

Global sustainable healthcare

Martin McKee

Abstract

Health systems worldwide must adapt to reflect the changing burden of disease, which has been characterized by a shift from communicable to non-communicable diseases. Sustainable health systems require investment in six building blocks, of which three – workforce, medicines and financing – are examined in this article. Sustainable financing involves collecting, pooling and redistributing resources. The preferred source of finance is general taxation, while pooling and redistribution should be equitable and involve the lowest possible transaction costs. Globally, there is a severe maldistribution of health workers, with the lowest number in places where the needs are greatest. Poor countries suffer from large-scale emigration, but even in rich countries there are often shortages in remote and rural areas. For many individuals, medicines are either unavailable or unaffordable. However, in all these cases, there is much that can be done to overcome the problems, if the political will exists.

Keywords Access to medicines; health systems; health workforce; healthcare financing; sustainable development goals

A political, moral and economic imperative

In September 2015, world leaders meeting in New York agreed on 17 Sustainable Development Goals (SDGs), to be achieved by 2030 (see Further reading). These followed on from the Millennium Development Goals (MDGs), which had guided international development policy between 2000 and 2015.

The SDGs were, however, quite different from their predecessors, with major implications for health and healthcare. First, the SDGs apply to countries at all levels of development, including the advanced industrialized economies. Second, they take a comprehensive approach to health, both in a specific goal (SDG 3), which is to achieve ‘good health and well-being’, and in several others, such as no poverty (SDG 1) and climate action (SDG 13), which address fundamental determinants of health. In contrast, the MDGs had included only a few health indicators, such as reducing child and maternal mortality and tackling HIV/AIDS, tuberculosis and malaria.

Progress towards achieving the 17 SDGs will be measured against 169 targets. Several of the targets for SDG 3 relate specifically to healthcare, in particular Target 3.8, ‘to achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all’. Others involve a combination of healthcare and wider preventive measures, such as Targets 3.1, to reduce maternal

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Key points

- Health systems must adapt to the changing burden of disease
- Health financing involves the collection, pooling and redistribution of resources. The most efficient collection system is general taxation
- Policies to ensure a sustainable health system require investment in a series of health systems building blocks

mortality, and 3.3, to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, while combating other communicable diseases. There are also many health-related targets relating to some of the other goals.¹

There are many reasons to improve access to safe and effective healthcare in a way that is sustainable, as described below.

The moral imperative: it is considered unacceptable to allow human beings to suffer in a world that has the means to alleviate their condition. Several factors have raised this high on the international policy agenda. The suffering of those living in poor countries has become more visible, reflecting a combination of greatly improved disease surveillance and major efforts to collate and disseminate the available information, most notably in the Global Burden of Disease project (see Further reading). In particular, this has highlighted the large and growing burden of chronic conditions worldwide, especially non-communicable diseases such as diabetes mellitus and cardiovascular disease. The plight of those suffering from preventable and treated diseases has also been rendered more visible by the increasing global reach of the media, in all its forms.

The political imperative: there is now a much greater recognition of the contribution that modern healthcare can make to preventing premature death and alleviating suffering. Coupled with this recognition, however, comes an appreciation that it is not enough that treatments exist – they should be provided to those in need. This, in turn, depends on the existence of strong health systems and, crucially, universal health coverage.

The economic imperative: the Commission on Macroeconomics and Health demonstrated how, in low- and middle-income countries, poor health acted as a brake on development. Those with long-standing illness were physically unable to engage in the physically demanding tasks, such as agriculture and mining, that dominated the economies of the countries in which they lived. Those experiencing severe illness also risked catastrophic expenditure, bringing financial ruin not only to them, but also to their extended families and, in some cases, to their employees if small businesses failed as a result. Subsequent research has shown that similar considerations apply in high-income countries, where the physical demands of work are often less, but where poor health is also associated with lower productivity and reduced workforce participation.

The changing burden of disease

Sustainable global healthcare will only be achievable if it anticipates changing health needs. The Global Burden of Disease project has examined, in detail, how patterns of disease have changed in almost all countries in the world. Two factors are driving this.

Changes in population size and structure: the number of people living in the world increased from 1.6 billion in 1900 to 7.6 billion in 2017 and is estimated to rise further, to 9.7 billion, in 2050. However, the distribution of population is also changing, so that the share of the world's population living in Africa is expected to increase by >50% between now and 2050, while that in Europe is expected to fall by almost 50%. The world's population is also ageing rapidly, through a combination of falling birth rates and more people surviving into old age, largely a consequence of better public health and healthcare.

However, these changes bring challenges for health systems, with most of the population growth in places where healthcare resources are already sparse, and ageing populations surviving, but with growing numbers of chronic conditions requiring treatment.

Changes in risk factors, and thus disease: there has been a marked decline in infectious disease and an increase in non-communicable disease, which has been termed the 'epidemiological transition'. There are further changes within the non-communicable diseases, although the pattern varies between countries. In high-income countries, smoking-related diseases are becoming less common but obesity-related ones are rising. The net effect is that those living to older ages are often much healthier than those at the same age in previous generations. Moreover, their health conditions are often manageable with low-cost medicines. Thus, ageing populations in these countries need not cost much more. Rather, it is the cost of dying that is important.

For most people, the largest share of their lifetime healthcare costs are in their final years of life. The real challenge of ageing populations is the increasing medical complexity involved, with multimorbidity demanding new ways of working focused on teams of health professionals rather than individual practitioners, and with increasingly well-informed patients playing a more active role in their own management.

Building health systems

The World Health Organization has developed a framework for health systems that comprises six building blocks (Figure 1).² Three of the most relevant are discussed in detail below.

Health workforce

Healthcare is labour-intensive. It requires adequate numbers of trained, dedicated and highly motivated staff. However, the complexity of modern healthcare makes it essential to have different health workers, with complementary skills, working in well-managed teams.

Globally, there is a severe shortage of health workers, which is exacerbated by their inequitable distribution. Health workers exemplify the 'inverse care law', whereby areas with greatest

health needs have fewest resources. This can be seen both between and within countries. Thus, even those low- and middle-income countries that do invest in training health professionals, such as India and the Philippines, lose large numbers of staff every year as they move to fill gaps within high-income countries, most of which have underinvested in training over many years (Figure 2).³ However, even in high-income countries, health workers are often concentrated in large cities. The problem of retaining doctors in rural areas of countries such as France has given rise to the term 'medical deserts'.

There is no single solution to these problems. International migration is a result of two forces: 'push' factors, such as low wages and poor working conditions; and 'pull' factors, such as international recruitment teams from rich countries and assisted travel. The World Health Organization has developed a code of conduct for ethical international recruitment. It has also identified a series of measures that offer some prospect of success in retaining health professionals in rural and remote areas (Figure 3).⁴ In addition it is essential to achieve the right skill mix, so that tasks are undertaken by the most suitably qualified staff.

Access to essential medicines

Health workers can achieve little on their own. They require facilities in which to work that have ideally been designed to meet patients' needs (e.g. disabled access, clear signage), equipment to make diagnoses and provide treatment, and medicines with which to provide treatment. Many health systems struggle with all of these resources. Thus, health facilities are often obsolete. Many are poorly designed. In many low-income countries, they may even lack such basics as running water or electricity. However, it is access to affordable medicines that has attracted most attention internationally.

When a patient obtains medicines from a pharmacy, it is the last episode in a long, often complex chain. Much can go wrong. First, there must be a treatment available. The primary duty of a pharmaceutical company is to its shareholders, to make a profit and give them a return on their investments. However, companies will only invest where there is a market for their products. This is not the case for what are termed 'neglected tropical diseases', where those afflicted have little purchasing power. There is also little incentive to invest in antibiotics, as resistance can emerge before the company has time to recoup its costs. Hence, a sustainable system must include imaginative approaches to drug discovery and development.

Second, there needs to be a reliable supply chain to ensure that medicines get through to patients, avoiding expensive mark-ups and entry of counterfeit products. Finally, pharmacies must manage their stocks effectively. A sustainable health system requires that all these steps work, although, in reality, medicines are either unavailable or unaffordable for many people.

Health system financing

Health systems can only function if there is a sustainable source of financing. Healthcare is different from most of the things that we buy. First, those who need it most are often least able to pay for it. In all societies, ill-health is concentrated among the poor, and the experience of an episode of ill-health can impoverish people.

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