

Globalization and Health Economics

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Globalization is a force shaping societies and economies for decades to come. There are growing flows of ideas, people and resources across borders as the world economy integrates. This is as true of health care sector as it is of other sectors. Globalization is the theme of the 4th annual Congress of the International Health Economics Association to be held in San Francisco in June 2003. Countries around the world have much to learn from each others' experiences. Some countries have been front runners in innovations in technology, organizational forms and management systems. Others have done well in equity in access to and outcomes of health care. There are many familiar trade-offs in health care: how to deliver quality care to consumers within reasonable costs; how to promote equity and still preserve choice in modes of financing and delivery; how to stimulate and reward innovations while passing on the benefits to the largest possible number of consumers. Developments in biotechnology and genetics offer exciting possibilities but are raising new policy questions. Different countries are grappling with these old and new policy issues in their own ways. There are lessons to be learned and past mistakes to be avoided.

The United States has much to offer.....

The US has by far the world's largest and most complex health care markets, now accounting for more than 35% of global health spending (according to World Bank Compilations). Health care spending crossed \$1.6 trillion in 2002. The US health care system leads in its emphasis on quality and choice to consumers. It is also characterized by rapid innovations in technology, and the emergence of new organizational modes of financing and delivering care. Its schools are world leaders in medical and health services research. They attract students, researchers and policy makers from around the world.

The rapid growth of managed care is one of the big stories of the US health care system in recent years. Managed care refers to modes of financing and delivering health care that manage health care decision making by patients and physicians. Managed care organizations provide coverage for care obtained from a set of predetermined providers specified by the plan. Managed care can limit and define the set of treatments provided, specify the providers who can provide care, and require prior approval for certain kinds of procedures and treatments. In effect, managed care seeks to control costs through the use of administrative controls on the type and amount of care provided. Managed care has brought innovations in organizational forms and management systems. The two most common organizational forms associated with managed care are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These managed care plans have become the main source of coverage through employers. Under conventional insurance plans, customers had little incentives to shop for low cost providers. But managed care has induced 'buyer-driven competition'. Managed care plans market themselves to employers on the basis of cost and therefore, these plans have strong incentives to control costs. There is evidence that managed care curbed the rise in health care costs during the 1990s although costs have started to rise again in the last few years with some evidence that managed care has run its course. Moreover, there has also been a backlash to mc by consumers and providers.

Market forces have lead to horizontal consolidation in hospitals. New and less invasive procedures that can often be performed on an outpatient basis have lead to excess capacity in hospitals; closures, acquisitions and mergers are all attempts to reallocate resources more efficiently. The cost of excess hospital capacity can be substantial; in 1995 it was estimated that an excess hospital bed cost about \$50,000 a year even after taking into account the need for some surplus capacity to meet unexpected demand. Hospital operating costs per patient were found to drop by about 9% if average bed occupancy rose from 59% to 79%. The US experience with managed care holds several lessons for other countries on how best to allow market forces to economize on health care costs while sustaining quality and choice.

The client orientation of the US health care system manifests itself in the quality of care, and the emphasis on patient rights. US patients are well protected in terms of privacy of medical records and safeguards against malpractice. Many US health care consumers also tend to be well informed on choices in plans, procedures, and providers. Information is supplied by the plans and providers themselves, by patient advocacy groups, and through the media, notably the internet in recent years.

New technology has revolutionized care in the US and could arguably be one of the biggest contributions of the US health care system to the world. Although technology has often been taken as a given in most

▲ **Top** economic models and policy debates, recent research has begun to focus on technological change as endogenous to health care markets. Newly developed technology has helped prolong life and enhance quality. Many previously untreatable conditions have become curable or rendered benign. A steady stream of new drugs and procedures expands the range of services for which consumers demand coverage. The expectation of growing health insurance coverage for drugs and new procedures in turn stimulates technological innovation.

The US has much to learn from others...

A major problem and embarrassment with the US health care system is the very large number of uninsured people. The actual number depends on the way insurance status is defined but 40 million and growing is a commonly cited figure. All other developed countries and many developing countries do a better job in providing access to care to all segments of their populations. In many parts of the world, access to basic health care is regarded as a fundamental right. Governments are committed to ensuring equity in access to care and in health outcomes across all population subgroups. Polling data in the US indicates that most people prefer providing insurance for all but balk at paying substantially more for doing so. Anecdotal evidence suggests that health care costs and concerns about insurance status have become a major source of anxiety in many households. Such anxiety detracts from a sense of well being. The pressure to extend coverage for basic services to all has been mounting; US decision makers in the public and private sector would do well to study other health care systems that have achieved egalitarian results with lower overall costs.

The US can also learn from other countries on how to do more with less. The US spends a higher proportion of GDP on health care than any other country but on many basic indicators does no better than most other developed countries and indeed a few developing countries. There is some evidence that administrative costs and other overheads are significantly more in the US. However, it has been argued that a major part of the rise in US health care expenditures has not been due to rising price of existing technologies but the price for new technologies. In particular, other countries are expected to face rising health care costs as their consumers demand access to new drugs and treatments.

The importance of health economics

Health economics can help clarify old and new trade-offs, enhance understanding of economic behavior in health care markets, and provide evidence for policy decisions [The strength of economics lies in the analytic apparatus built up over several decades. This apparatus supplies the researcher with a powerful set of concepts and methodologies to bring to bear on a problem. The field of health economics has grown rapidly; in the US, the number of PhDs awarded annually in health economics has increased 12-fold since 1965. The IHEA world conference in Rotterdam in 1999 attracted about 600 participants. In contrast, about 2000 participants from over 60 countries are expected to attend the IHEA 4th World Congress. This congress provides a valuable opportunity for health economists, health service researchers and policy makers to interact and exchange ideas and experiences.

The plenary speakers include Dr Gro-Harlem Brundtland, Dr Julio Frenk and Prof. Dan McFadden. Dr. Brundtland, Director-General of WHO, has emphasized the close links between health and economic development. She has sought to make health central to the debate on economic development. She has argued that poor health is not just a product of a low level of economic development but also a cause. She has also stressed the key role of civil society and private sector in advancing public health goals. Dr. Frenk has been the Minister of Health in Mexico since 2000. Prior to that he was the Executive Director, Evidence and Information for Policy, WHO. He shares many of the convictions of Dr Brundtland; he has striven to bring rigor and clarity to key debates on public health issues. Prof. McFadden is the E. Morris Cox Professor of Economics at the University of California, Berkeley, and the recipient of the 2000 Nobel Prize in Economics. He has done pioneering work in econometrics and economic theory; the title of his talk is "Health, Wealthy and Wise?: The causal structure of the Association of Health and Socioeconomic Status." The congress will cover a broad spectrum of topics. There will be sessions dealing with econometric advances and their applications to health care such as contingent valuation models, spatial analytic methods in health market research and others. Some key topics covered include convergence or divergence of health systems, the economics of infectious diseases, heart disease, cancer, mental health and substance abuse. Of note would be the issue of the consumer in a global health market. There will also be presentations on cutting edge issues such as bio-terrorism, the economics of trust and health care, and the development of and impact of biotechnology.

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