Health systems, economics and policy

Tutor: David Price
Semester 1
First lecture: Monday, 24 September

Aim: to enable students to analyse and evaluate health care systems in both developed and developing countries from the perspective of equity of access to comprehensive health care services

Barts and The London School of Medicine and Dentistry
www.smd.qmul.ac.uk

Overview lecture

- What you can expect to find on QMPlus, resources
- Lecture notes on pdf
- The assignment
- Seminar arrangements and week 2 seminar
- Course overview
- A brief presentation

QMPlus

- https://qmplus.qmul.ac.uk/login/index.php

Assignment

- What strategies would you advise the health minister of a low income country to adopt in order to achieve universal access to health care? Explain your recommendations.

Seminars

- Choose seminar groups
- P/T will have priority
- Week 2 seminar:

Read the overview of the World Health Report 2000 and in 300 words for class discussion contrast this WHO analysis of health system shortcomings with the Alma Ata Declaration of 1978.

Course overview

https://qmplus.qmul.ac.uk/login/index.php

Short presentation

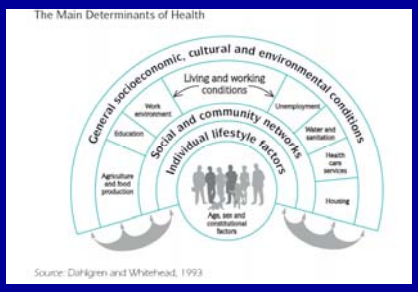
Health care is a determinant of the health of a population

The health care system distributes resources and addresses poverty

The public health standard is universal access to essential care (Alma Ata, 1978)

How is redistribution achieved?

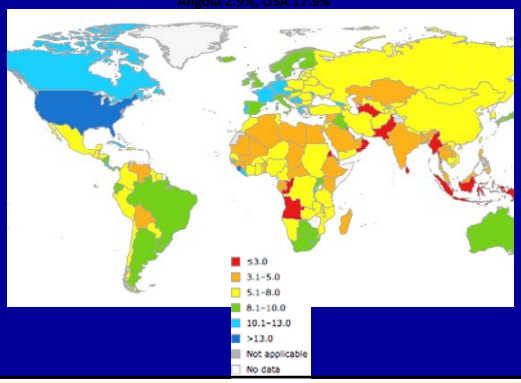
Main determinants of health



The role of health care in population health

- It is generally accepted that improvements in health status in the last century were due to improvements in personal health care (treatment of disease), better disease prevention programmes (immunization and changes in personal behaviour such as smoking and diet), and changes in social economic conditions (such as housing, income, sanitation, education and nutrition).
- The need to state the contribution of health care is a consequence of the 'Go for growth' argument.

But there is wide variation in expenditure on health care.
Total expenditure on health as a percentage of gross domestic product (measured in US$), July 2012, WHO
Angola 2.9%, USA 17.9%



This variation is reflected in differences in life expectancy
Life expectancy at birth by region, 1970-75 and 2000-05

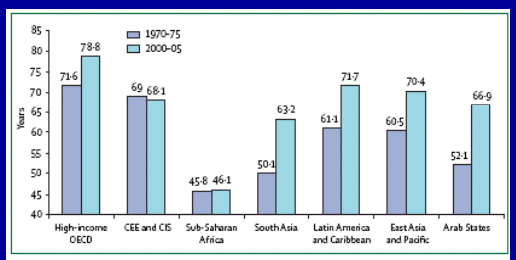


Figure 1: Life expectancy at birth by region, 1970–75 and 2000–05

How should health care be funded and administered?
By the market or by government?

- http://www.youtube.com/watch?v=sa69fxqydXg

Estimated sources of excess costs in US market system of health care (2009) (US Institute of Medicine report, 2012)
(Total spending at 2009: $2.9 trillion; 50 million Americans cannot get health insurance)

Category	Sources	Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion
Inefficiently Delivered Services	• Mistakes—errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion
Prices That Are Too High	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion

Class, health, and the American elections

- "In the USA, 2012 polling shows that 26% of Americans have faced grave financial difficulties due to medical costs, and 58% have delayed treatments due to their inability to pay out-of-pocket expenses or insurance copays.
- "For those without health insurance or senior citizens' Medicare coverage, a startling 81% say they forgo treatments, as do 72% of poor Americans earning less than $40 000 a year."
- Laurie Garrett, Lancet, September 1, 2012

Temporary camps in the USA

- http://www.youtube.com/watch?v=sa69fxqydXg

Cancer survival rates and class
Canada and USA

- There are few if any differences in survival of different income groups in Canada but substantial differences in the United States.
- People with cancer who came from poor populations in the United States had worse survival than equally poor people in Canada. This was as true for poor whites as it was for poor African Americans.
- Survival among the wealthiest groups in Honolulu was better than for the wealthy in Toronto, but, for the most part, differences between upper income groups in the two countries are neither statistically nor substantively significantly different.
- Cancer survival patterns in Honolulu were more nearly like survival in Toronto than was any other American city. Because Hawaii is the one American state that has attempted, though with only partial success, to implement universal medical insurance, the evidence suggests that the differences in cancer survival documented in these studies are primarily the result of differences in access to health services.'
- (Kunitz S (2007) The health of populations. London: Oxford University Press

Should the government pay? Should the government provide?

Three arguments for public service provision

"To the extent that the public financing reimburses private sector costs (such as US Medicare payments), there are powerful incentives for the private providers to inflate costs, especially since patients themselves cannot effectively monitor the quality of care offered by their doctors and health facilities.

"[The] presence of a large private sector may create not merely the incentive of individual providers to raise their costs, but also a relentless lobbying pressure to attend to the needs and wants of the middleclass rather than the poor. […]In such a case, the public sector is likely to become the sector of last resort for the poor, whereas the private sector becomes the politically dominant sector in the society, able to reap large public outlays on behalf of the politically powerful middle and upper classes.

"Much good public health is based on systematic applications of best practice technologies applied at population scale and systematic monitoring and data collection. Vaccine coverage should be applied comprehensively in order to achieve herd immunity in the community."

"These limitations imply that efficiency as well as equity calls for highly systematic and broad coverage of key intervention strategies." (Lancet, 2012; 380: 944)

When the private sector predominates

Queues, Quacks and Chaos - The Reality of Indian Health Care

http://www.youtube.com/watch?v=eSsHTNUUT_E&playnext=1&list=PL545006C5F5385831&feature=results_main