THE EMERGING MARKETS SYMPOSIUM

GREEN TEMPLETON COLLEGE | OXFORD

Health and Healthcare in Emerging Market Countries

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Findings and Recommedations

The Millennium Development Goals emphasize the need to combat infectious diseases and improve child and maternal health care in the poorest countries. Yet with almost two thirds of the world's preventable deaths EMCs face a silent health crisis that has yet to engage international attention. They must now use their growing stature to ensure global decisions on health take full account of EMC perspectives and priorities. Addressing this challenge, the Emerging Markets Symposium reached the following findings and recommendations:

FINDINGS

Realities

EMCs Are Diverse But Have Shared Attributes

EMCs include Brazil, China, India, Indonesia, Mexico Russia, Turkey and 15-20 smaller countries, mostly in South and East Asia, Central and Eastern Europe and North and South America. They are geographically, economically and politically diverse but generally have sound financial institutions, energetic private sectors, liberalized economies and strong prospects for sustainable growth.

Health Is a Function of Social, Economic, Biological and Cultural Environments and the Accessibility, Availability and Quality af Healthcare Systems.

Because many health issues fall beyond the domain of health departments, healthcare and public health strategies must take full account of non-medical determinants of health including economic and social conditions, lifestyle choices and the impact of social environments on health and life-expectancy.

EMCs Must Anchor Health and Healthcare Strategies in Their Distinctive Economic, Social, Cultural, Political and Spatial Characteristics... and Unique Priorities.

The health of social groups, regions and urban and rural populations in EMCs reflects contrasting economic conditions and healthcare options. In most EMCs urban elites live in privileged environments with virtually unlimited access to cutting edge healthcare; urban middle classes enjoy improving living and working conditions and increasing access to insured healthcare; many urban poor live and work in unhealthy environments and depend on healthcare of variable quality provided by clinics and public hospitals; and the rural poor often live in conditions similar to those found in the world's poorest countries with limited access to healthcare of any kind.

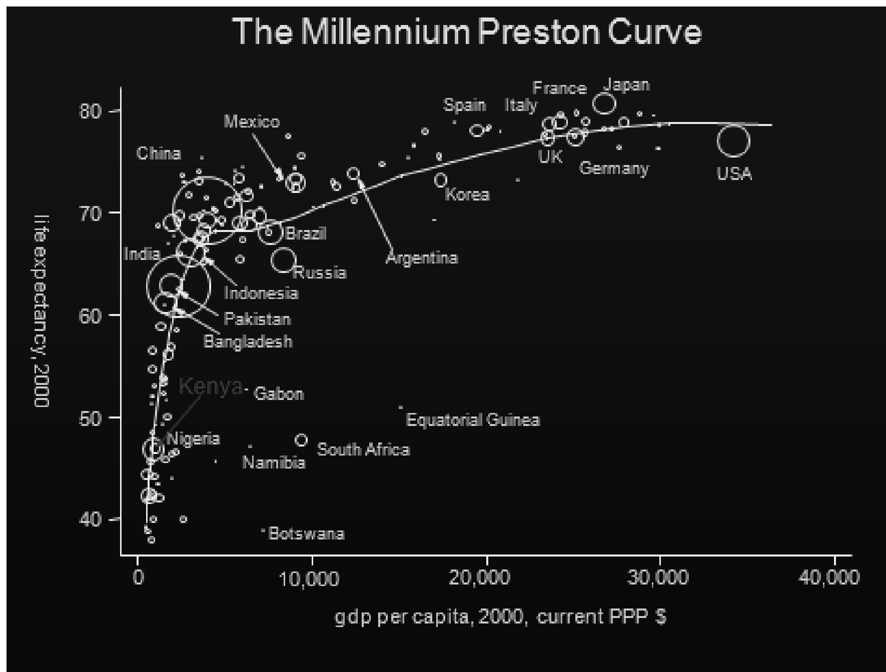
Health and Healthcare Strategies and Policies Must be Anchored in Better Research

There is an urgent need for research to lay stronger foundations for health and healthcare policies and strategies in EMCs on issues ranging from healthcare professionals' preferences for urban living, specialization and private practise, to the cost-effectiveness of information and communications technologies, to the enabling conditions of single-payer healthcare systems to the causes and consequences of health worker migration.

Challenges

Health Problems in EMCs are Growing Faster Than Their Economies.

EMCs face exceptionally difficult and complex health and healthcare challenges not least because international comparisons confirm that (as shown below), once per capita income levels exceed those recently achieved by India, improvements in health indicators slow rapidly.



[The 'Preston Curve' was first described by Samuel Preston in 'The *Changing Relation between Mortality and Levels of Economic Development*', Journal of Population Studies, 1975.

Subsequent work by others (e.g. *'The Preston Curve 30 Years On'* by David Bloom and David Canning, International Journal of Epidemiology, June 2007) has generally confirmed Preston's findings]

This version is from Angus Deaton, 'The Health and Wealth of Nations', Rome, 2007

The Health Of EMCs is Both a Cause and Consequence of Rising Real Incomes

The challenge for health and healthcare policy in EMCs is to extend life by reducing premature death ***and*** to improve the quality of life by enabling healthy adults to be productive, and healthy children to become productive adults.

EMCs Face Unique Health and Healthcare Challenges

Epidemiological change, demographic growth and asymmetric economic and social conditions mean EMCs must simultaneously cope with chronic diseases traditionally associated with wealthier countries ***and*** infectious diseases and other threats to public health typically associated with poorer countries. Because EMCs account for more than half the world's population they must confront these burdens on a massive scale with far fewer resources (averaging less than 20% of per capita healthcare expenditures in OECD nations) than wealthier countries

Strong Leadership is Imperative

Health and healthcare issues in EMCs rarely get the attention they deserve and cannot be resolved without strong national leadership that, among other things, can promote effective collaboration between government, the private sector and civil society.

Opportunities

The Importance of Mutual Learning

EMCs must learn from the positive and negative experiences of wealthier and (some) poorer countries but, increasingly, must look to each other (rather than OECD countries) for inspiration and example. Being less burdened by institutional, political and cultural legacies and constraints than wealthier countries, EMCs enjoy greater freedom than OECD countries to create innovative approaches to health and healthcare.

Following Their Leaders

Other EMCs should learn from the examples of Brazil, China, India, Russia, Indonesia, Mexico and smaller countries that have developed universal healthcare programmes, each of which, in distinctive ways and with varying success, seek to satisfy the contrasting needs, priorities and financial means of different socio-economic groups, regions and urban/rural populations through a mix of public, voluntary, private non-profit and (predominantly) private (for-profit) healthcare providers.

RECOMMENDATIONS

1. EMCs Should Provide Universal Healthcare

The Reason Why

EMCs should adopt universal healthcare as an ethical and economic imperative and organizing principle of national health policy (i) because universal access to healthcare is a civil right; (ii) because inclusive systems that spread risks across large populations are inherently more efficient than systems from which large parts of the population are excluded and (iii) because quality healthcare extends and improves the quality of life, enhances adult productivity and expands lifetime learning capacity.

Contending With Diversity

In designing or improving universal healthcare systems EMC governments must contend with the fact that the needs and priorities of socio-economic groups and urban and rural populations range from unconstrained demand for the treatment of chronic illness from urban elites to basic needs for water and sanitation for the rural poor.

Building For The Long Term: Lessons Of Experience

In designing new (or improving existing) universal healthcare systems, EMC governments should take advantage of the experience of both wealthier (OECD) countries and EMCs, and should take special account of facts that:

- Recognizing demand for healthcare is inelastic whereas the supply of services is elastic, some OECD countries (notably Japan) have successfully contained costs through centralized price controls and have found that inequities arise if payment systems are not integrated in some way (particularly where out-of-pocket payments are the main source of

financing). Some countries have also found that the viability of public and private systems may be threatened if consumers are allowed to switch between them.

- Because, in general, their financial, human and institutional resources are relatively weaker than those of OECD countries, most if not all EMCs are currently unable to create the conditions needed to establish unified central control or single payer systems and should instead focus on improving multiple delivery and payment systems.

- EMC governments have struggled to integrate private and public sector initiatives, to ensure public and private providers share common social goals, to accommodate market failures and shortcomings in public sector management, and to manage the drain of financial and human resources from less well endowed (public) systems to better endowed (invariably private) systems.

- While research on cost-effective solutions to universal healthcare is needed, the experiences of both wealthy countries and EMCs suggest that improvements in multi-tiered provider systems and fragmented payment systems are contingent on:
    - Improving financial management and transparency in public health and healthcare services;
    - Improving government regulation of private healthcare services;
    - Aligning healthcare education/training with the evolving needs of health and healthcare systems;
    - Strong leadership in health and healthcare at the highest levels of government; and
    - Minimizing costs and maximizing productivity

Costs and Productivity

Abundant evidence shows the viability of universal healthcare systems depends, in part, on minimizing costs and maximizing productivity. There is also evidence that EMCs may enjoy significant cost and productivity advantages over OECD countries with respect to labour, drugs and devices and information and communications technologies.

Their labour cost advantages reflect relatively lower salaries, wages and benefits than in OECD countries and the fact that, to deliver public health and healthcare services, many EMCs have created non-traditional roles for unconventionally trained low-cost healthcare workers (often recruited from local communities) whose limited skills are leveraged by centrally located professionals. (see [2] below for additional recommendations on healthcare education)

Savings also flow from the facts that domestic producers of medical drugs and devices in an increasing number of EMCs enjoy cost and process engineering advantages over multinational producers and that multinationals (e.g. GSK) are now pursuing collaborative research and development, manufacturing and marketing partnerships with EMC firms to produce affordable and effective drugs for domestic and other markets. If EMC firms continue to harmonize domestic and international quality and safety standards and to build comparable records in the design, production, distribution and use of medical devices, these advantages will have an increasing influence on the financial viability of their universal healthcare programmes.

Information and communications technologies will also play critical roles in leveraging the productivity of EMC healthcare resources by making it possible to reduce costs and errors in health service delivery; improve the efficiency of healthcare administration, management and organization (including the creation and management of virtual networks and organizations); permit patient evaluation, diagnosis and treatment; enable the continued development of telehealth systems to deliver services to relatively inaccessible locations; supervise and support non-traditional health workers in marginal areas; facilitate access to patient information and records, therapies and drug information; support knowledge sharing; and (eventually) enable the construction of universal electronic medical records to promote personal health management.

Starting (Or Restarting) On The Right Foot

The long run sustainability of universal healthcare depends on such factors as adequate financing, controlled costs, transparent governance, effective regulation, innovative uses of human resources, the availability of affordable drugs and devices and the creative use of ICT. But the credibility of new and reformed healthcare systems depends - at least in the short run - on realistic promises, deliverable objectives, clear priorities and manageable expectations.

In most EMCs, high income urban populations - and to an increasing extent - urban middle classes with employer based insurance will generally be served by private sector providers. Public sector providers will focus on marginal urban and rural populations. Their priorities will vary from country to country in light of specific conditions but are likely to include low cost/high yield interventions with high impacts on mortality and life expectancy such as:

- Fiscal and legal instruments (safety warnings, food labelling and transport policies) to change relationships between the use and abuse of tobacco and alcohol, obesity and HIV/AIDS ***and*** adult and child health, disability, lost productivity and premature death.

- Initiatives to attenuate efforts by multinational corporations to expand EMC markets for tobacco, alcohol and non-nutritious foodstuffs intended to offset stagnant or declining demand for (some of) these products in wealthier countries.

- School programmes to deliver primary and preventative child healthcare (but not nutrition programmes which should focus on mothers and pre-school children) and to teach health maintenance (setting examples to wealthier countries where health education in schools is inhibited by restrictive practises)

- Education programmes, including sexual and reproductive education that target women in poor urban and rural communities with the aim of reducing net reproduction rates, maternal and infant mortality, teenage pregnancy and illegal abortions and improving family health.

2. EMCs Should Develop New Human Resources for Healthcare

New Approaches To Healthcare Require New Human Resource Paradigms

Most EMCs enjoy relative freedom from the cultural and economic constraints and legacy systems that inhibit innovative approaches to developing and deploying human resources for healthcare in wealthier countries. They should use it to create new roles, responsibilities, relationships and working practises for professional and other healthcare workers.

The main recommendation is that whereas in both EMCs and wealthier countries, highly qualified medical professionals provide services to those who can afford private healthcare, in EMCs they must also play essential roles in training, developing and supervising non-traditional health-workers (e.g. community health workers, clinical officers, female health workers).

In several EMCs non-traditional health-workers with limited education, often recruited from local communities, have been successfully trained for jobs rather than careers and - supported and supervised by medical professionals in central locations using state of the art information and communications technologies - have become the public face of primary care for disadvantaged urban and rural populations.

Some EMCs have created successful incentives to persuade medical professionals to work (at least temporarily) in marginal and remote areas. But efforts to replicate their models may be limited by cultural and political specificity. Other EMCs may find it easier (and more cost effective) to emulate EMCs that have pioneered the use of non-traditional, low cost health-workers (adapting precedents to their own conditions).

Reconfiguring Healthcare Education

Human resource strategies for universal healthcare may begin but cannot end with new paradigms. EMC governments, universities, medical schools and other institutions (including foreign institutions where EMC medical professionals are trained and educated) must also:

- Equip doctors and other high-level healthcare professionals with improved management, leadership and conceptual skills and new models of social and professional accountability.
- Emphasize teamwork, problem solving and community service, the use of evidence in decision making and awareness of resource constraints.
- Provide specialized training for healthcare managers and policy makers in integrated health and healthcare education programmes (see below).
- Support a shift from conventional (high-cost, doctor-centred, large-hospital care) healthcare delivery systems to sustainable patient centred systems with less skilled health workers.

International Migration Raises Issues Of Global Policy Coherence

The international migration of public health and healthcare professionals and other workers is often cited as the proximate cause of EMC manpower deficits. But not all EMCs have deficits; some are net importers; there are push as well as pull factors; the costs are partially offset by remittances; and it is sometimes argued it is neither feasible nor appropriate to intervene in healthcare labour markets. Permanent or long term losses of skilled health workers are nonetheless legitimate issues for many EMCs not least because health manpower deficits in

some wealthy countries are partly attributable to deliberate restrictions on the output of qualified medical professionals.

The current situation and - in the absence of countervailing action, its potential implications - points to the need for both multilateral and national action.

Multilateral Action
WHO should:

- Produce an International Code of Practise on international migration with guidelines on fair compensation by receiving countries to source countries.
- Discourage source countries from viewing compensation as an alternative to efforts to reduce the propensity of healthcare professionals to migrate in search of better conditions and professional opportunities (e.g. by ensuring regular payments of wages and salaries).
- Develop international standards to govern healthcare qualifications and promote the growth of national and international quality assurance associations.
- Collaborate with academic institutions in research on healthcare migration to build a factual framework for understanding and resolving issues surrounding international and internal migration by healthcare workers.

Beneficiary Governments
Countries (including EMCs) that benefit from the immigration of healthcare professionals from EMCs and poorer countries should be strongly urged by the international community to:

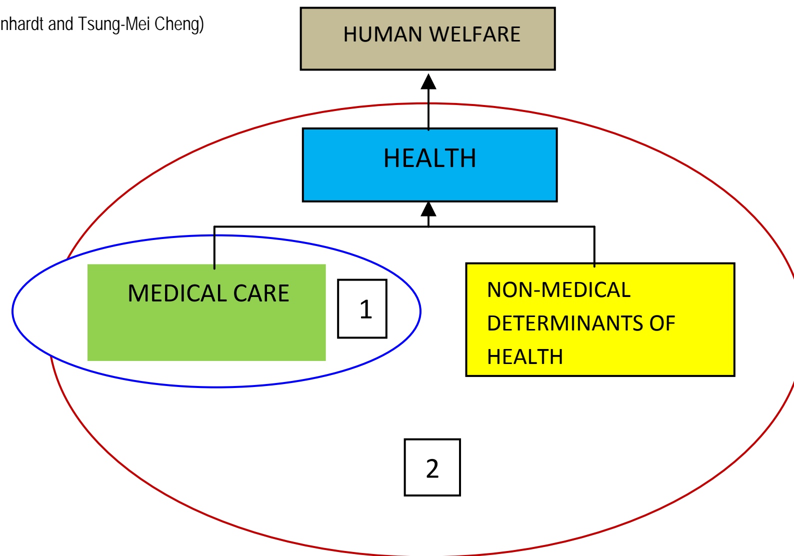
- Offer financial support for public health and healthcare training and education in EMCs (and other countries affected by out-migration)..
- Provide sufficient health science education in their own countries to eliminate manpower deficits and diminish demand for migratory health professionals while helping stabilize health workforces and strengthening health systems in EMCs.
- Offset the impact of international migration by supporting and funding short and longer term assignments in EMCs by healthcare professionals from beneficiary countries.

3. EMCs Should Develop Integrated Health Strategies

Heath and Healthcare
EMC governments should develop strategies that take full account of non-medical determinants of health including economic, social and environmental conditions, education, internal and external security, behavioural and lifestyle choices and correlations between socio-economic equity, health and life-expectancy.

These strategies should provide a framework for coordinating action between all branches of government with health-related responsibilities (which typically include ministries responsible for

fiscal, monetary, trade, social welfare, labour, housing, transport, urban development, infrastructure, water supply and sewerage, education, environmental, food security, transportation and traffic management and internal and external security policies).



Leading by doing

Taking account of the fact that few OECD governments have developed comprehensive or 'joined-up' health strategies or have integrated medical education with the education of public health officers and hospital administrators, EMC governments should empower Ministers of Health or other senior figures to monitor the health consequences of all government decisions, create 'joined up' health policies, coordinate health-related decisions and corresponding actions and ensure universities and medical schools train future generations to manage and execute them. Whereas most debates on health in OECD countries - and increasingly in EMCs - focus on Area 1 in the above chart, EMCs should increasingly focus on the domain of Coordinating Ministers (Area 2).

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