What Emerging Economies Can Learn From High Income Countries in Health

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Obvious Lessons

- Health spending will grow, including public
- Lack of an agreed global best practice model
- Historic accidents and social compact matter more than science
- Macro links between spending and results are tenuous

➢ Reforming health is a huge political challenge, and will get harder over time

- ✓ Vested interest will only grow with time and with increased spending
- ✓ It becomes easier to demagogue through political system

Less Obvious Lessons

- Exploit the huge literature on HICs Health Sector and the heterogeneity of experience (but be careful & good luck)
  - Cost Drivers
  - (lack of) Value for Money
  - Growing links between health sector and country competitiveness
- Use the main health sector reform levers
  - Sources of funding & pooling mechanisms and competitiveness
  - Purchasing function
  - Organization (mainly public/private issues)
  - Capacity gaps (Management, Data, and Regulation)

Cost Drivers in High Income Countries

- High income elasticity at the National Level, less so for individuals (due to insurance)
- “Cost disease” theory for non-progressive sectors
- Aging less of a factor than proximity to death
- Technological progress
- Insurance coverage

Source of Funding

- "Between 1967 and 1986, no fewer than 10 OECD countries abandoned SHI in favor of the tax financed"

- "By contrast, in the 1990s, all four of the OECD's new central European countries abandoned the tax-financed Semashko model in favor of SHI"

➢ "finds that adopting social health insurance in preference to tax financing increases per capita health spending by 3–4 percent, reduces the formal sector share of employment by 8–10 percent, and reduces total employment by as much as 6 percent."

A. Wagstaff, "Social Health Insurance versus Tax-Financed Health Systems"

Purchasing

- US Medicare spends a fortune every year on procedures with little proven benefit:
  - In 2009, > $100 million on colonoscopies, 40% for men over age 75
  - Around $ 1 billion a year on kyphoplasty and vertebroplasty, for vertibral fractures (no proven pain relief evidence)
  - $1.6 billion a year on drug-coated cardiac stents (no more effective than drugs of life-style changes, plus risks due to complications)
- Medicare estimates that between 15 and 30 percent of expenditures in wasteful
- Reimbursement procedures are not sophisticated and incentives are misaligned.

NYTimes.com, “Squandering Medicare’s Money” May 26, 2011

Mixed Ownership of Delivery in Europe Works Well

		France	Germany	Netherlands	UK
Hospitals	Ownership Financing	Pub. & Priv. Public	Pub. & Priv. Public	Private (*non-profit*) Public	Public Public
PHC	Ownership Financing	Private Public	Private Public	Private Public	Private Public
Specialists	Ownership Financing	Private Public	Private Public	Private Public	Pub. & Priv. Public
Dental	Ownership Financing	Adult: Child: Public Adult: Pub&Prv Child: Public	Adult: Child: Public Adult: Private Child: Public	Adult: Child: Public Adult: Private Child: Public	Adult: Child: Public Adult:Pub. & Priv Child: Public
Drug access	Ownership Financing	Private Pub. & Priv.	Private Pub. & Priv.	Private Pub. & Priv.	Private Pub. & Priv.
Ambulance	Ownership Financing	Private Public	Private (& P) Public	Private (& P) Public	Public Public

Source: Maynard 2005; European Observatory HiT reports (various)

Some Closing Thoughts

- Cost considerations are important, but so are:
  - value for money,
  - tacking inequality, and
  - safeguarding competitiveness
- Ideology tends to fail the health sector (e.g. competition in insurance), but intelligent use of reform levers can be very helpful:
  - Focus on effectiveness with the sector but also on the larger economy
  - Purchasing reforms is key for aligning incentives
  - Information systems are not sexy, but critical for decision making
  - Capacity of the MOH as regulator/steward