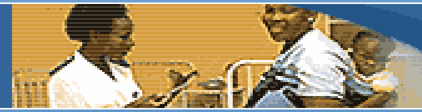

World Bank – Health Systems Development — *April 2006*

Leadership Forum

"Development Opportunities Presented by Investment in the Health Sector of Emerging Market Economies" by **Simon Stevens**, President, UnitedHealth Group International & Visiting Professor of Health Policy, London School of Economics.

Editorial

Beyond BRIC towards New Emerging Health Care Markets.

Featured Reading

Market Driven Health Care - Who Wins, Who Loses in the Transformation of America's Largest Service Industry, by Regina Herzlinger, May 1998.

Related Event

World Health Care Congress
April 17 to 19, Washington D.C.

Bulletin Board

- Beyond BRIC
- Market Analysis
- Deloitte
- IFC
- World Bank

Archives

- Leadership Forum
- Economic Viewpoints
- Editorials
- Featured Events
- Featured Readings
- HSD Newsletter

Newsletter Subscription

You are subscribed to the **HSD Newsletter**

The purpose of this list is to provide policymakers, health professionals, practitioners, and development experts an open forum for the posting and discussion of news and information relating to Health Systems Development (HSD). We are looking forward to a dynamic and informative discussion. Please share your knowledge and views.

- Join HSD News List: join-hsdnews@lists.worldbank.org
- Posting to the List: hsdnews@lists.worldbank.org
- Unsubscribe: leave-hsdnews@lists.worldbank.org
- List Manager: listmanager@lists.worldbank.org

Contact: Editor: Alexander S. Preker (Lead Economist) apreker@worldbank.org

The Development Opportunities Presented by Investment in the Health Sector of Emerging Market Economies

Author **Simon Stevens**
President, UnitedHealth Group International
Visiting Professor of Health Policy
London School of Economics

As countries get richer their citizens want more healthcare – as their revealed preferences for health spending demonstrate. But too often, the broader contribution a high performing healthcare system can make to national economic prosperity is underappreciated. And in turn, as policy makers seek to improve the performance of healthcare, too often the role of a well functioning demand side is downplayed relative to the necessity of supply side reform.

So for health reformers wanting to ensure their health sectors contribute optimally to economic prosperity, here are six policy tests.

- first, are the upstream determinants of health status and effective demand being tackled effectively? The reality is that most countries have yet to take meaningful cross-sectoral action to avert significant future morbidity and fiscal burdens such as smoking and obesity.
- second, does the design of the country's healthcare financing mechanism take account of its wider economic impacts? In some of the social insurance countries, raising health finance from an overly narrow fiscal base may produce distortions particularly in the traded sector of the economy. In many middle income countries high out-of-pocket healthcare payments tend to reinforce overly high individual savings rates, so greater risk pooling could help rebalance domestic economic output.
- third, is the healthcare system actively contributing to improved labour productivity? For current workers, sickness absence generates significant costs to employers and employees. For potential workers, avoidable ill health excludes them from the labour market creating poverty, social dislocation and the need for transfer payments and other fiscal burdens.
- fourth, is the healthcare system actively supporting existing informal supply? In most countries the economic value of patient self care and informal care by relatives and others probably exceeds that of the formal healthcare sector. For example it has been estimated that patients with diabetes in western european health systems spend just three hours a year with a health professional – which means that for the other 8757 hours annually they are their own 'health professional'. Seen in this light it is obvious that rather than being seen purely as drivers of 'demand', patients are in fact one of the grea test resources a healthcare system possesses. Yet most countries fail to act systematically on that insight by funding and promoting patient health literacy and empowerment.
- fifth, is consideration being given to the economic multiplier effects of well targeted healthcare spending? Healthcare systems produce economic effects not just by drawing in financial resources and producing healthcare outputs, but also by procuring inputs in product and labour markets, meaning that healthcare systems' buying power can be used to advance social objectives and develop biomedical partnerships to boost knowledge-intensive sectors of the economy.
- and, crucially, sixth: are comprehensive policy drivers in place to maximise health sector productivity and allocative efficiency so as to minimise the crowding out of other valued social programmes and/or personal consumption? As an illustration of the importance of this point: a recent UK government calculation estimated that by 2023, nearly four percentage points of GDP would be being wasted if, in the intervening period, health sector productivity growth remained flat as against increasing by 2% a year.

Patients need payers (because in healthcare, principals need agents)

The answer, at least to the sixth test, is almost invariably "no". And one critical but under-appreciated reason for this is that most countries' healthcare systems typically lack sophistication and 'clout' on the demand side, relative to the supply side. The result is some nationally-specific combination of foregone efficiency, quality, responsiveness and equity.

In industrialized economies, this demand side problem partly arises from weaknesses in the established payer / purchaser function. Here, tax-funded single payers and statutory social insurers struggle to break free from their institutional histories as passive reimbursers rather than active purchasers of care.

For many developing and middle income countries, the demand side problem arises from the absence of a well functioning third party payer system altogether. In jurisdictions such as India and parts of China, out-of-pocket payment will often be the predominant financing mechanism. This absence of risk pooling may expose individuals to substantial financial shocks and welfare risks. But a further, indirect, consequence is that patients in these countries typically therefore lack an agent to buy or organize healthcare resources on their behalf - which can leave consumers exposed to price inflation and provider-induced consumption. Indeed one way of characterizing the situation is as 'consumer directed healthcare' minus any of the necessary infrastructure needed to make consumer directed healthcare work, such as a contracted provider network and the provision of meaningful information to support consumer choice.

Specifically, these missing, welfare-enhancing, payer functions include:

- the credentialing of providers on quality, safety and economic criteria
- aggregation of consumer purchasing power to counterbalance provider pricing power (so enhancing technical efficiency)
- scrutiny of provider treatment patterns to help reduce the oversupply of inappropriate care, and stimulate the supply of appropriate care (improving allocative efficiency)

- supporting, incentivising and orchestrating consumers' use of the health delivery system so as to improve the use of rational upstream care and reduce inappropriate demand (boosting allocative efficiency and equity).

Strengthening the demand side

What can be done to redress this systemic imbalance?

For industrialized countries with established third party intermediaries, a key challenge is to create the managerial incentives needed to drive increasing payer/purchaser sophistication and - the flip side - to make transparent the currently opaque opportunity costs of poor demand side stewardship.

This means that in place of 'static' approaches to improving payer performance (such as hierarchical oversight or regular 'top down' organizational restructurings), policy makers need to consider 'dynamic' mechanisms to allow successful payer/purchasers to expand, and poorly performing intermediaries to be replaced. How, then, can this be achieved?

In tax-based single payer systems, a modest but potentially important incremental move towards a 'dynamic' or 'self improving' payer/purchaser system would entail establishing periodic competition for the role of payer/purchaser for a defined patient population (typically residents of a geographical area). In mature markets this could entail the transfer of capitated risk, but in the early stages contracts could be let on an Administrative Services Only (ASO) basis coupled with performance incentives. These type of approaches may be particularly necessary in countries such as the UK where concern is rising that without much stronger healthcare purchasers, the significant extra tax resources flowing into the National Health Service might produce inflation rather than improved output, quality or responsiveness.

In social insurance systems, an incremental step has been to allow patients or employers to choose their health insurer rather than being obliged to use a captive entity, and to dissolve the bias in respect of not-for-profit ownership of health insurers as the Netherlands has recently done. The Dutch case in particular will be watched especially carefully for lessons on the extent to which it is possible to risk-adjust the premiums of insurers competing to provide a nationally specified minimum benefits package.

By contrast, the position in developing and middle income countries requires a different policy response. As a first step, these countries may consider stimulating the provision of non-risk product and services by domestic and international payers/purchasers. They have the potential to generate at least some of the benefits that risk pooling delivers as a byproduct.

Beyond that, stimulating risk pooling in countries that currently lack it will generally improve welfare, however a number of constraints mean that mandating compulsory risk cover may be impractical in the near term. Specifically, underdeveloped taxation systems mean that the single payer 'Beveridge' option is usually not available as a principal funding mechanism. Similarly, the high proportion of citizens outside the formal labour market (including dependents, retirees and workers in the parallel economy) means that 'Bismarckian' employment-based social insurance may also be limited in its applicability.

This has led some analysts to argue that under these circumstances the only feasible incremental step may be to promote more risk sharing via the development of voluntary insurance pools, as advocated in a recent paper by Mark Pauly and colleagues.

However for this to happen, many jurisdictions will need to make changes to the way their health insurance sector currently operates. First and foremost regulators need to remove distortions that stand in the way of a properly functioning health insurance sector. These are often greatest in the very countries that most need to stimulate more risk sharing. If countries decide they want access to best in class tools from international payers/purchasers, they will need to examine the impact of existing controls on foreign participation. In addition, common distortions include, but are not limited to, an absence of sophisticated health insurance-specific regulation; the erection of significant legal or economic barriers to entry; and price controls or other distortions in other insurance sectors, especially life insurance, which mean that health insurance is used as a loss-leader by multi-line insurers. Tackling these barriers to the formation of voluntary risk pools will be an important step towards the social protection and potential efficiency gains that a sophisticated third party payer/purchaser system can bring.

Simon Stevens is president of UnitedHealth Group International, and visiting professor of health policy at the London School of Economics.

For examples from other industries of how this insight is being applied see: Prahalad CK, Ramaswamy V. *The future of competition: co-creating unique value with customers.* Boston: Harvard Business School Press (2004)

The terms 'purchaser' and 'payer' are here used interchangeably in recognition of their different national usages. In the United States however the terms are often used to distinguish the role of an employer in funding or 'sponsoring' health insurance, and the role of the health insurance company in then procuring health services on employees' behalf.

Stevens S. *Health Affairs* 23, no 3 (2004):37-44

For more detail on the new Dutch system see www.zn.nl/international/index.asp

Pauly MV, Zweifel P et al. *Health Affairs* 25, no 2 (2006):369-379

References

1. For examples from other industries of how this insight is being applied see: Prahalad CK, Ramaswamy V. The future of competition: co-creating unique value with customers. Boston: Harvard Business School Press (2004)

2. The terms ‘purchaser’ and ‘payer’ are here used interchangeably in recognition of their different national usages. In the United States however the terms are often used to distinguish the role of an employer in funding or ‘sponsoring’ health insurance, and the role of the health insurance company in then procuring health services on employees’ behalf.

3. Stevens S. Health Affairs 23, no 3 (2004):37-44

4. For more detail on the new Dutch system see www.zn.nl/international/index.asp

5. Pauly MV, Zweifel P et al. Health Affairs 25, no 2 (2006):369-379

Editorial

Beyond BRIC towards New Emerging Health Care Markets

Goldman Sachs economists coined the term "BRIC" in 2003 for a group of leading developing market economies - Brazil, Russia, India, and China. Their research indicated that these four countries could become larger than the world's six most developed countries in the next 40 years.

Despite criticism decrying this prediction as “crystal ball gazing”, the notion of BRIC has captured the international investment community's imagination. It provides an intriguing glimpse into a world no longer dominated by U.S., European, and Japanese interests, while altering the economic landscape for the next generation.

As is often the case, the health sector is already leading the way in this respect. India has one of the largest pharmaceutical industries in the world, exporting drugs to both developed and developing markets. Its call centers are used by in the health industry just as it is by other sectors of the economy. Its largest private hospitals can give even top centers in the US a run for their money in terms of clinical outcomes. And with 350 million middle income people seeking a higher standard of care than can be provided through the publicly subsidized National Health Service, the private health insurance market is expanding rapidly.

Although the context is different, the story for China is similar. Its pharmaceutical production has expanded rapidly during the past decade. Being one of the last sources of cheap labor, China can undercut the price of manufacturing goods and consumables in most or the rest of the world. Although the share of the population who has private health insurance remains one of the lowest in the world, China has the largest private health insurance market in the world.

The Brazilian health care system continues to be turbulent. Although the SUS (Sistema Único de Saúde) should provide equitable healthcare to all Brazilian citizens, provisions under its charter outstrip the realities of fiscal space allocated to health. The private sector is a vibrant part of the service delivery system, it has a strong pharmaceutical manufacturing sector, and there are several successful private health insurance systems.

Russia belongs to this group but a closer look at its political and economic peculiarities call into question its membership with this exclusive group of "breakout industrializing countries. Russia's growth is based on (and limited by) different factors that exist in Brazil, India, and China. Today, the Kremlin appears less interested in opening Russia's economy to market forces than in leveraging the country's enormous resource wealth to consolidate state control. This has led some to recast the group as BIC (Brazil, India and China), leaving out the R for Russia.

Although characterized by less “buzz” than the billion populated BRIC, a new group of countries have emerged as promising emerging markets. This includes Egypt, Mexico, Poland, South Africa, South Korea, and Turkey. They may not have the buzz of billion-plus population markets, but their growth is impressive – growth opportunities in the health sector of these countries may offer investors superior value. These six leading non-BRICs are notable for their strong growth profiles, fast-track reform agendas, and investor-friendly climates.

Eastern Europe, from the Baltic to the Balkans, is likewise blossoming thanks to reforms put in place after the collapse of the Iron Curtain. Unlike the largely export-dependent BRICs, most of these countries are prospering chiefly on domestic demand from surging consumer spending. They do not suffer from India's volatile equity market, mainland China's disclosure paranoia, Brazil's hostile political environment and Moscow's penchant for interfering with private business. And the stars of the past – the Asian Tigers –have not been able to reinvent themselves.