

The Global Economy and Health

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Results for Development Institute

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Organization of the session

- The economic point of view on health
- Some facts about the economy and health
- Some facts specific to low- and middle-income countries
- Global factors and trends influencing the health sector
- Takeaways from the session

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Economics point of view

- Concentration on resources—including, but not limited to, money
- Focus on equity and inequity (who gets what?)
- Interest in efficiency (getting the most for the resources devoted to health)
- Analytic approach:
 - Examination of the way things are and how the way they are deviates from what we might want
 - Determine the factors that influence the situation
 - Propose changes in incentives to shape changeable factors to move closer to what we want

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World Bank Income Groups, 2016

| Group | Income Range | Number of Countries |
|---------------------|----------------|---------------------|
| Low Income | \$0-1,045 | 31 |
| Lower-Middle Income | \$1,046-4,125 | 51 |
| Upper-Middle Income | \$4,126-12,735 | 53 |
| High | \$12,736+ | 80 |

Funding of healthcare

- Always a combination of users and governments—for low- and sometimes lower-middle-income countries donors contribute
 - Users' direct payment a larger share of the total the lower the income of the country overall-but exceptions
 - Donor contributions never the majority—except in emergency situations
- One truth: funding will never be enough—some choices have to be made between:
 - Funding for health and other needs and wants and
 - Within the health sector among competing demands

Organization of healthcare

- Rich countries:
 - Usually privately provided primary care, bigger role for government provision in secondary and tertiary hospitals
 - US an exception with lots of private hospitals alongside government hospitals
- Middle- and lower-income countries:
 - Try to make government the provider of all levels of care—but fail
 - Nearly everywhere a rapidly growing private provider sector, concentrated at the primary level, but also growing in secondary care

Spending on healthcare

- High-income countries spend a lot more than middle-income countries, that spend more than low-income countries and overall health is better in higher-income countries
- But:
 - Costs are much higher in higher-income countries so the money doesn't go as far (HRH paid much more, facilities cost more)
 - Spending more buys more health, but there are *diminishing returns* to spending more on healthcare—many other factors contribute to health besides healthcare
 - Lots of variation in how much is spent and what is achieved—one extra dollar spent doesn't necessarily buy one dollar's worth of extra health

Total Health Expenditure, World Bank Income Groups, 2014

| Income Group | Nominal | |
|--------------|---------|---------|
| | 2005 | 2014 |
| High | \$3,171 | \$4,539 |
| Upper Middle | \$163 | \$487 |
| Lower Middle | \$38 | \$89 |
| Low | \$16 | \$36 |
| Global | \$704 | \$1,058 |

Total Health Expenditure World Bank Income Groups, 2014

Gaps are smaller when in PPP terms

| Income Group | Nominal | | Purchasing Power Parity (PPP) | |
|--------------|---------|---------|-------------------------------|---------|
| | 2005 | 2014 | 2005 | 2014 |
| High | \$3,171 | \$4,539 | \$3,152 | \$4,608 |
| Upper Middle | \$163 | \$487 | \$402 | \$869 |
| Lower Middle | \$38 | \$89 | \$150 | \$268 |
| Low | \$16 | \$36 | \$58 | \$92 |
| Global | \$704 | \$1,058 | \$828 | \$1,273 |

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59% growth in spending by low-income countries 2005-14

53% growth in global spending 2005-14

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Ratio of high-to low-income spending went from 54:1 to 50:1 between 2005 and 2014

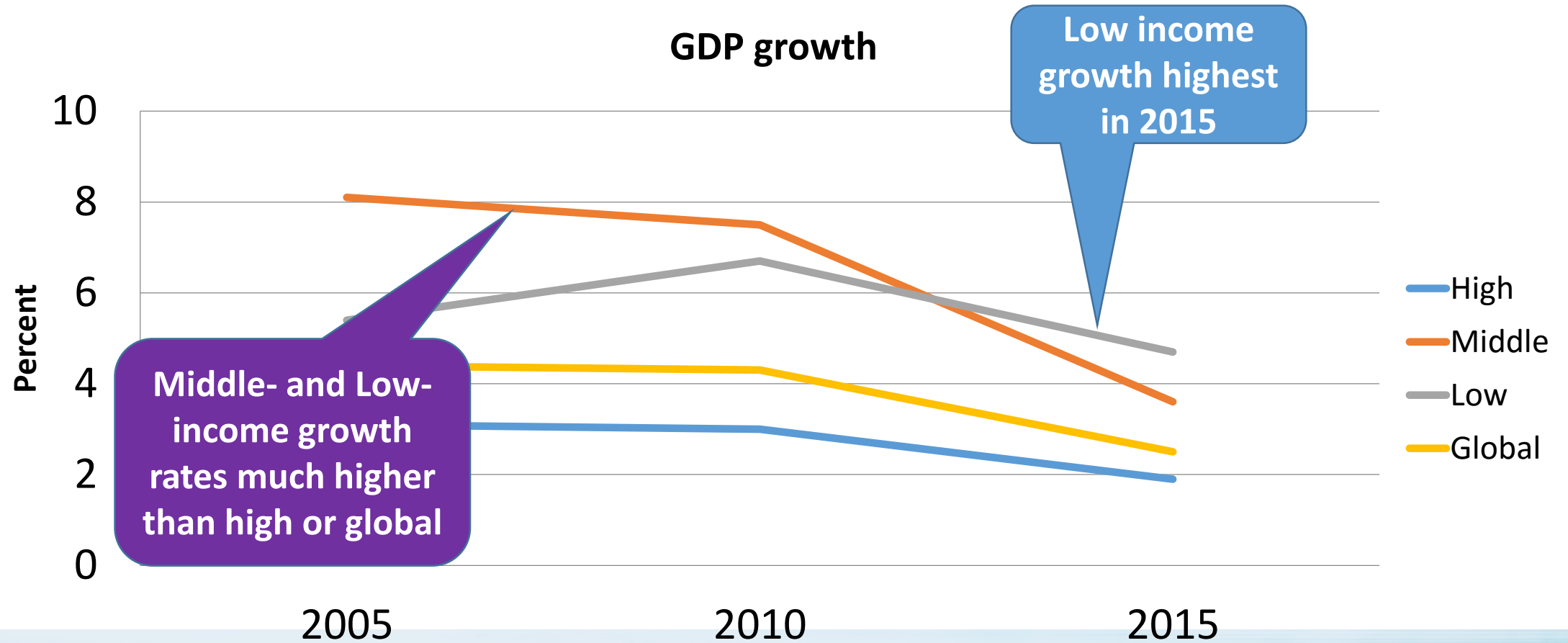
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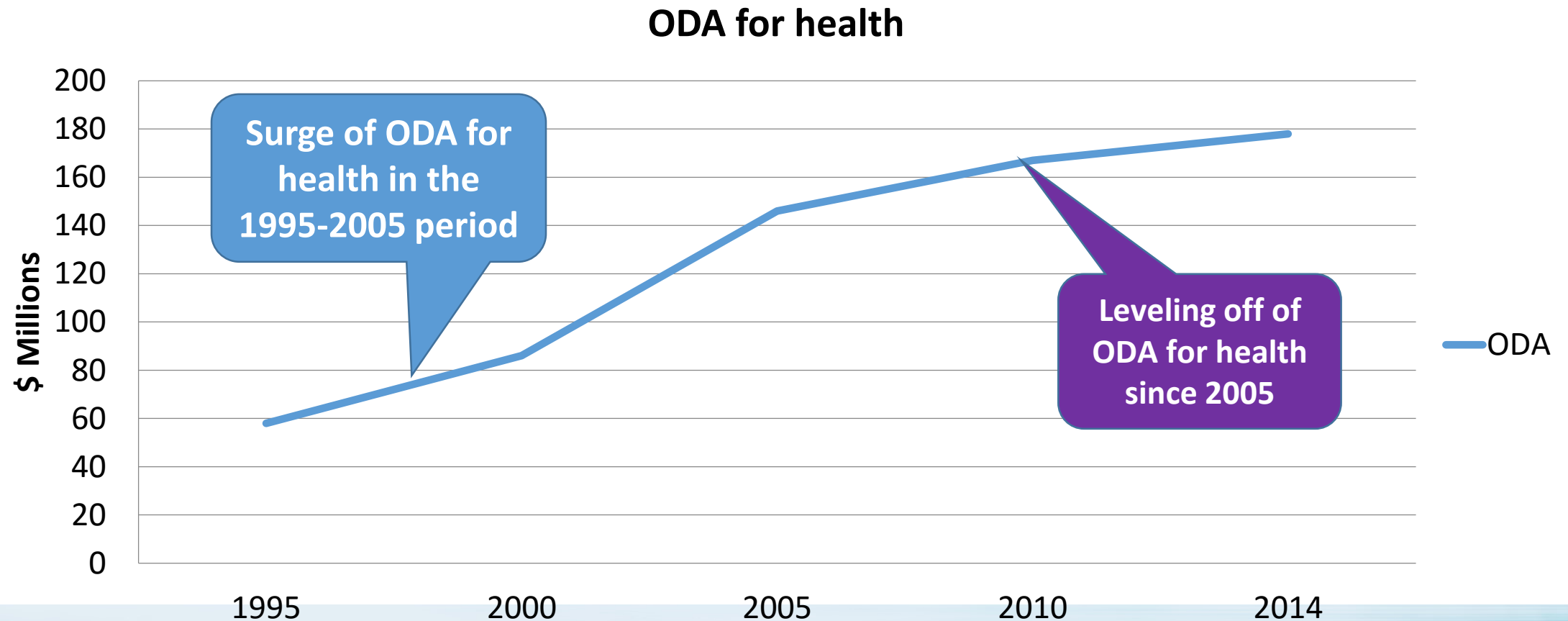
Low- and middle-income countries will fund a bigger share of healthcare

- Their economic growth has been positive and faster than the rich countries in the 2000s
- International assistance has been flat-lining or declining (after a surge in the early 2000s)
- Populations are demanding more as their incomes grow, they become more urban, and their exposure to what others have grows through the internet

Gross Domestic Product (GDP) Growth, World Bank Income Groups, 2005-2015



Official Development Assistance (ODA) for health, OECD, 1995-2014



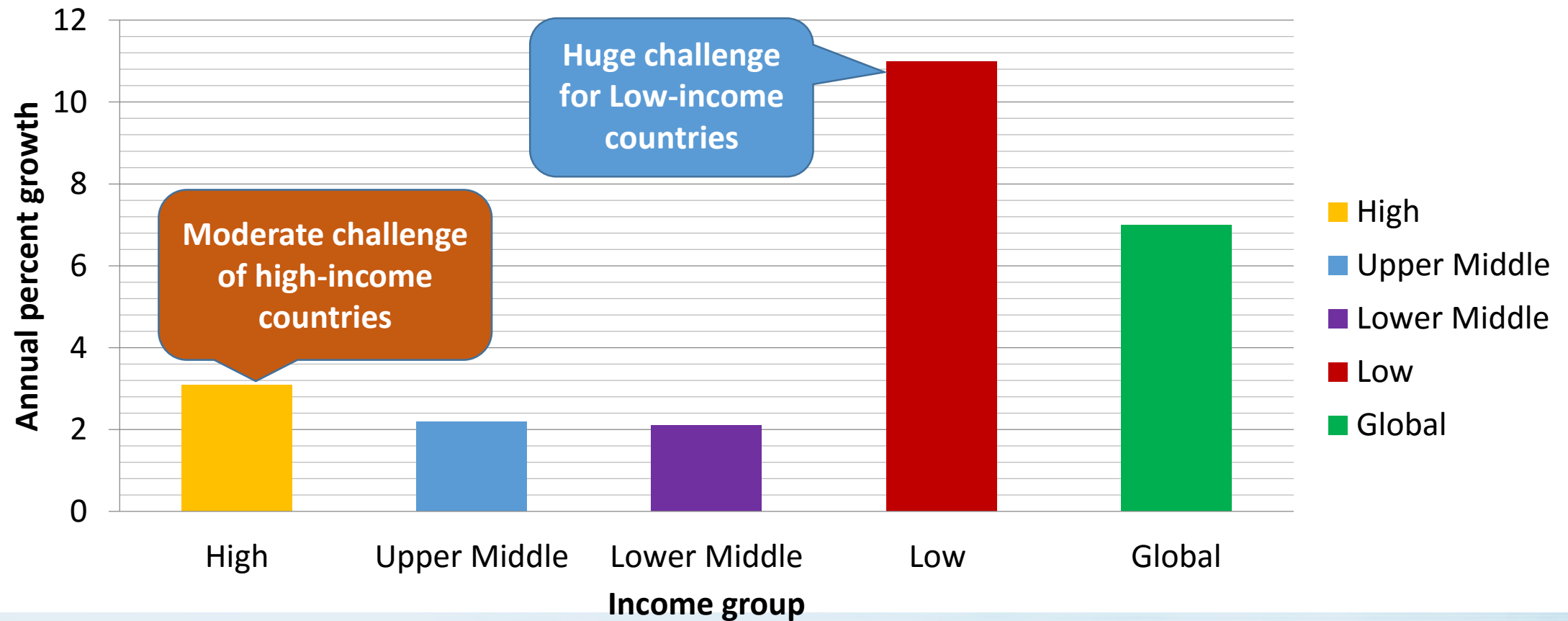
Double-burden of disease

- Low- and some middle-income countries:
 - Have not yet completely resolved the challenges of communicable diseases
 - Have populations that are aging and “benefiting” from higher incomes—that bring with them more non-communicable diseases--NCDs (e.g. hypertension and diabetes)
 - 75% of NCD deaths globally occur in low- and middle-income countries; 82% of premature (before age 70) NCD deaths (WHO)
 - Requires continued efforts (and money) to prevent and treat malaria, diarrhea, respiratory infections
 - While also preventing, identifying early, managing, and treating NCDs (more costs)

Worldwide scarcity of human resources for health (HRH)

- High-income countries:
 - Already aging
 - Need for more HRH—especially nurses
 - Fewer young people, fewer of them pursuing nursing
- Middle-income countries:
 - More demand for healthcare
 - Need for and growing ability to pay for HRH
 - Epidemiology changing rapidly to NCD focus
 - Population aging beginning
- Low-income countries:
 - Already far short of adequate HRH numbers
 - Young populations will allow many new HRH to be trained
 - Pull to emigrate will strengthen

HRH growth need to meet need by 2030 a daunting challenge



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Global trends and factors influencing healthcare

- Sustainable development goals (SDGs)
- Universal health coverage (UHC)
- Growth in private provision of healthcare
- Uneven quality of care
- Interest in more “strategic purchasing” of healthcare

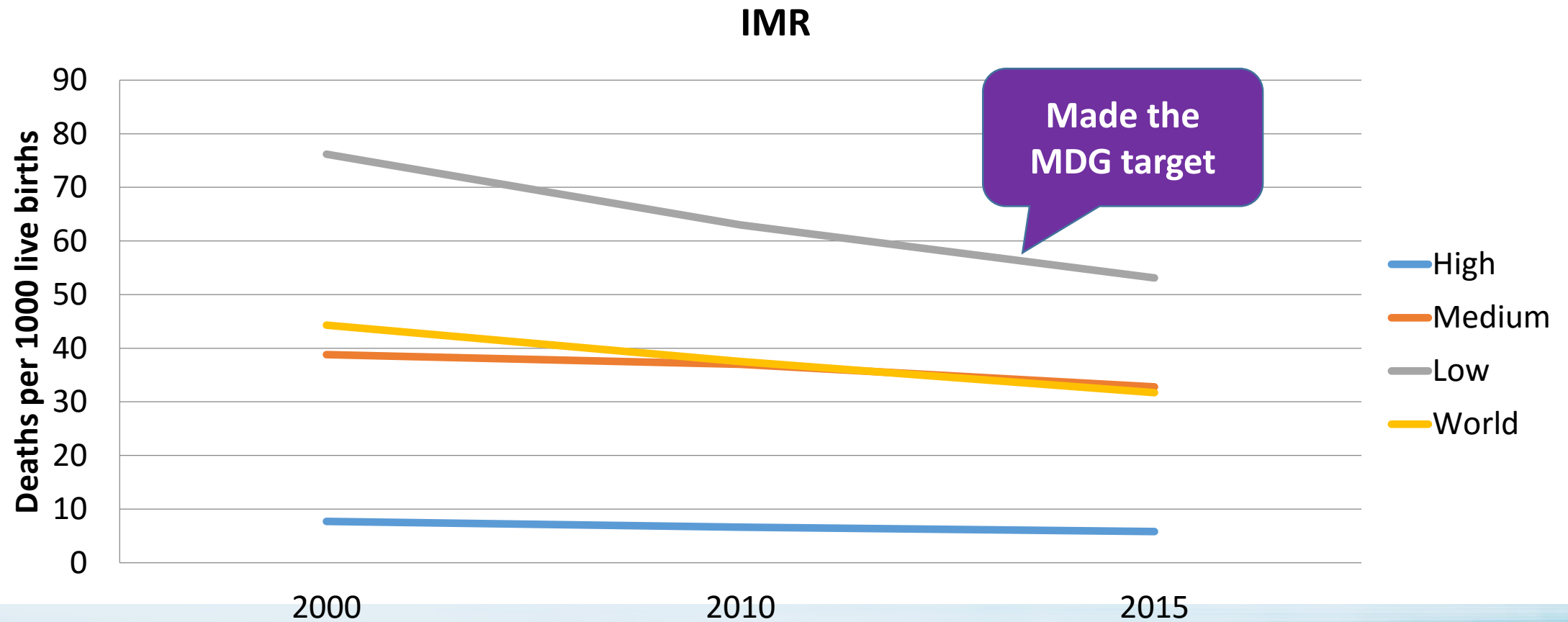
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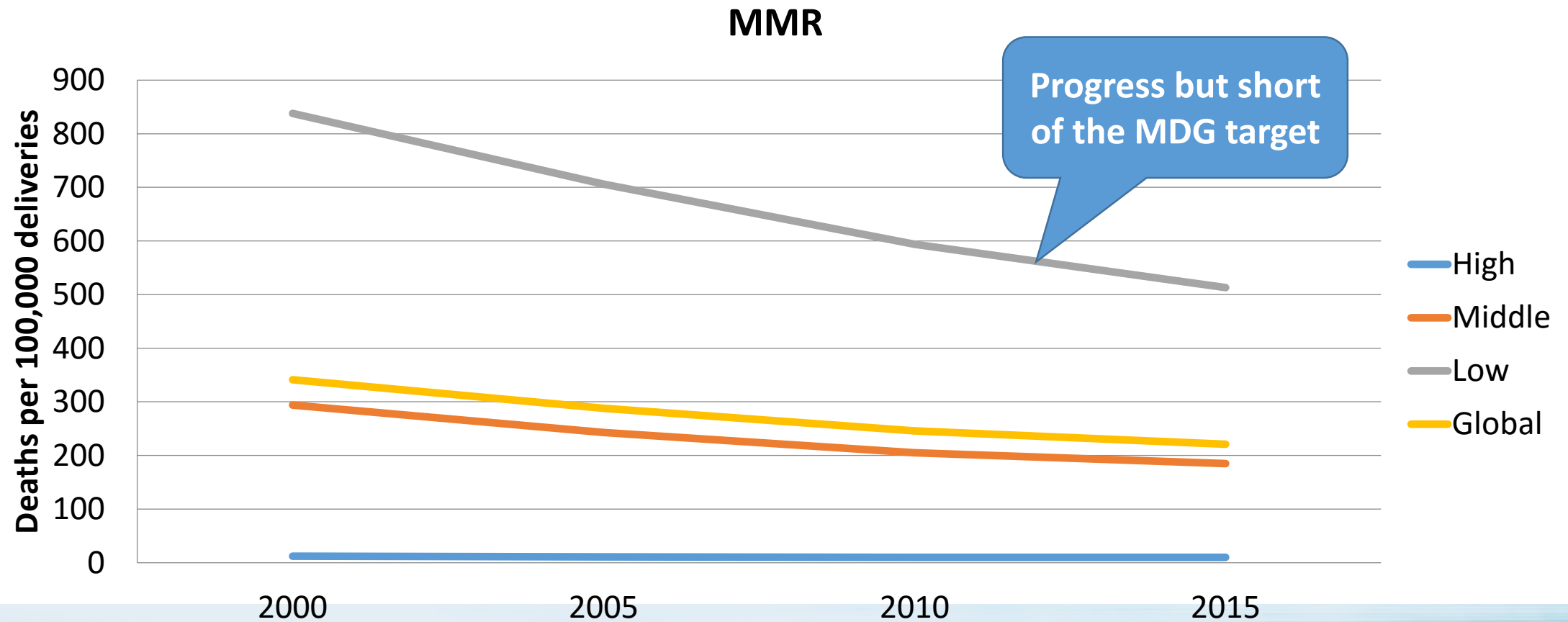
Sustainable development goals (SDGs)

- Preceded by the Millennium Development Goals for 2000-2015 in which three of the eight goals focused on health:
 - MDG 4: Reduce child mortality
 - MDG 5: Improve maternal health
 - MDG 6: Combat HIV/AIDS, malaria, and other diseases
 - Succeeded in focusing attention on maternal and child health, HIV, and malaria—but not all targets achieved everywhere
- SDGs for 2016-2030 have 17 goals with one focused on health
 - SDG 3: Ensure healthy lives for all and promote well-being for all at all ages

Infant mortality rate (IMR)



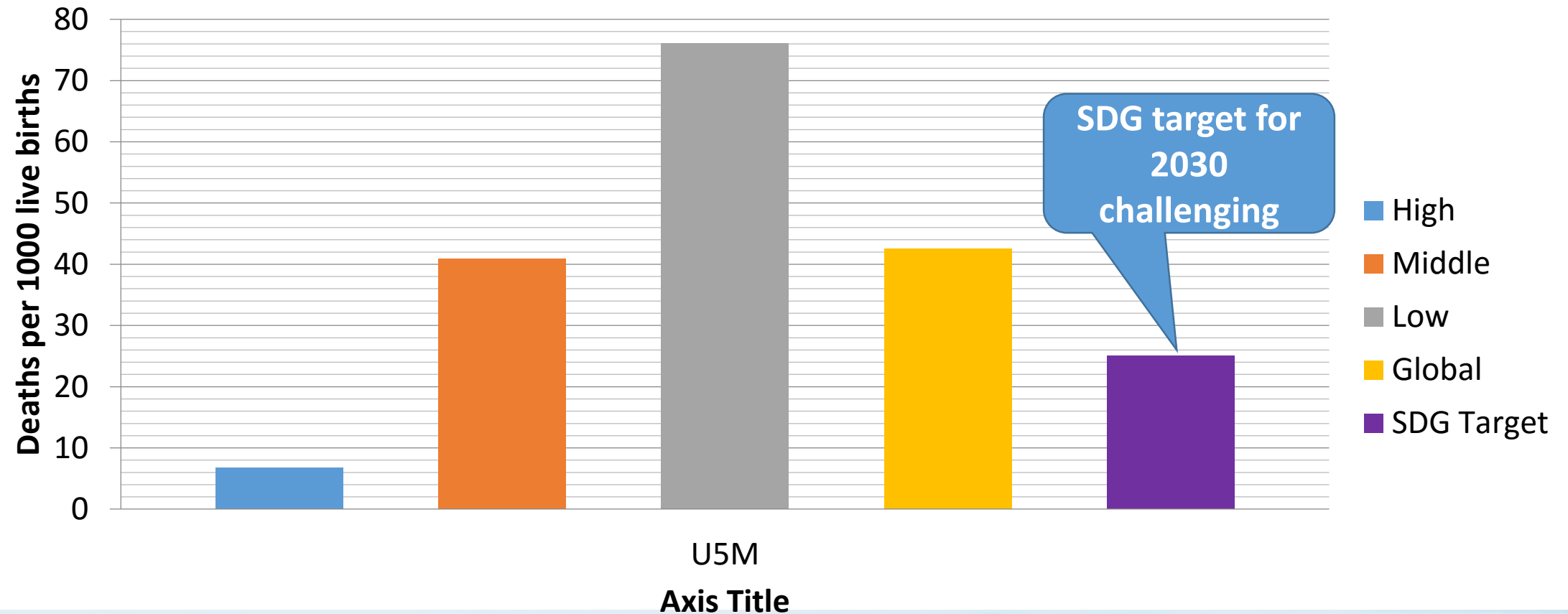
Maternal mortality ratio (MMR), WHO



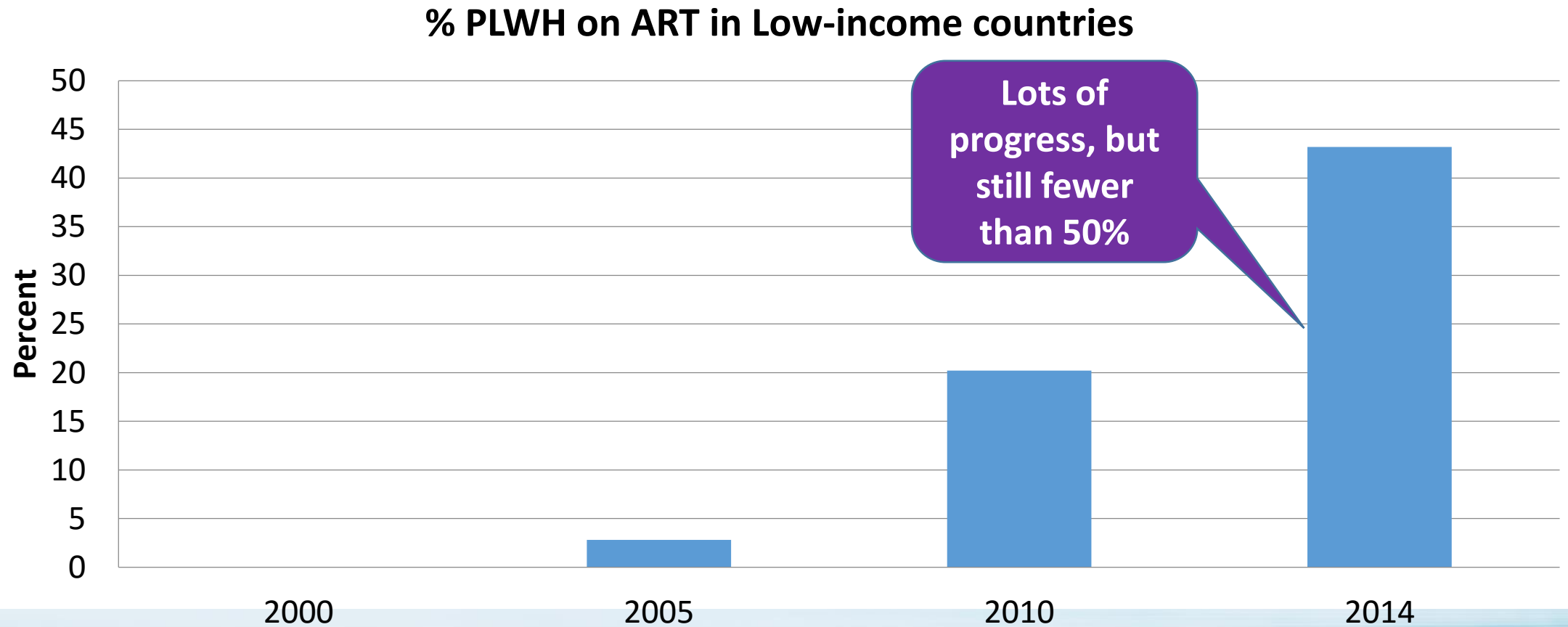
SDG 3 has many targets

- **3.1** By 2030, reduce the global **maternal mortality** ratio to less than 70 per 100,000 live births
- **3.2** By 2030, end preventable deaths of **newborns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- **3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other **communicable diseases**

Under 5 mortality, 2014 and SDG target, World Bank



Progress on HIV 2000-2014, WHO



SDG 3 has many targets

- **3.4** By 2030, reduce by one third premature mortality from **non-communicable diseases** through prevention and treatment and promote mental health and well-being
- **3.5** Strengthen the prevention and treatment of **substance abuse**, including narcotic drug abuse and harmful use of alcohol
- **3.6** By 2020, halve the number of global deaths and injuries from **road traffic accidents**

SDG 3 has many targets

- **3.7** By 2030, ensure universal access to **sexual and reproductive health-care** services
- **3.8** Achieve **universal health coverage**, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- **3.9** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and **air, water and soil pollution** and contamination

SDG 3 has many targets

- **3.a** Strengthen the implementation of the World Health Organization Framework Convention on **Tobacco Control** in all countries, as appropriate
- **3.b** Support the research and development of **vaccines and medicines** for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health

SDG 3 has many targets

- **3.c** Substantially increase health financing and the recruitment, development, training and retention of the **health workforce** in developing countries, especially in least developed countries and small island developing States
- **3.d** Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**

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Universal health coverage (UHC)

- **UHC** is SDG 3's target 3.8
- It usually is taken to mean arranging for **financial protection** for health for all—often through the development of some form of **national health insurance** scheme
- Ghana and Rwanda in sub-Saharan Africa and Thailand in Southeast Asia are considered UHC pioneers among low- and lower-middle income countries
- Turkey and Mexico also are models of middle-income countries that attained something approaching UHC rapidly in recent years
- 27 countries in all regions have joined the Joint Learning Network for UHC

Universal health coverage (UHC) challenges

- **Mobilizing sufficient resources** (usually from mandatory contributions from the formally employed, government revenues, and earmarked taxes—examples VAT in Ghana and sin tax in the Philippines--, voluntary contributions)
- Having the **administrative apparatus** to pay insurance claims
- Assuring **quality** of care
- Including **prevention and promotion** in addition to cure
- **Controlling costs**, especially for drugs (Ghana's big problem), when less-than-strategic purchasing is used
- Counting on the **informally employed** to join and pay voluntarily
- Integrating both government and **private providers** into UHC programs
- Defining an insured **package of benefits**

Universal health coverage (UHC)

- Advantages:
 - Facilitates **strategic purchasing** to improve quality and efficiency
 - Puts **purchasing power** behind all of those covered (especially important for the poor and rural)
 - Offers **financial protection** from either foregoing care or paying so much for it that it is impoverishing
 - Meets the political and, sometimes, constitutional pledge of providing **healthcare for all**

Global trends and factors influencing healthcare

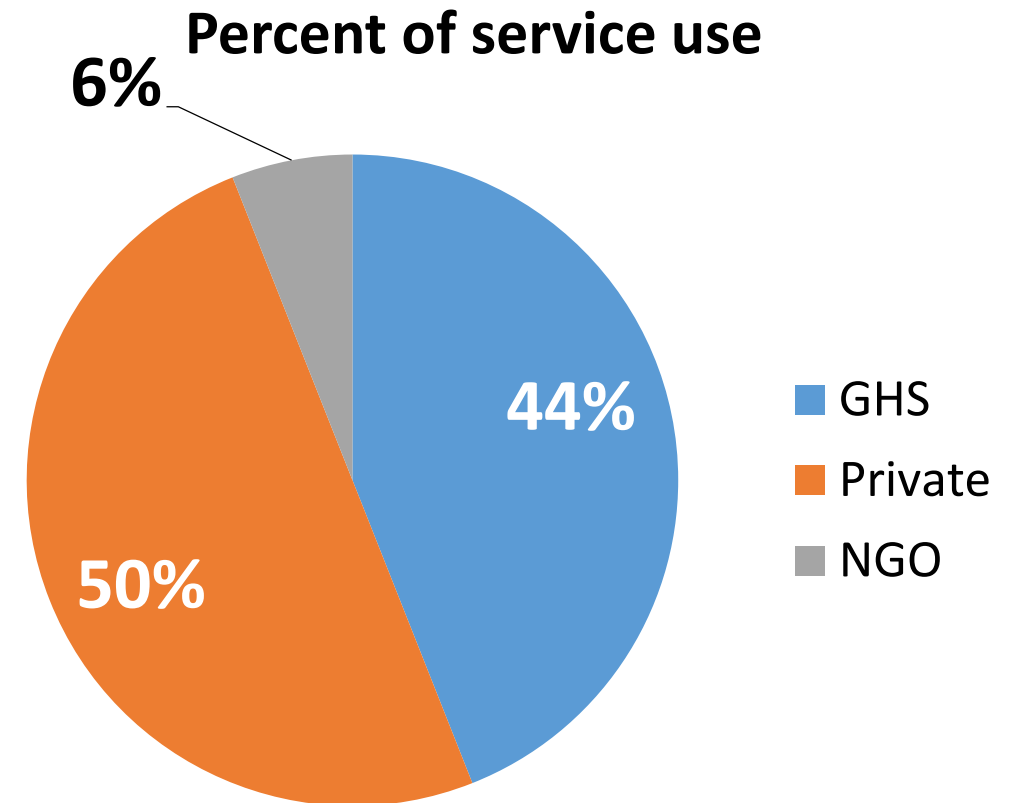
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Growth in private provision of healthcare

- Private provision has grown rapidly in low- and middle-income countries
 - Government provision has not kept up with demand
 - **Quality** of care is **uneven** and only **weakly regulated** in both government and private sector
 - Both an opportunity and a challenge

Example: Use of private services the majority in Ghana

- In 2008: 50% of use of health services in commercial private facilities, but MOH had only a 4-person unit for oversight
- Consumers found all short of optimal quality
 - On government side: long wait times, stock outs of drugs, poor “customer service”
 - On private side: uncertain qualifications of personnel—about half of the for-profits not officially registered



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Uneven quality of care

- As in the Ghana example, quality of care a major concern of both consumers and policymakers
- Regulation of quality weak and uneven—lack affordable, feasible models
 - Many countries have regulations “on the books” that emulate those in rich countries, but are too complex and costly to implement
 - Need for simpler, but focused approaches, likely with government and private collaboration, using health financing tools (more on this later)

Uneven quality of care

- Private providers want effective, but low burden regulation
- Example from private providers in Benin:
 - They want to protect their reputations to ensure that they don't lose their markets
 - They also have professional pride
 - They seek means to upgrade skills and keep up with the latest developments in medicine and technology
 - They would consider collaboration with government on “peer” regulatory efforts and in providing data, if they can get something back and the regulation is fair and doesn't require huge time and effort

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Interest in more “strategic purchasing” of healthcare

- Strategic purchasing means using the way providers are paid to influence their behavior
- Behaviors of providers include:
 - Who they serve
 - How efficiently they use resources
 - Concern for quality
 - Customer service
 - Balance between curative and preventive care

Interest in more “strategic purchasing” of healthcare

- Now providers are paid mainly as follows:
 - Government providers: line-item budgets and inputs (drugs, reagents, supplies, HRH, equipment, facilities) provided in kind
 - Private providers: fee-for-service payment from the pockets of users
- These payment methods **fail to signal desired behaviors**:
 - Government providers tend to be **inefficient in use of resources, neglect quality** and customer service, subject to **corruption** in use of resources
 - Private providers tend to **over-prescribe** care, **neglect prevention** relative to curative services

Interest in more “strategic purchasing” of healthcare

- Taking a more strategic approach to payment is drawing the attention of countries such as Cambodia, Ghana, Kenya, Malaysia, the Philippines, and Vietnam
- They are considering (and piloting): capitation, case-based payment (e.g., DRGs), and strategic use of fee-for-service to direct incentives for quality, customer service, the right balance of prevention and cure, and efficient use of inputs

Interest in more “strategic purchasing” of healthcare

- Purchasing of drugs also is getting “strategic attention” in the form of **separating prescribing from dispensing, essential drugs lists, formularies, consumer and provider information** (e.g. concerning generics’ efficacy), managing **drug wholesale markets**
- A frequent complement to strategic purchasing is developing and linking to payment systems **treatment guidelines or protocols** to improve quality and increase efficiency

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Takeaways

- **Economic factors are important** to shaping healthcare systems
- The movement toward **UHC** will be a prominent feature of health systems to 2030
- Increased use of ***strategic purchasing*** in provider payment should help attain greater efficiency, equity, and quality