentage) of GDP, there is not a robust relationship connecting economic development and expenditure. The estimated fit is nearly flat and there are countries with similar GDP per capita with different expenditure levels.

In turn, prepaid private expenditure as a share of total expenditure is very small across all levels of economic development, while the share of development assistance for health increases at the very low levels of GDP per capita and peaks at GDP per capita of $801.

On average, the proportion of total health expenditure obtained from government sources rises as GDP increases. At the 80th wealth percentile (GDP per capita of $27,617), the analysis estimates that health expenditure is mainly financed by the government (72.2%), with only 24.9% sourced from out-of-pocket. At the 20th wealth percentile (GDP per capita of $2,267), the analysis estimates that out-of-pocket

Table 2. Health expenditure by source (2014)

Countries (2014)	Government expenditure %	Prepaid expenditure %	Out-of-pocket expenditure %	Development assistance for health expenditure %	% GDP for Health
Low income	18.0	18.0	18.0	18.0	18.0
Middle-low-income	35.9	35.9	35.9	35.9	35.9
Middle-high-income	57.2	57.2	57.2	57.2	57.2
High-income	63.4	63.4	63.4	63.4	63.4
Total (2014)	59.2	59.2	59.2	59.2	59.2
Argentina	55.8	55.8	55.8	55.8	55.8

Table 3. Changes in health expenditure per capita 1995-2014

Countries (2014)	Mean expenditure		Annualized changes	Absolute changes
	1995	2014		
High-income	$2,997	$5,221	3.0%	$2,244
Middle-high-income	$309	$914	5.9%	$605
Middle-low-income	$105	$267	5.0%	$162
Low-income	$51	$120	4.6%	$69
Argentina	$1525	$1,322	-0.6%	-$160

financing is 44.8% of total expenditure, while development assistance for health is 23.1%.

However, "...the results show that some countries deviate substantially from average trends." (2)

Countries such as Algeria and Japan not only have greater than modelled health expenditure per capita, but also greater than modelled share of financing from government. However, countries such as Uganda and the USA have greater than modelled health expenditure per capita, but less than modelled share of financing from government. Conversely, countries such as Ethiopia and Thailand, have less health expenditure per capita than modelled, but higher than modelled share of financing from government,

The situation of Argentina is very particular, sharing with countries such as India, Pakistan, Bangladesh, Nigeria, Indonesia, Philippines and a Latin American country (Venezuela) the sad reality of having reduced not only the total health expenditure per capita, -0.6% per year over 20 years, about one third of the modelled average, but also the percent financed by the government by 23%. Yet, prepaid private expenditure increased 4 times and out-of-pocket expenditure increased over 25% than the modelled average used in the study (see Table 3).

Although during the first decade of the millennium, development assistance for health grew at an annualized rate of 11.3%, in particular for malaria, tuberculosis, and HIV/AIDS, since 2010, total development assistance for health has abruptly decreased to 1.8%, with reductions in expenditure (–1.4%) for the largest health focus area, which is HIV/AIDS. Twenty-four percent of development assistance for health focused on HIV/AIDS, while child and maternal health projects received 14.8% and 11.3% of funding, respectively.

Health expenditure was relatively stable across the spectrum of economic development. At a median GDP per capita ($8,346) in 2014, 29.0% of total expenditure was on inpatient curative and rehabilition care, 30.6% on outpatient curative and rehabilitation care, and 23.5% on medical goods, which include pharmaceuticals. These values dropped marginally at the highest values of GDP per capita, where long-term care is more prominent. Government expenditure by type of goods and service is very similar to total expenditure.

The authors of the study "...highlight three distinct health financing stages that emerge along the spectrum of economic development. In the first stage, health financing is dominated by development assistance for health and out-of-pocket expenditure. In the second stage, development assistance for health subsides, and the primary sources of healthcare financing are out-of-pocket and domestic government expenditure. Finally, the third stage includes countries with the highest GDP per capita, which tend to finance healthcare using government expenditure." (2)

Even though the share of out-of-pocket health expenditure peaks at GDP per capita of $2456, it remains a major source of expenditure for many countries beyond this point. "The modelled trends do not show an accelerated decline in out-of-pocket expenditure till above GDP per capita of $20,000. This threshold is crucial because out-of-pocket financing has been linked to less access to prescribed medicines, less access to care, more adverse health outcomes, and impoverishment." (2)

The authors conclude that "the availability of prepaid resources for health, such as government expenditure, is one of main determinants of access to healthcare, and can lead to population health gains... This is at the core of the pursuit for universal health coverage."

POTENTIAL EXPENDITURE ON HEALTH BETWEEN 2015 AND 2040

Although health expenditure tends to increase with economic development, the huge variations among health financing systems will continue growing. In absolute terms, low-income and lower-middle-income countries are increasing their health expenditure at a much slower rate than more economically developed countries, which increases the health expenditure gap and calls attention to the need for political intervention. Estimates of future expenditure can be beneficial for policy makers and planners to identify financing gaps and adjust long-term planning and processes.

All the projections were similar and consistent, and were based on series of ensemble models, where frontier analyses were used to identify patterns exhibited by the countries that dedicated the most funding to health, and these frontiers were then applied to estimate potential health expenditure for each low-income or middle-income country. All estimates are adjusted by inflation and purchasing power.

The authors estimate that global expenditure on health will increase from US $9.21 billion in 2014 to $24.24 billion (uncertainty interval [UI] 20.47–29.72) in 2040. In per capita terms, this growth is from $1,279 in 2014 to $2,872 in 2040, with an annualized growth rate of 3.0% (Table 4).

Upper-middle-income countries are expected to increase faster their health expenditure at 5.3% per year, going from $914 in 2014 to 3,093 in 2040. Lower-middle-income countries are expected to grow only a little slower at 4.2%, from $267 to $8,444. High-income countries will increase their expenditure at a lower rate, 2.1%, from $5,221 to $9,215, and a slower growth rate is expected in low-income countries (1.8%) from from $120 to %195 per capita in 2040.

In Argentina, the growth rate in health expenditure will be half of the one expected for its group (upper-middle-income), and from being above the average of its group it will be definitively below the average (see Table 4).

This growth will largely be driven by the increase in government health expenditure, which globally, will increase from 59.2% in 2014 to 65.3% in 2040,

but will remain low in low-income countries (18% to 29.4%) and high in high-income countries (63.4% to 65.3%). Out-of-pocket and prepaid private health financing are also expected to grow, although less than growth in government expenditure (22.8% to 21.4% and 17.4% to 12.9%, respectively) (Table 5).

In Argentina, growth in government expenditure will be lower than the one expected in its group (middle-high income countries), with a similar decrease in volunteer prepaid insurance expenditure and lower decrease in out-of-pocket expenditure.

Underpinning these trends are the enormous variations in the level of health expenditure. In 2014, health expenditure ranged from $33 in Somalia to $9,237 in the USA., but in 2040, national expenditure is expected to span an even larger range: from $42 in Somalia to $15,026 in the USA. But the gap between the "frontier" and individual countries suggests that many countries may be able to divert more resources to health, and low-income countries as a whole could spend 64.3% more on health. For example, the USA and the United Arab Emirates, for instance, which are expected to have similar GDP per capita in 2040, spend very different amounts on health. The USA is expected to spend 18.5% of GDP on health by 2040, whereas the United Arab Emirates is estimated to spend just 4.6% by that time. "Overall, in low-income and middle-income countries, more government health expenditure per capita is increased by reprioritisation of health in the government budget, rather than the raising of more government resources." (3)

However, "Contextual features such as national debt, corruption, or a substantive portion of the economy being informal (meaning it is not taxed or monitored by the government) might be distinct challenges for some countries, and might make reaching the expenditure frontier difficult… In some cases, in fact, we expect that without proactive policy changes, these differences will widen over time." Additionally, the Addis Ababa Action Agenda of 2015 recommends increasing domestic funding for health.

This approach to the future was performed excluding many factors affecting the result, as tax policy, issues related with national debts, government capacity, structure of the economy, demand, health system efficiency, disease burden, and population age structure.

Gomez-Gonzalez and Reyes state that: "The forecasts show that the group of high-income countries currently expends on health an average of $5,221 per capita, and this expenditure will increase by more than $3,994 between 2014 and 2040. Meanwhile, low-income countries will increase their current per capita health expenditure ($120) by only $75 over the same period of time. The expansion of the health expenditure gap between developed and developing countries will clearly continue to impact on life expectancy and the life-quality gap, calling for the need to increase government expenditure in low-income and lower-middle-income countries, and maintain the promotion of development assistance for health policies." (4)

DOES THE POLITICAL AGENDA OF GOVERNING PARTIES HAVE ANY INFLUENCE ON THE HEALTH OF THE POPULATION?

Navarro et al. group developed countries into four major political traditions that governed in those countries from 1950 (immediately after World War II) to 2000, according to the number of days they governed.

Table 4. Future changes in health expenditure per capita 2014-2040

Countries	Health expenditure per capita		Absolute changes	Annualized changes
	2014	2040		
High-income	$5,221	$9,215	$3,994	2.1%
Middle-high-income	$914	$3,903	$2,989	5.3%
Middle-low-income	$267	$844	$577	4.2%
Low-income	$120	$195	$75	1.8%
Total	$1,279	$2,872	$1,593	3.0%
Argentina	$1,322	$3,012	$1,690	3.0%

Table 5. Health expenditure by source (2014-2040).

Countries	% of 2014 total health expenditure				% of 2040 total health expenditure			
	Government expenditure	Prepaid expenditure	Out-of-pocket expenditure	Development assistance for health expenditure	Government expenditure	Prepaid expenditure	Out-of-pocket expenditure	Development assistance for health expenditure
Low-income	18.0	17.2	29.1	35.7	29.4	14.4	29.9	26.3
Middle-low-income	35.9	3.1	58.0	3.0	45.6	2.7	50.5	1.2
Middle-high-income	57.2	8.7	33.8	0.3	71.2	6.4	22.3	0.0
High-income	63.4	22.7	13.9	0.0	65.5	22.0	12.5	0.0
Total	59.2	17.4	22.8	0.6	65.3	12.9	21.4	0.4
Argentina	55.8	13.2	30.9	0.0	65.0	11.3	23.7	0.0

The four groups were delineated as follows: a) social democratic (Sweden, Norway, Denmark, Finland and Austria), b) Christian democratic, conservative, in the Judeo-Christian tradition (Italy, Netherlands, Western Germany, Belgium and France), c) liberal (United Kingdom, Ireland, Canada and USA), and authoritarian conservative or dictatorships (Spain, Portugal and Greece). The four political traditions range from the most pro-redistributive (social democratic parties) to the least pro-redistributive (authoritarian or totalitarian conservative governments). The level of income distribution in each country is represented by the Gini coefficient and the Theil index. (5)

Over a 50-year period (1950-2000), in countries with "social democratic parties" the average Gini coefficient was 0.225 (countries committed to redistributive policies) They also provided universal healthcare coverage and social benefits to all citizens; the average public social expenditure in this group was 30% of the GDP, and the average public healthcare expenditure was 7.2% of GDP; they generated social services (including child care and home care). On average, in this group, 82% of women were in the labor force (excluding Austria with 48%), and these societies had a low crime rate.

Countries with "christian democratic governing parties" have been less committed to redistributive policies than the social democrats, and the average Gini coefficient within this group was 0.306. The average public social expenditure was 28% of the GDP, and the average public healthcare expenditure was 6.4%; they provided universal healthcare services but only 62% of women in these countries were in the labor force.

Countries with "liberal parties" do not have a strong commitment to redistributive policies and they do not offer universal social services, except universal healthcare, which is provided in all but the USA. Here, the group average Gini coefficient was 0.320, (USA 0.372). Public social expenditure was 24% of the GDP, with an average public healthcare expenditure of 5.8%.

Countries governed by "conservative dictatorships" have very low public transfers and poor public services, and the most unequal income distribution. The average Gini coefficient for the group was 0.423, the average social expenditure at the end of each dictatorship was very low, only 14% of GDP in 1970, and the average public healthcare expenditure was only 4.8% of the GDP. Since the establishment of democracy, however, these countries have developed (due to the programs of the social democratic parties) and the average public social expenditure is 20% of GDP, with a public healthcare expenditure share of 5.8% (Table 6).

Two key health outcomes were used to measure the effects of political traditions: infant mortality and life expectancy at birth.

The authors of the study state that: "The analysis reveals a clear, robust, and significant negative correlation between, on the one hand, the cumulative years of government by pro-redistributive parties and the resulting level of income redistribution (measured by the Theil index) and, on the other, infant mortality...it also shows a positive correlation between redistributive policies for the entire period from 1971 to 1988, the implementation of policies designed to reduce social inequality was associated with low rates of infant mortality...a negative correlation between income inequality and life expectancy, for both women and men. However, this correlation is weaker than that noted for infant mortality, and the results are not always statistically significant."

Do politics matter in health policy?

"Our analysis makes an empirical link between politics and policy, by showing that political parties with egalitarian ideologies tend to implement redistributive policies. But the connection between ideology, social class constituency, and implementation of particular policies is complex, as can be seen from the fact that, during the past 30 years, many countries governed by social democratic parties have implemented neoliberal policies...

An important finding of our research is that policies aimed at reducing social inequalities seem to have a salutary effect on population health, which would explain why health indicators such as infant mortality are better in countries that have been governed by pro-redistributive political parties." (5)

Table 6. Characteristics of the governing parties (between brackets years in the government, maximum 50 years)

	Social democratic parties	Christian democartic parties	Liberal parties	Authoritarian conservative parties Dictatorships
Countries (time in years)	Sweden (45) Norway (39) Denmark (35) Finland (32) Austria (31)	Italy (41) Netherlands (41) Western Germany (37) Belgium (35) France (29)	United Kingdom (36) Ireland (35) Canada (35) United States (28)	Spain (25) Portugal (24) Greece (8)
GINI coefficient	0.225	0.306	0.320	0.423
Social public expenditure	30% GDP	28% GDP	24% GDP	20% GDP
Public health expenditure	7.2% GDP	6.4% GDP	5.8% GDP	5.8% GDP

THE RELATIONSHIP BETWEEN POLITICAL ECONOMY OF AUSTERITY AND HEALTHCARE

Against the usual belief that the magnitude of recession is related with reductions in government health expenditure, Reeves et al. in a cross-national data analysis of 27 European countries from 1995 to 2011 evaluated changes in healthcare expenditure and did not find a significant association with annual change in GDP (p=0.31), or cumulative decline (p=0.40) or debt crises measured by public debt as a percentage of GDP (p=0.38). Nor did the ideology of governing parties have an effect. In contrast, each $100 reduction in tax revenue was associated with a $2.72 drop in health expenditure (95% CI: $1.03–4.41). (6)

International Monetary Fund (IMF) borrowers were almost 4 times more likely to reduce healthcare budgets than non-IMF borrowers (OR 3.88, 95% CI: 1.95–7.74), even after correcting for potential confounders.

"With exposure to loan from international financial institutions, tax revenue falls, and decisions to implement cuts correlate more closely with healthcare expenditure change than underlying economic conditions or orientation of political parties in the European Union (EU) member states."

During the economic recession that started in 2007, "...politicians used large financial stimulus packages to bail out banks, absorbing their debts into the public sector's balance sheet... In parallel, recessions led to increasing job losses and falling incomes, leading to declining consumer expenditure and associated tax revenues. This resulted in large increases in government deficits (when annual government expenditure exceeds revenues), increasing national public debts. How best to respond to these combined threats of large falls in production, unemployment, and escalating debts and deficit has been a topic of vociferous debate.

The European Commission, the European Central Bank, and the International Monetary Fund (the so-called 'troika'), along with leaders of many European nations, placed an explicit priority on deficit reduction.

To reduce deficits, governments began implementing austerity programs, so called because they typically involve budget cuts... It has been hypothesized that larger economic shocks, such as GDP falls, unemployment, and debt, may rapidly trigger policy makers to make deep healthcare cuts." (6)

However, as we have already seen, there was no correlation between the size of the economic recessions that began in Europe in 2007, defined as the peak-to-trough change in GDP, with the subsequent magnitude of budget and healthcare cuts.

Other possible hypotheses for reductions in healthcare expenditures have been rejected, as visibility, cumulative recession, political parties' agenda and public debt as a percentage of GDP, but reception of IMF loans was significantly associated with the decision to implement large cuts to the health sector (favoring the 'international institutions' intervention hypothesis).

CONCLUSIONS

All of us, or at least most of us, think that access to the best healthcare possible is an inalienable right of man. An editorial of *The Lancet* states that: "Certain concepts resonate so naturally with the innate sense of dignity and justice within the hearts of men and women that they seem an insuppressible right. That healthcare should be accessible to all is surely one such concept. Yet in the past, this notion has struggled against barriers of self-interest and poor understanding.

Healthcare systems with extra fees for consultations, services or medications: "Regardless of the euphemism chosen to describe shared payments, they are in reality a locked gate that prevents access to healthcare for many who need it most. They should be scrapped."

Therefore: "The vision of UHC (universal health coverage) is rapidly becoming a reality, with access to healthcare no longer the privilege of a few, but the birthright of many." (7)

We have observed that the large differences of global health financing in the immediate past will increase in the near future, and that developed countries with higher income per capita also have higher health expenditure per capita, indicating greater possibilities of personal and community healthcare. Countries spending the most on healthcare provide UHC for their citizens mostly through government funds.

Argentina is one of the few countries that reduced the total and government expenditure on health per capita in constant US dollars over the past 20 years (1995-2014); however, health expenditure remains predominantly financed by the state (government and workers' health insurance, 55.8%), followed by out-of-pocket expenditure (30.9%).

The situation of Argentina is very distressing and discouraging, sharing with only 7 out of 184 countries the reality of having reduced not only the total health expenditure per capita (-0.6% per year over 20 years), about one third of the modelled average, but also the modelled share of financing from government by 23%. In projections to 25 years, growth rate in health expenditure in Argentina will be half of the one expected for its group (upper-middle-income) with lower decrease in out-of-pocket expenditure.

The mandatory Universal Health Coverage (UHC) could be funded by the state so that "*all the population*" has adequate personal care by establishing "*a single universal primary health care*" (with primary care physicians, nurses and community social workers), with the possibility that the primary care physician can refer patients to a specialist outpatient clinic. Workers' health insurance would pay to the State the health expenditure of their associates; but they would be part of a unique and universal outpatient healthcare for all the population, adequate to the different needs of the social groups.

The fragmentation of the "*hospitalization and re-*

habilitation" system is significant, even within the State, with different systems of national, provincial and municipal hospitals. The institutions should merge in only one entity, with public financing (government and workers' health insurance), and representation of the State, Workers' Unions and Consumers to manage different levels of care for hospitalized patients, modernizing and building new facilities when necessary. They would thus provide patients with full-time, adequate and well-paid staff, participating in the management of the different levels of care and maintaining a cross-training system between different hospitals, different clinics and also between hospitals, primary care physicians and outpatient specialists.

It is necessary, or rather essential, that those of us who work in health should begin to discuss not only how to stop the decline, but how to promote a healthcare system that responds to the needs of all Argentines.

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REFERENCES

1. Savedoff WD. What should a country spend on healthcare? Health Aff (Millwood). 2007;26:962-70. http://doi.org/d2gnjn
2. Global Burden of Disease Health Financing Collaborator Network. Evolution and patterns of global health financing 1995-2014: development assistance for health, and government, prepaid private, and out-of-pocket health expenditure in 184 countries. Lancet 2017;389:1981-2004. http://doi.org/f94cq9
3. Global Burden of Disease Health Financing Collaborator Network. Future and potential expenditure on health 2015-40: development assistance for health, and government, prepaid private, and out-of-pocket health expenditure in 184 countries. Lancet 2017;389:2005-2030. http://doi.org/f94bmw
4. Gomez-Gonzalez JE, Reyes NR. Patterns of global health financing and potential future expenditure on health. Lancet 2017;389:1955-6. http://doi.org/cchd
5. Navarro V, Muntaner C, Borrell C, Benach J, Quiroga A, Rodríguez-Sanz M, et al. Politics and health outcomes. Lancet 2006;368:1033-7. http://doi.org/cw6q4n
6. Reeves A, McKee M, Basu S, Stuckler D. The political economy of austerity and healthcare: Cross-national analysis of expenditure changes in 27 European nations 1995-2011. Health Policy 2014;115:1-8. http://doi.org/f2xsws
7. The struggle for universal health coverage. Lancet 2012;380:859. http://doi.org/f2ft24