

## Development Research Group

### Knowledge in Development Note 7

#### Health

June 2007

Good health is an end in its own right, but it is also a key to economic success—at the household and country levels. Death and illness, especially in the case of a breadwinner, can have potentially devastating consequences for a household.<sup>1,2</sup> Well nourished children learn better, stay longer in school, and become more productive workers in adulthood.<sup>3,4</sup> High rates of mortality from communicable and other diseases lower a country's expected rate of economic growth. The AIDS epidemic in Africa has been estimated to knock 0.3-1.5 percentage points off rates of economic growth.<sup>5</sup> In East Asia as a whole, severe acute respiratory syndrome (SARS) is estimated to have reduced GDP by 2% during the second quarter of 2003. Poor countries typically have the highest rates of mortality and morbidity. Just one percent of the world's 11 million under-five deaths and just two percent of total maternal mortality occurred in high-income countries.<sup>6</sup>

The 'technology' for improving health is not perfectly understood. Not all curative and preventive health care interventions are known to be effective. Many—including many delivered in high-income countries—have never been rigorously evaluated. But many have been evaluated and have been shown to be effective. Among them are interventions thought to be crucial to reducing malnutrition, child mortality, maternal mortality, and mortality from communicable diseases such as Tuberculosis (TB), malaria and HIV/AIDS—the health Millennium Development Goals.<sup>7</sup> These interventions are not expensive and can be delivered in a low-income setting. The challenge is less one of developing new technologies—new tests, new drugs, and so on—although developments in some fields (HIV/AIDS for example) would be welcome. Rather the challenges are: (a) preventing people from falling ill in the first place, (b) ensuring they receive health care when they need it, and (c) ensuring that the care they receive is appropriate to their needs.

#### **Our understanding to date**

##### *Prevention of disease*

For each disease there are a variety of preventive activities that are known or believed to be effective. Yet many people often do not undertake them. Education is one factor, but its effects are not always as expected. For example, education predicts behaviors that protect against HIV/AIDS like condom use, use of counseling and testing, discussion among spouses and knowledge of HIV/AIDS transmission, but it also predicts a higher level of infidelity and a lower level of abstinence.<sup>8</sup> Public health systems are often better at top-down reactive work, such as bringing disease outbreaks under control,

than they are at the more routine collaborations required for proactive disease prevention.<sup>9</sup>

*Non-use and under-use of health services is extensive*

Many people do not seek care when they fall sick, even if their condition is not a trivial one. As a result, many children die unnecessarily, while many health facilities are under-used. Lack of awareness is one reason for this apparent lack of demand. When most children in a community are stunted mothers fail to recognize malnutrition; when they do, improvements often follow.<sup>10</sup> Benefits are often also perceived to be low relative to the costs incurred in using services. The costs include informal (under-the-table) payments as well as formal charges, which given the lack of health insurance in many developing countries can be very large and pose an especially large deterrent to poor households who are often least likely to have insurance coverage; they also include transport and time costs.

Inadequate incentives for providers to deliver care are another factor. Facilities may have too few patients, but health staff are frequently missing from their posts, often moonlighting in their private practices,<sup>11</sup> or drugs and other key consumables are unavailable because they have been ‘borrowed’ by staff to use in their private practice. Incentives partly explain these conditions. High rates of absenteeism among health workers reflect the fact that as salaried staff they have little incentive to focus on treating more patients or treating them well.

Solutions include demand-side and supply-side measures. On the demand side, conditional cash transfer (CCT) schemes provide cash payments to households conditional on their seeking and receiving specific interventions, such as preventive care for young children and mothers. These have had a remarkable impact on the use of services, but their use has thus far focused on a narrow range of maternal and child health interventions.<sup>12</sup> Health insurance reduces the cost of care at the point of use without providing a positive financial incentive to use care, but even so typically has a positive impact on utilization—and on a broader range of services than covered under CCT schemes.<sup>13,14</sup> However, covering entire populations has proved complicated.<sup>15</sup> Other demand-side measures include steps to reduce the size of informal payments and investments in infrastructure to reduce the time costs associated with using health facilities—fully staffed health facilities are of little use if they lack electricity and prospective patients are unable to get to them because of poor roads.

One obvious supply-side reform is to change the way providers are paid. In the case of preventive care, it is increasingly common for providers to receive an amount per item of service delivered. Sometimes, the price and the providers themselves will be decided through a competitive contracting process.<sup>16</sup> In the case of curative care, fee-for-service is also used, but tends to encourage providers to deliver unnecessary care—see below. Paying according to the number and diagnosis of patients (diagnosis-related groups) is a favored alternative. Other supply-side measures include improved governance and oversight of health facilities, sometimes through community-based

organizations or local governments. More radical reforms include an institutional separation of the functions of delivering health care and ‘purchasing’ it, where a government body (often the insurance agency) is charged with commissioning or purchasing care from providers, which may include private as well as public providers.

***The quality of care received by those who do get care is often poor***

Inappropriate care—often but not always involving unnecessary services—is common. Lack of knowledge among health providers is one factor. But there also seems to be a difference between what providers say they ought to (and will) do when confronted by a patient and what they actually do when a patient shows up. Those who know more also do more. In India private sector providers apply more of their knowledge than public providers do, but also are more inclined to over-prescribe drugs.<sup>17</sup> More competition in the local “market” does not, it seems, guarantee that patients get the care they need. In part, this is because patients are a poor judge of their medical needs, and demand more drugs and tests than they require. In a market where providers face stiff competition, providers may fear losing patients if they deny patients care they demand but do not need. For these reasons, quality of care could inadvertently worsen with increase in the demand for care, such as through the provision of health insurance. This is why measures aimed at strengthening demand need to be accompanied by supply-side reforms that encourage providers to deliver appropriate care.

Treatment protocols, lists of approved drugs, and training of staff are among the methods that have been used to improve the quality of care. Incentives are critical, however.<sup>18</sup> Financial sanctions to providers deviating from protocols are used. Paying providers a set amount for each type of case, dictated by the resources required if the relevant treatment protocol is used, is a better method, though this may encourage *under-treatment* especially in complex cases. Having a knowledgeable purchaser of health services sitting across from the provider is believed by some to be more likely to lead to a better outcome than reliance on ill-informed patient-consumers to keep providers in check. Others hope that the publication of quality ratings of different providers (e.g. mortality among patients receiving surgery) will, it hoped, empower patient-consumers.

***The international aid community for health has expanded***

Development assistance in the health field has grown in volume and has become considerably more crowded in the last 10 years or so. International initiatives focused on single diseases (e.g. Stop TB), groups of diseases (e.g. the Global Fund for AIDS, TB and Malaria) and single interventions (e.g. the Global Alliance and Vaccine Initiative) have emerged. New foundations dedicated largely to health issues (e.g. the Gates Foundation) have sprung up. Bilateral and multilateral aid in health has also increased. These developments have increased the opportunities to tackle health problems in the developing world, but pose considerable coordination issues and risk overwhelming small poor countries who can find themselves overextended simply meeting the requests of the various donors. The need for specialization according to comparative advantage is widely acknowledged but ‘players’ are reluctant to be left out of partnerships, particularly

since many seem to promise ‘quick fixes’. Recently, it has become increasingly clear that there are, in fact, no quick fixes in the health sector, that vaccines and insecticide-treated bednets cannot be dropped from helicopters like manna from heaven but require a well-functioning health system in place where the various actors—households, providers, insurers and government—face the right incentives, have the necessary resources, and operate within strong systems of governance and under sensible but tightly enforced regulations. The Bank’s new health sector strategy commits to repositioning the Bank as a leader in the field of the economics of health and health systems, the challenge being to ensure that the Bank becomes once again a leader in ideas as well as in the transmission and testing of ideas through its lending activities.

### **Current and future research directions**

Ongoing research is geared toward understanding better the demand and supply sides of the health sector, and the scope for increasing the timely use of preventive and curative care and for improving the quality of care. Much of the work involves evaluation of programs, including Bank-financed ones, and much feeds into ongoing and planned analytic and advisory activities at the Bank.

On the demand-side, work is underway on the construction of and impacts of health insurance systems, and on cash transfer schemes, including ones where transfers are *not* conditional on use of health services. Work is also underway on the analysis of policies aimed at preventing health shocks and improving households’ ability to recover from them. Research is also examining the impact of information on child care through community-based programs in enhancing both nutrition and the management of childhood illnesses as well as in promoting the cognitive development of young children.

On the supply side, work on provider absenteeism continues, the emphasis now being to understand factors driving absenteeism and the success of policies to reduce it. Work on the quality of health is being extended to other countries and to understanding the determinants of quality and the impact of changing incentives facing providers on their performance. Policies being explored include contracting, decentralization to local governments (to give people a greater say in evaluating the performance of local providers), and mass media promotion of quality indicators to promote ‘yardstick’ competition. Indeed, the appropriate role of government in health insurance and service provision continues to be an important research question. Some governments make the mistake of thinking they need to do everything in health care; others over-rely on the market. Government’s role should be dictated by considerations of market failure as in other sectors. Health insurance need not be delivered by government, but there is a case for mandatory insurance to prevent adverse selection and for subsidies for the worse off. Health services are being delivered by public or private providers, but patients lack the information to be the discriminating consumers they are in other sectors.

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## Endnotes

Most Bank documents cited in this summary are available through the documents and reports portal of the World Bank <http://www-wds.worldbank.org/>. The word “processed” describes informally reproduced works that may not be commonly available through library systems.

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