More health for the money

By Ian Anderson
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About 20-40% of health expenditure is lost to inefficiency says a new WHO report that looks at how to accelerate progress towards universal health coverage and prevent 100 million people falling into poverty when they pay for health care.

Each year the World Health Organisation publishes *World Health Report*, focusing on policy or programming priorities particularly of concern to developing countries. Recent reports have covered important issues such as the shortage of health workers; health and human security; or the need to revitalise primary health care.

This year's *World Health Report* focuses on an important aspect of health financing: how to provide "universal coverage" (ie where virtually all people have access to good quality, needed, health services *without* facing catastrophic financial expenses). This year's theme has particular importance in Asia where government expenditure on health is often low, and rates of private, direct, "out of pocket" expenditure on health are correspondingly amongst the highest in the world.

This detailed and well researched Report makes four important points.

First, governments can achieve "more health for the money" by improving efficiency of health financing. Importantly, the Report estimates that from 20-40% of all health spending globally is currently wasted through inefficiency and waste. The report identifies ten leading sources of inefficiency in health. These include: purchasing practices for medicines (under-use of generics; use of substandard or counterfeit medicines; irrational prescribing policies); misaligned incentives (fee for service payments); management

practices (medical errors, costly staffing mixes); poor investment decisions (hospital size; technology choices) etc.

Secondy, direct "out of pocket" expenditures are not just a financial barrier to essential health care: they can also be an independent source of impoverishment and debt. The Report notes finds that, globally, about 150 million people suffer financial catastrophe annually as a result of paying for health care out of pocket, while 100 million are pushed below the poverty line. Given their low incomes, but high health needs, the 'near poor' are particularly vulnerable to financial impoverishment from even small fees and charges, including for medicines, transport, and user fees. (The very poor sometimes escape further impoverishment by simply going without essential care). Lack of universal coverage and financial protection even affects some OECD countries: medical debt is the principal cause of personal bankruptcy in the USA, with illness or medical bills contributing to 62% of bankruptcies in 2007.

Thirdly, universal coverage is not the prerogative of high-income countries: Brazil, Chile, China, Mexico, Rwanda and Thailand have recently made great strides in mobilising additional revenue for health, reducing out of pocket direct payments, and improving the efficiency and equity of health financing. Each uses different approaches but certain broad lessons are clear. For example, the Report finds it is impossible to achieve universal coverage through insurance schemes when enrolment is voluntary: low-risk people – usually the young and healthy – will opt out, while it is difficult to ensure the self-employed make contributions. Other policy conclusions include the finding that having multiple, small, fragmented health insurance pools are often inequitable and financially unsustainable: consolidating such pools is usually sound policy.

Fourthly, there needs to be "more money for health". The report notes that to achieve the Millennium Development Goals for health, 49 low income countries need to spend an (unweighted) average of a little more than $US 60 per capita by 2015 "considerably more than the $US 32 they currently spend". The report identifies several opportunities for developing countries to generate more revenue domestically. For example, a 50% increase in tobacco excise taxes would generate US$1.42 billion in additional funds in 22 low-income countries for which data are available. If all of this were allocated to health, it would allow government health spending to increase by more than 25% in several countries, and at the extreme, by 50%. Raising taxes on alcohol to 40% of the retail price would have an even bigger impact.

The report also notes that if development partners "were to immediately keep their current international pledges, external funding for health in low-income countries would more than

double overnight and the estimated shortfall in funds to reach the MDGs would be virtually eliminated".

This is an important report and essential reading for people interested in how more and better spending on health can reduce poverty. It main contribution is some timely ideas on how better health spending can save more lives.

Ian Anderson is a consultant and a Research Associate with the Development Policy Centre. He has recently completed almost 25 years at AusAID. Ian specialises in the economics and financing of the health-related MDGs.

About the author/s

Ian Anderson
Ian Anderson is an Associate at the Development Policy Centre. He has a PhD from the Crawford School of Public Policy, Australian National University, and over 25 years of experience at AusAID.