Session XII

Panel: financing global surgery for improved health, welfare, & economic development

THE LANCET Commission on Global Surgery

Gavin Yamey, Vanessa Kerry, Robert Marten | May 6, 2015 | Boston, USA

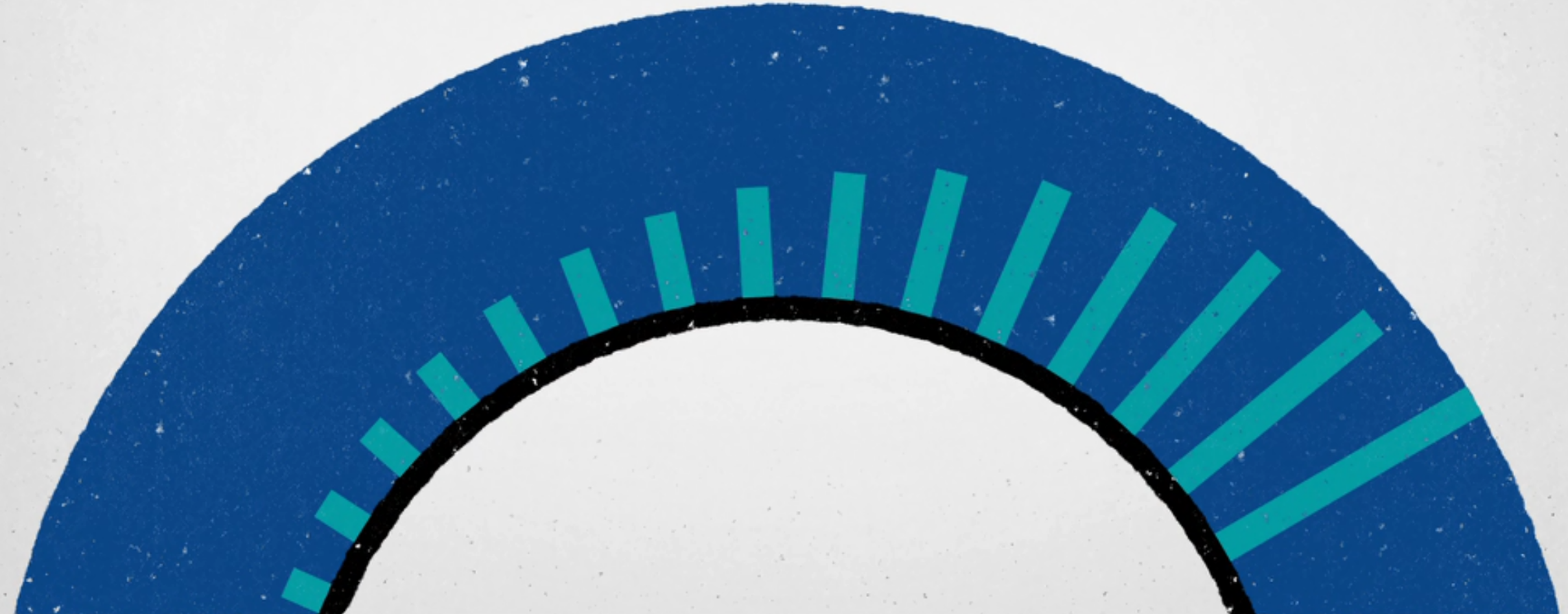
Moderator- Gavin Yamey

- Leads the Evidence-to-Policy Initiative (E2Pi) at the Global Health Group, University of California, San Francisco (UCSF)
- Teaches masters courses in global health policy at UCSF and the London School of Hygiene and Tropical Medicine (LSHTM).
- Commissioner, and lead writer, of The Lancet Commission on Investing in Health (CIH).
- Commissioner of The Lancet Commission on Global Surgery, with a primary interest in the finance and economics of global surgery

@GYamey @globlhealth2035 @GHSatUCSF

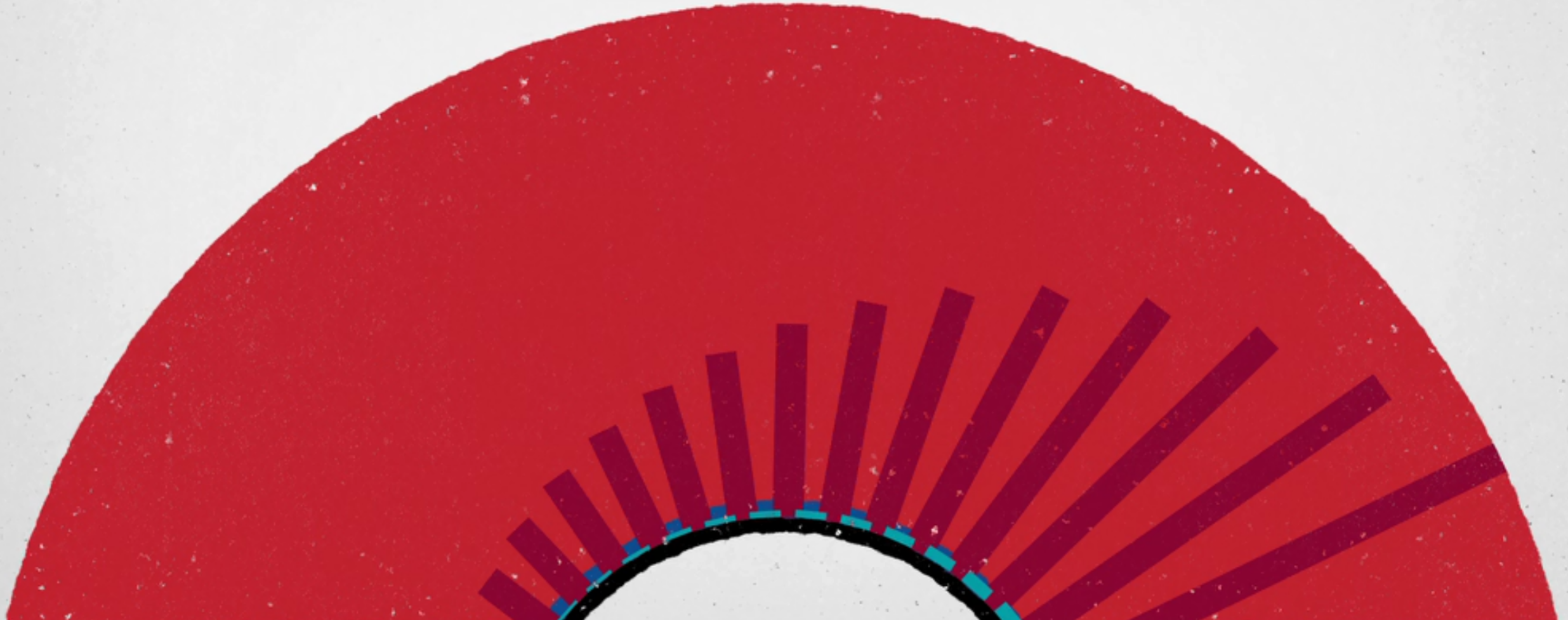
Cost of Surgical Expansion (2015-2030)

$350,000,000,000



Total GDP Losses (2015-2030)

$12,300,000,000,000



Agenda

- *The present situation*—what is the policy problem?
- *The way forward*—our proposed policy solutions
- *Recommendations*—for governments and international collective action

The Present Situation

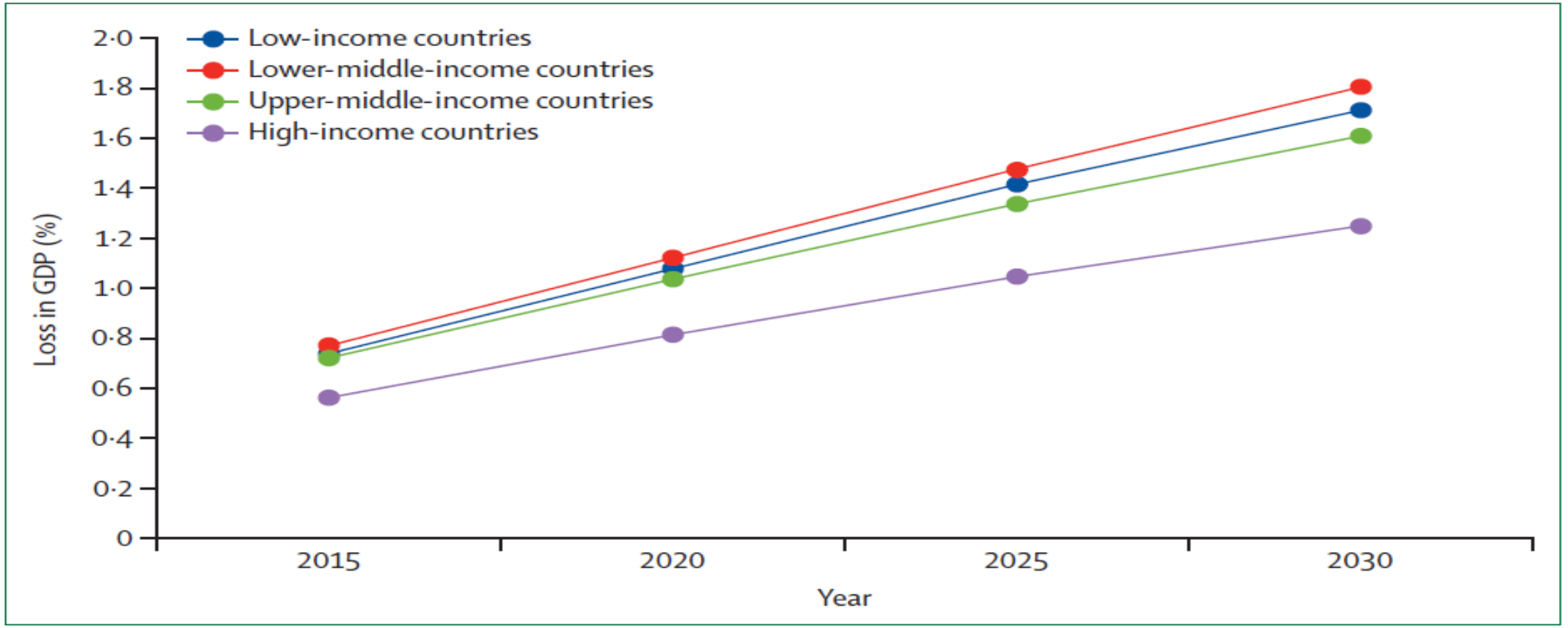
1. There is a strong economic case for investing in surgery

- Conditions have large macro-economic impact
- Treatments are highly cost-effective
- Costs are paid mostly out of pocket and can be impoverishing

2. The present financing arrangements are very weak

- Coordination and tracking of funds is very poor
- Financing systems create access barriers, inequity, poverty
- Paying providers for inputs, not outputs, impairs quality/efficiency

Surgical conditions cause lost economic productivity



Annual value of lost economic output due to surgical conditions

Surgical conditions cause large welfare losses

GDP alone fails to capture full value of better health

So we also used a broader measure: value of a statistical life (VSL)

VSL: intrinsic economic value that people place on living longer

In 2010 alone, $14.5 trillion in welfare was lost due to surgical conditions; $4 trillion in LMICs

Surgical treatments are a “best buy” in global health

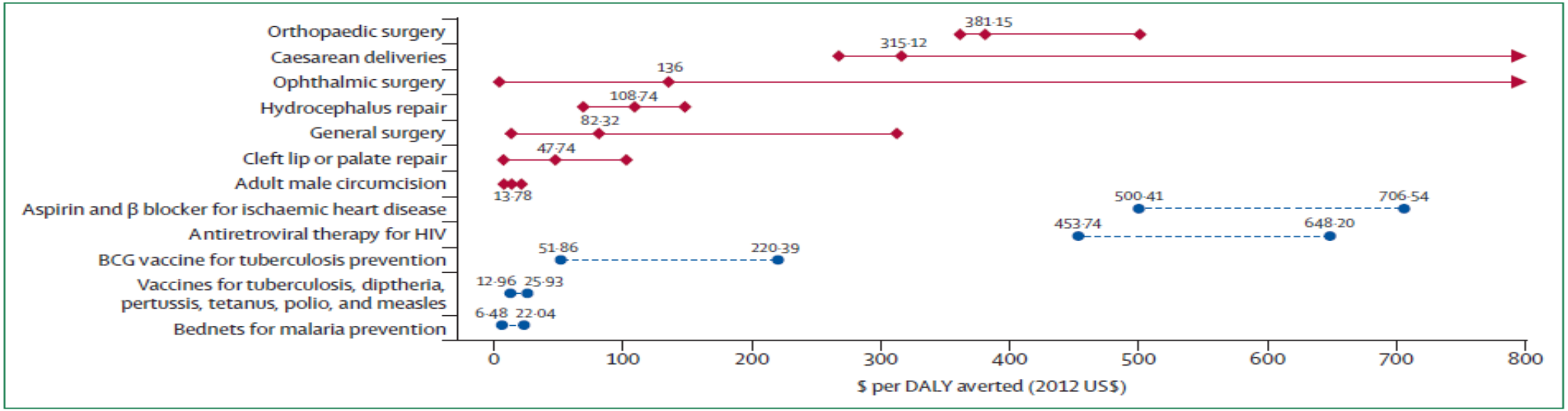


Figure 13: **Cost-effectiveness of surgery in low-income and middle-income countries compared with other public health interventions**
Data points are medians, error bars show range. Surgical interventions are denoted by the diamonds and solid lines, public health interventions by the circles and dashed lines. Reproduced from Chao and colleagues,[53] by permission of Elsevier. DALY=disability-adjusted life-year.

Economies of scale make surgery even more attractive

Cost-effectiveness studies have mostly examined isolated procedures, ignoring "platform" effects

Once you have a platform in place (initial capital outlays, staff training), there are huge economies of scale and scope

Studies of single interventions aren't as useful to policymakers—decisions are about surgical *platforms*

Debas et al, 2006: platform of surgical services delivered in 1st level hospital is very cost-effective ($33/DALY in SSA)

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Costs are paid mainly out-of-pocket and are impoverishing

33 million
people/year suffer catastrophic expenditures from accessing surgery

20%
of all cases of catastrophic health expenditure

Additional **48 million**
people/year suffer catastrophic expenditures from non-medical costs of accessing surgery

Poor coordination and alignment of funds can lead to fragmented services

Public sector

- General revenues (taxation)
- Social insurance (contributions from insured, insured's employer, or state into a public insurance scheme)

Private sector

- Out-of-pocket payments
- Private insurance

External

- Grants from donor agencies
- Concessional loans from development banks

We have no idea how much the world is spending on surgery

DONORS

Databases that track aid for health do not collect specific data on surgery

→

We examined one donor: USA

NGOs: elective eye surgery, cleft palate

USAID/NIH: fistula, trauma research

DOMESTIC

Countries do not collect specific data on their spending on surgery

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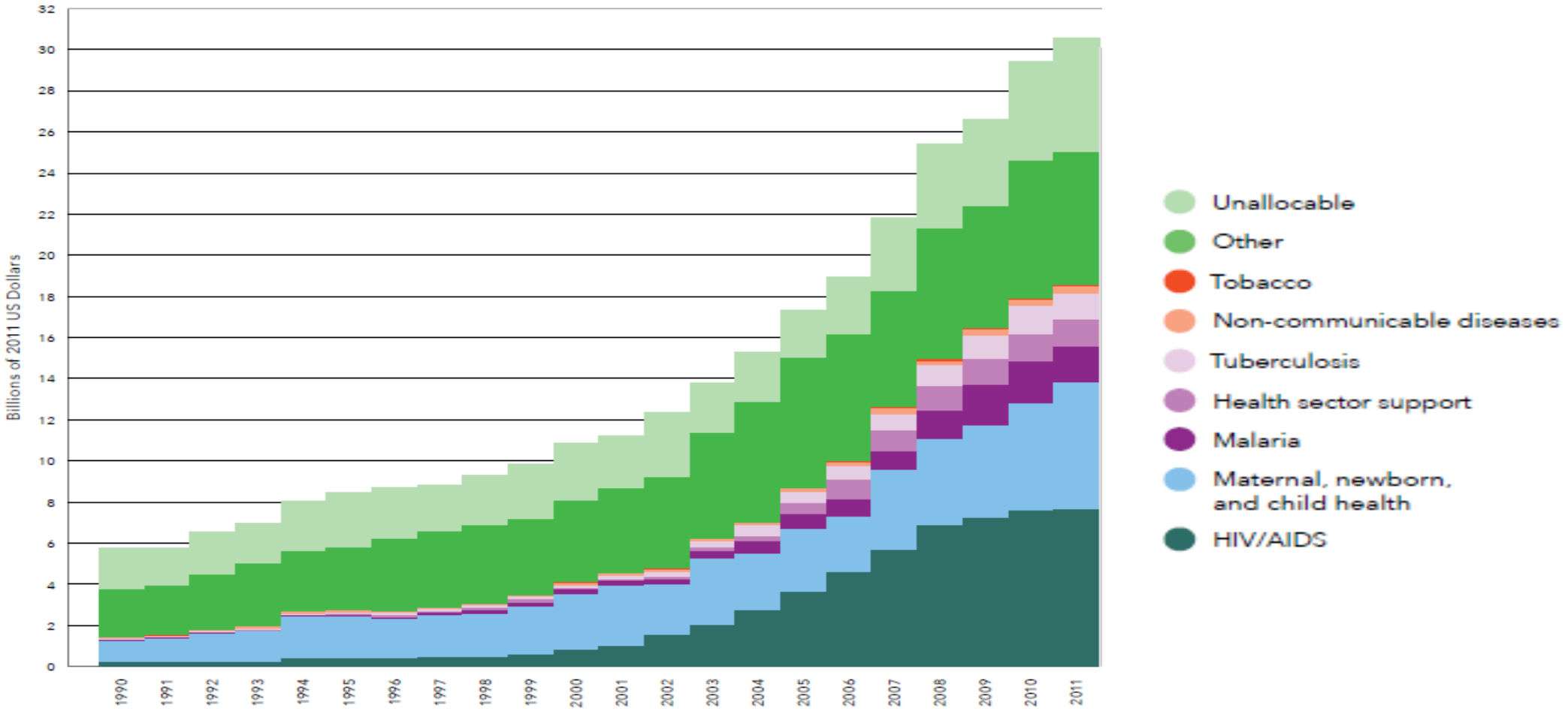
We examined 958 National Health Accounts, 1996-2010

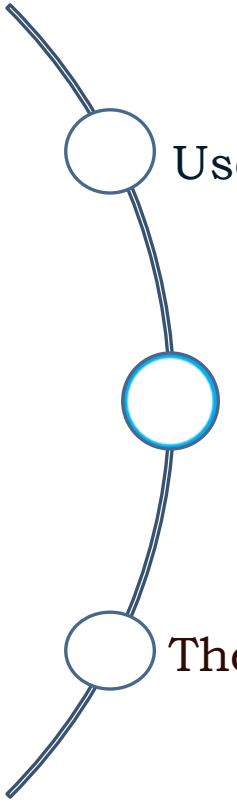
Only Georgia & Kyrgyzstan reported surgical spending

"Golden decade" of health aid: perhaps it neglected surgery?



Source: Institute for Health Metrics & Evaluation

The bulk of financing is direct payments from user fees (OOPs)



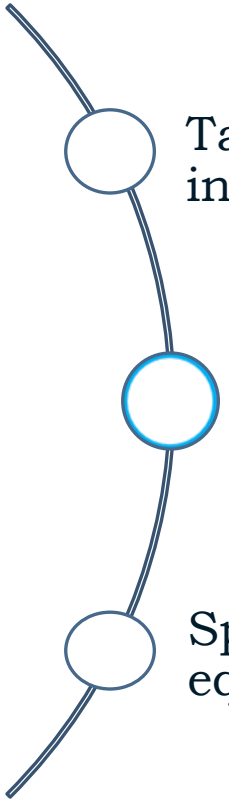
- User fees dominate even when stated means of financing is general taxation
- OOPs are a barrier to accessing surgical care; removing them is associated with increased use of services (e.g. C-sections)
- They are regressive: higher burden on people with low income

On top of user fees, two other OOP expenses are a barrier

· Costs of surgical supplies (e.g. gloves, sutures, dressings, intravenous fluids, antibiotics)

· Costs of transport and food—these can be impoverishing *even when the care is free*

Indirect (prepaid) financing, in which risk is pooled, is a better mechanism but is under-used



Target groups pay regular contribution either from general taxation or insurance models (premiums, copayments)

Treatment expenses are then paid for when a member of the pool is sick

Spreads out payments for services, minimizes costs for users, promotes equity and financial risk protection

Key features of surgical care make prepayment preferable to user fees

Time-critical and life- or limb-threatening conditions

Unpredictable, cannot plan or save for financial consequences

User fees are often high and can be catastrophic

Paying for inputs rather than outputs is dominant, and can reduce quality and efficiency

INPUT-BASED PURCHASING

Government payments

Inputs: personnel, supplies, equipment

Little attention to quality, efficiency; little use of mechanisms to motivate providers

STRATEGIC PURCHASING

Government payments

Predefined outputs: payment is linked to quality measures

Policy Solutions

Scale up donor and domestic financing

Track aid to surgery and domestic spending

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Introduce at least an element of strategic purchasing

Adopt prepaid, pooled coverage that includes surgery; include surgery in UHC service package

1. Governments

2. International collective action

1. UHC policies should cover surgery from early in expansion pathway
2. Avoid user fees, adopt prepaid financing; risk pooling with one pool and one payer promotes access, equity, FRP
3. Domestic resource mobilization for surgery will be essential for scale-up
4. National health accounts should track spending on surgery
5. Strategic purchasing should be strengthened as way to promote quality/efficiency

1. Donor support for UHC should include surgery/anesthesia
2. Traditional aid and innovative global health financing are crucial to “kick-start” scale-up of services
3. Urgently need to track DAH for surgery
4. Donors could support new global effort to better track surgery in national health accounts
5. International collective action has a crucial role to play in financing R&D for new surgical technologies for use in LMICs

Panel Focus:

How can we generate funding to improve surgical care globally?

Panelist- Vanessa Kerry

- Founder and CEO of Seed Global Health, an NGO promoting the sustainable development of human resources for health.
- Director of the program in Global Public Policy and Social Change in the Department of Global Health and Social Medicine at Harvard Medical School.
- Holds an MSc in health policy, planning, and financing from the London School of Economics and the London School of Hygiene and Tropical Medicine
- Critical care physician at Massachusetts General Hospital serving as the Associate Director of Partnerships and Global Initiatives at its Center for Global Health

@vbkerry @seed_global

Panelist- Robert Marten

- Joined the Rockefeller Foundation in 2010
- Manages relationships with current and prospective grantees
- Works on the Transforming Health Systems (THS) initiative and is coordinating the Foundation's Post-Ebola Resilience Building work
- Previously worked with The World Bank, the WHO, German Technical Cooperation, the Global Public Policy Institute, and the United Nations
- Holds a Master's of Public Policy from the Hertie School of Governance, an MPH from Johns Hopkins, and is pursuing a doctoral degree at the London School of Hygiene and Tropical medicine

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