2022

ASIA & THE PACIFIC HEALTH FINANCING FORUM

Increasing health system efficiencies in light of COVID-19 and longer-term trends

Financing Primary Health Care: Opportunities at the Boundaries

September 15-16, 2022
Bangkok, Thailand

Co-hosted by:

WORLD BANK GROUP · Australian Aid · GLOBAL FINANCING FACILITY · USAID FROM THE AMERICAN PEOPLE

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Health Care in a Changing World Economy

Aaditya Mattoo
EAP chief economist

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Three points

I: Recent shocks affect the capacity to finance health care

II. Long term trends affect the pattern of demand for health care

III. Grand bargain: reforms for efficiency and restructuring

I: Recent shocks and the capacity to finance health care

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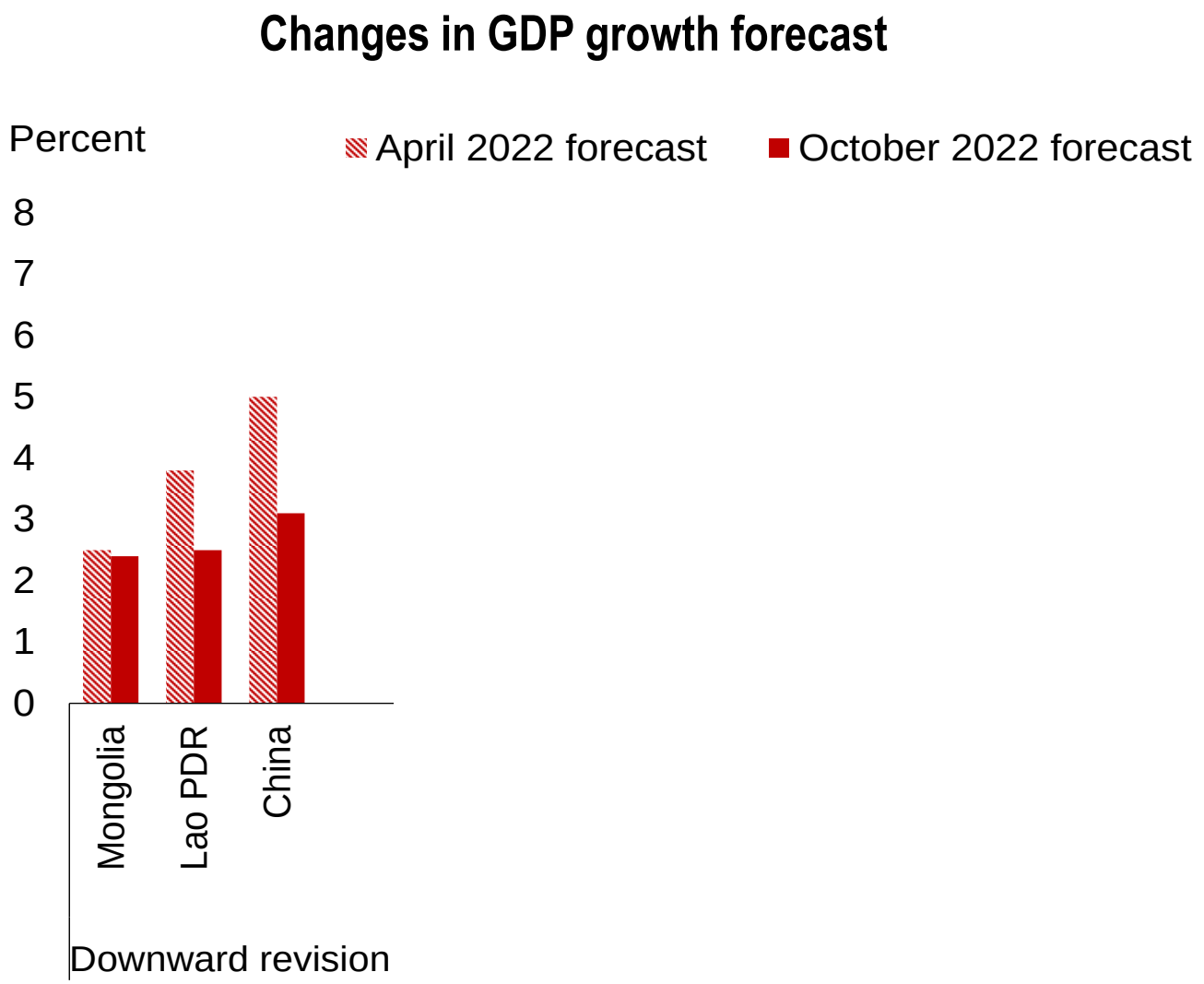
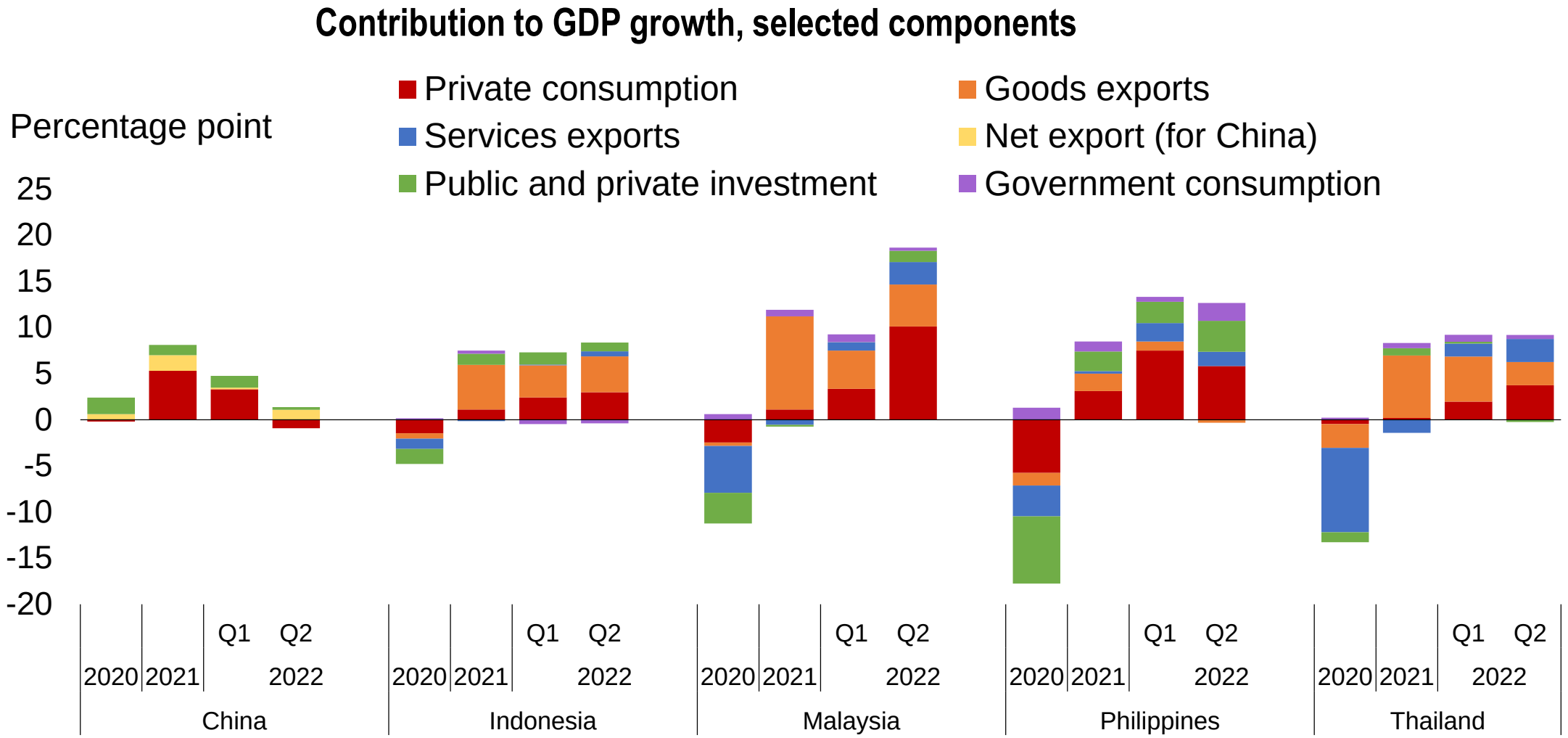
Three shocks affect capacity to finance health care

Role reversal: China slows down, rest of the region accelerates…



Why -1

Rebounding from the pandemic, private consumption and exports are driving growth in EAP outside China

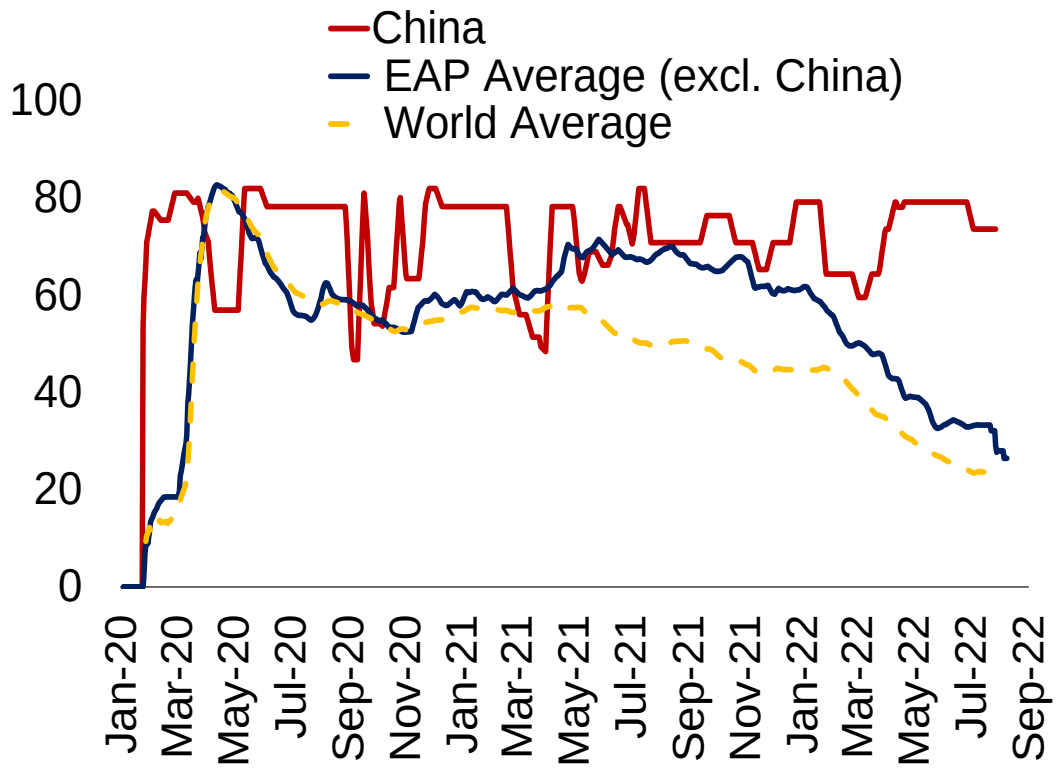


Source: Haver Analytics
Note: China's private consumption includes government consumption

Disease

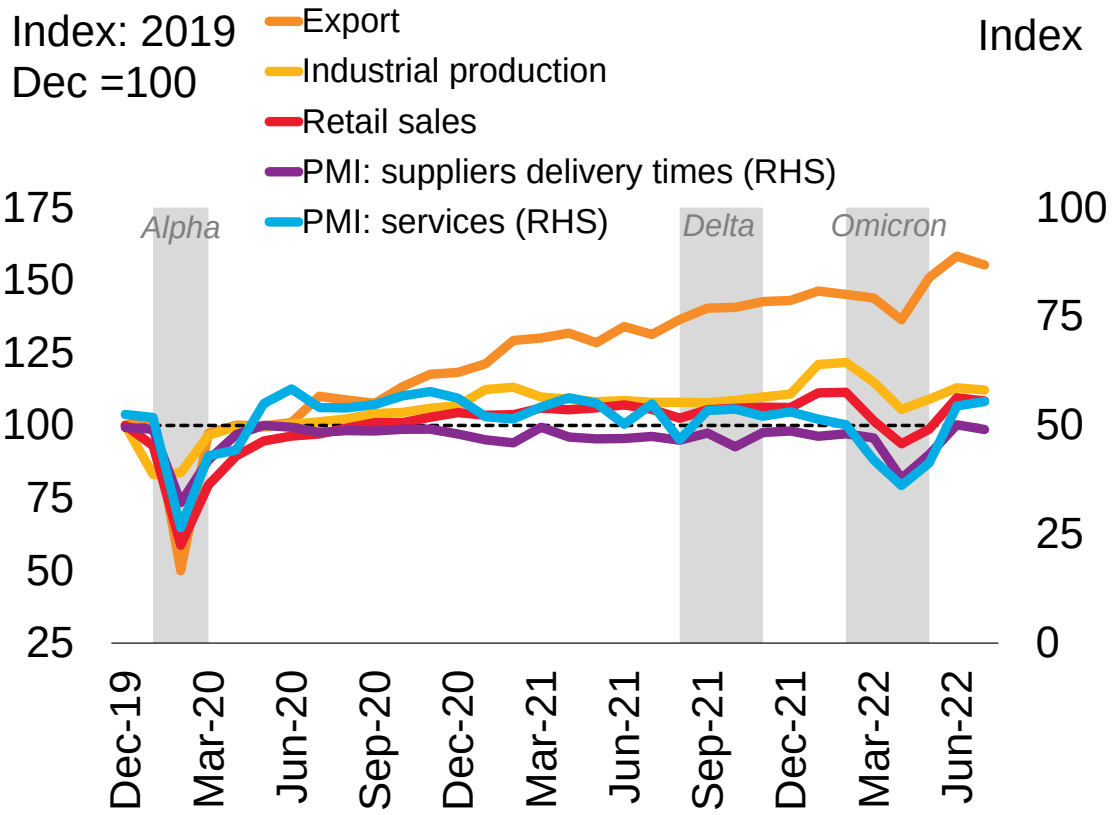
Recurrent outbreaks amidst China's zero-COVID policies are disrupting economic activity

Stringency divergence between China and rest of EAP



Source: Haver Analytics

COVID-19 infection waves and economic activity

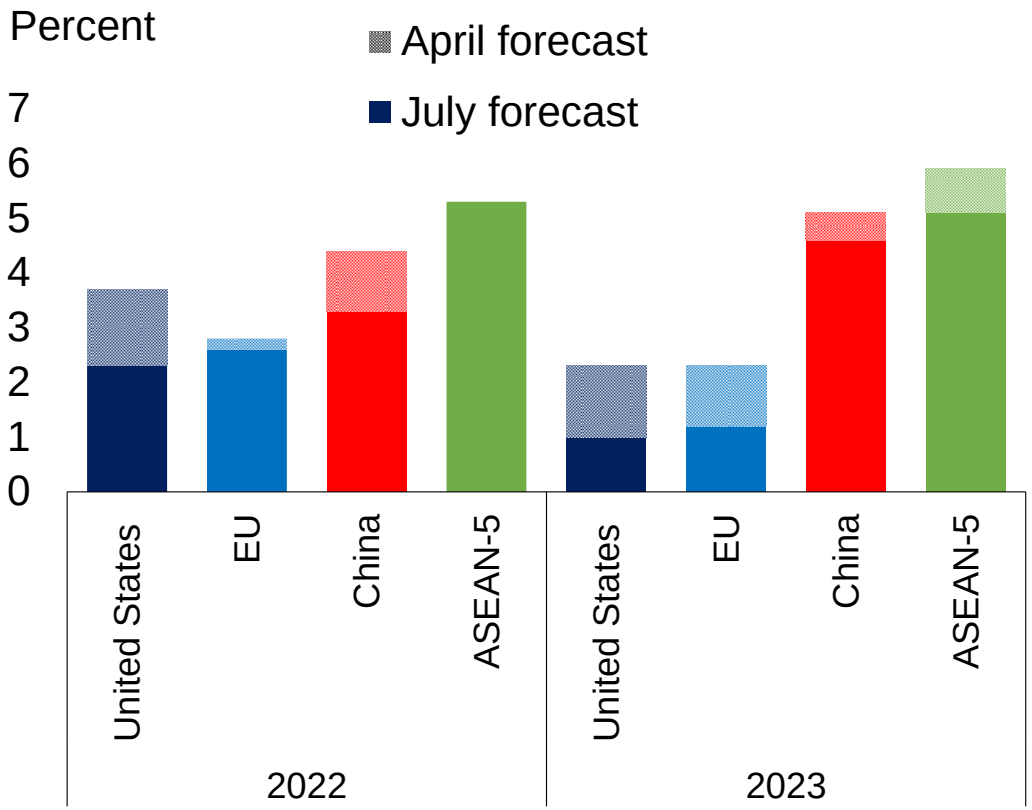


Source: Haver Analytics, Johns Hopkins University Center for Systems Science and Engineering's COVID-19 Data.

Deceleration

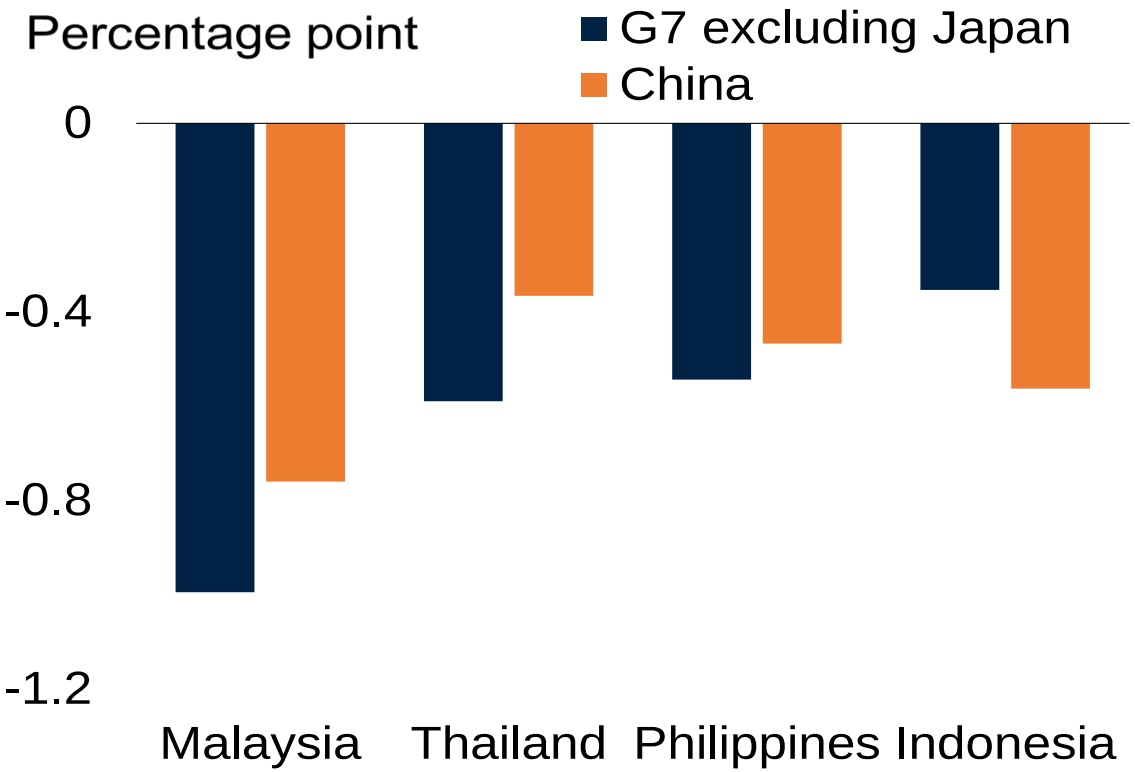
Slowing global growth will negatively affect growth in the region

Revisions in GDP growth forecast



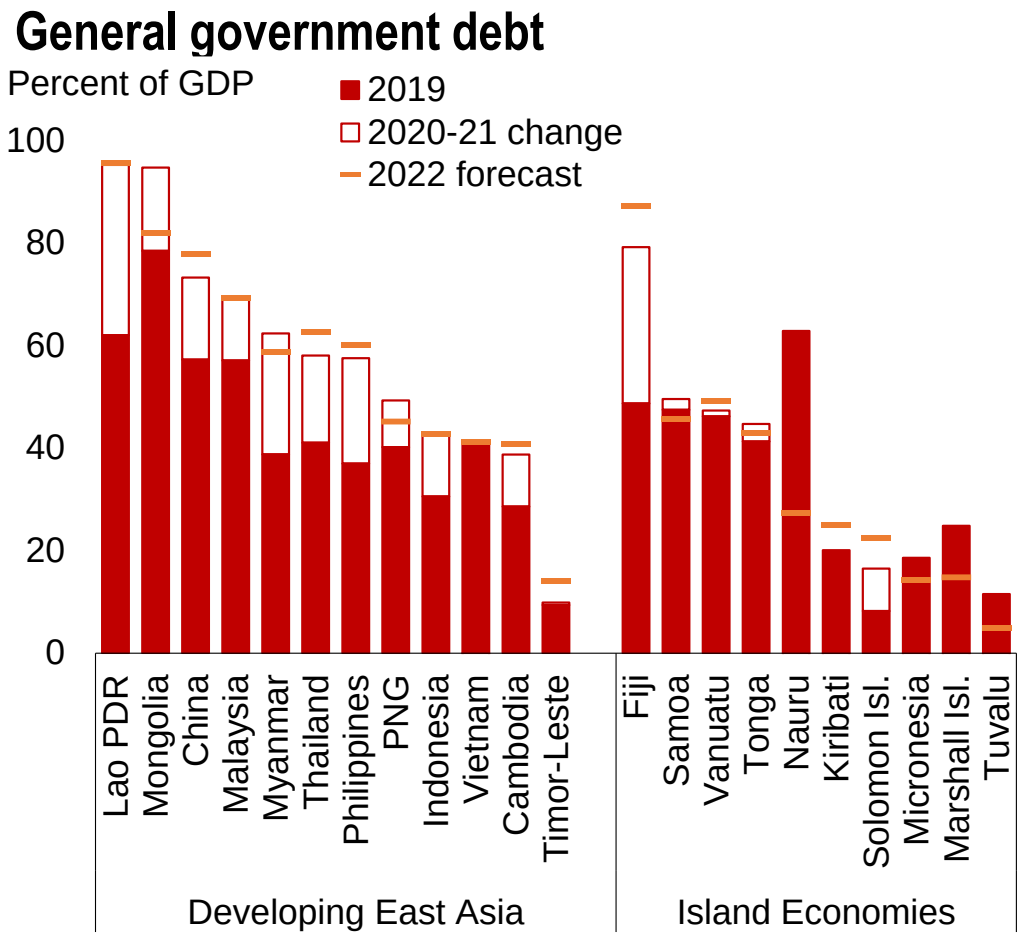
Source: IMF

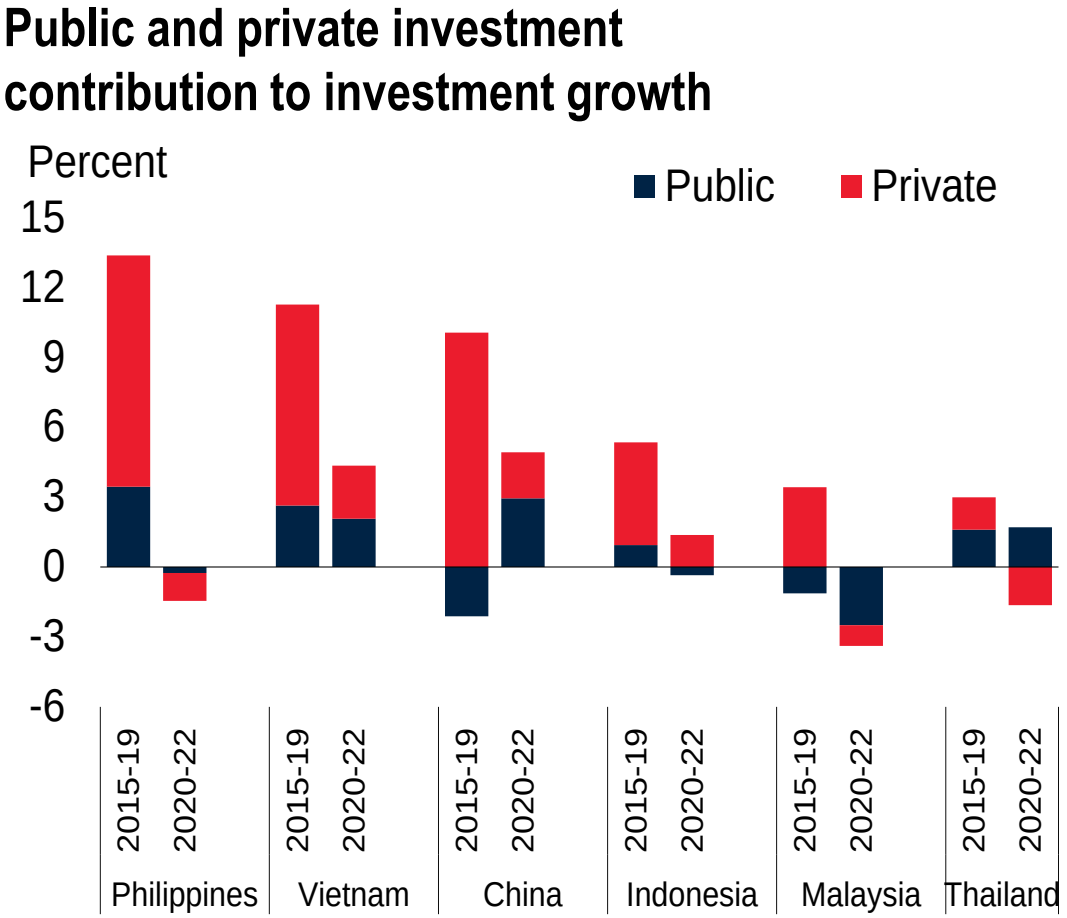
Impact of a 1 p.p. decline in the G7 (excl. Japan) and Chinese GDP growth rate



Source: IMF, WEO; World Bank staff estimates
Cumulative impact on growth after one year.

The increasing burden of debt, is inhibiting the revival of investment

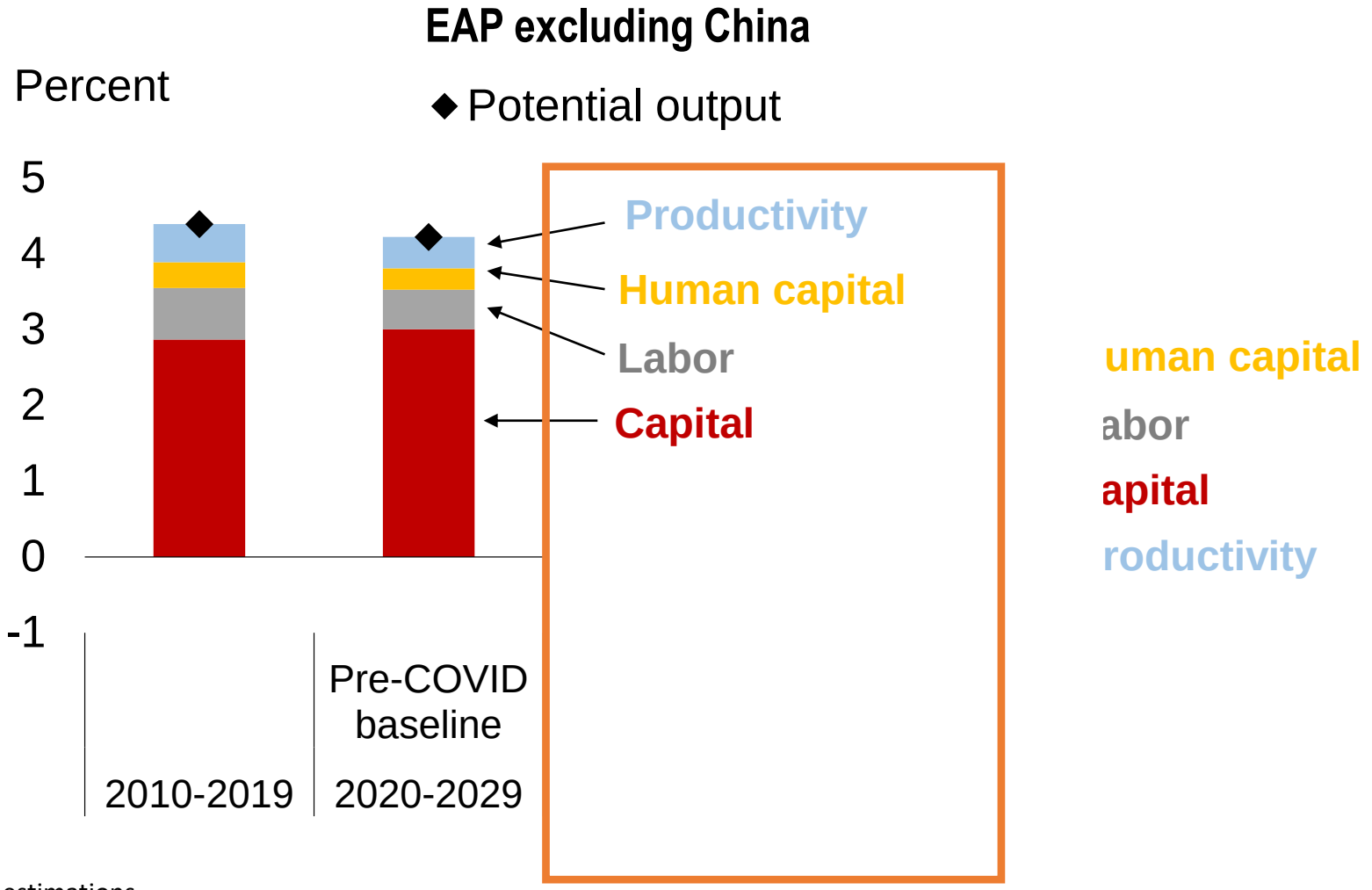




Source: IMF Investment and Capital Stock Database 2021, Government Financial Statistics, International Monetary Fund, Haver Analytics, World Bank staff estimates

Notes: B. Shows decomposition of real investment growth. 2015-19 and 2020-22 refers to average during each respective period. Decomposition of investment growth for 2020-22 represents team's forecast and assessment

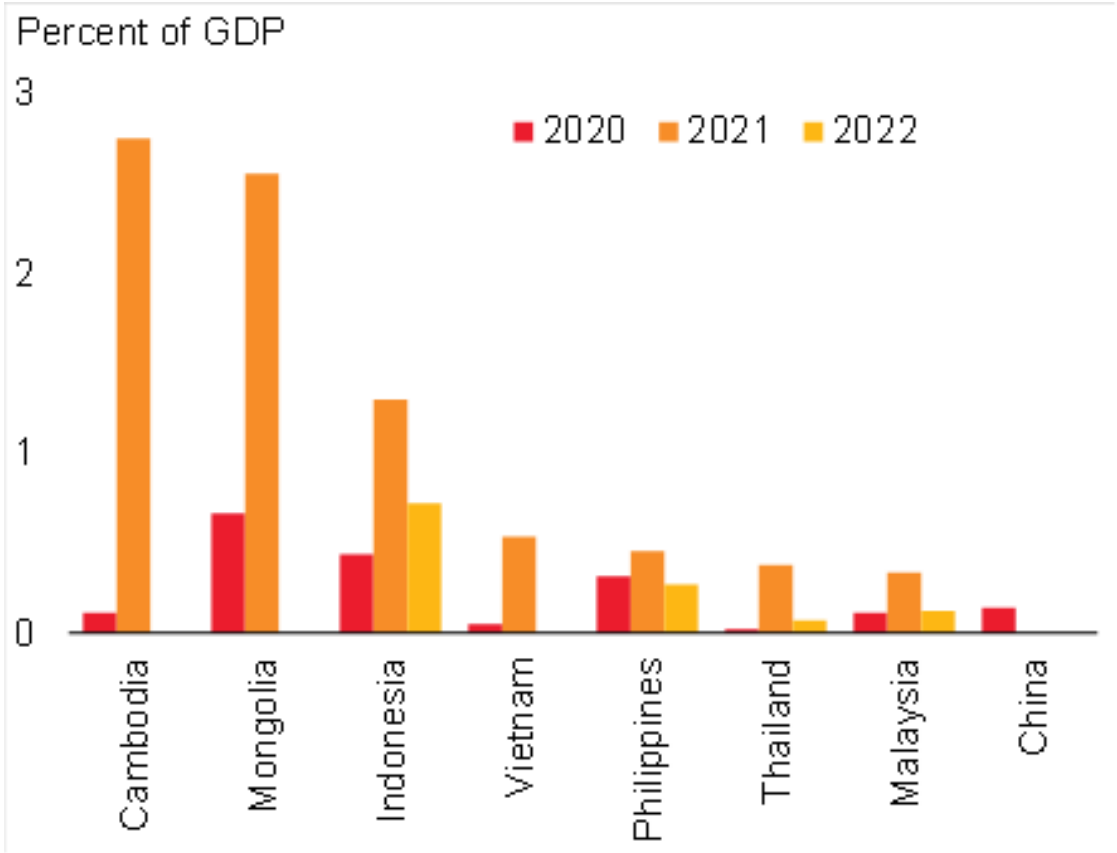
Shocks could lead to a decade of slower growth



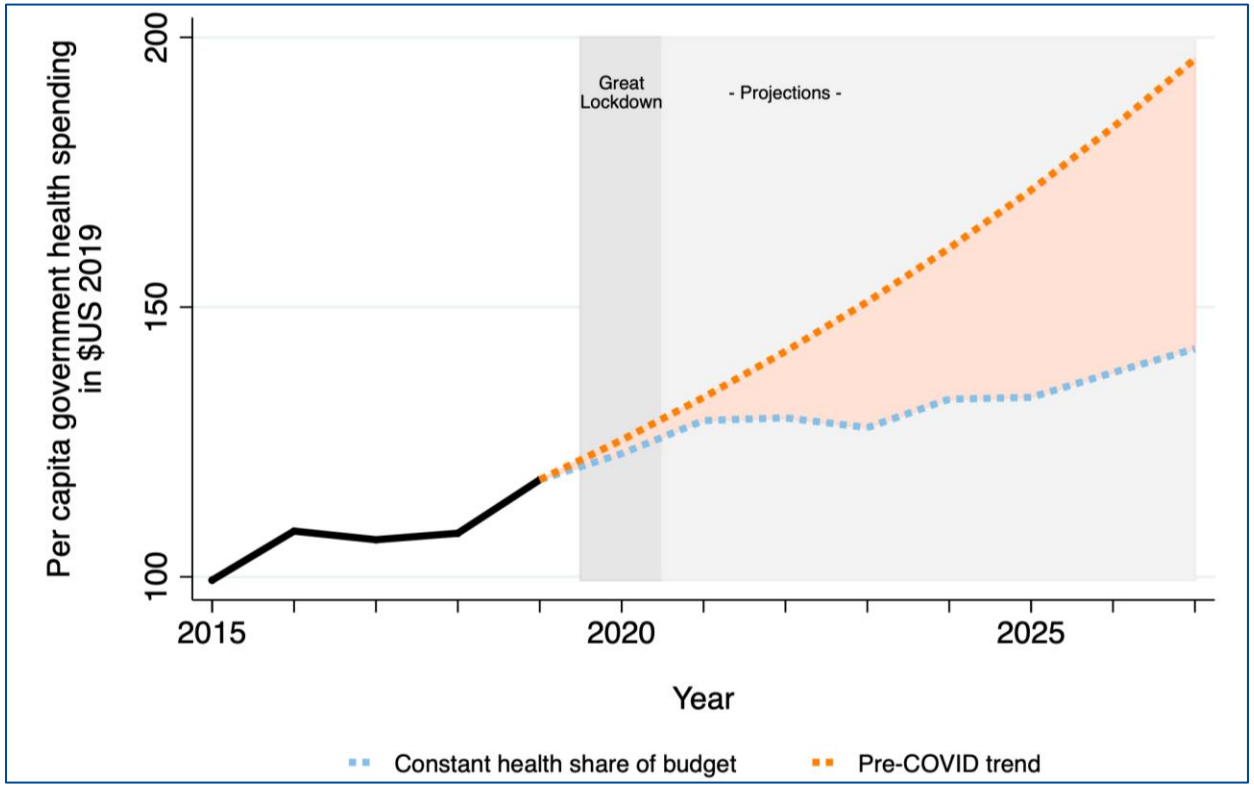
Source: Penn World Tables; World Bank Staff estimations
Notes: GDP-weighted averages of production function-based potential growth. Productivity refers to total factor productivity growth

Public spending on health as a share of GDP grew during the pandemic; but growth may diminish in the coming years unless prioritized

Per capita public spending on health in Developing East Asia, 2020-22

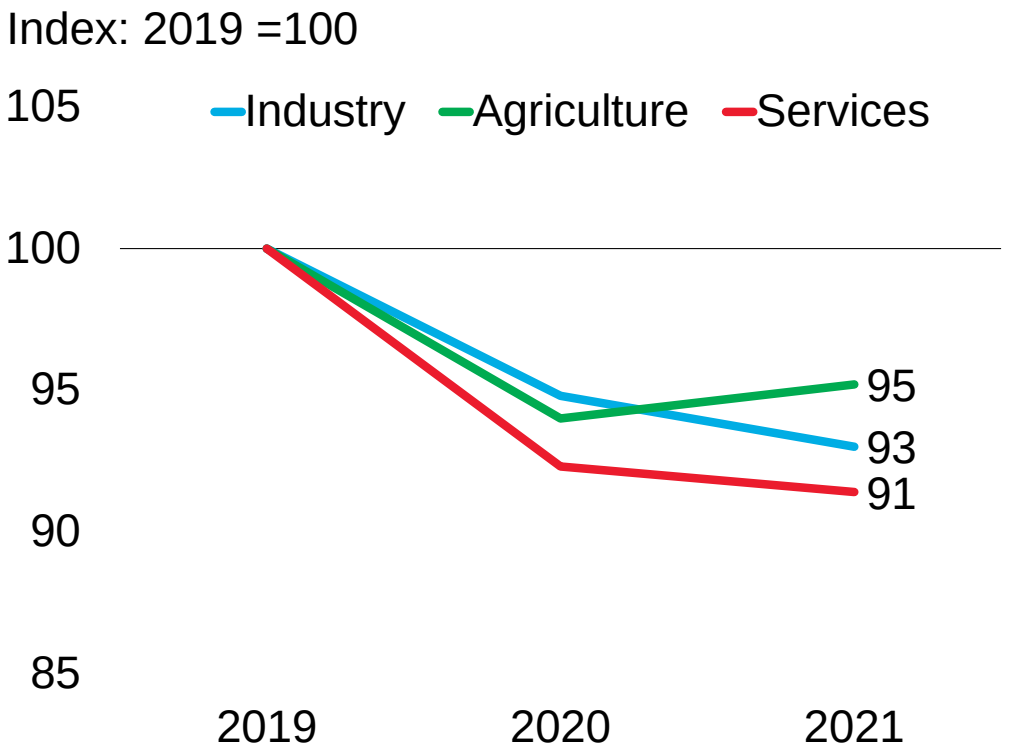


Per capita spending projections on health in Developing East Asia,

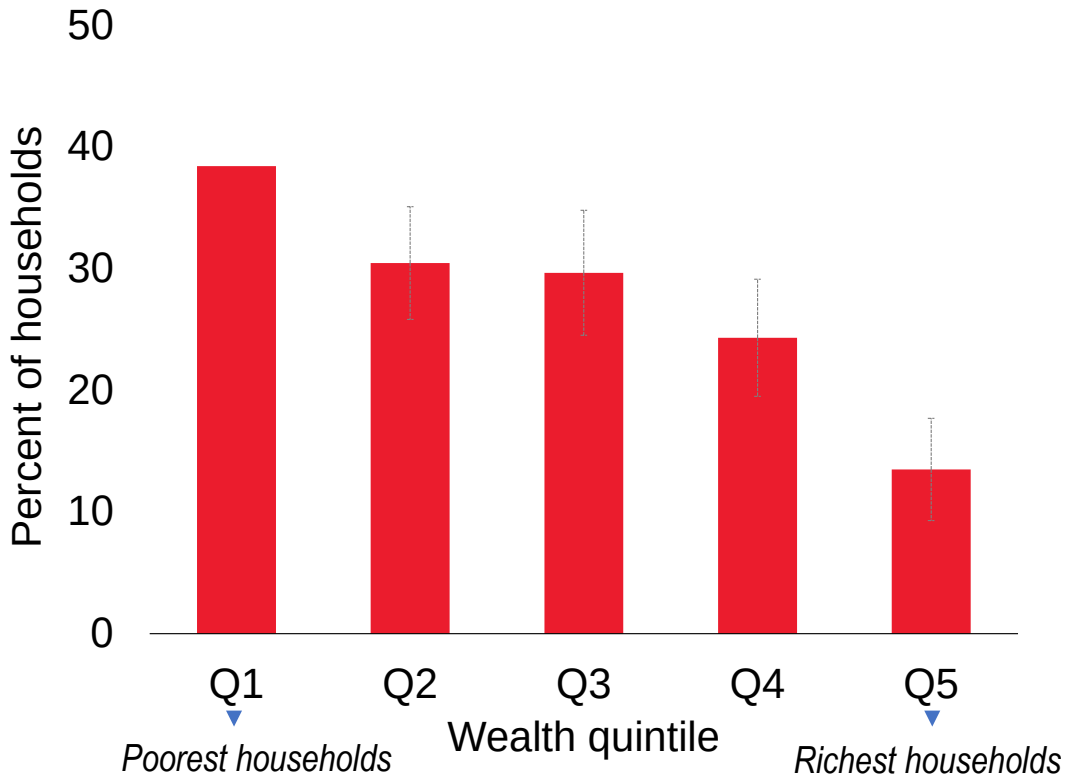


Households: Shrinking incomes and rising prices

Real earnings (Indonesia)



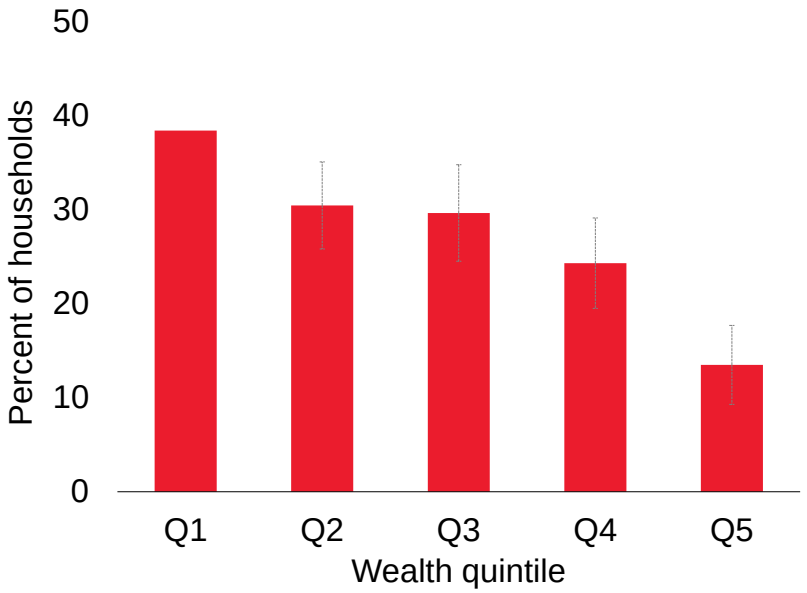
Food insecurity



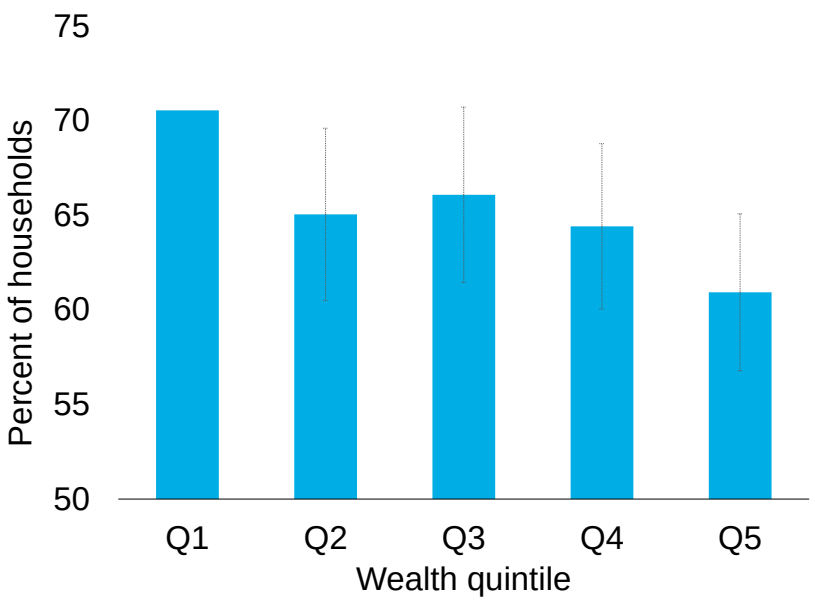
Source: World Bank staff estimates; World Bank High-frequency Household Phone Surveys 2020-21.

Rising inequality across multiple dimensions

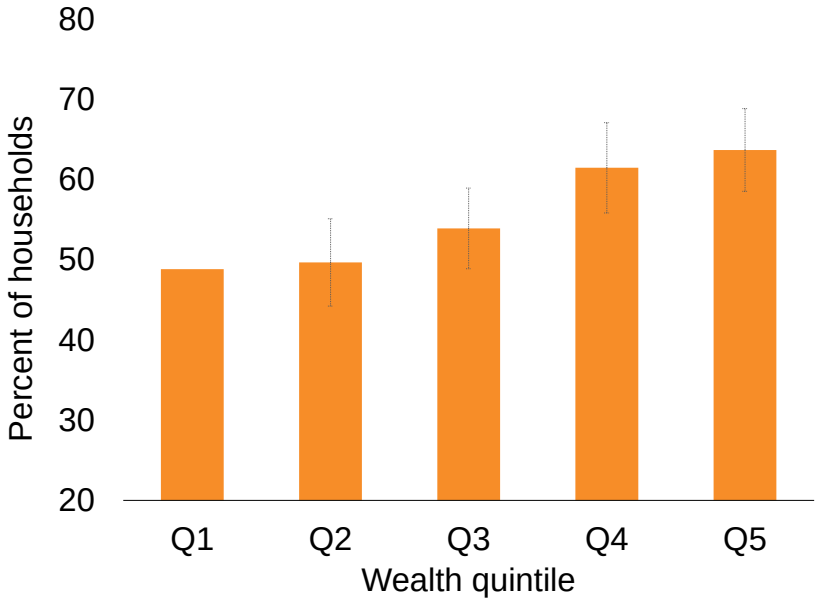
Food insecurity



Increased debt or sale of assets



Interactive education opportunities



Section II. Long term trends and the pattern of demand for health care

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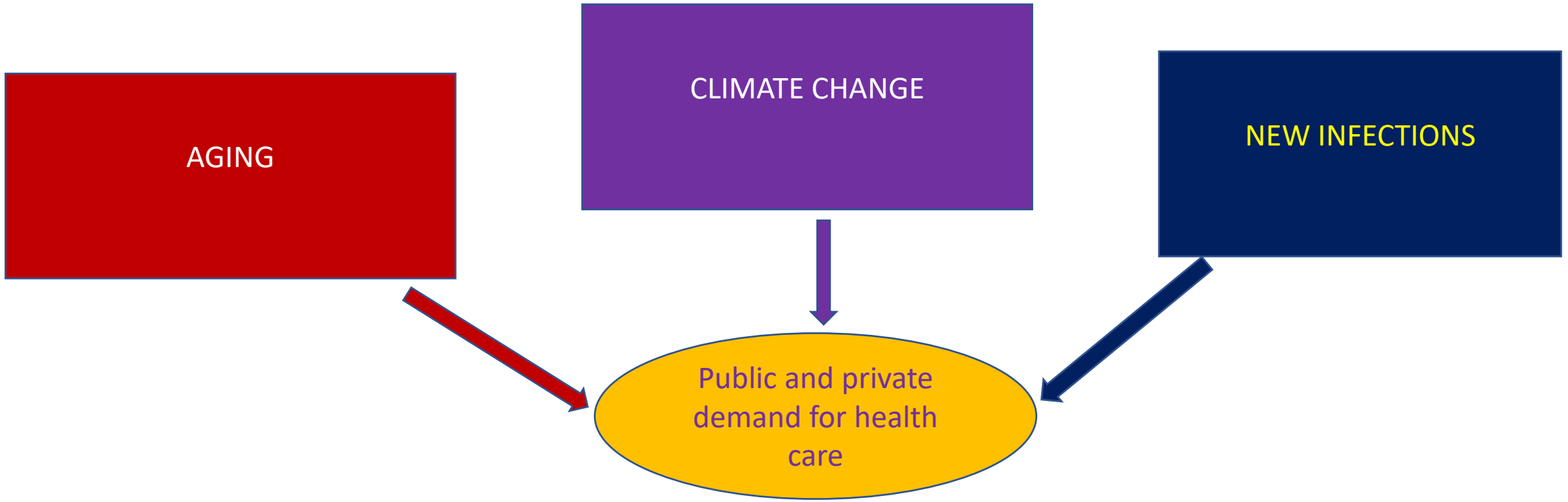
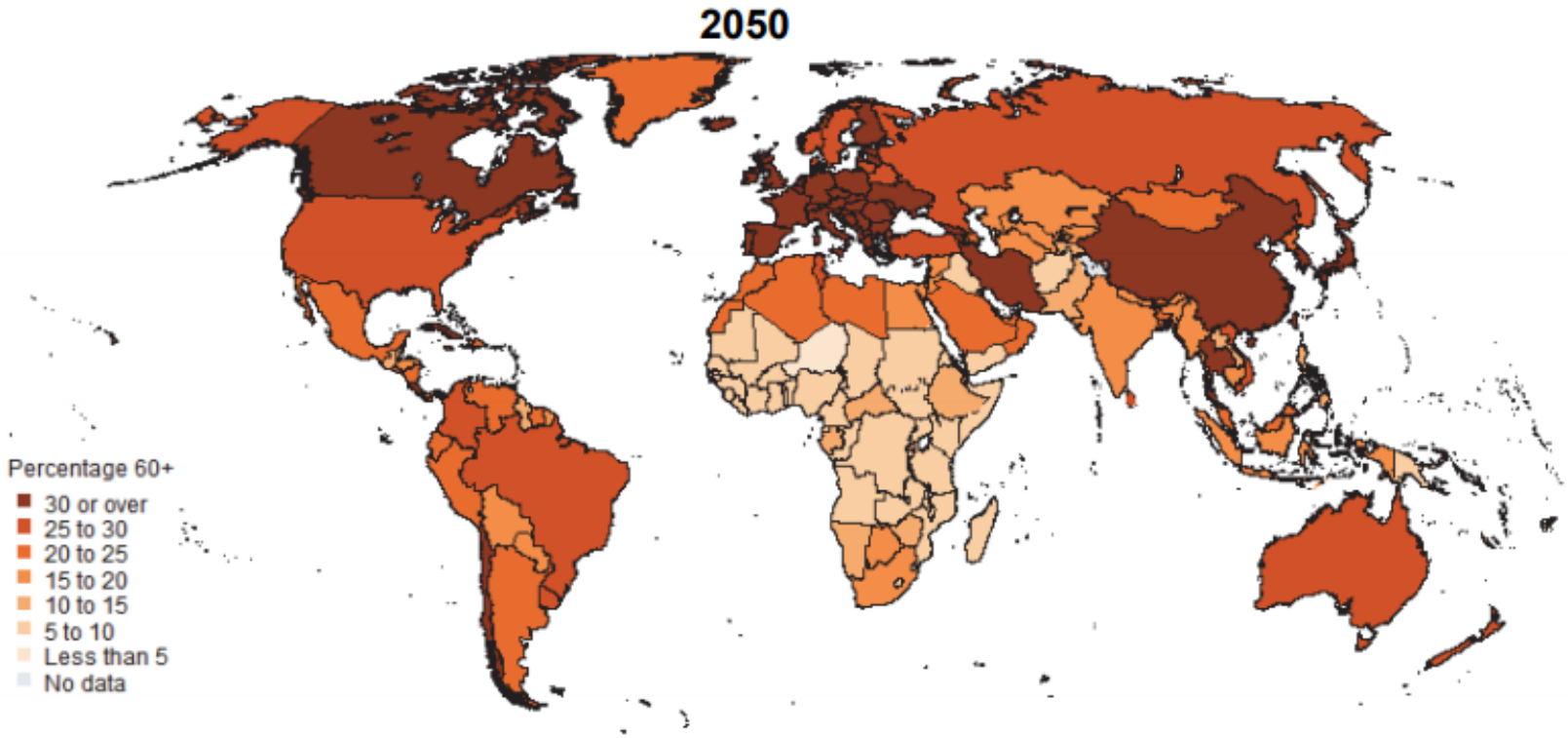
Three long term developments affect the pattern of demand for health care



An Aging Population

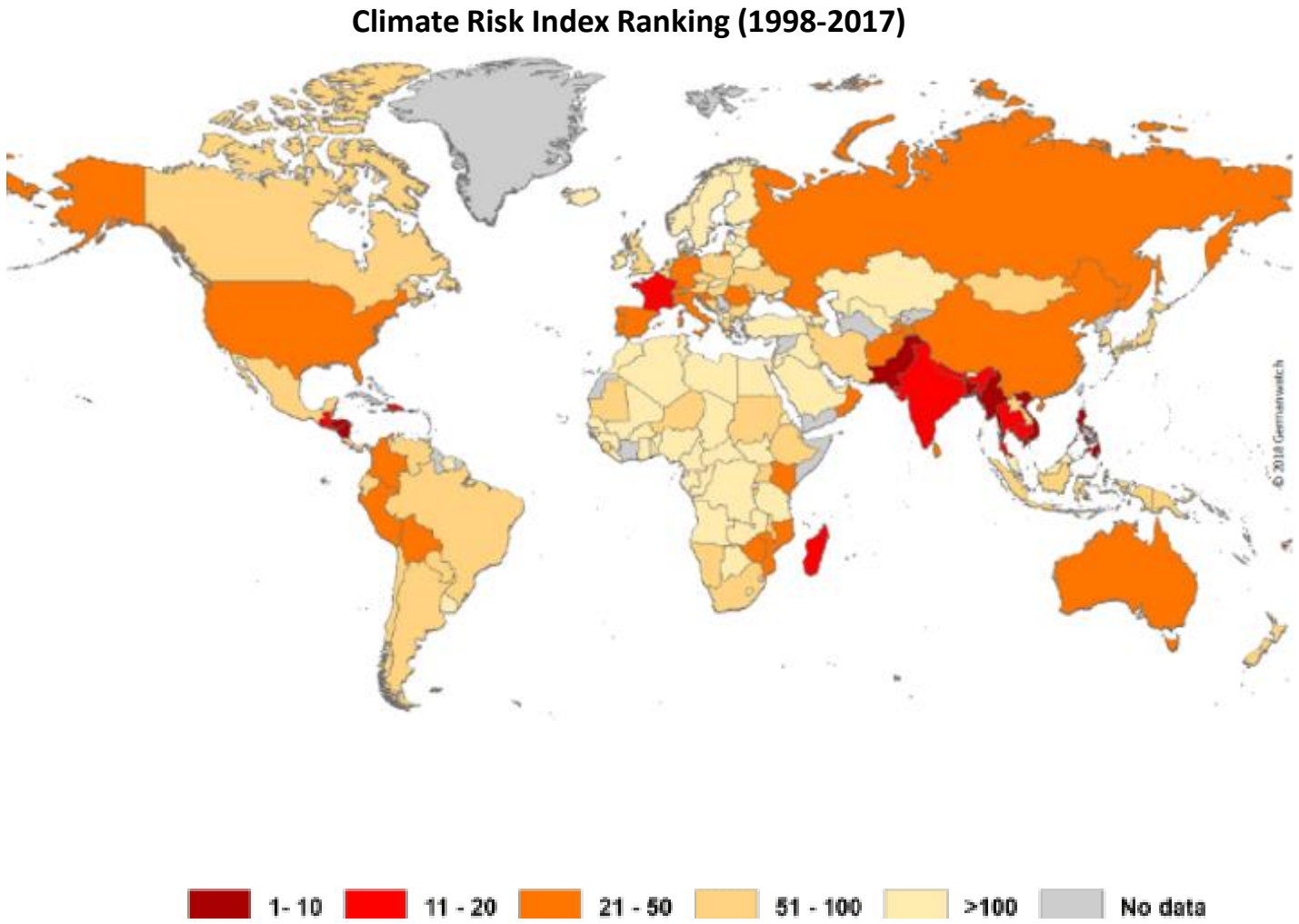
The share of EAP's population aged 60 and over is rising quickly

Proportion of population aged 60 or over

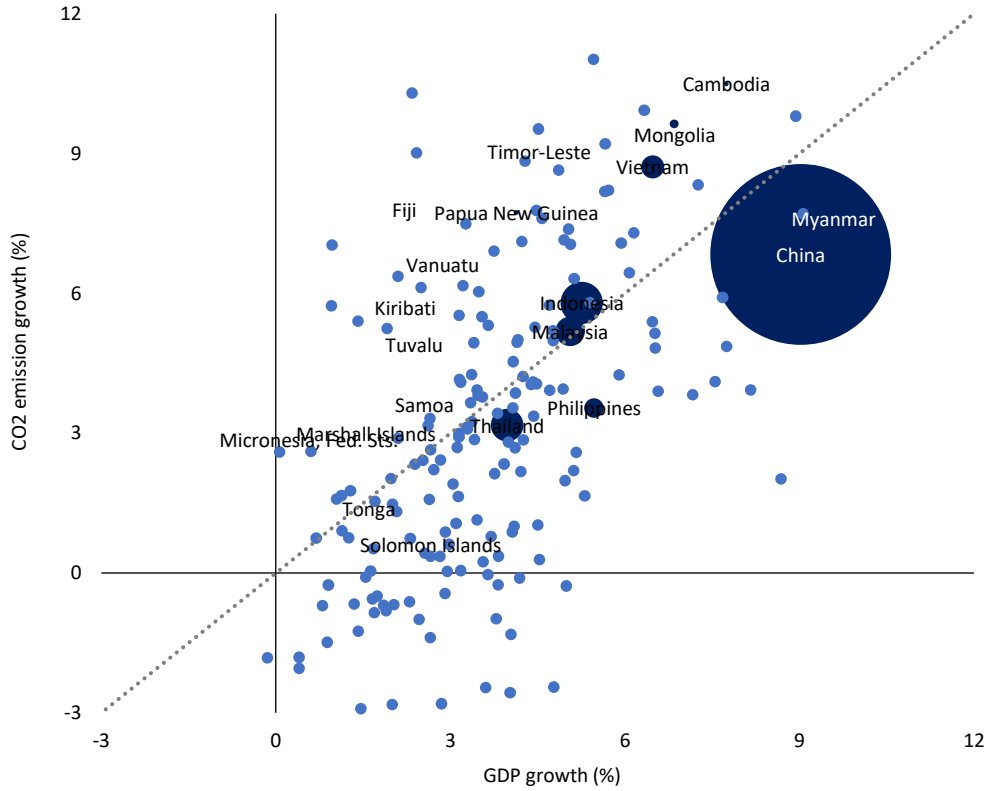


A Changing Climate

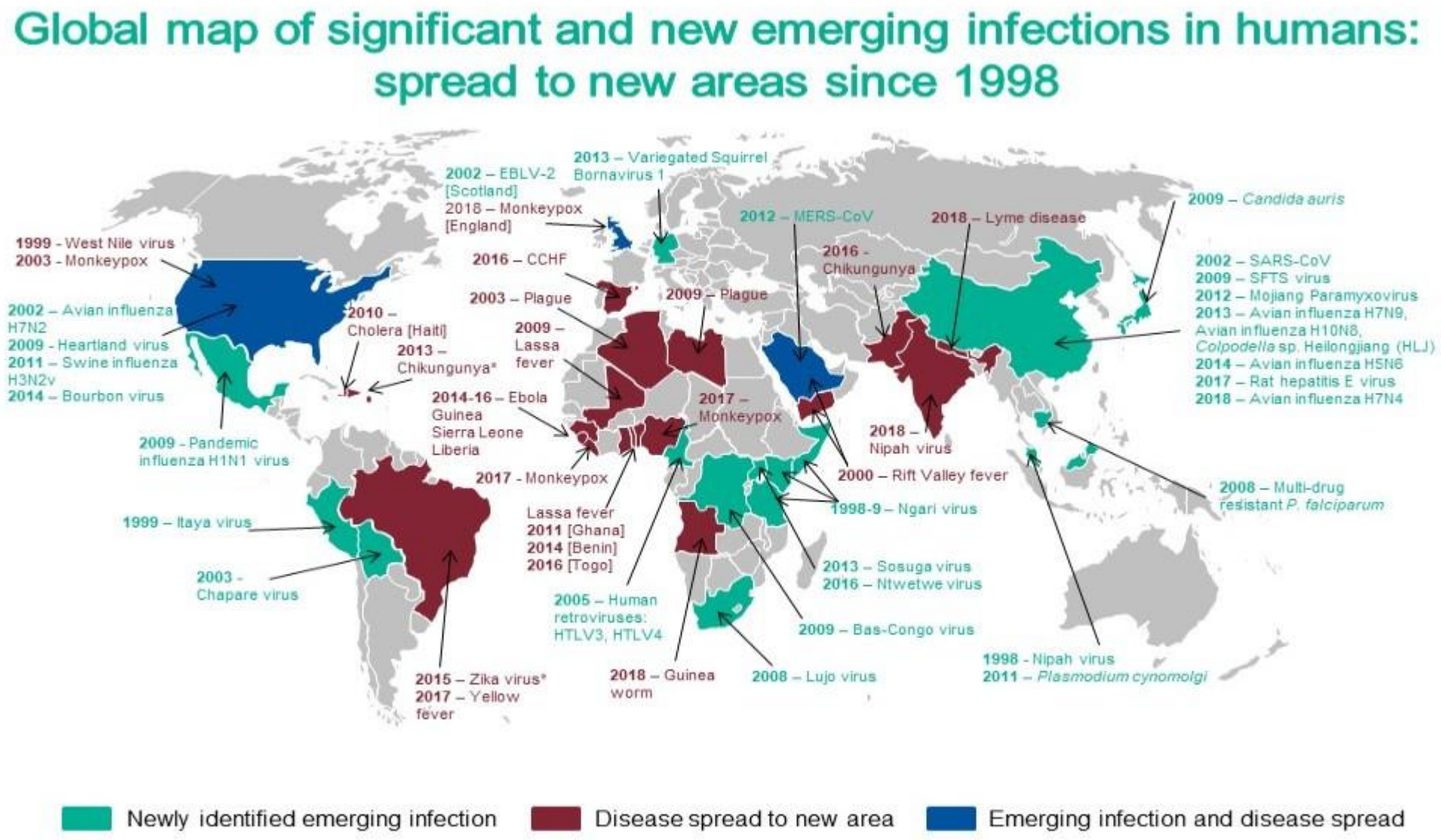
EAP countries are highly exposed to climate change impacts



And their growth is carbon intensive

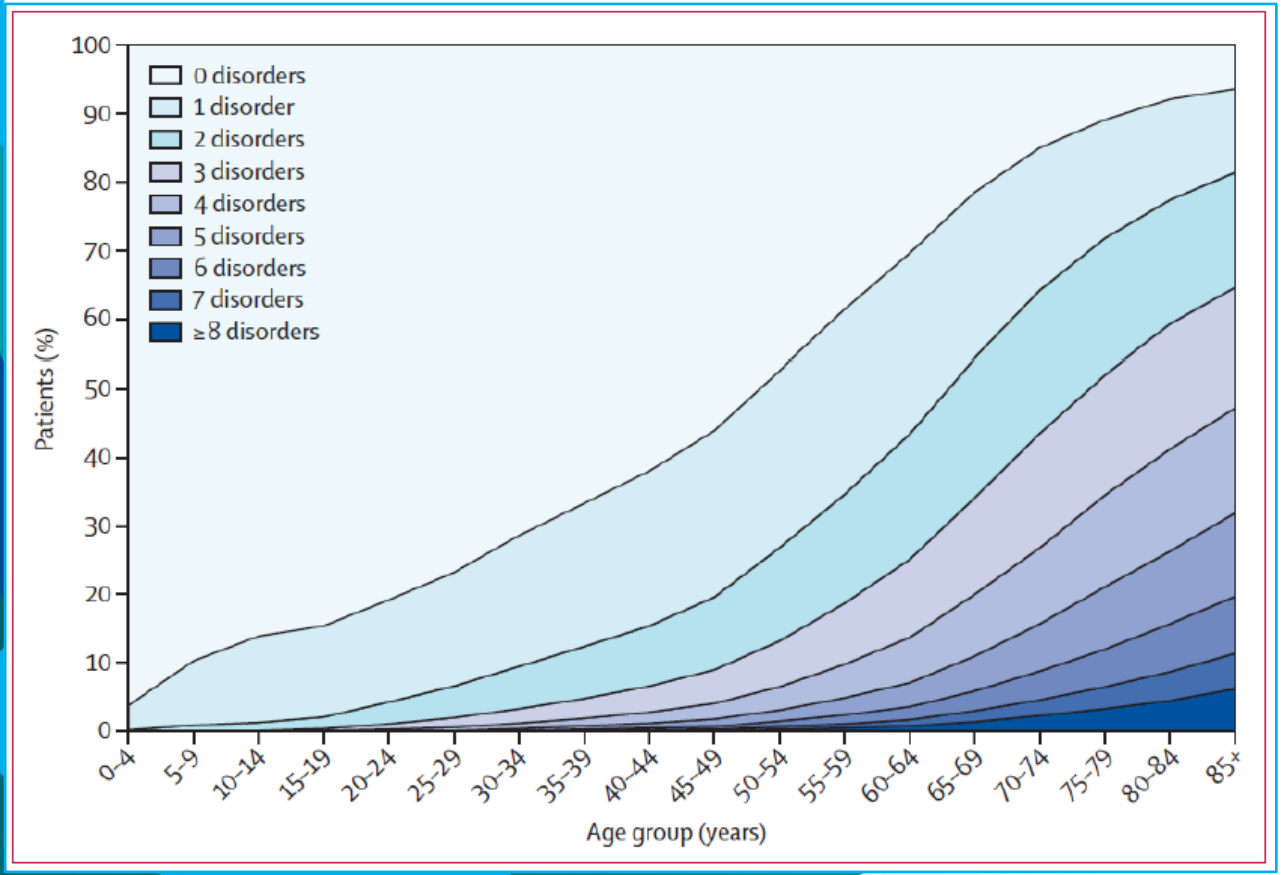


A threat of new infections



Aging is an important risk factor for NCDs and leads to more complex and costly health care needs

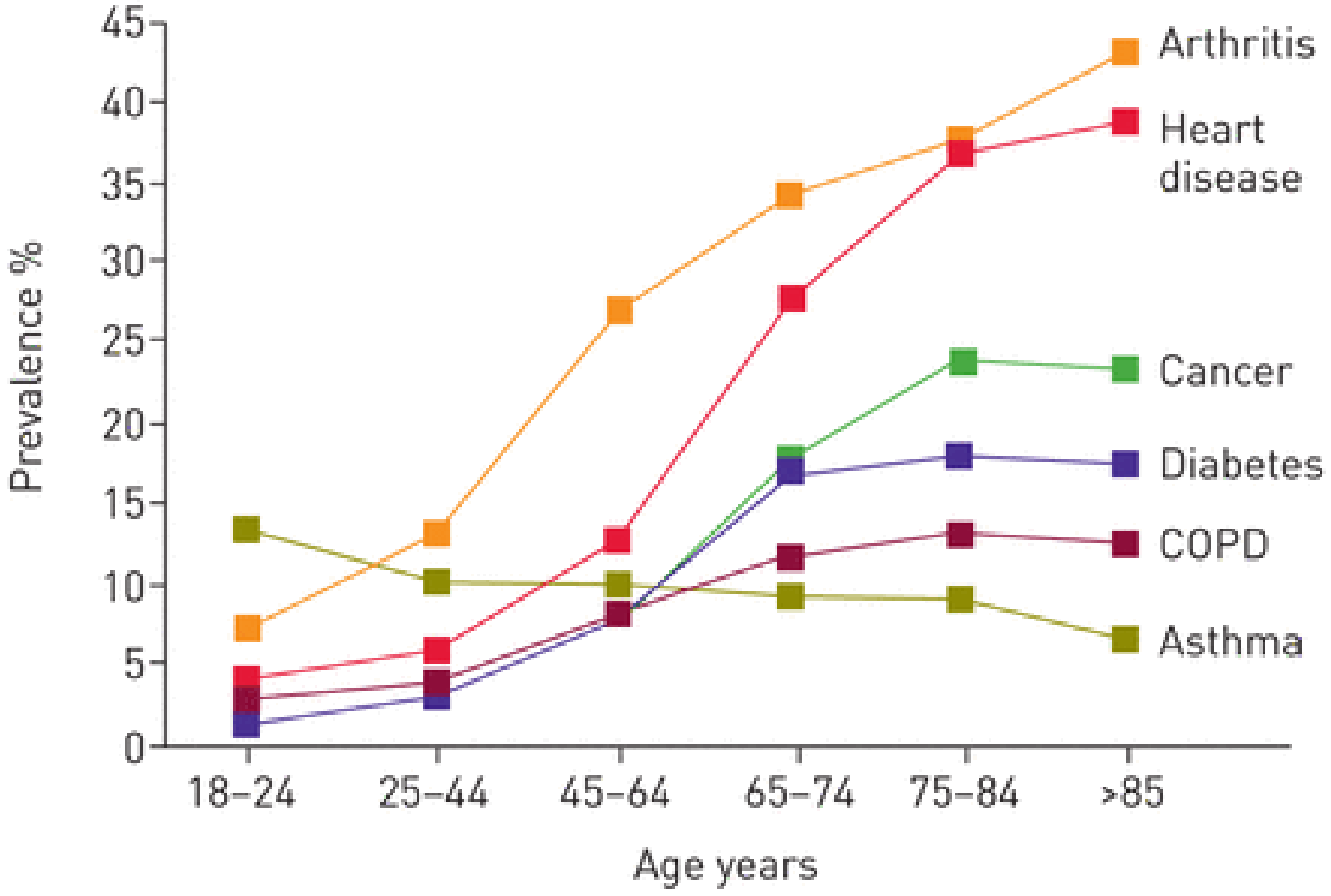
Correlation between age and number of disorders



Example from an EAP country: annual health care claims for an elderly person can be 4x that of a young person

Age Cohort	National
00-04	15,313
05-09	5,301
10-14	4,369
15-19	6,726
20-24	5,894
25-29	6,790
30-34	13,256
35-39	10,708
40-44	11,380
45-49	13,962
50-54	18,956
55-59	24,234
60-64	29,131
65+	20,980
ALL AGES	11,671

Age-related diseases and changing demand for health care



Source: Harris RE, ed. Epidemiology of Chronic Diease Global Perspectives. Massachusetts, Jones and Bartlett Learning, 2013

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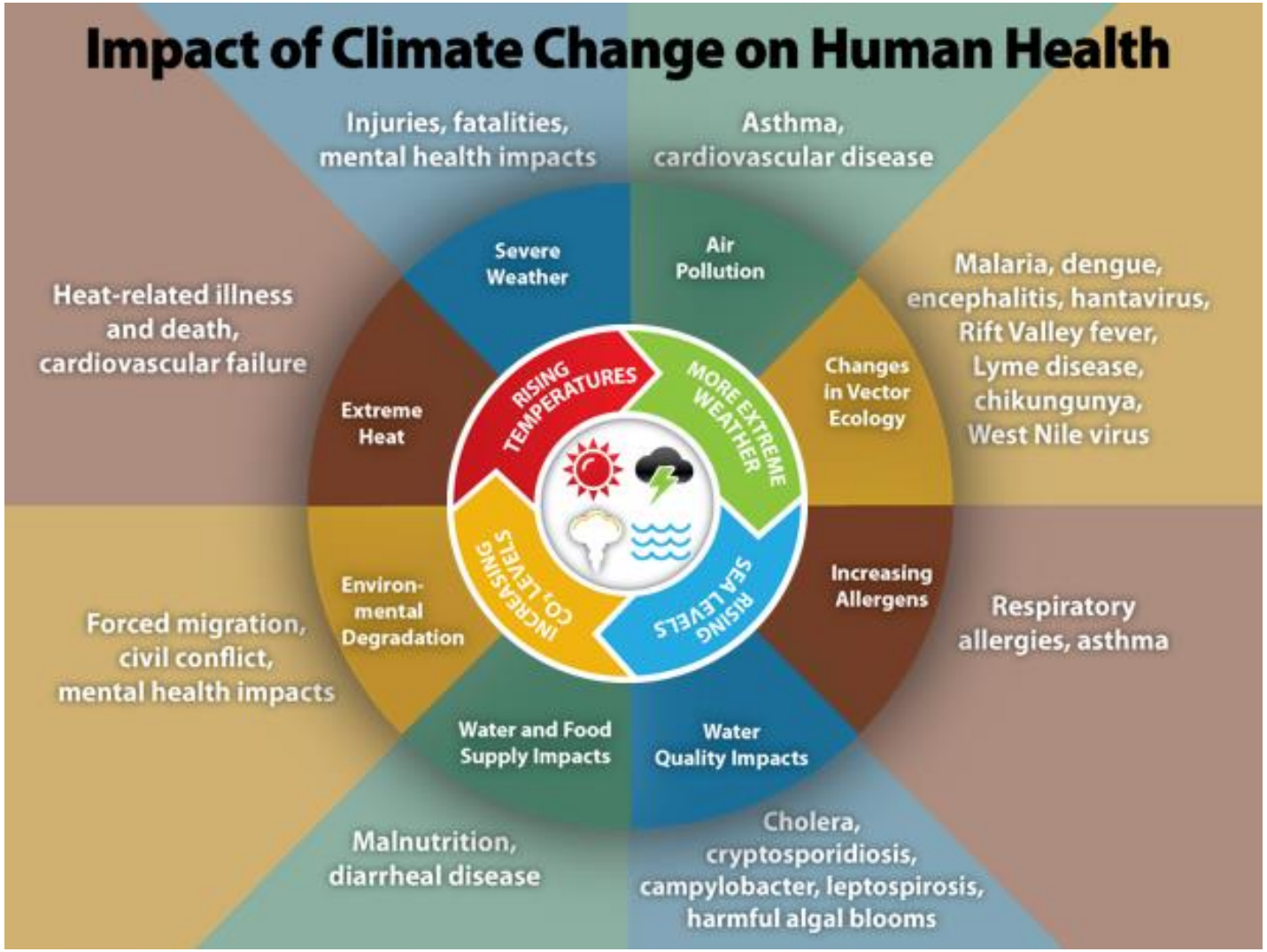
Source: World report on Ageing And Health

Climate change and health



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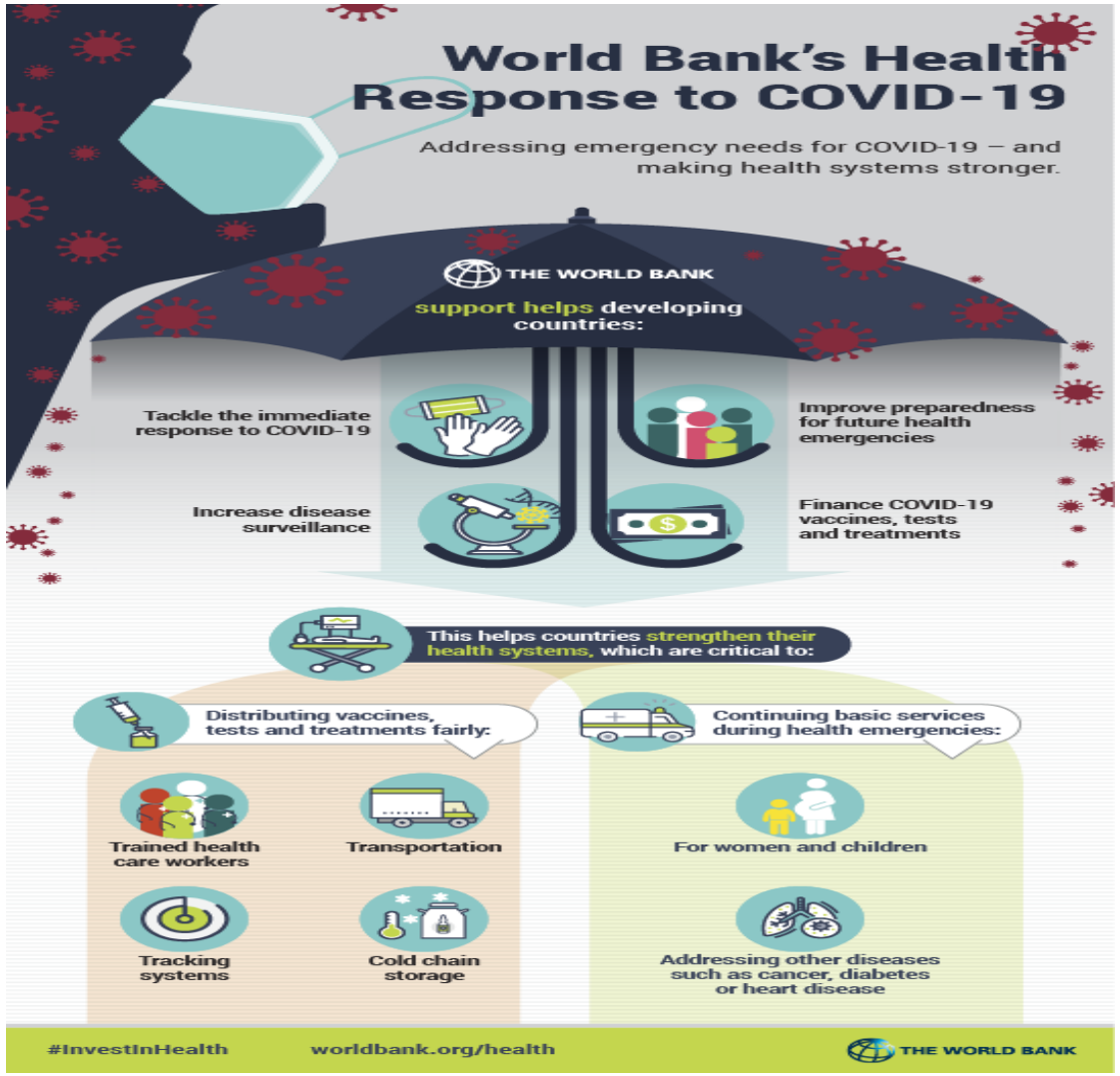
The elements of pandemic preparedness



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Section III. Grand bargain: Reforms for efficiency and restructuring

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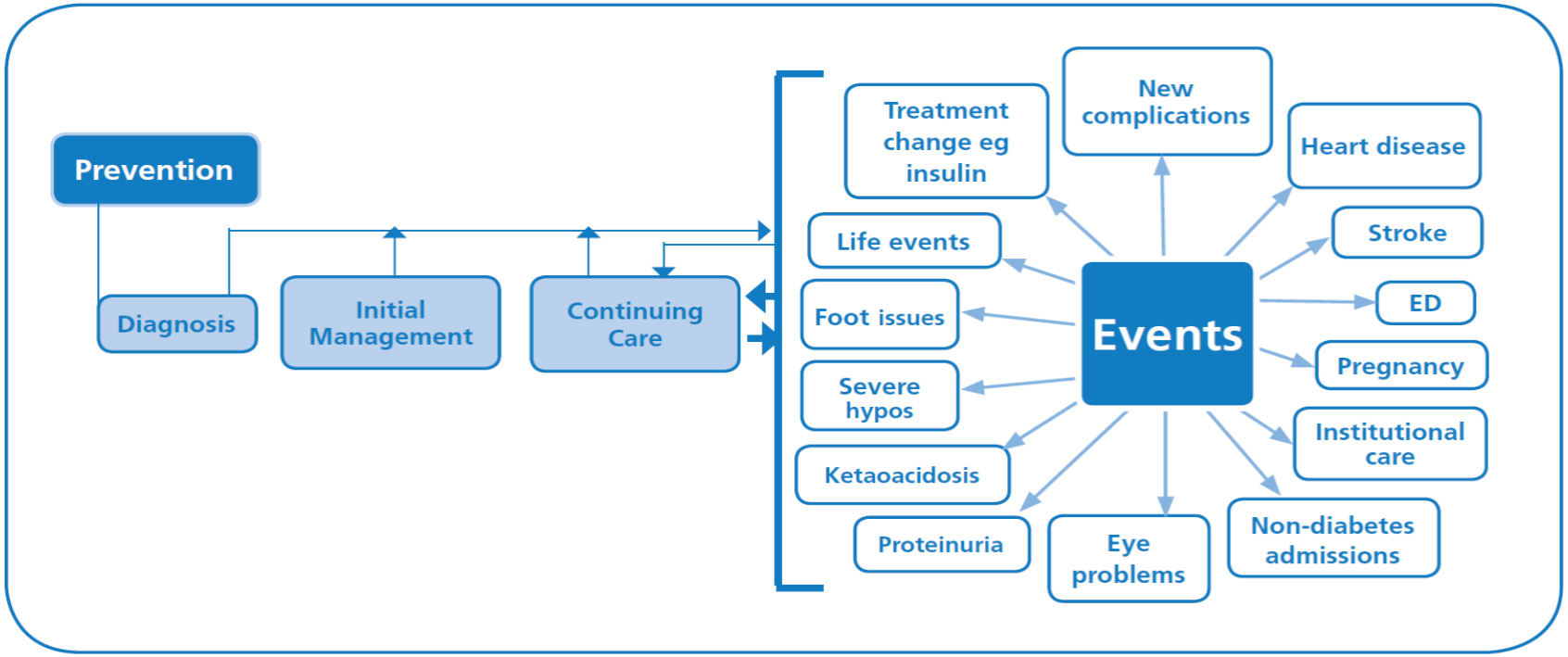
Where is our health budget spent?—example of type 2 diabetes

- Most budget spent on managing the disease events, instead of prevention, early diagnosis and management



Where is our health budget spent?—Conventional vs older person-centered care

Table 4.3. Conventional care versus older-person-centred and integrated care

Conventional care	Older-person-centred and integrated care
Focuses on a health condition (or conditions)	Focuses on people and their goals
Goal is disease management or cure	Goal is maximizing intrinsic capacity
Older person is regarded as a passive recipient of care	Older person is an active participant in care planning and self-management
Care is fragmented across conditions, health workers, settings and life course	Care is integrated across conditions, health workers, settings and life course
Links with health care and long-term care are limited or non-existent	Links with health care and long-term care exist and are strong
Ageing is considered to be a pathological state	Ageing is considered to be a normal and valued part of the life course

Changes in demand for health care calls for re-orienting health system delivery model

- Focus on NCD prevention and early disease management
- Shift from hospital-centric health system to reimagining primary care delivery model
  - Strengthen disease surveillance mechanism
  - Leverage on functional information system and digital solutions
  - Ensure the supply of essential medicines in PHCs

Many LMIC countries still don't have essential medicines for NCDs available at their PHCs

Table 1. Percentage of Member States with general availability of essential medicines in primary care facilities of the public health sector, by income group, 2019

Medicines	Low-income (%)	Lower-middle-income (%)	Upper-middle-income (%)	High-income (%)	Global (%)
Insulin	45	63	90	96	78
Aspirin (100 mg)	71	87	93	100	90
Metformin	61	78	95	100	87
Thiazide diuretics	68	76	92	100	87
ACE inhibitors	58	63	92	100	82
Angiotensin II receptor blockers	29	50	78	96	69
Calcium channel blockers	45	63	92	100	80
Beta blockers	55	61	92	100	81
Statins	29	48	83	98	71
Oral morphine	13	17	40	86	44
Steroid inhaler	19	33	77	96	63
Bronchodilator	55	70	92	100	83
Sulphonylurea(s)	35	57	90	98	76
Benzathine penicillin injection	68	76	85	96	84

Source: HEALTH SYSTEM CAPACITY FOR NONCOMMUNICABLE DISEASE MANAGEMENT (WHO)

What should we do?

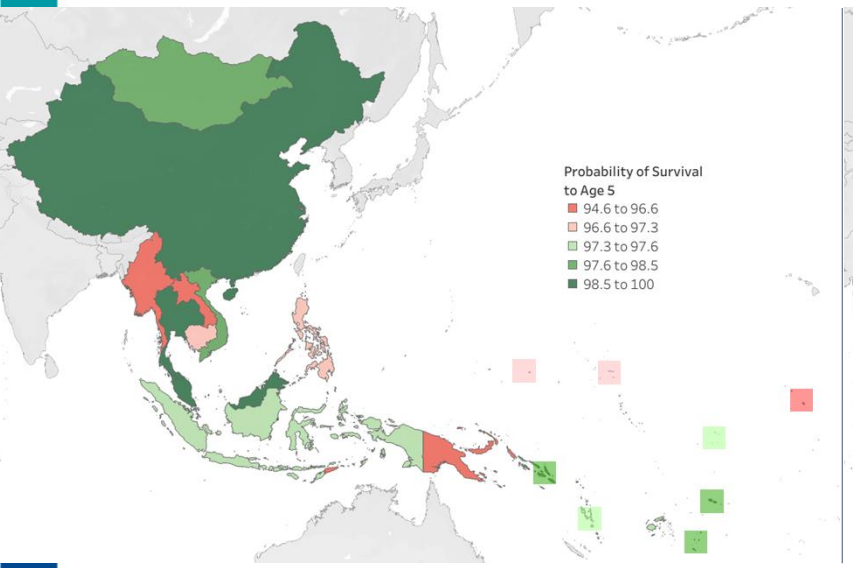
- Do more with less? Focus on enhancing economic efficiency of health care
- Or ask for more? Focus on mobilizing resources for health care

- Help develop a compact between ministries of health and finance: reform in exchange for resources

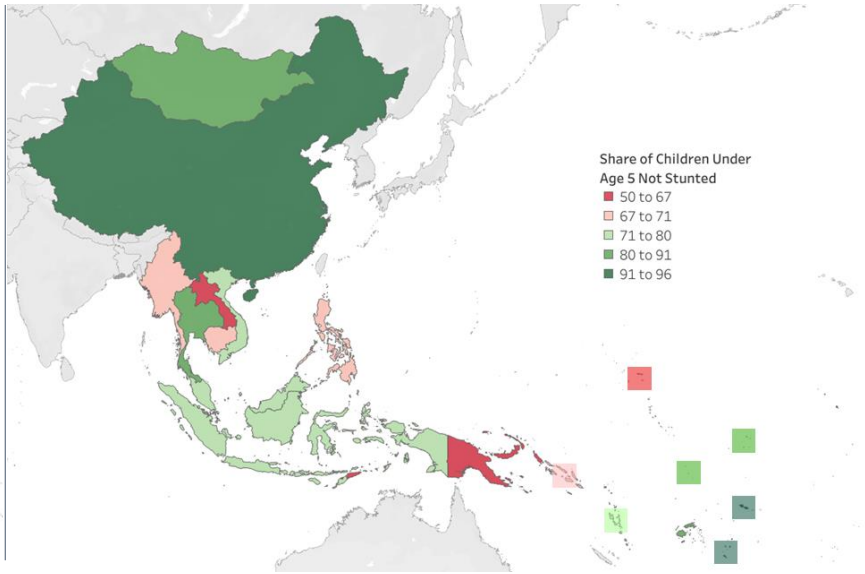
- And hence generate a virtuous cycle: finance for health for growth…

Improving health can boost human capital and productivity, and hence growth

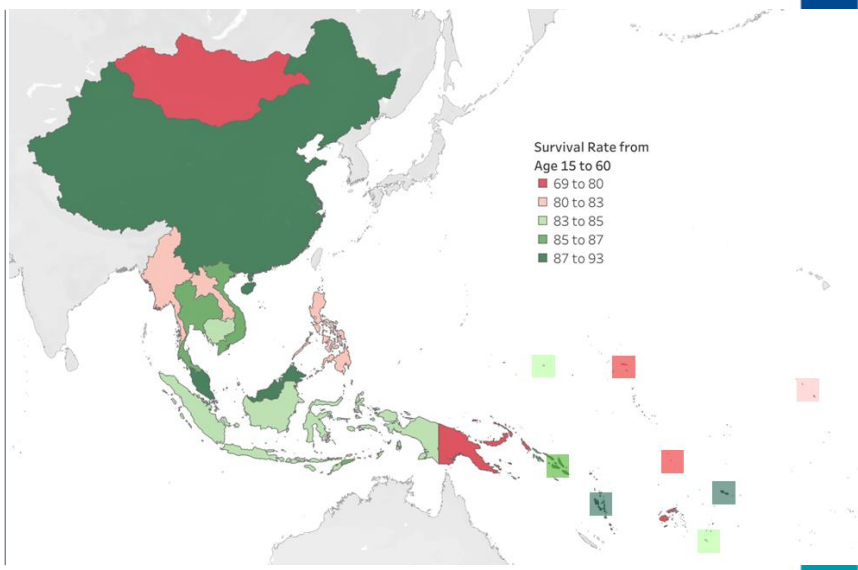
1.Child Survival



2.Child Stunting



3.Adult Survival



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WALKING THE TALK: REIMAGINING FIT-FOR-PURPOSE PRIMARY HEALTH CARE

Huihui Wang M.D., Ph.D.

Senior Economist, World Bank

Primary Health Care: Time to Deliver

- 40 years after the Alma-Ata declaration on primary health care (PHC), the Astana declaration reemphasizes the importance of **renewing political commitment to PHC, and achieving universal health coverage (UHC)**
- A primary health care approach focused on **organizing and strengthening health systems** is required to achieve UHC

Primary Health Care: Time to Deliver

- Health systems founded on well-functioning PHC provide health security, stability, and prosperity
- The COVID-19 pandemic has inflicted devastating health and economic costs, but also created a once-in-a-generation chance for transformational health-system changes
- PHC has unique capabilities to help systems meet challenges such as urbanization, persistent high burden of preventable diseases, but features of traditional PHC systems must evolve to take full advantage of existing strengths and build new ones

Primary Health Care: Time to Deliver

- Improving health outcomes and making health systems more efficient, equitable, and resilient can be understood as PHC's "purpose." PHC platforms are "fit" to the extent that they achieve this purpose.

- **Fit-for-purpose PHC** is a **health- and social-service delivery platform** uniquely designed to meet communities' health and health care needs across a comprehensive spectrum of services – including health services from promotive to palliative – in a continuous, integrated, and people-centered manner.

Reimagining primary health care will require four high-level structural shifts using three priority reforms

Four fundamental shifts in PHC design, financing, and service delivery

PHC is great, **BUT IT CAN DO BETTER**

1. From dysfunctional gatekeeping to **QUALITY, COMPREHENSIVE CARE FOR ALL:** An ambitious shift that strengthens the range and quality of services that is obtainable at PHC facilities

2. From fragmentation to **PERSON-CENTERED INTEGRATION:** a shift toward cohesive local PHC teams centered around patients' needs

3. From inequities **TO FAIRNESS AND ACCOUNTABILITY:** Make policy and implementation choices that support the equitable, efficient delivery of essential service packages

4. From fragility to **RESILIENCE:** Ensure that financial and human-resource surge capacity is built into health sector planning and resource allocation at local levels

Reimagining primary health care will require **four high-level structural shifts using three priority reforms**

High-performing PHC delivers required care at the most appropriate level of the health system

From dysfunctional gatekeeping to QUALITY, COMPREHENSIVE CARE FOR ALL

Treat all patients with respect and build care around patients' need and preference

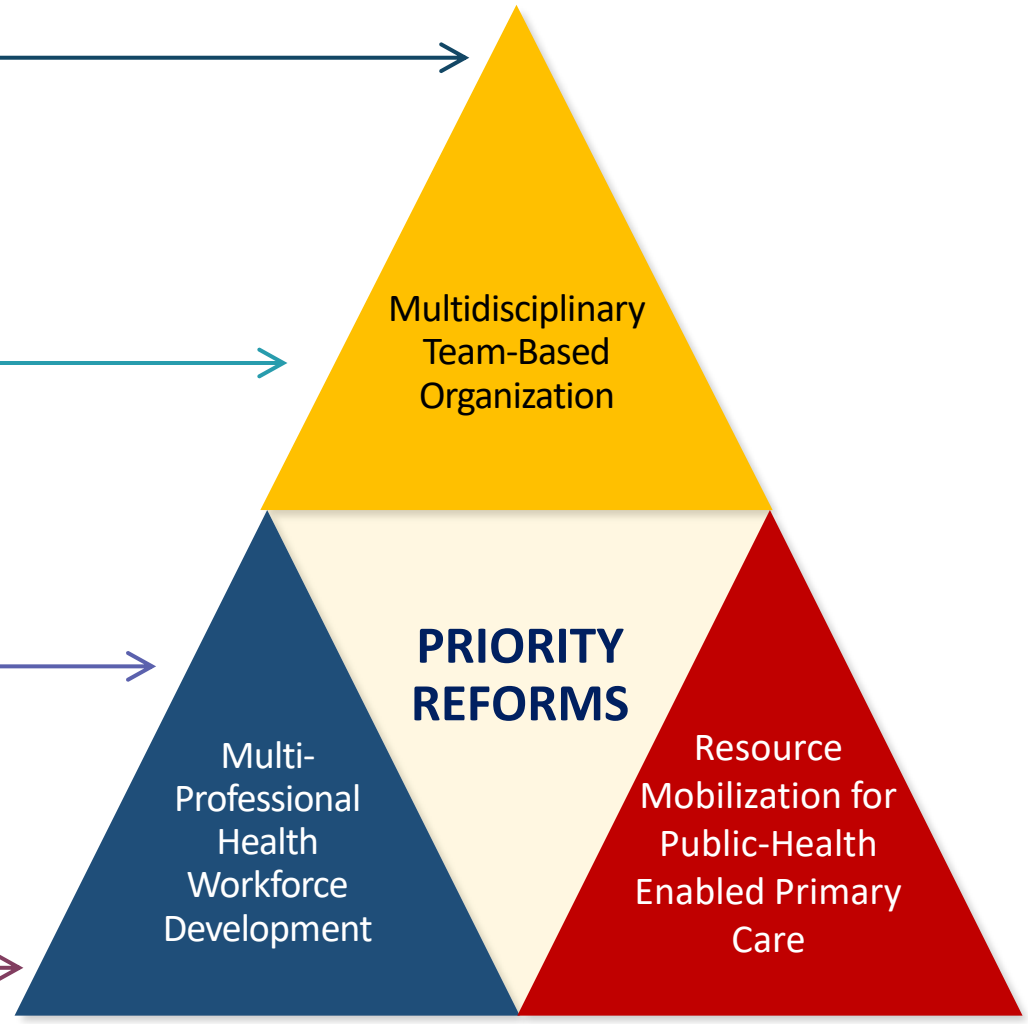
From Fragmentation to PERSON-CENTERED INTEGRATION

Deploy policies that support equitable, efficient delivery of a PHC-driven essential service package

From Inequities to FAIRNESS AND ACCOUNTABILITY

Build financial and human-resource surge capacity into health sector planning and resource allocation at the local level

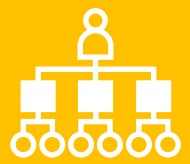
From Fragility to RESILIENCE



Reform 1: “fit for purpose” multidisciplinary team-based organization

Active community-oriented outreach model through a multidisciplinary core team of health service providers to meet a full range of local health needs, including public health functions like surveillance

Clear delineation of responsibilities will be necessary in the construction of the primary care team (CHW, nurses, doctors, pharmacists)



Patients are assigned (“empaneled”) to dedicated PHC professionals who facilitate access to comprehensive PHC services and coordinate care with the other levels of the health system

Reform 2: “fit for purpose” multi-professional health workforce

Medical education reforms should embed education within community clinical settings and orient medical graduates to generalist/primary care specialization: interprofessional education and community diagnosis.

Reorienting medical education and on-the-job training to build workforce competencies necessary for delivering integrated patient-centered care: data use skills, soft skills, and such as leadership, communication, and emergency management in communities.

Rewarding team members for creative thinking, problem solving and managing complexity. Protecting health workforce during public health emergencies (physical protection, psychological and practical support).

Reform 3: “fit for purpose” financing for public-health enabled primary care

Increase in government revenue facilitates equitable access to health services and improves financial protection for the population. Access barriers need to be removed to ensure equity. PHC should be free at the point of care.

A prioritized health benefits package for primary care, customized to the local burden of disease, community values, and citizen preferences is a justification for resource allocation

Invest in surveillance and public health functions.

Reform 3: “fit for purpose” financing for public-health enabled primary care

Ensuring PHC teams to be accountable for the experiences and health outcomes of the entire empaneled population through provider payment mechanisms, intergovernmental fiscal transfer and community engagement.

Having systems in place that guarantees the ability to surge the required funding to the front lines before and during a crisis, as well as the ability to amend the benefit package quickly in response to crisis

Reform 3: “fit for purpose” financing for public-health enabled primary care

	Ideal Approach for Team-Based Care Models
Payment Recipient	A team of providers or an integrated unit
Payment Criteria	Based on health outcomes, value of health care
Relevant Time Horizon	An extended time (often multiple years)
Beneficiary Population	A defined population group assigned to providers (i.e., empanelment)
Incentives for…	Health promotion and preventive care
	Retaining patients at the PHC level where appropriate
	Close coordination across providers

Practical prerequisites for translating reimagined PHC into actionable policies

1. Whole-of-government commitment and leadership
2. Readiness to invest
3. Accountability for outcomes


THANK YOU
Walking the Talk: Reimagining Primary Health Care After COVID 19
https://openknowledge.worldbank.org/handle/10986/35842

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