It is better to be
rich and healthy

than to be
poor and sick

--Prof. Antônio Carlos Coelho Campino

Economic arguments for the public role in control of chronic diseases and conditions

PAHO Regional Workshop on the Economic, Fiscal and Welfare Implications of Chronic Diseases in the Americas, 23-24 Nov 2009

Philip Musgrove

What’s special about a chronic health problem ?

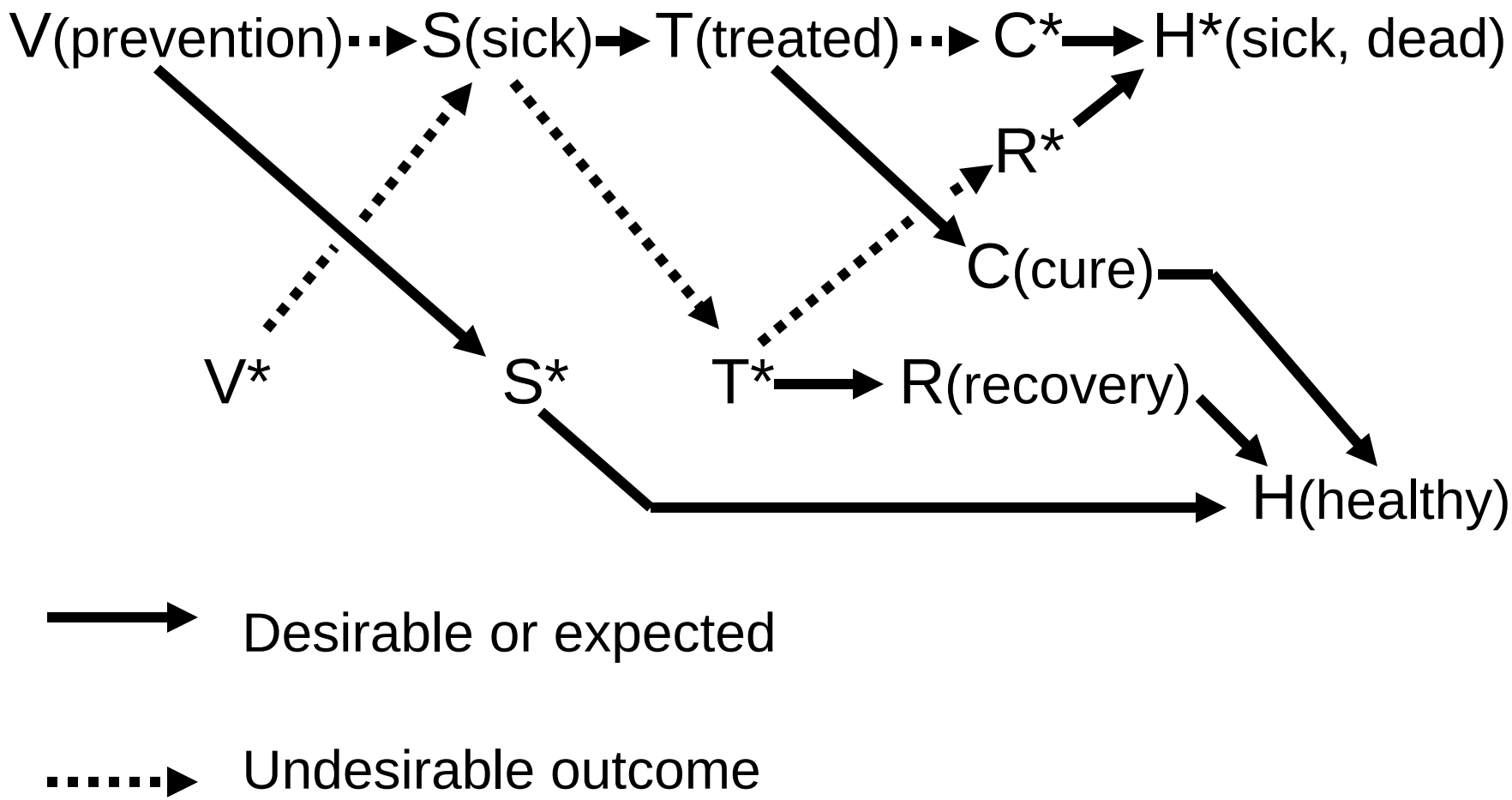
--Prevention needs to be chronic, too (not once-only, like immunization)

--Treatment needs to be frequent, often regular (requires continuous contact and monitoring)

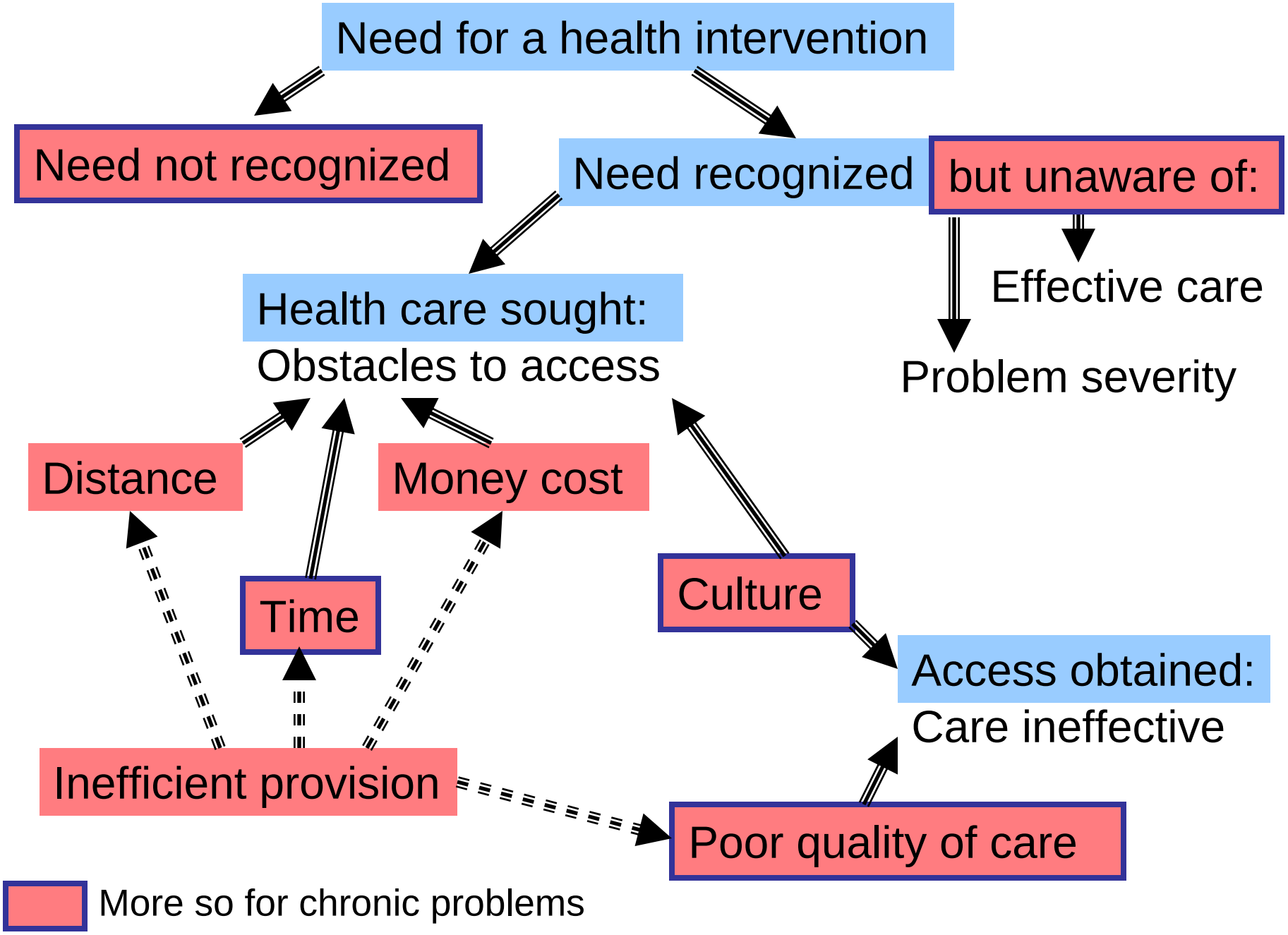
--Is not identical to permanent (loss of a leg means a chronic disability but not necessarily chronic care)

--Is not identical to non-communicable (AIDS and TB are counter-examples; so is sudden death from stroke or heart attack)

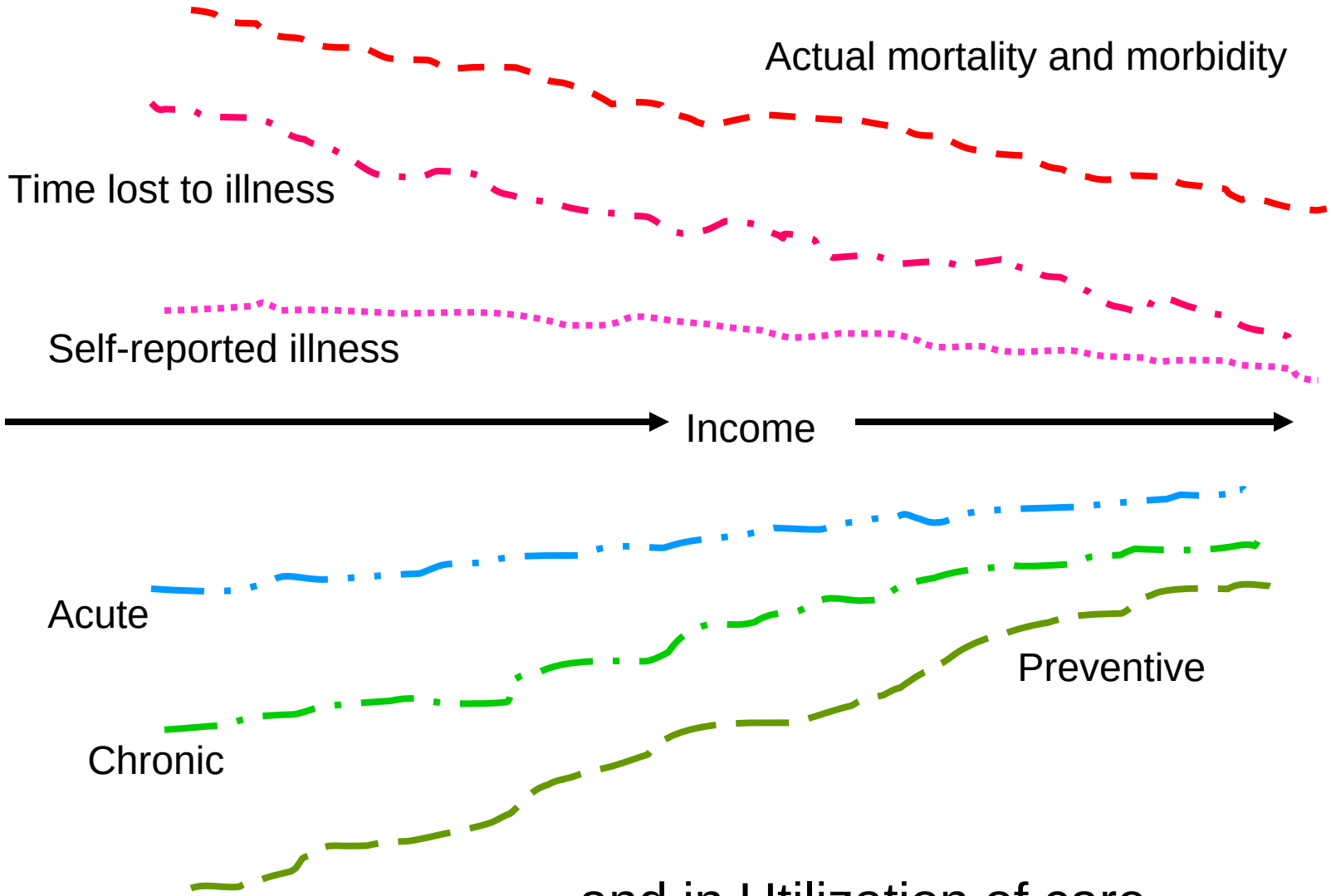
Schematic representation of an episode of illness or injury



Are these pathways → more common for chronic illness?


Need for a health intervention
Need not recognized
Need recognized
but unaware of:
Effective care
Problem severity
Health care sought:
Obstacles to access
Distance
Money cost
Time
Culture
Access obtained:
Care ineffective
Inefficient provision
Poor quality of care
More so for chronic problems

Income gradients in health-related variables…



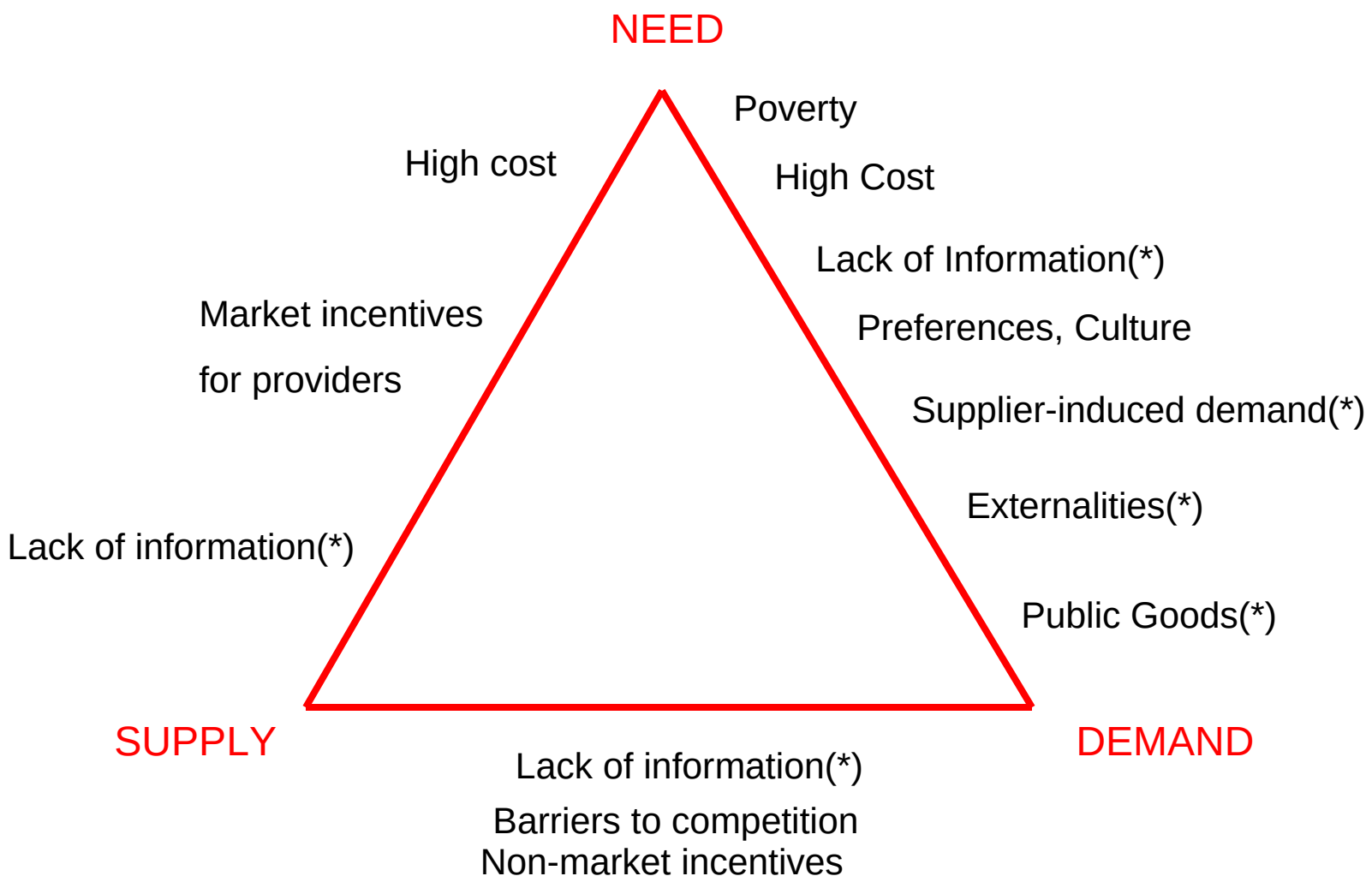
…and in Utilization of care

Indicators (%) of medical attention for people with chronic health problems by income quintile, Brazil, 1997

	Quintile					
Indicator	1	2	3	4	5	Total
Consulted a professional	54.7	63.3	70.3	78.9	82.9	71.1
Among those who did consult:						
Follow-up visit with the same professional	51.7	58.8	65.7	73.0	80.7	68.3
Periodic check-up for the problem	60.9	65.3	70.3	77.6	82.5	73.1

Source: Campino AC et al., Health system inequalities and poverty in Brazil, PAHO Scientific Publication No. 582, 2001, Table 7.

Need, Demand and Supply for Health Care



(*)Sources of market failure and therefore reasons for public intervention

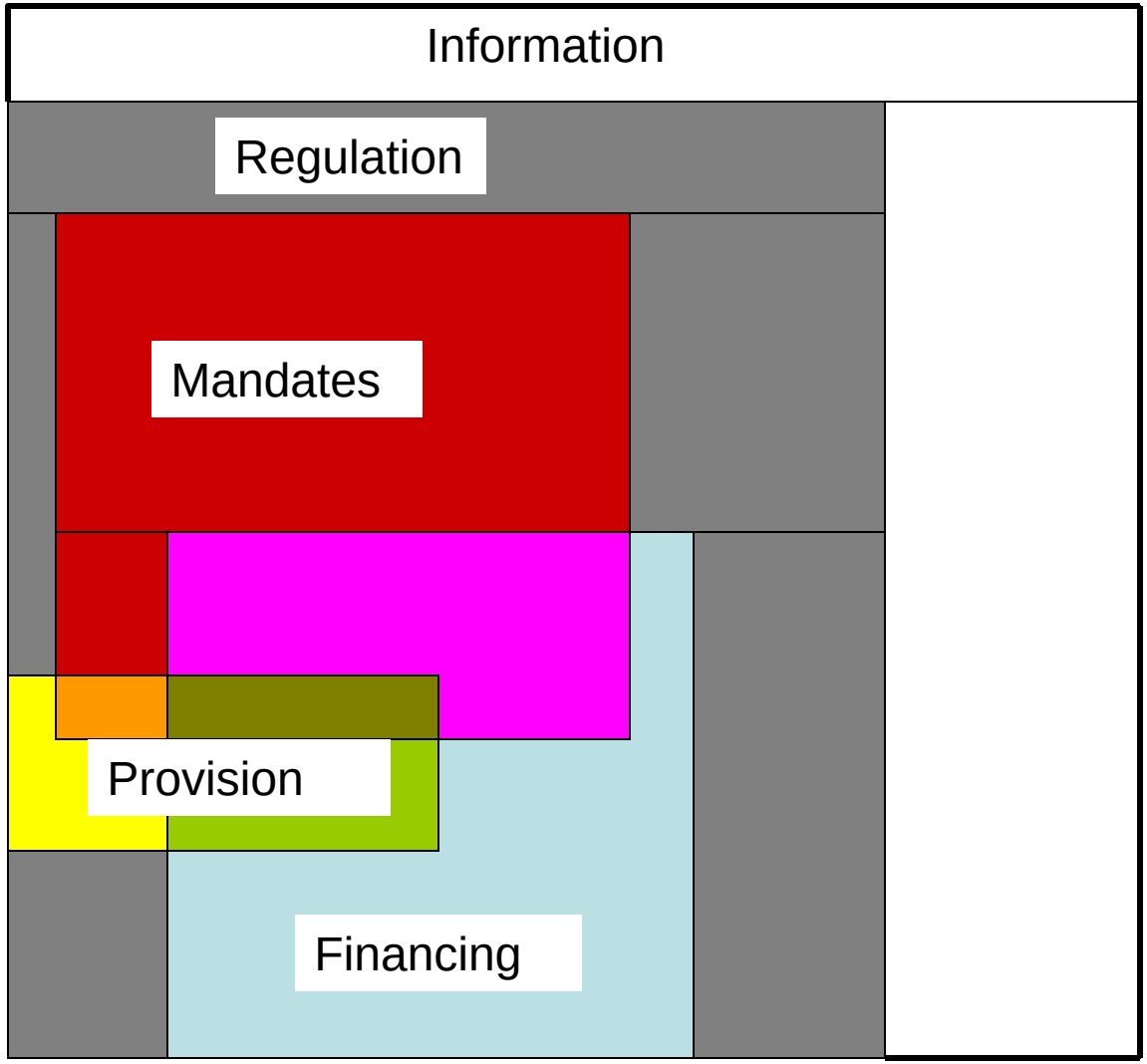
Do the classic market failures for acute health problems also hold for chronic conditions ?

--*communicable* externalities rarely exist (transmission of HIV and HPV are important exceptions)

--public goods matter for *some* conditions (asthma as a result of air pollution, neurodegenerative disease from mercury in water or food, public safety to reduce mental illness and injuries)

--supplier-induced demand can exist (but may be too *little*, if patients don't maintain regular contact with care)

--perverse incentives for providers are at least as common and even more dangerous (incentives for treatment but not for prevention or even for cure)



Relations among Instruments of Public Intervention in Health

Instruments are often most effective if used in combination

Examples:

--information and regulation to affect diet

--finance and provision to encourage exercise

--information and mandates for safer driving

--information, mandates and taxation (reverse finance) to control smoking and alcohol abuse

--finance (changes in payment) and provision (training) to improve continuity of care

Payment mechanisms as means of distributing risks

Cost per person or patient depends on health problems (conditions), episodes of needed care, services per episode, specific processes per service, and the cost of each process. Which are relevant to ageing or chronic conditions ?

Cost per person in an interval of time =

No. of conditions/person (age-related) x

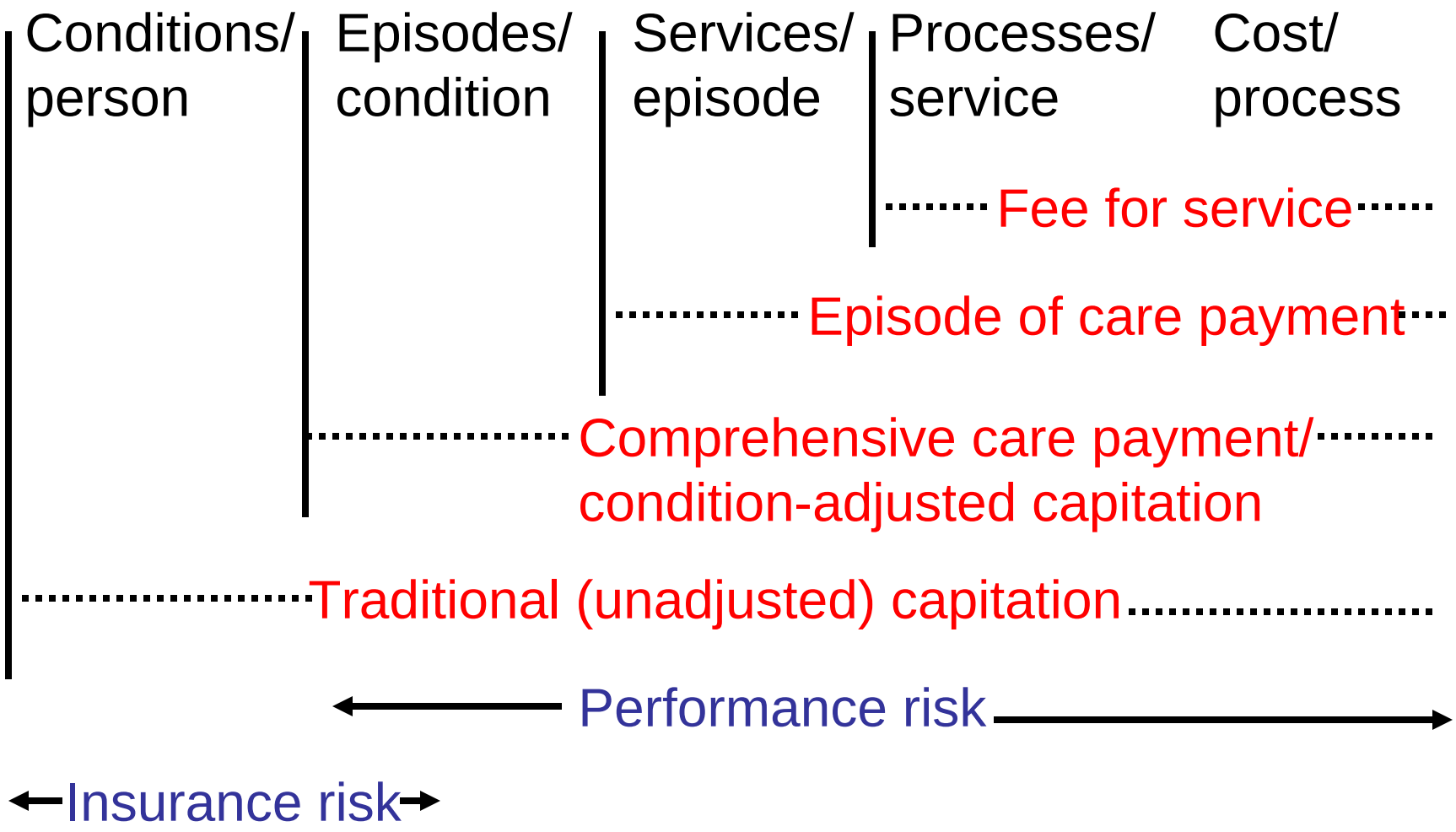
No. of episodes of care/condition (more for chronic)x

No. and type of services/episode for each condition x

No. and type of processes/service x

Cost/process

How much risk, and of what kind, does the provider assume under different payment mechanisms ?



Source: Miller H, *Health Affairs* 2009

Paying for Performance:

what ways are especially relevant for chronic conditions?

Paying providers to—

- Follow specific protocols, use checklists
- Achieve specific targets for coverage
- Achieve specific improvements from baseline
- Recruit patients and maintain contact with them

Paying (or otherwise motivating) patients to take better care of their health