Escalation of health care cost: Causes and consequences

Cost escalation deprives people of access to health facilities. Poverty and poor health are closely intertwined. Poor health traps the poor into poverty and living in poverty contributes to poor health. With limited government budgeting for the health sector, any excess cost related to patients' care will compel patients to make out of pocket payment, thus inability to pay deprives the marginalised population of adequate health coverage.

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SINCE the time of Hippocrates (460 BC), the father of medicine, medicine has undergone dramatic changes from magic, mysticism, miasma and religious ritual to the 20th century modernised body of knowledge and technology which can save lives and reduce disability from diseases, which was a mere dream not far back.

National Health Expenditures in USA			
	1960	1985	2003
	(in billions of current dollars)		
Aggregate spending	27	427	1,679
Per capita	143	1,765	5,670
	(in billions of constant 2003 dollars)		
Aggregate spending	166	730	1,679
Per capita	891	3,019	5,670
Share of GDP	5.1%	10.1%	15.3%

Source: National Health Expenditures, USA

The benefits reaped have invited some effects, which have compromised the very basic tenets of equity and accessibility, through the mounting costs of universal health care; many lives are saved at the cost of denial of service to many who cannot afford it.

In 2005, total national health expenditure in USA rose by 6.9 percent -- twice the rate of inflation. Total spending was $2 trillion in 2005, or $6,700 per person, which represents 16% of GDP. U.S health care spending is expected to increase at similar rate for the next decade, reaching $4 trillion in 2015, or 20% of GDP (US Health statistics, 2006).

In New Zealand, in the 12 months to March 31, 2006, total health care cost escalation was 6.4% per annum. Escalation of surgical costs for the same period was 7.7%, while medical costs increased by 3.6% (Southern Cross Health Care, 2006). In general hospitals in China, between 1990 and 2002, nominal outpatient spending per patient increased 8.14 times (from 10.9 Yuan to 99.6 Yuan), and nominal inpatient spending per admission increased 6.6 times (from 473.3 Yuan to 3597.7 Yuan) (Qingyue Meng et al, 2004). Health care costs in UK in 1960, 1980 and 1985 were, respectively, 3.9%, 5.8% and 6.1% of GNP (Schieber and Poullier, 1989).

Despite the Bangladesh government's commitment to free health care services for the people, cost escalation has forced the rural people to incur, on average, an expenditure of Tk.342 per episode of acute illness. For major illnesses, per episode treatment cost is estimated to be Tk.2,696, with 18% incurring a cost of more than Tk.3,000 and 12% spending more than Tk.5,000.

Nearly 97% rural households make major expenses on health in a year, accounting for 15% of the annual expenses incurred by a household (Sharifa B, 1997). Factors influencing rising health care costs are:

General market inflation

The general rise in costs of almost all commodities and utilities has an effect on medical expenditures. There is always a rising inflationary trend in supplies, materials, fuel, food and medicines, which affect the overall health expenditure, making it costlier everyday.

Changing demographic pattern

With better living standards, health technology, nutrition, and hygienic practices, people are healthier today and are living longer than before, but geriatric diseases have become a natural phenomena, which are chronic in nature and costly as well.

Technological development

Better technology has contributed better diagnostic and therapeutic opportunities, but has also increased the cost of health care, making it available only for the privileged. There are at least four expensive technologies already, or soon to be, in the market for the treatment of heart disease: a drug-eluting stent that is triple the price of earlier stents, doubling annual expenses to $4.6 billion; an improved ventricular assist device for use with patients who are not candidates for transplantation, at an estimated cost of $16 billion a year; increased use of the implantable cardioverter defibrillator, adding 400,000 new patients at a cost of $24 billion, or $120 billion to treat the estimated backlog of 2 to 4 million patients; and the long pending artificial heart, which could add costs of $11 billion a year (Danniel Collahan, 2007).

Unplanned health care facilities

Without appropriate need analysis and cost-effectiveness analysis, the mushrooming of health facilities, concentrated in urban areas, with most modern equipments has increased the average overhead cost and total cost in general. If an MRI machine can serve a definite number of people, having more than one machine, owned by different hospitals in the same locality, spreads the patients, which means that fewer patients than its capacity avail the facility, thus rendering the service costlier.

Inclination toward curative than preventive care

Curative care is individual directed, and there is no collective benefit. Whereas preventive care is community or group oriented, from which the whole population can benefit. In curative care, there is recurrence of episodes and continued incurring of costs, whereas preventive care gives long term protection to the population against many diseases, thus, in the long run it is cost effective and cheap.

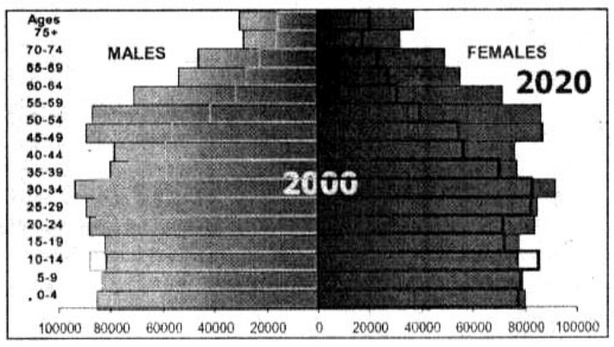
Supplier induced demand (SID)

Health is not a commodity, and there is no scope for the patients to prefer any type of care for any health situation. Due to asymmetry of information, it is the physicians who decide the need of the patients, and act as the agent of the patients. This unique characteristic in health care has allowed the physicians to prescribe more, but avoidable, medicines and laboratory investigations, making the service more expensive. It has been seen that in any hospital 8% of tests can easily be avoided without any impact on the quality of care (BM Shakharkar, 2003).

Increased proliferation of super specialists

The rate of referral to super-specialists has risen considerably, due to the attitude of the patients consulting a specialist, and a defensive attitude of the hospital itself, making the care costlier; whereas the majority of the physical ailments are curable at the general practitioner (GP) level.

Defensive attitude of outpatient departments (OPD)



Population demographic pattern in 2000 and estimated in 2020 in SEA countries (Ref:WB)

A study has revealed that 65% of the patients can be sufficiently cured at the OPD level; 35% requiring referral, out of which 10% are acute in nature and 25% are chronic. If the majority of the patients from OPD are referred to specialists or advised for admission, there is unwarranted wastage of facilities, with increased cost.

Tendency for admission to hospital

If the majority of the patients who are curable at the OPD level are unwisely admitted to hospital, it leads to non-availability of beds for those who really need admission; thus depriving the society from the facility and increasing the cost for the patients who are unnecessarily admitted.

Defensive medicines

When a disease can be treated by a less expensive treatment and procedure, prescribing expensive medicines and procedures instead as a defensive approach is also increasing the costs.

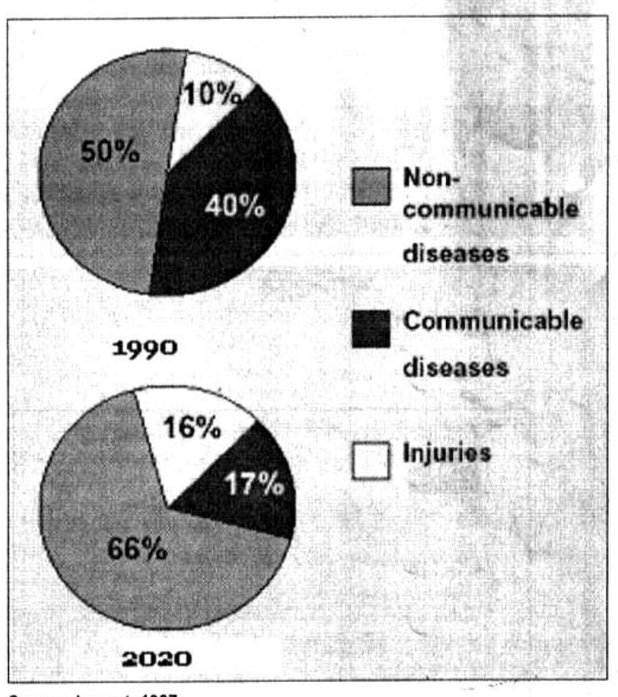
Ineffective referral system

Due to lack of adequate service personnel, equipments, facilities and overall lower quality of services at the peripheral health centers, patients are compelled to report directly to secondary or tertiary level hospitals, thus overburdening the facilities with minor ailments and, in effect, hampering the specialist services in terms of quality.

The most striking fact, however, is that despite many planned efforts to develop a sound health care delivery network in rural areas, the public sector performance in taking care of people's health is appallingly poor. For acute illnesses their contribution stands only at 12%, and rises to 23% for the major ones.

Moral hazard

When there is an insurance system to cover the health care costs, there is a tendency of the consumer to over-utilise the services needlessly. In 1996, Americans spent $202 billion for physicians' services (19% of total health care spending), of which 25% were "unnecessary" visits (US hospital statistics report, 1998).



Source: Lancet, 1997

Changing pattern of diseases

In the past, we were more concerned about communicable diseases (CD), but changes in socio-economic standards have also changed the disease pattern, causing more non-communicable diseases (NCD) like heart diseases, diabetes, and cancers, which are expensive to treat and put an extra burden on already resource-starved health facilities.

Lack of efficiency

In health care systems, there is widespread lack of cost awareness among all levels and, in general, there is inefficiency in management, which also contribute to cost escalation of health care costs.

Cost escalation deprives people of access to health facilities. Poverty and poor health are closely intertwined. Poor health traps the poor into poverty and living in poverty contributes to poor health. With limited government budgeting for the health sector, any excess cost related to patients' care will compel patients to make out of pocket payment, thus inability to pay deprives the marginalised population of adequate health coverage.

For accessibility and equity, efficient mechanisms, which will envisage cost containment, universal health insurance policy and community participation in decision making, monitoring, and evaluation of services are prerequisite. "Medical impoverishment" is a tragic consequence of cost escalation, compelling people to make a dire choice: either die without treatment, or save a life by sinking the family into poverty.

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Mobile phone sector in Bangladesh

The Bangladesh experience of mobile phone liberalisation suggests an important policy lesson for other countries; that is, in an industry like the mobile phone sector where network externalities and switching costs are important, delaying new entry (sequential entry strategy) creates first-mover advantages for incumbents. Bangladesh waited four years before issuing the second mobile license.

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CONVENTIONAL wisdom says developing competition in services markets by encouraging private sector participation (both local and foreign) brings large gains for consumers. The gains come in different forms, such as reduced service charge, improved service quality, variety of services and easy access to service. Liberalisation of the telecom sector has been especially welcomed by users because of the supply side constraints in the telecom sector. Moreover, the advent of mobile phone technology, with its unique features of 24 hour availability and instant access, created a huge demand for it.

Although liberalisation of the telecom sector was done in the belief that it would bring benefit to the consumers in terms of cheaper price and better quality of service, that has not always been the case. Contrary to conventional belief, telecom liberalisation resulted in negative consequences for some users in some cases. Liberalisation (especially fixed line telephone) sometimes causes higher prices for customers due to tariff rebalancing and result in reduced access.

In tariff rebalancing, long distance prices fall while (to maintain rates of return) line rentals (and often local call charges also) increase. For instance, in Australia, line rentals increased by 47% after liberalisation (during 1998-2000). In the Northern Territory of Australia, connection to the fixed network had dropped by 2.3 percent after liberalisation. Service standards had also fallen. Similarly, consumers could not reap the benefits of liberalisation (such as lower price) in the UK during 1984-1990 as competition was restricted between the British Telecom (BT) and the new entrant MERCURY (which was licensed to compete with the BT in some segments), and the liberalisation was partial. In 1991, duopoly policy was ended and entrance of new firms was allowed, resulting in intense competition and significant fall in prices, and more than 50% reduction in telephone fees.

In LDC countries, telecommunications reforms have brought mixed results. After privatisation of the state owned enterprises, the prices for residential local services have risen in some LDCs with the beginning of cost based pricing and discontinuation of cross-subsidisation; however, large business users of long distance and international services have benefited from rebalancing of tariffs. In Mexico and Argentina, tariffs went up after telecom reforms.

The question may arise; why does opening of the telecom sector to both domestic and foreign competition not benefit consumers? One reason is that a liberalised market does not necessarily mean a competitive market. A market can be legally "open" to new entrants, but entry may nonetheless still be unattractive to them if the entry barriers and other costs (such higher fees for interconnection facilities, delayed interconnection etc.) become too high to be competitive and profitable.

This happened in the case of New Zealand. NZ liberalised its telecom market unilaterally in 1989. But it did not set up an independent regulatory body to oversee and monitor the telecom sector; it rather depended on generic antitrust laws. In absence of a regulatory watchdog, the incumbent telecom service provider (Telcom) created obstacles in negotiating and providing interconnection facilities to the new entrants. This resulted in a long court battle between the incumbent and the entrants, and the overall regulatory environment was not conducive for ensuring competition. The absence of a regulatory body failed to ensure fair competition in NZ telecom sector until 2000 when NZ appointed a telecommunications commission.

In Chile, the reverse has happened. Chile achieved a competitive and contestable local telephony market because of its strong pro-market reforms. It imposed interconnection obligations upon incumbents that resulted in strong and significant entry of new operators, making the market more competitive and robust.

In the mobile phone sector, in the countries that followed a sequential approach (i.e. initially awarding license to one mobile phone company, allowing it to run alone for some time, then giving the 2nd license, 3rd license and so on), the liberalisation benefits in terms of reduced cost and accessibility has been minimal. This has been the case in Bangladesh. In the initial years after mobile phone sector liberalisation (1993 - early 1997) in Bangladesh, consumers were denied liberalisation benefits. The usage price of mobile phone was very high since there was no competition during the period. This happened due to the adoption of sequential approach in liberalising the mobile phone market.

When City Cell first came to the market (in the 1990s), a mobile phone was too expensive. Connection cost was nearly $1500, and call charge was 25 cents/minute. There was no ceiling on mobile phone call charge. No authority (like ACCC in Australia) existed to restrict anti-competitive behaviour and ensure reasonable pricing by mobile a phone operator. Indeed, in the absence of an effective regulator with necessary teeth, the mobile phone market in Bangladesh during 1993-1998 was a supplier's market that earned super profits at the expense of consumers.

Thus, it is clear that liberalisation of the sector per se cannot guarantee the benefits of competition. The beneficial impacts of liberalisation can only be achieved where liberalisation is not restricted by adopting sequential strategy, and is combined with an independent regulatory body. It is, therefore, advisable for a country to put in place an independent regulatory authority to restrict misuse of market power (by dominant operator), promote competition, ensure growth of the sector, as well as protect consumer welfare. A competition commission is necessary to address anti-competitive behaviour or collusive behaviour on the part of service providers.

The good news is that the telecom regulatory authority of Bangladesh, with other government agencies, has been playing a praise-worthy monitoring role to bring discipline in the sector by curbing illegal activities in the sector and implementing measures (such as price capping) to ensure consumer welfare. Moreover, the Bangladesh Telecom Regulatory Commission (BTRC) has shown its competence, efficiency and sincerity in realising "lost revenue' of the BTTB (about Tk. 500 crore so far) through detection of illegal use of VoIP and unauthorised international call termination (it is unauthorised as the BTTB is the sole provider of international calls to and from Bangladesh) by some unscrupulous subscribers of the mobile phone operators (allegedly in connivance with the operators) (The Daily Star, November 12).

In this regard an executive of a phone company is of the view that "Many VoIP operators route their traffic via dedicated E1 circuits -- each equipped with 30 lines -- provided by the mobile operators. This indicates their clear collusion with the VoIP operators (The Daily Star, February 10, 'Foreign mobile operators involved in racket')."

The Bangladesh experience of mobile phone liberalisation suggests an important policy lesson for other countries; that is, in an industry like the mobile phone sector where network externalities and switching costs are important, delaying new entry (sequential entry strategy) creates first-mover advantages for incumbents. Bangladesh waited four years before issuing the second mobile license. It helped the first entrant to monopolise. The big advantage of simultaneous over sequential entry is that competition is initiated on a level playing field, before tariff mediated network externalities and switching costs take hold.

Moreover, in liberalising the telecom sector, the policy makers should keep in mind that a minimum number of players (may be three, four or more, depending on the market size, tele-density and availability of radio spectrum) are needed in the sector to have a competitive environment. The scarcity of radio spectrum might force the governments to limit the number of mobile phone operators. Provision for additional spectrum is a must to support mobile phone companies in providing new services such as 3G. Limiting the number of mobile phone operators is also necessary to help investors recoup their investment. Consolidation of the sector sometimes becomes necessary to sustain the growth and investment in the sector (by keeping it profitable). But the number of mobile phone companies should not be so limited that it substantially lessens competition and turns the market into a sellers one.

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Emergency and the internet

But there has been something different this time around -- it's emergency in a time of internet. Yes, the internet was already very much with us 8 years ago when General Musharraf came to power, but those were days of dial-up connections, when having internet access meant little more than being able to use email and connecting to newspapers and news channels in different parts of the world.

KAMILA SHAMSIE

I was in a supermarket in London, in the dairy aisle, when a fellow Pakistani-in-London called on my mobile to say, "I'm calling to inform you about a state of emergency." As I was expecting her and her husband for dinner there was a moment when I thought that she meant some domestic crisis was forcing her to cancel our evening plans. When the real meaning behind her words became apparent, a split second later, I couldn't help but be aware of how familiar my reaction -- despair, confusion, anger, uncertainty -- was.

I was four when Zia-ul-Haq came to power, and in the thirty years that followed I had learnt more than enough about "state of emergency," "martial law," "crackdown on opposition" and all those other phrases which were in the news by the following morning.

But there has been something different this time around -- it's emergency in a time of internet. Yes, the internet was already very much with us 8 years ago when General Musharraf came to power, but those were days of dial-up connections, when having internet access meant little more than being able to use email and connecting to newspapers and news channels in different parts of the world.

This time it's been different. In the days after the emergency, I had Pakistan's GEO news channel on almost 24 hours a day. Not via cable or satellite -- but via live streaming video feed on-line. As the government ordered cable operators in Pakistan to block all news channels except state-run PTV, the internet hummed with directions towards websites which hosted live feed -- and soon enough the websites of several news channels, too, allowed you to watch their transmissions live via your broadband connection.

If time was of the essence, and you only wanted to see the most interesting programming of the day from two or three different channels, the blog pkpolitics.com uploaded clips of talk shows and discussion programs, updated every few hours. For news of protests in your neighbourhood, wherever in the world you might be, there were blogs, facebook groups, email list serves. The somewhat ironic outcome of all this is that as a Pakistani living abroad, with high-speed internet access, you were likely to have more up-to-date information, and generally feel more plugged-in, than a great many people in Pakistan who didn't have the same facility. Realising that, it becomes obvious that while the internet is a useful tool in times of civil protest, it's also a very limited tool which can only reach small proportions of the population.

For those of us, far away, to whom the internet affords a virtual 24-hour news feed of life back home, the disconnect between the world outside our window and the world we're attached to via our computers can seem very bizarre. Of course, if I were in Pakistan my life would be following more or less its normal routines despite all the turmoil -- but it would be following its normal routines within a world of turmoil, a world in which everyone is keeping one eye on the news, and the air is heavy with rumours and denials. But to live actually in London while feeling yourself virtually in Pakistan is deeply disorienting.

All this struck me, particularly the first weekend after the emergency, when I left London and my internet connection to take part in a writing festival in Sussex. As chance would have it, I was part of a panel discussion about the importance of location when writing fiction. One of my co-panellists said that when she wrote she tried to ask herself, would this story work if I lifted it out of its location and set it down somewhere else? Would it work if it were set in a different time period? For her, she said, it was essential that the answer to both questions were "yes." The stories should have at their heart a human drama, not dependent on time or place.

I felt something close to envy hearing that. When writing about Karachi it is impossible to imaging lifting the story out of its location and placing it somewhere else. Politics and civil discontentment impress themselves so firmly on the daily fabric of our lives that time and place can rarely be irrelevant to a plot. Does a character turn on the television to watch the news? Well, if it's November 2007, they'll only receive one news channel, parroting distorted versions of the world outside.

Does a couple drive to the airport? If it's October 18, 2007, they'll get caught in the carnage accompanying Benazir's homecoming. Is there a legal battle afoot in the plot? If it's anytime in the latter half of 2007, there are lawyers' strikes to contend with. Whenever I sit down to write anything set in Pakistan, there is a part of my brain which first pauses to ask what was happening politically at that moment in time? How will it affect daily routines, and the directions in which I want the plot to go?

A friend once said to me, "If you're writing about Pakistan you don't ever have to worry about running out of stories." If that's true, why does so much these days feel like a re-run?

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