World Health Forum

HEALTH CARE — WHO PAYS?

Selected articles from World Health Forum

World Health Organization
Geneva

Health care — who pays?

Reprinted from ***World Health Forum***

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This collection of reprints from ***World Health Forum*** is reproduced in support of the Technical Discussions, Fortieth World Health Assembly, May 1987, at the request of the office for Health-for-All Strategy Coordination. The contribution of Mr Andrew Creese, Division of Strengthening of Health Services, is gratefully acknowledged.

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Introduction

This collection of articles from *World Health Forum,* 1980–86, reflects the growing concern with economic and financial aspects of health care. Rising costs, combined with limited government budgets for health, have compelled policy-makers to focus on resource issues. Progress towards health for all will depend, in most countries, on the generation of new sources of financing, on some reallocation of existing resources, and on an increase in cost-consciousness at all levels.

The perspective common to all these articles is the recognition of scarcity of funds and resources, and the consequent need to make careful choices in order to avoid waste. A number of analytical tools, of which cost-benefit analysis and cost-effectiveness analysis are perhaps the best known in the health field, have been developed so that choices can be made in a consistent and explicit fashion. These methods do not make the choices. Policy-makers, managers, providers and users of health care must make the choices on the basis of several factors including economic considerations. This approach to decision-making promotes realistic housekeeping since health economics is not simply a set of tools, or a collection of jargon, or even a language: it is a way of coping rationally with scarcity—of making the best use of scarce resources.

The articles are grouped into three broad themes. First, articles dealing with the *perspective and principles* of economics as applied to health and health care; second, those concerned with *financing* and *cost control* issues; and last, those presenting *empirical analysis* based on a variety of country experiences. A brief introductory comment precedes each section. The articles are diverse in subject matter, country focus, and in length, and should not be taken as representative of the balance of concerns in health economics more generally. Health economics is predominantly an empirical activity. There is little treatment in these contributions of budget management, the determinants of demand for health care, resource allocation mechanisms, manpower mix, and health status measurement in relation to economics.

Nevertheless, this selection of articles illustrates that many alternative ways of achieving health for all exist; although documentation and analysis of the economics of health for all are still in infancy, well-conceived primary health care strategies can satisfy *both* the requirements of economic efficiency *and* the needs for greater social equity.

Foreword

Ten years ago the World Health Assembly launched a new initiative for worldwide health development, popularly known as Health for All by the Year 2000. To reach that target a new approach to health and health care is required, in order to ensure a more equitable distribution of health resources and to lessen the gap between the health "haves" and "have-nots". At the outset, the need was recognized to rationalize the use of existing resources and to generate and mobilize additional ones.

Improving people's health is both a sound economic investment and a highly justified ethical goal. It can be achieved even with financial limitations, provided that clearly defined lines of action are pursued with determination by communities and all levels of government. To make progress towards the attainment of health for all, certain critical issues regarding the financing of health plans and the best deployment of resources have to be clarified.

This selection of articles from *World Health Forum* presents a number of views and experiences concerned with financial support to national health-for-all strategies. The articles illustrate the points to be considered as well as the difficulties in finding solutions and making appropriate decisions. They indicate that the collective commitment of all concerned is required in order to expand economic support for achieving greater equity in health. Individuals, families, communities, the private sector, and nongovernmental organizations in addition to governments must all be fully involved. Economic partnership in health has to be reinforced and applied to meet the challenge of health for all. The task is huge, but the potential rewards for humanity are even greater.

H. Mahler, M.D.
Director-General

Part 1: Economic perspectives and principles

The impact of medical decision-making on health sector costs is a theme common to each of the four articles in this section. Abel-Smith's article on cost-effectiveness offers several examples of cost pressures resulting from health care providers' control over resources, and the author makes a strong argument for greater cost awareness by both consumers and providers. Beeson's "Point of View" is essentially similar, making the argument that economic principles have a place in the medical curriculum.

Brunet-Jailly challenges complacency about the linkages between health spending and health status, arguing that expansion of medical services will, on existing evidence, only benefit physicians and the medical industry—a point echoed in Beeson's note. The importance to economists, as well as to epidemiologists, of establishing firmer measures of the effects of health care on health status is made clear.

The condensed book by Abel-Smith & Leiserson offers a synoptic account of the role of health in the process of economic development and provides an illustrative example of health sector expenditure analysis and its role in planning. It also identifies the major alternative mechanisms for financing health services and introduces cost-benefit and cost-effectiveness analysis as means of identifying economically rational policies.

Perhaps the message that is most apparent from these readings is that economic decisions are most commonly made in the health sector by clinicians, who frequently have little knowledge of their cost consequences and little incentive to avoid expensive diagnostic and therapeutic options. In such circumstances, and with health service users in a weak position to assess their needs for care, waste is inevitable.

Articles in Parts 2 and 3 outline strategies to control and improve the situation.

World Health Forum, 5: 88–90 (1984)

Health Economics

Brian Abel-Smith

Improving cost-effectiveness in health care

The rising cost of health care, without commensurate improvement in the health of those served, is a major concern in many countries. A report from a meeting held in Finland suggests some practical ways of obtaining more effective care at a more reasonable cost.

Social security institutions, faced with rising costs, an erosion of their financial bases because of unemployment, and an apparent lack of improvement in the health status of populations commensurate with the increased expenditures, are attempting to find practical solutions to their fiscal crises. In September 1982, the International Social Security Association organized a meeting of experts in Turku, Finland, at the invitation of the Social Insurance Institution of Finland, to consider these problems. Present were researchers and social security administrators from 17 countries, together with representatives of WHO, OECD, and the European Centre for Social Welfare Training and Research. What emerged from the meeting was an analysis of the sources of economic inefficiency in health care and some pragmatic suggestions for change.

Sources of Inefficiency

Economic efficiency in health care can be defined as the provision of necessary care of good quality at minimum cost. Thus, the immediate aim is to move towards a more economical balance of services and to eliminate ineffective, excessive, and unnecessary medical procedures.

Both demand and supply play a part in generating extra costs in health care.

Consumer demands that generate fees are not likely to be resisted. But patients themselves are not always sensitive to the cost of their treatment, particularly if they are not paying at the time of care or if the cost of their medical insurance can be set against taxes. These factors contribute to the excessive and unbalanced supply of services that is a major cause of increased costs and inefficiency.

Economic inefficiency in the supply of health care can take several forms. One is the excessive use of hospital beds intended for the care of acute illness when quality care could be provided elsewhere at a lower cost. Because patients are needed to justify jobs and budgets, hospitals tend to try to keep their beds filled. Payment per day of care adds to pressure to admit patients unnecessarily and to extend length of stay, the latter partly because the cost of providing care normally decreases during the latter part of a hospital stay. Moreover, the higher the occupancy rate, the greater is the funding for new medical equipment, which

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enhances the hospital's prestige. Nursing homes, lower-cost hospital units under the control of general practitioners, hostels and other residences, and day hospitals and day nurseries may prove to be cheaper alternatives to hospitalization—though not, of course, for every type of patient.

Excessive and unnecessary medical procedures also constitute a form of economic inefficiency: doctor-initiated repeated visits, the excessive prescribing of drugs, the prescribing of costly drugs when less expensive equivalents are available, the excessive use of laboratory and X-ray services, and unnecessary surgery. Here, the incentives and pressures operating on care-providers are important considerations. Doctors are more likely to provide excessive services when they are paid according to the procedures they carry out than when they are on a salary or paid on a capitation basis. Also, when they have purchased equipment they have a clear financial interest in seeing that it is used, as the capital cost of such equipment has to be repaid out of fees for services. In authorizing expenditure on health care—often under the sales pressure of manufacturers—doctors do not always act simply as prudent purchasers on their patient's behalf. By putting their own interests first, they can cause distortion of demand.

When local health facilities are provided with more equipment and specialized facilities than are necessary to meet demand, medical equipment can itself be a source of inefficiency. Manpower, too, presents problems—for instance, when highly trained professionals such as doctors and dentists are used for tasks that could be handled by less qualified personnel, such as nurses and dental assistants.

Finally, the provision of curative services when earlier preventive action might have been cheaper is also a form of economic inefficiency.

The Planning of Services

The logical way to increase efficiency is to plan for a correct balance of types of available service and trained manpower necessary to meet medical needs, geographically distributed on a rational and equitable basis. In many countries this could mean a reduction in hospital beds for acute care and limitations on the supply of doctors. What is acceptable in one country, however, may be unthinkable in another. Thus, for many countries the practical problem is not how to produce a blueprint for wholesale reform but how to find politically realistic ways of moving towards greater economic efficiency.

Recent OECD figures (for Belgium, Canada, Finland, France, the Federal Republic of Germany, India, Israel, the United Kingdom, and the USA) show that studied pragmatism has produced a marked deceleration in the growth of health costs in relation to gross national product. Many factors could be involved in this deceleration: a relative decline in the incomes of doctors and health service employees, reforms in fee structures, a decrease in the ratio of hospital beds to population, greater use of day hospitals and community care of the mentally ill and (in some countries) the elderly, greater use of nurses in primary health care, a decrease in capital construction and thus in depreciation costs, restrictions on pharmaceutical prices and sales promotion activities, pharmacist substitution policies, and deliberate planning to promote chosen priorities and greater efficiency.

Restriction of Rights

These factors do not apply to all countries, as situations and obstacles to reform vary. It is possible, however, to generalize about the latter and to consider the ways they have been dealt with in gradual approaches to reform. Broadly speaking, these obstacles consist in the rights traditionally exercised by students, practitioners, and consumers of health care—rights that have come to be modified, qualified, or limited in the face of economic stagnation or decline.

More and more countries have come to appreciate that a growing excess of medical manpower is a critical cause of economic inefficiency, as it limits interest in delegating tasks to less-qualified personnel and leads to an excess of medical procedures. Quotas are being established for medical school places and postgraduate training, and existing quotas are being cut, thus curtailing the range of subjects available for study.

The right of professionals to choose where to practise has led to a surplus of doctors in the most attractive places. Some countries have closed off particular areas to new entrants; others have gone no farther than controlling posts in hospitals.

Some countries have introduced controls on the purchase of heavy equipment, and many have regulations that prevent new hospitals from being built or older ones from being enlarged except in accordance with a central or regional plan.

Professional freedom has been further curtailed by a general trend to hold down medical fees. This, of course, incurs the risk that doctors will start charging patients more than the fees laid down, particularly in systems in which the patient is reimbursed for payments for health care. In Quebec, Canada, "overbilling" by doctors is penalized by excluding those guilty of the practice from participation in health insurance arrangements.

Pricing of Medical Procedures

It is recognized that a scale of payments according to relative values of different medical acts influences the number and type of acts performed. In some countries (e.g., Canada), scales of values have been left for the profession to determine. In others, social security agencies have achieved changes in relative values, paying more, for example, for medical consultations and less for diagnostic tests. In Belgium successive cuts in payments for pathology tests have sharply reduced their rate of increase.

Clinical freedom and medical secrecy are further obstacles to reform: they limit access to information on resources used in treatment and on diagnoses that would enable insurers to evaluate doctors' performance. A number of computerized monitoring systems attempt to judge the provision of care in terms of what was "medically required" or of norms related to diagnosis. Where medical secrecy prevents insurers from knowing the diagnosis, the ratios of different procedures can be examined and major deviations from the average questioned, though it is recognized that judging against the average suffers from the limitation that the average itself may be excessive.

Encouraging Cost Awareness

Some countries are trying to make doctors aware of more economical prescription practices, informing them of the differences in the cost of equivalent or near-equivalent drugs that can be substituted for more expensive ones they may be using. In some provinces of Canada and most states in the USA, pharmacists are empowered to substitute cheaper "equivalents" unless the doctor has specifically forbidden substitution on the prescription.

Consumer rights also play a role in economies in health services. Where patients have freedom of choice with regard to physicians, hospitals, and insurers, rational planning becomes difficult. The common practice of making specialist care accessible only on referral from another doctor has the potential of reducing the costs of health care.

There is widespread interest in the possibility of making consumers more aware of the costs of health care. Cost-sharing can induce the consumer to require the provider to be cost-conscious, but it does not work when patients have private insurance to cover their share of the costs. Moreover, in some circumstances cost-sharing can have perverse effects. For instance, if out-of-hospital services are subject to cost-sharing and inpatient services are not, an incentive is created to use the more expensive hospital services; or if patients are made to pay for taxis to convey them to hospitals for consultations, this may lead to increased use of the much more costly ambulance service, as happened in the Netherlands.

A number of countries are deliberately planning to promote chosen priorities and greater efficiency—Finland, India, Israel, and the United Kingdom among them. Unlike the other countries represented at the meeting in Turku, the USA has had very limited success in containing health care costs and promoting efficiency; its current approach seems to be through market mechanisms as a possible means of achieving what other countries appear to be able to achieve by regulation and negotiation. □

World Health Forum, 5: 65–66 (1984)

J. Brunet-Jailly

An economist looks at health strategy

We can no longer accept that the health system operates efficiently. First, there is nothing to ensure that the available resources are put to the best possible use, and the medical profession ought to be concentrating on defining criteria for the allocation of resources by evaluating the various diagnostic and treatment techniques and the various ways of organizing the health services. Second, the idea has frequently been advanced that an improvement in the health status of the population contributes to economic development by encouraging productive activity, but studies by economists have cast considerable doubt on that notion.

No effective health system can be built on a number of separate and uncoordinated specialist activities that are bound to compete with each other for limited national resources. However well intentioned the people are who want to help solve the health problems in their own field, any system built up from such initiatives can only be a monster unadapted to its environment.

The evidence has to be faced. Maximum expansion of the supply of medical services will largely benefit only the physicians and the medical industry.

So far, the medical profession has been unable to provide any reliable measurement of changes in health status as a result of increased medical activity. Some may claim the disappearance of certain diseases or the increase in life expectancy at birth or the reduction in mortality rates, and certainly they are indicative of a trend. But to link this trend to the increase in medical activity is quite another matter, for there is evidence to show that certain diseases began to decline before medical knowledge was sufficiently advanced to deal with them and that a rise in the standard of living may produce an effect on health status independent of any medical activity. Indeed, recent experience in the developed countries shows that an increase in medical activity produces no corresponding increase in productive activity.

It is not the place of an economist to define a public health strategy. But the picture of society provided by economic analysis suggests that an effective strategy can be defined only if we question the principles on which physicians have tended to base their professional strategy and replace them by something more fundamental. Studies are now being made on the efficacy of different systems of health care (e.g., health centres compared with village health workers) and on the comparison of the results obtained from purely medical activities and those from nutrition and hygiene projects. Such analyses of technical efficacy can then serve as a basis for the analysis of economic efficiency. Because each activity has a cost that can be estimated at any given moment, it is possible to ascertain which of them is the least expensive for achieving a given result, or, alternatively, which activity can produce the best result with the resources available. Analyses of this kind will reveal a soundly based range of choices.

The formulation of indicators of health status, the development of criteria and techniques for evaluating health activities, and the measurement of the relationships between health status and economic activity are all strictly necessary before a real strategy for health care can be planned. Experience shows that such studies are feasible, and the criticism of the basis of medical strategy has proved that they are needed. Nevertheless, such research is very rare. Could this be due, in part at least, to the fact that physicians are so preoccupied with protecting their position that they will not cooperate in collecting information that may call into question the practices and structures of the medical profession? □

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World Health Forum, **4**: 215–216 (1983)

Paul Beeson

Doctors must learn economics

The economic aspects of modern medical service deserve a better-defined place in formal medical education. Our system of providing medical care was designed by doctors and is characterized by customs that suit the interests of doctors. The time to cause young members of the profession to think objectively about that system is before they move into the ranks of high-income earners. Unless we arouse some concern about it during the early phases of medical training, we run the risk of turning out doctors who will conduct themselves like members of a self-serving guild.

Doctors, by their own professional fees and especially by their decisions about hospital admission, diagnosis, and therapy, generate at least three-fourths of the total health bill of the nation. Essentially, then, we have about 400 000 solo operators making the decisions that use up a huge amount of money. For personal convenience and benefit, doctors are prone to lobby for wasteful facilities, requiring extra manpower and equipment — too many hospital beds, too many institutions equipped for open-heart surgery, etc. No one can be precise about it, but we do carry out diagnostic procedures that are not needed, we do make too much use of intensive-care facilities, and we do perform some surgery for less-than-crystal-clear indications. Partly stemming from such practices, health care costs now amount to nearly one-tenth of the gross national product in the USA, exceeding $240 billion at the beginning of this decade (*1*). Thus, the American health care system is, in itself, a factor in the world economy.

In a subtle way our system of third-party reimbursement, in which a patient does not pay directly for the treatment he receives, contributes to extravagance, because there is no insistent reason for doctors or patients to worry about costs. This system of payment pervades all aspects of the national economy; indeed, the "fringe" health insurance benefits in labor contracts add to the cost of most of the things we buy. Thus, the figures given, say, for the health expenditure of an "average family of four" may not really convey the true cost, which is to some extent concealed in such other categories as clothing and transport.

A.S. Relman has directed attention to what he terms "the new medical-industrial complex" (*2*). He refers to the trend whereby many kinds of medical service are beginning to be provided as commercial enterprises on a profit-making basis. This includes such innovations as corporations that operate private hospitals and nursing homes, businesses that contract for chronic dialysis, commercial diagnostic laboratories, and organizations that provide emergency services for hospitals. He emphasizes the responsibility of the physicians who deal with this kind of big business, because physicians act then as advisers and purchasing agents for their patients. Obviously, there are troubling ethical problems here that have been little discussed. While there is nothing basically wrong with the idea that some aspects of health care should be operated on a business-like basis, the medical profession will not merit trust unless it can be seen to avoid conflicts of interest. Relman suggests that doctors should not invest in companies that render medical service and certainly should not operate such companies themselves.

Aside from things that are part of the doctor's daily work, other economic matters could usefully be explored in medical school. I have already mentioned that our third-party reimbursement systems conceal cost outlay, to both doctors and patients. Another undesirable feature is their tendency to reward performance of procedures and admission of patients to hospitals while failing to compensate adequately for medical service given on an ambulatory basis. Politicians and economists are going to insist that we give more thought to cost effectiveness and technology assessment. Therefore, our medical students should gain

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working acquaintance with the principles and techniques of such evaluations.

In matters of the kind I have been mentioning, some of the best resources for teaching may be in departments of public health and community medicine or in the school of public health. Unfortunately, with the competition for space in the curriculum, experts in these fields may be under-used, and their teaching may be relegated to the elective category rather than being a compulsory part of medical education. □

1. FREELAND, M. ET AL. *Health care finance review*, **1** (3):9 (1980).
2. RELMAN, A. S. *New England journal of medicine*, **303**:963 (1980).

World Health Forum, **1** (1, 2): 142–152 (1980)

Condensed book

B. Abel-Smith[1] and A. Leiserson[2]

Making the most of scarce resources*

"Spending more on health services does not necessarily buy better health." This is the lesson that the authors seek to drive home by an examination of the close interrelation between socioeconomic factors and health and by analysing the choices open to developing countries in allocating scarce resources. They strongly advocate a unified approach to meeting basic needs, suggest how a national health policy should be planned, and discuss different ways of financing the health service.

At the Twenty-ninth World Health Assembly, the Director-General of WHO was requested to ensure that the Organization take an active part "in supporting national planning of rural development aimed at the relief of poverty and the improvement of the quality of life".

This book has been written primarily for senior health administrators and teachers of health personnel in developing countries. It has two aims: first, to show what health administrators can do, with others, to reorient national planning in the direction cited by the World Health Assembly; second, to point out some of the implications for the planning and administration of health services.

The Inequity of Past Development

Over the last 25–30 years, gross world production has roughly trebled, while the world's population has increased by barely two-thirds.[3] But the rich countries of the world have become relatively richer and the poor countries relatively poorer. The relative poverty of the developing countries is indicated by the share of world output available to their populations:

> In 1972 the industrial market economy countries, with only 17% of the world population, accounted for 67% of total world output (using ordinary exchange rates to calculate national totals on a common basis). At the other extreme, 26% of the world's population lived in countries whose total output accounted for under 3% of the world total.
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> If . . . exchange rates give a distorted picture of the real value of national production, then the correct figures would probably not be so extreme.[4]

Apart from the occasional radio, bicycle, and poorly staffed primary school, life in the rural areas of many developing countries continues much as it did centuries ago. Unemployment, underemployment, malnutrition, bad housing, an unhealthy environment, and lack of minimum education persist on an enormous scale after 30 years in which planning for development has been increasingly accepted. The expectation of life in developing countries has lengthened considerably, but there is little other evidence that the basic needs of the poor are met to a greater extent now than 30 years ago.

Past development policies were devised with good intentions, but emphasis was put on economic growth without careful examination of who would benefit from it. It was assumed that the beneficial effects of growth would spread throughout the economy. This has tended not to happen or to happen very slowly. Consequently, a new thrust in development planning today aims at meeting basic needs directly. These include minimum requirements for food, shelter, and clothing, for household equipment and furniture, and for essential services

* This is a condensation of *Poverty, development, and health policy*, published by the World Health Organization in the Public Health Papers series as No. 69 (1978). All who are attracted by the authors' ideas are urged to read the full exposition. The book is available through the usual channels for WHO publications.

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[3] *What now?* Uppsala, Dag Hammarskjöld Foundation, 1975, p. 26.

[4] *Employment, growth and basic needs.* Geneva, International Labour Office, 1976, p. 29.