

Accounting for good health

The problem

There are theoretical reasons and empirical evidence for significant inefficiencies in expenditure on health services. The theoretical reasons relate to 'imperfections in health markets' and these largely arise from differences in the amount of information about optimal treatments available to healthcare providers and to consumers. However, the empirical evidence suggests great differences between countries. Cuba, Kerala and, earlier, China and Sri Lanka are widely quoted examples of countries that produce good health outcomes at low cost. Kerala, with annual per capita income of only \$1,254 in purchasing power parity dollars, has an infant mortality rate of only 31 per 1,000 live births. This rate is not only 40 percent lower than that in the Punjab, with twice Kerala's income, but 35 percent lower than that in Brazil, which has more than four times Kerala's per capita income. Infant mortality in Shanghai, China, is lower than in Manhattan, and the recorded infant mortality rate of 16 in Jamaica is lower than that of African-Americans in the United States. In 19 industrialised countries between 1997-8 and 2002-3 when expenditure in health was growing rapidly, mortality, amenable to treatment, declined by 16 per cent on average but only by 4 per cent in the US where health expenditure grew most rapidly.

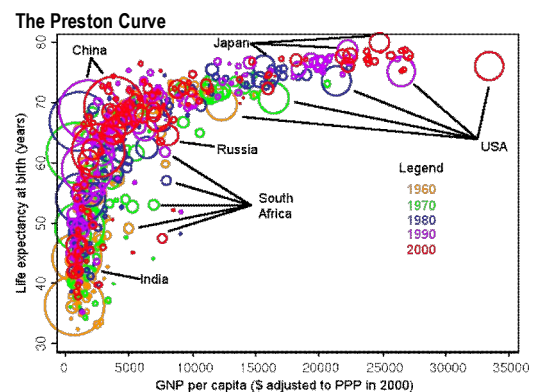
The research question

This project sets out to find out why some countries do so much better than others in generating good health outcomes.

This question has been the subject of a great deal of research but OPI is hoping to clarify what appears to be a complex relationship between health expenditure and health outcomes by adopting an innovative approach.

Many studies have shown that income is more important for health than expenditure on healthcare, particularly at low levels of income (the 'Preston Curve' illustrated). In earlier work commissioned by OPI, Matt Andrews of the Kennedy School of Government showed that if measures of health outcomes are corrected for income, countries' relative performance changes dramatically.

However, as the examples suggest, there are substantial variations in health outcomes at the same level of income (see the scatter of points around the Preston Curve illustrated). The question the research sets out to answer is: what features are typical of countries who 'box above (and below) their income weight'?



Do they spend more in healthcare? Is their healthcare expenditure more efficient? Are their healthcare providers better motivated to work effectively or are they simply healthier places to live?

The approach

The project will examine data from the 193 WHO member states. It will correct Child Mortality and Life Expectancy rates for income and identify countries that produce better health outcomes than expected for income. The health systems in these countries will then be examined in more detail to see if common factors can be identified which might explain their good performance. These may include the amount they spend on healthcare, how health services are funded or how doctors and nurses are motivated to perform well.

Practical implications

The results should point to features of high performing health systems at different levels of income which might be replicated in poorer performing countries.

Status: Being implemented with funding from the Association of Chartered Certified Accountants.