



# GLOBAL ACCESS TO HEALTHCARE

*Building sustainable health systems*

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## **CONTENTS**

- 2**    **About this report**
- 3**    **Executive summary**
- 6**    **Introduction**
- 8**    **Chapter 1: The Global Access to Healthcare Index -  
An overview of results**
- 16**   **Chapter 2: What contributes to better access?**
- 22**   **Chapter 3: How do access to healthcare and human  
development correlate?**
- 26**   **Chapter 4: Political commitment and trust and their  
impact on access to healthcare**
- 29**   **Conclusion**

## ABOUT THIS REPORT

*Global access to healthcare: Building sustainable health systems* is an Economist Intelligence Unit report, commissioned by Gilead, which examines the challenges and opportunities countries face as they attempt to improve access to high-quality healthcare that meets the needs of their populations. The report is based on the findings of a global index of 60 countries, additional desk research and the insights from 15 in-depth interviews with a range of senior healthcare experts, including healthcare practitioners, academics and policymakers.

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- Amit Thakker, chairman, Africa Healthcare Federation, Kenya
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## EXECUTIVE SUMMARY

Access to healthcare is a key topic of debate worldwide. Countries are facing a range of healthcare challenges, from rising numbers of patients with multiple chronic diseases amid population ageing to providing access to new and innovative treatments that are also cost-effective. Healthcare systems must reconcile these challenges against a backdrop of already stretched budgets. As a result, the ability of populations to access the healthcare they need is increasingly under the spotlight.

In 2016 The Economist Intelligence Unit developed the Global Access to Healthcare Index to measure how healthcare systems across 60 countries are working to offer solutions to the most pressing healthcare needs of their populations. The index looks at access to healthcare through a set of accessibility and healthcare-system measures, thereby assessing both the current track record of countries in meeting their populations' healthcare needs and the extent to which they have established the necessary health infrastructure to provide sustained access. This is done by assessing countries on a total of 23 sub-indicators within these two domains to evaluate whether citizens in each country have access to the appropriate health services.

The index examines access to specific kinds of care, including child and maternal health services, care for patients with infectious diseases and non-communicable diseases (NCDs), access to medicines, and the extent to which there are inequities in access (accessibility domain). The index also measures the conditions that allow for good access to effective and relevant healthcare services, such as policy, institutions and infrastructure (healthcare systems domain).

The index finds that performance in the accessibility domain is generally stronger than in the healthcare systems domain, suggesting that much more needs to be done to develop and extend coverage, the geographical reach of infrastructure, equity of access, and efficiency to improve the sustainability of health systems. And while developed countries are generally among the top performers in our ranking system, the results of the index show that, given enough political will and public faith in government institutions and other healthcare providers, even smaller, less wealthy countries can perform well.

### *Key findings*

**Political will and a social compact are prerequisites for both access and sustainable health systems.** Most of the countries with the highest scores on the index share a political and financial commitment to improving access to healthcare and a strong civil society in which corruption levels are low, accountability is high, and the public expects services to be available for them. "Access and provision [are] determined by the trust that people have in the state. [...] The more people trust, the more they are willing to pay for one another," observes Onno Schellekens, managing director of the PharmAccess Foundation in Amsterdam. Strong leadership can help to provide guidance to ensure that resources are deployed effectively, but this must be balanced by transparency and accountability.

**Public investment underpins good access and demonstrates the commitment of governments to ensuring the health of their populations.** A minimum level of public investment in healthcare systems, and especially in innovation, is necessary to extend access reliably. For lower- and middle-income countries, compulsory public financing is often more successful at extending coverage than patchier attempts to create prepaid insurance programmes. Public investment in infrastructure is, of course, vital to making sure there are clinics and hospitals to provide services. At the same time, public investment also plays an important role in innovation: research from the US National Institutes of Health (NIH) and other publicly funded institutions has led to the development of statins and vaccines used around the world, notes Prabhat Jha of the Dalla Lana School of Public Health at the University of Toronto. In an era of austerity, however, such investment is likely to face an uphill battle in which political leadership will be ever more vital.

**Universal coverage does not mean universal access, but extending universal health coverage (UHC) can be a crucial part of improving access.** There is an important distinction to be made between the ability to access healthcare services and its successful delivery to a wide population. A right to healthcare may be guaranteed in law but not actually available in reality, especially in remote or underdeveloped regions. It may be accessible but not affordable. “We need to be careful in allowing countries to say that they are providing access and see if they really are providing the services,” says Robert Yates, project director for the UHC Policy Forum at Chatham House in London.

**Access to data is fundamental.** Transparent and accurate data are one of the most important components of identifying the health requirements of a given population and ensuring that they receive the care they need. Reliable data can provide information about the principal health challenges facing a society and about treatment outcomes, making it easier for health systems to prioritise investment of scarce resources. The expansion, and more extensive use, of health technology assessment (HTA) is a major way in which countries can use data more effectively.

**A well-trained and integrated workforce is the backbone of a sustainable healthcare system.** Informed workers with a strong connection to local communities can help to improve the quality of care and lead to a healthier population, even if the number of highly educated professionals is sparse. Countries such as Ethiopia and Iran have improved access to basic primary care by training people from local communities to provide health education, test for illnesses such as malaria, administer vaccinations and monitor hygiene in homes, leading to improved outcomes in areas such as child and maternal health. In wealthier countries more integrated systems of healthcare delivery, still in their infancy, have the potential to create better co-operation across specialties.

**Good primary care is a vital building block for good access.** The level of development of a country’s primary-care system is not only indicative of the political commitment of its leaders to providing healthcare but is also a foundation for any sustainable healthcare system. Moreover, experts are increasingly viewing primary care as one of the best investments governments can make at a time of strained public finances, especially given the growth of chronic diseases worldwide. “Those countries with a good primary-care infrastructure can deliver better care at a better cost than the countries that have decided to do everything mainly through sophisticated hospitals,”

explains Rafael Bengoa, co-director of the Institute for Health & Strategy in Bilbao, Spain, and former minister for health and consumer affairs in the government of Spain's Basque region. "It is actually quite simple: as a policymaker, you cannot meet the 'triple aim' [improving the patient experience of care; improving the health of populations; and reducing the per-capita cost of healthcare] without a good primary-care set-up."

## INTRODUCTION

Good population health is closely interconnected with economic development and wealth. Sir Michael Marmot, an expert on health inequalities, and colleagues have argued that lifestyles and the conditions in which people live and work have a key impact on their health.<sup>1</sup> Countries which protect human rights and explicitly recognise healthcare as one of these rights are arguably more likely to attempt to address inequities in access to healthcare.

Between 1970 to 2000 increasing life-expectancy rates across the globe were driven by progress in combatting premature mortality.<sup>2</sup> Many developing countries have shown significant improvements in their efforts to meet the UN's Millennium Development Goals (MDGs), and the countries that have signed up to the Sustainable Development Goals (SDGs) have agreed to aim for a 40% reduction in premature deaths by 2030. As part of the SDGs, countries have pledged to reduce child and maternal deaths and mortality from tuberculosis, HIV and malaria by two-thirds, and deaths from non-communicable diseases (NCDs) and other causes by one-third.<sup>3</sup>

Yet it is increasingly clear that insufficient investment in health, particularly in the developing world, has led to disparities in health outcomes globally. Many of the experts interviewed for this report argue that a strong commitment to increasing public investment in health coverage and health systems is vital.

This is especially true in developing countries, many of which are continuing to struggle with the toll of infectious diseases while at the same time facing a growing burden from NCDs, accidental deaths and the impact of poor sanitation and other environmental factors. Wealthier countries are also struggling with the pressures placed on their health systems by population ageing, the rising prevalence of chronic diseases, co-morbidities and the demand for access to new health technologies.

Multilateral support for universal health coverage (UHC) has grown significantly in recent years. A 2010 report the World Health Organisation (WHO) identified direct payments, including user fees, as "by far the greatest obstacle to progress" towards UHC.<sup>4</sup> A UN resolution of December 2012 urged governments to move towards providing all people with access to affordable, quality health services.<sup>5</sup> Moreover, all UN member states have agreed to try to achieve UHC by 2030 as part of the SDGs.<sup>6</sup>

Despite the increased recognition of the importance of widening access, definitions and terminology can be confusing. The Global Access to Healthcare Index looks at access to specific kinds of care, including child and maternal health services, care for patients with infectious diseases and NCDs, access to medicines, and the extent to which there are inequities in access. The healthcare systems domain in the index measures the conditions that allow for good access to effective and relevant healthcare services, such as policy, institutions and infrastructure.

But the categories measured by the index raise other question as well. In particular, there is the question of how to define "access" to healthcare. Is access the same thing as universal coverage? Does it mean the right to have *any* treatment, regardless of income, or does it mean the right to

<sup>1</sup> R Wilkinson and M Marmot (eds.), *Social determinants of health : the solid fact*, second edition, World Health Organisation, 2003.

<sup>2</sup> IMF, *Health and development: why investing in health is critical for achieving economic development goals*, December 2004, p. 14. Available at: <http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf>.

<sup>3</sup> O Norheim *et al*, "Avoiding 40% of the premature deaths in each country, 2010–30: review of national mortality trends to help quantify the UN Sustainable Development Goal for health", *The Lancet*, Vol. 385, No. 9964, pp 239–252, January 17th 2015.

<sup>4</sup> WHO, *Health Systems Financing: the path to universal coverage*, 2010, p. 4.

<sup>5</sup> UN, *Global health and foreign policy*, General Assembly, Sixty-seventh session, Agenda item 123, December 6th 2012. Available at: [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E](http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E)

<sup>6</sup> WHO, *Universal health coverage (UHC), fact sheet*, updated December 2016. Available at: <http://www.who.int/mediacentre/factsheets/fs395/en/>

purchase *affordable* healthcare? In the debate about healthcare reform in the US, some members of the Republican-controlled Congress have stressed their desire to guarantee “universal access” to affordable healthcare coverage rather than “universal coverage”.<sup>7</sup>

Moreover, does access to care necessarily mean the same thing as high-quality care? Does it mean appropriate care? As these questions demonstrate, the terminology surrounding access is frequently complicated by semantic distinctions that depend on what sort of health system is being discussed.

Even in high-income, relatively generous welfare states such as those in Europe, there may be a trade-off between access in terms of affordability and convenience of service. “It may be that you have generous rights, such as in Sweden, but it might take a lot of time before you can see a doctor,” says Johan Hjertqvist, president of the Health Consumer Powerhouse, a Stockholm-based health policy think-tank. Indeed, even within Europe, inequities in access to healthcare contribute to substantial disparities in life expectancy between countries.<sup>8</sup>

In this paper, we will look at our Global Access to Healthcare Index rankings and assess the performance of countries across different income levels. We will also examine the key factors contributing to better access, as well as the role of human development and political commitment in extending healthcare delivery and improving its value.

<sup>7</sup>“In Private, Republican Lawmakers Agonize over Health Law Repeal”, *The New York Times*, January 27th 2017. Available at: [https://www.nytimes.com/2017/01/27/us/politics/affordable-care-act-republican-retreat.html?\\_r=0](https://www.nytimes.com/2017/01/27/us/politics/affordable-care-act-republican-retreat.html?_r=0)

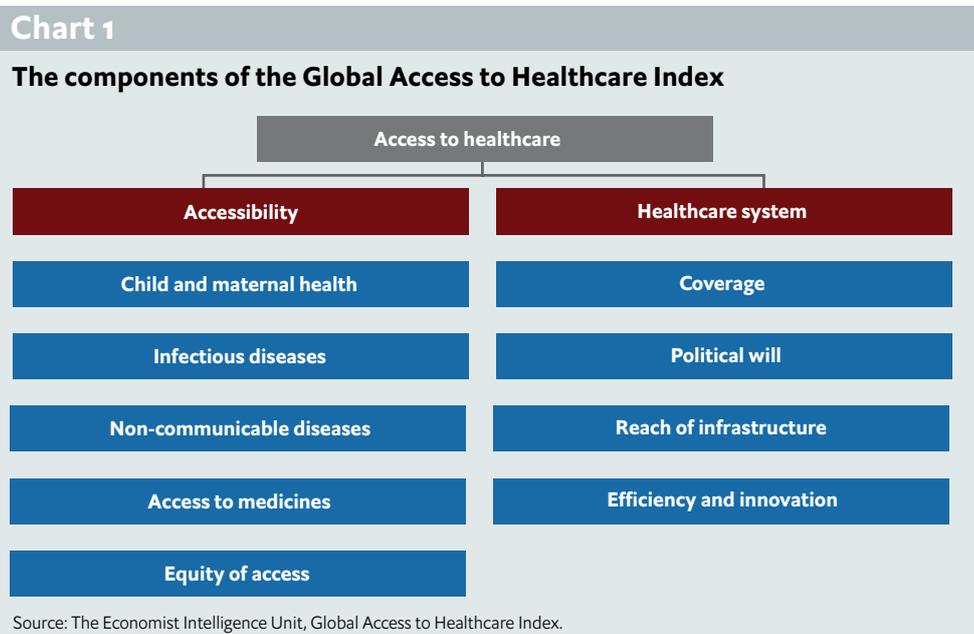
<sup>8</sup>UCL Institute of Health Equity, *Review of social determinants and the health divide in the WHO European Region: final report*, updated reprint 2014. Available at: <http://www.instituteofhealthequity.org/projects/who-european-review>

# CHAPTER 1: THE GLOBAL ACCESS TO HEALTHCARE INDEX - AN OVERVIEW OF RESULTS

The two domains that comprise The Economist Intelligence Unit’s Global Access to Healthcare Index—accessibility and healthcare systems—include a number of sub-categories, all of which contribute to the ranking of the 60 countries included in the index (see chart 1). The 60 countries are from each of the four broad regions of the world—Africa/Middle East, the Americas, Asia-Pacific and Europe—representing a diversity of income levels.<sup>9</sup>

The accessibility domain provides a country-level snapshot of current access to prevention and treatment services across a set of disease areas: child and maternal health services; infectious diseases, such as malaria, HIV/AIDS, tuberculosis and viral hepatitis; and non-communicable diseases, such as cardiovascular diseases (CVDs), cancer and mental health. The index evaluates these areas according to a series of key performance indicators, focusing on health outcomes. The index evaluates progress within these sub-indices considering current global policy agendas, such as the Sustainable Development Goals (SDGs).

In the case of the healthcare systems domain, the index measures the conditions that allow for good access to effective and relevant healthcare services, such as policy, institutions and infrastructure. The index takes a forward-looking approach to the category, namely, is the country implementing the right mechanisms today for optimal access tomorrow?



<sup>9</sup> For a detailed description of the methodology, please refer to the accompanying methodology paper: The Economist Intelligence Unit, *Global Access to Healthcare Index: Methodology*, May 2017. Available at: <http://acesstohealthcare.eiu.com/methodology/>

### **Full coverage does not necessarily equate with better access and quality**

The top six performers—the Netherlands, France, Germany, Australia, the UK and Canada—are all relatively wealthy, developed countries. By contrast, the bottom six overall performers—Cambodia, Ethiopia, Nigeria, Uganda, the Democratic Republic of the Congo (DRC) and Afghanistan—are all poorer, and in many cases populous, countries with major challenges to ensure healthcare access.

But income levels are not the only precursor to success in providing access to healthcare. Several middle-income countries are ranked highly and ahead of some high-income countries, including for example Cuba (7th), Brazil (joint 12th), Thailand (15th), Colombia (joint 16th) and Kazakhstan (joint 16th). (See chart 2.)

Chart 2<sup>a</sup>

#### **Top-performing countries in the Global Access to Healthcare Index** (score out of 10)

Rank	Country	Score
1	Netherlands	9.1
=2	France	9.0
=2	Germany	9.0
=4	Australia	8.8
=4	UK	8.8
6	Canada	8.6
7	Cuba	8.5
=8	Italy	8.4
=8	Japan	8.4
=10	Spain	8.3
=10	US	8.3
=12	Brazil	8.0
=12	Israel	8.0
14	Taiwan	7.8
15	Thailand	7.7
=16	Colombia	7.5
=16	Kazakhstan	7.5
=16	South Korea	7.5
19	Poland	7.4
=20	Chile	7.3
=20	Romania	7.3
=20	Turkey	7.3

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

Indeed, many experts interviewed for this report say that the full healthcare coverage common to many high-income countries does not necessarily equate with high-quality care, and that quality cannot be seen as separate from access. “The issue is, when you talk about universal health coverage, [sometimes] you mean access to a poor set of services with financial burdens and high out-of-pocket costs,” says Francesca Colombo, head of the health division at the OECD in Paris. “One of the things that is more important is not just that there is UHC but that the services are most effective and deliver the most health. You can have financial protection, but if health services are of poor quality, not available and not safe, then access is an issue.”

The accessibility domain looks at access to specific kinds of care, including child and maternal health services, care for patients with infectious diseases and non-communicable diseases (NCDs), access to medicines, and the extent to which there are inequities in access. High-income countries, led by Australia, the Netherlands and France, top the rankings in this domain. However, Brazil, an upper-middle-income country, is also in the top ten (see chart 3).

<sup>a</sup> The index includes 60 countries from each of the four broad regions of the world—Africa/Middle East, the Americas, Asia-Pacific and Europe—representing a diversity of income levels.

Chart 3<sup>b</sup>

### Top-performing countries in the accessibility domain

(score out of 10)

Rank	Country	Score
1	Australia	9.5
2	Netherlands	9.3
3	France	9.2
4	Germany	9.1
5	Italy	9.0
=6	Japan	8.9
=6	Spain	8.9
=6	UK	8.9
=9	Brazil	8.8
=9	Israel	8.8

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

### Performance in individual accessibility areas

Most countries included in the index have, or are moving towards, high coverage rates in essential child and maternal-health services, including immunisation, birth facilities and family planning (see chart 4). The trend, which is seen across all countries by income group, reflects the higher priority given to healthcare for women and girls in particular. Only a few countries clearly lag behind, for example Nigeria in terms of measles immunisation coverage, Ethiopia in terms of births attended by skilled health personnel, and the DRC in terms of demand for family planning employing modern methods.

Chart 4<sup>c</sup>

### Top-performing countries in the area of access to child and maternal-health services

(score out of 10)

Rank	Country	Score
1	China	10.0
2	Thailand	9.8
=3	Cuba	9.7
=3	Taiwan	9.7
=5	Brazil	9.5
=5	UK	9.5
=7	Canada	9.4
=7	South Korea	9.4
=9	Netherlands	9.3
=9	Uzbekistan	9.3

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

In the area of access to infectious diseases care, the index shows a strong commitment to the fight against malaria, HIV/AIDS and hepatitis B across most of the countries included in the index, with particularly strong results in Algeria, Italy and Cuba (see chart 5). That said, a significant minority of 17% of the countries studied have prevalence of malaria but no coverage of insecticide-treated nets, including for example India, South Africa and Venezuela. At the same time, there is a relative lack of access to tuberculosis treatment among high-income countries, such as Japan and Germany. Two Latin American countries—Chile and Argentina—lag behind the rest in terms of their tuberculosis treatment success rate (new cases).

<sup>b</sup> The metrics evaluated in this domain include: access to child and maternal health services; access to infectious diseases care; access to non-communicable diseases care; access to medicines; and equity of access to healthcare.

<sup>c</sup> The metrics evaluated in this sub-domain include: measles immunisation coverage; births attended by skilled health personnel; and demand for family planning employing modern methods.

In more than three-quarters of the countries studied the percentage of adults and children with HIV known to be receiving treatment 12 months after the initiation of antiretroviral therapy is 80%+, but in South Africa it is only 42%, while in both Argentina and Mozambique it is 66%. Similarly, the hepatitis B immunisation coverage among one-year-olds is 80%+ in three-quarters of the countries, but some, such as Ukraine (46%) and Nigeria (66%) lag behind. In the UK the percentage is zero: given the low prevalence of the disease, the country does not vaccinate children for hepatitis B.

### Chart 5<sup>d</sup>

#### Top-performing countries in the area of access to infectious diseases care

(score out of 10)

Rank	Country	Score
=1	Algeria	9.5
=1	Italy	9.5
3	Cuba	9.3
4	Australia	9.2
5	Taiwan	8.9
=6	Kazakhstan	8.8
=6	Spain	8.8
8	US	8.7
9	France	8.5
10	Russia	8.4

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

### Chart 6<sup>e</sup>

#### Top-performing countries in the area of access to non-communicable diseases care

(score out of 10)

Rank	Country	Score
1	Canada	9.9
2	Japan	9.7
3	Netherlands	9.6
4	Australia	9.5
5	UK	9.3
6	Germany	8.9
=7	France	8.6
=7	Poland	8.6
=7	Spain	8.6
=7	US	8.6

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

<sup>d</sup> The metrics evaluated in this sub-domain include: elimination and prevention of malaria; 12-month retention on antiretroviral therapy (HIV/AIDS); tuberculosis treatment success rate (new cases); hepatitis B immunisation coverage; quality of a national viral hepatitis plan; quality of a programme for hepatitis B in the national viral hepatitis plan; and quality of a programme for hepatitis C in the national viral hepatitis plan.

<sup>e</sup> The metrics evaluated in this sub-domain include: smoking prevalence five-year trend (male); level of taxes on tobacco; radiotherapy coverage; availability of cervical cytology; availability of colon-cancer screening; availability of oral morphine; existence of a mental-health plan; and expenditure on mental health.

Instead, the UK's initiatives regarding hepatitis B, including immunisation, screening and treatment, are focused on high-risk populations.

Moreover, there is a failure to recognise the threat of hepatitis C in a number of countries, based on the speed of policy development. For example, more than one-third of countries (23 out of 60) have no national viral hepatitis plan, and a similar number (21 out of 60) get the lowest score for the quality of their programme for hepatitis C in the national viral hepatitis plan.

Performance in the area of non-communicable diseases is also varied. Unsurprisingly, high-income countries top the ranking, reflecting the fact that their health systems have been dealing with NCDs for a much longer period of time than those in less developed countries amid population ageing and rising levels of people living with multiple chronic diseases (see chart 6).

While there have been significant achievements in reducing smoking prevalence as a risk factor for cardiovascular diseases and cancer across the world, lower-income countries, such as Afghanistan, the DRC and Mozambique, lag behind in providing radiotherapy. Worryingly, more than one-third of countries (23 out of 60) are underproviding basic colon-cancer screening services. There is also a shortage

of palliative care across low- and middle-income countries. One particular area where expenditure remains low is mental health, with 42% of countries (25 out of 60) receiving the lowest score in this category (with little or no spending), although mental health plans have been adopted in most countries (the exceptions are Honduras, Kazakhstan and Nepal).

Although access to medicines is better in high-income countries, this is not consistent, with some less wealthy countries—notably Brazil and Thailand—outperforming high-income ones

Chart 7<sup>f</sup>

### Top-performing countries in the area of access to medicines

(score out of 10)

Rank	Country	Score
1	Netherlands	9.7
=2	France	9.6
=2	Germany	9.6
4	Australia	9.5
=5	Italy	9.4
=5	UK	9.4
7	Brazil	9.1
8	Romania	9.0
=9	Israel	8.9
=9	Thailand	8.9

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

(see chart 7). This is often achieved through special arrangements, such as licensing agreements for the production of generics, or through standalone approaches, such as the direct import of medicines from other countries. All countries are experiencing limitations regarding effective access, including significant co-payments for patients, shortages, inequities in insurance coverage and guidelines for prioritising patients to manage the burden on the health system.

In all disease areas covered in this category, there are some countries that lag behind in providing access. For malaria, this applies to seven countries, for cardiovascular diseases to 15 countries, for diabetes to 13 countries,

for hepatitis B to eight countries, for hepatitis C to 21 countries, and for cancer to two and four countries respectively (three drugs were included in the assessment). For HIV/AIDS the percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV is below 10% in four countries (Indonesia, Iran, Pakistan and Afghanistan).

Chart 8<sup>g</sup>

### Lowest-performing countries in the area of equity of access to healthcare

(score out of 10)

Rank	Country	Score
51	India	3.4
=52	Kenya	3.3
=52	Ukraine	3.3
54	Nepal	3.2
55	Afghanistan	3.0
56	Nigeria	2.8
57	DRC	2.6
58	Cambodia	2.5
59	Ethiopia	2.0
60	Bangladesh	1.6

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

Equity of access to healthcare varies greatly both between countries and within them, with inequities persisting even in high-income countries. That said, one-half of the countries included in the index get the highest score. Inequities are greatest in low- or lower-middle income countries (see chart 8). This indicator in particular (and the accessibility domain more generally) shows a stronger correlation with a country's ranking in the Human Development Index than with income. This correlation will be discussed in more detail in Chapter 3.

Five countries (Bangladesh, Cambodia, the DRC, the Dominican Republic and Ukraine) have no specific policies aimed at guaranteeing access to healthcare for

children (or these have not been implemented), while even more countries (16) have no specific policies aimed at guaranteeing access to healthcare for the unemployed (or these have not been implemented). The rural/urban ratio of births attended by skilled health personnel, expressed in

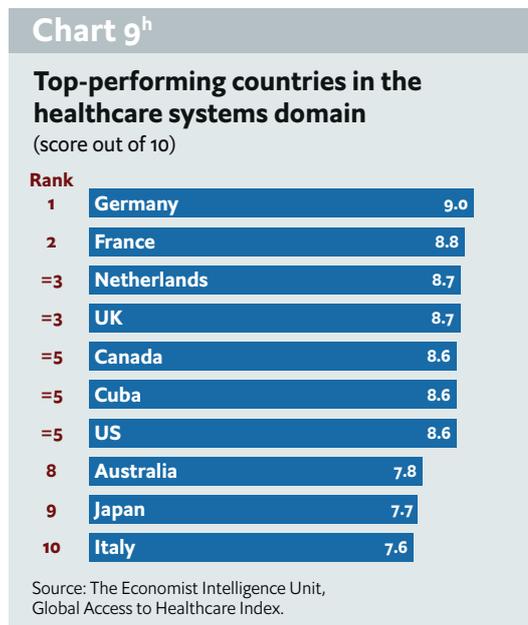
<sup>f</sup>The metrics evaluated in this sub-domain include: for malaria, availability of artemisinin-based combination therapy (ACT); for cardiovascular diseases, availability of statins; for diabetes, availability of metformin; coverage of people receiving antiretroviral therapy (HIV/AIDS); for hepatitis C, availability of direct acting antivirals (DAAs); for hepatitis B, availability of entecavir or tenofovir; and for cancer, availability of doxorubicin, fluorouracil (5FU) and docetaxel.

<sup>g</sup>The metrics evaluated in this sub-domain include: existence of policies for access to healthcare for children; existence of policies for access to healthcare for the unemployed; and rural/urban ratio of births attended by skilled health personnel.

decimals, is 1.0 in 35 countries (highlighting no or little rural/urban divide), but it is comparatively low in Afghanistan (0.4), Guatemala (0.4), Nigeria (0.3) and Ethiopia (0.1).

The results of the index suggest that while access to healthcare may not be consistent across regions, the existence of strong healthcare systems capable of making access sustainable is even less evident.

Many of the experts interviewed for this paper argue that even highly developed health systems (often those located in high-income countries) may have the wrong policies in place to deliver healthcare efficiently in the future. In particular, there is a growing realisation that a preoccupation with inputs into a healthcare system, including physical infrastructure and hi-tech interventions, has often superseded the analysis of outcomes for patients and society.



“Building some kind of equivalent structure or system that can bring various functions of healthcare together is much more complicated than delivering quick access,” says Mr Hjertqvist of the Health Consumer Powerhouse, adding that health systems reflect the culture, values and levels of corruption of a country, among other factors. “You can speed up access to doctors, but that doesn’t mean they are less corrupt, or that there is more patient safety.”

The healthcare systems domain in the Global Access to Healthcare Index aims to uncover to what extent countries are implementing the right mechanisms today for appropriate access in the future. Germany, France and other high-income

countries perform best in this category, but Cuba also manages to get into the top ten (see chart 9).

### **Performance in individual areas of the healthcare systems domain**

With regard to the specific sub-indices covered in the healthcare systems domain, efforts to extend financial protection to the population are evident in high-income countries. However, some middle-income countries are also doing well in this category, as is seen in the high scores of countries such as Cuba, Thailand and South Africa (see chart 10).

This reflects the focus of many middle-income countries on investing in primary care and addressing preventable diseases. Cuba, for example, receives top marks for sustainable financial protection (based on out-of-pocket expenditure on health, adjusted by a rating of reliance of the healthcare system on external funding), while Vietnam tops the ranking for prevention and public-health services as a percentage of total health expenditure. Low-income countries such as Ethiopia, Cambodia, Afghanistan and Uganda perform badly for financial coverage.

<sup>h</sup> The metrics evaluated in this domain include: population coverage of the healthcare system; political will for increased access to healthcare; reach of healthcare infrastructure; and efficiency and innovation of the healthcare system.

### Chart 10<sup>i</sup>

#### Top-performing countries in the area of population coverage of the healthcare system

(score out of 10)

Rank	Country	Score
1	Netherlands	9.4
=2	Cuba	9.2
=2	France	9.2
=2	Thailand	9.2
5	Canada	8.9
6	US	8.8
=7	Germany	8.7
=7	South Africa	8.7
=7	UK	8.7
10	Japan	8.6

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

### Chart 11<sup>i</sup>

#### Top-performing countries in the area of political will for increased access to healthcare

(score out of 10)

Rank	Country	Score
=1	Australia	10.0
=1	Canada	10.0
=1	Cuba	10.0
=1	France	10.0
=1	Germany	10.0
=1	Japan	10.0
=1	Netherlands	10.0
=1	UK	10.0
=1	US	10.0
10	UAE	8.5

Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

The index measures the political will for increased access to healthcare according to out-of-pocket expenditure as a percentage of total health expenditure and general government expenditure on health as a percentage of total government expenditure. Nine countries share the top spot in this category. High-income countries dominate the top ten, but Cuba is again among the best-performing countries (see chart 11). Almost one-third of countries (18 out of 60) get the best score for out-of-pocket expenditure on health, while 12 countries get the best score for growth in government expenditure on health. Belarus, Russia, Cambodia, Venezuela, Argentina and Tanzania are the worst performers in terms of political will based on these indicators.

Most of the experts interviewed for this paper agree that the existence of both political will and good governance is key for healthcare reform that makes a genuine impact; indeed, scores in this category are strongly correlated with the Corruption Perceptions Index.<sup>10</sup> "I think that what you see in many of these countries is that in the end the state is the best option to cover everyone, but if the state is not operating properly, you need private insurance," says Onno Schellekens, managing director of the PharmAccess Foundation in Amsterdam. He notes that countries such as Indonesia, Thailand and Rwanda have been particularly innovative in this respect,

but that the process of extending coverage "requires civil society to become active to get a social contract between employers and unions and employees".

High-income countries have the advantage of a more comprehensively developed health infrastructure. Countries that do well in the ranking for the reach of healthcare infrastructure (see chart 12) have a high density of physicians and of nursing and midwifery personnel, and a high quality of vital statistics (with cancer mortality data used as a representative example). Unsurprisingly,

<sup>i</sup>The metrics evaluated in this sub-domain include: sustainable financial protection and prevention, and public health services as a percentage of total health expenditure.

<sup>j</sup>The metrics evaluated in this sub-domain include: out-of-pocket expenditure as a percentage of total expenditure on health (ten-year growth), and general government expenditure on health as a percentage of total government expenditure (ten-year growth).

<sup>10</sup> Transparency International, Corruption Perceptions Index. Available at: <http://www.transparency.org/research/cpi/overview>

Chart 12<sup>k</sup>

### Top-performing countries in the area of reach of healthcare infrastructure

(score out of 10)



Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

low-income countries such as the DRC, Mozambique, Tanzania and Ethiopia have fewer resources to invest in healthcare infrastructure and, accordingly, perform poorly in this category.

However, many lower-income settings have been successful in reaching their populations with basic resources, among them three countries formerly or currently under communist rule, namely Cuba, Belarus and Russia. That said, several of those interviewed observe that these countries are also outliers in terms of their salary structure, making it more difficult to replicate their results.

The efficiency and innovation category comprises expenditure on research and development (R&D) as a percentage of GDP (topped by South Korea); the existence and independence of health technology assessment, or HTA (27 countries get top marks for higher institutional development); the existence of mechanisms for identifying interventions for de-adoption (present in 17 countries); the existence of performance-based payment models in hospital remuneration (present in 30 countries); and the existence of performance-based payment models in primary care (present in 39 countries).

Chart 13<sup>l</sup>

### Top-performing countries in the area of efficiency and innovation of the healthcare system

(score out of 10)



Source: The Economist Intelligence Unit, Global Access to Healthcare Index.

Initiatives aimed at bringing about innovation, while more often present in high-income countries, are equally found in middle-income countries such as Brazil, Turkey and Indonesia (see chart 13). Some lower-income countries, such as Ethiopia, are also introducing innovative measures, albeit to a lesser extent. Greater use of HTA to evaluate the cost-effectiveness of healthcare solutions is one factor contributing to increased innovation and efficiency.

<sup>k</sup> The metrics evaluated in this sub-domain include: density of physicians; density of nursing and midwifery personnel; and quality of vital statistics (cancer mortality data).

<sup>l</sup> The metrics evaluated in this sub-domain include: expenditure on research and development (R&D) as a percentage of GDP; existence and independence of health technology assessment (HTA); existence of mechanisms for identifying interventions for de-adoption; existence of performance-based payment models in hospital remuneration; and existence of performance-based payment models in primary care.

## CHAPTER 2: WHAT CONTRIBUTES TO BETTER ACCESS?

Access to healthcare and healthcare systems can be defined in a number of ways. There is the straightforward question of whether the services exist in the first place. Are there enough hospitals or clinics, doctors, nurses and midwives, medicines and equipment? In the case of medicines, are they registered or approved in the country? Are they available/in stock? Are healthcare workers trained in the latest clinical practice guidelines? And what are the links that frequently (but not always) exist between these basic conditions for providing care and the financing decisions made by governments and health ministries?

Once the necessary infrastructure is in place, there is the issue of health coverage, including whether it is universal or not, and whether access and universality are the same as affordability. Inequities in health provision can be defined in a myriad of ways and can be found both between and within countries. Evaluating results is key: although many countries have adopted explicit health-benefit packages containing priority health services that must be made available to all citizens, the real test is the extent to which such services are truly accessible.

Finally, many of the experts interviewed for this paper point out that access to care, even high-quality care, is not always the same as access to the “right” care. The growth in health technology assessment (HTA) and the evolving focus on healthcare outcomes and the appropriateness of the care delivered to individual patients are essential for the delivery of care that is high-value as well as high-quality.

### **Financial commitments**

Over the last couple of decades there have been growing multilateral efforts to encourage countries to increase the amount of money they spend on healthcare. The WHO has recommended that countries spend a minimum of 5% of GDP on health in order to be taken seriously on provision of access.<sup>11</sup> Meanwhile, in the Abuja Declaration of 2001 the heads of state of African Union countries pledged to set a target of allocating at least 15% of their budgets to improving healthcare. Over a decade later, however, many of them were still making insufficient progress (see chart 14).<sup>12</sup>

Moreover, out-of-pocket spending continues to account for a significant portion of total expenditure. In several populous developing countries, such as India, Pakistan and Nigeria, the public sector spends less than or around 1% of GDP.<sup>13</sup> Many of these countries have traditionally depended on limited public expenditure being supplemented with foreign aid, although these sources of funding are increasingly precarious owing to political pressures and austerity budgeting in developed countries. A 2015 report by The Economist Intelligence Unit highlighted that resource-allocation decisions are becoming more difficult for governments as healthcare aid flows have stagnated since the global financial crisis. Attention is increasingly turning to improving aid effectiveness to ensure that every dollar goes as far as possible.<sup>14</sup>

<sup>11</sup> WHO, *How Much Should Countries Spend on Health?*, 2003. Available at: [http://www.who.int/health\\_financing/en/how\\_much\\_should\\_dp\\_03\\_2.pdf](http://www.who.int/health_financing/en/how_much_should_dp_03_2.pdf)

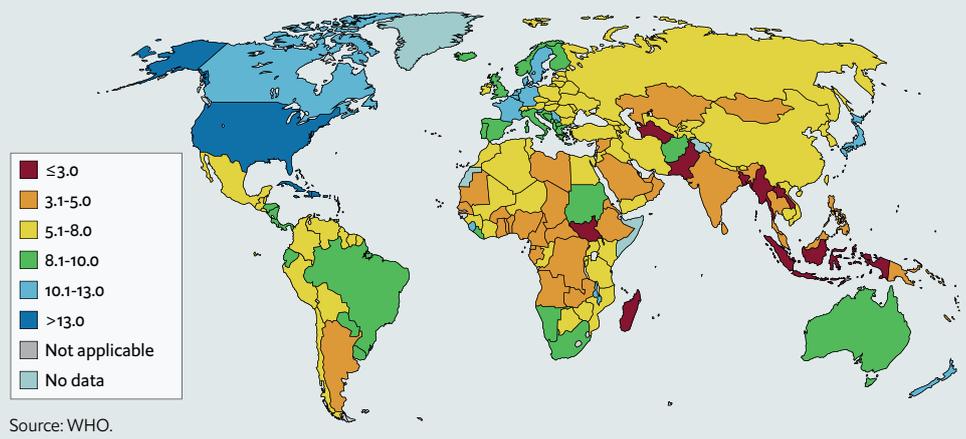
<sup>12</sup> WHO, *The Abuja Declaration: Ten Years On*, 2011. Available at: [http://www.who.int/healthsystems/publications/abuja\\_report\\_aug\\_2011.pdf](http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf)

<sup>13</sup> World Bank, Health expenditure, public (% of GDP). Available at: <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>

<sup>14</sup> The Economist Intelligence Unit, *Driving value in healthcare spending in low- and middle-income countries*, 2015. Available at: [http://pages.eiu.com/rs/783-XMC-194/images/Driving\\_Value\\_in\\_Healthcare\\_Spending\\_EIU.pdf](http://pages.eiu.com/rs/783-XMC-194/images/Driving_Value_in_Healthcare_Spending_EIU.pdf)

Chart 14

### Total expenditure on health as a percentage of GDP, 2014



“Income and health are directly correlated in terms of out-of-pocket expenditure, except for countries such as Cuba,” says Dr Schellekens of the PharmAccess Foundation. “If you are not willing to pay for the poor, you will perform worse than other countries with a similar level of development.”

But even expenditure over and above the odds does not guarantee good outcomes, observes Rafael Bengoa, a former health minister in Spain’s Basque region and director of the health department at the Deusto Business School in Bilbao. “I think most people in countries that are investing 6% or 6.5% of their GDP [in healthcare] are getting access [to all the areas in the index sub-domains], but some are provided access to medicines with co-payments and some without. In Europe, you have access to acute care, but chronic-disease care is so weak that you cannot say you have access to those services.”

In developing economies, meanwhile, a key challenge is ensuring that money is used resourcefully. “You don’t just need to give money to the health ministry, but make sure there is efficiency in the health ministry before you commit more,” says Amit Thakker, chairman of the Africa Healthcare Federation in Nairobi, Kenya. “Politics are at play, and health is such a technical ministry that it is subject to political trickery.”

Marie-Goretti Harakeye, a public health specialist and head of the health division for the African Union Commission, points out that in 2016 the African Union (AU), in co-operation with the Global Fund, launched a scorecard to assess the domestic financing of healthcare. The scorecard was developed as a financial management tool and a means of comparing the spending patterns of the organisation’s member states. It measures the domestic health spending of the 54 (now 55) AU member states in relation to key health-financing benchmarks to gauge whether their governments are investing enough to meet their populations’ healthcare needs. Moreover, the scorecard is an accountability tool to evaluate the efficacy and judicious nature of Africa’s domestic and international financing for health. It assesses domestic funding and compulsory contributory funding for healthcare per capita (the WHO recommends US\$86 per capita) and as a percentage of GDP and public spending. In addition, it highlights countries with high levels of out-of-pocket spending and measures tax revenue as a percentage of GDP.

“We are encouraging countries to work on national health insurance and other health financing mechanisms and to ensure predictable resources to move towards the universal health-coverage goal,” Dr Harakeye says. “In Africa, there is a need to increase impact and maximise effectiveness in the goals of ending epidemics, which will achieve greater health security and long-term prosperity. We need to identify and solve bottlenecks and absorption-capacity issues to ensure efficient spending.”

The Global Access to Healthcare Index suggests that political commitment is closely linked to financial commitment, irrespective of a country’s income. In poorer countries, such as Ethiopia, Rwanda and Malawi, political commitment has brought about health reforms. In 2014 health accounted for 8% of budgetary spending in Nigeria and for 10% in Rwanda.<sup>15</sup>

However, this is not true in all cases. In the US, which spent some 17% of GDP on healthcare in 2014, nearly 10m people remain without coverage, and the fate of another 20m—covered by the Affordable Care Act introduced by the previous president, Barack Obama—remains unclear after a commitment from both his successor, Donald Trump, and the Republican-dominated Congress to repeal it. Indeed, Republican leaders have suggested a distinction between “universal coverage” and “universal access” to coverage.<sup>16</sup>

Another aspect of financing concerns the role of publicly funded research in developing health innovations through bodies such as the US National Institutes of Health, says Prabhat Jha, a professor at the Dalla Lana School of Public Health at the University of Toronto. “In the longer term, with ageing populations in particular, there will be a need for newer therapies—drugs for diabetes and heart disease, for example. Where are those investments going to come from, given that it’s mostly sustained publicly funded research that leads to these results over decades?” Expanded access provides health systems with incentives to “create drugs that more of the public needs to use”, according to Professor Jha.

Ultimately, those interviewed say, the willingness to make game-changing commitments to health financing boils down to strong leadership. “You look around the world, and you can see these big health coverage success stories and almost name the politician and the year it happened,” says Robert Yates, project director of the UHC Policy Forum at Chatham House, a London-based think-tank. “Big success stories are often not slow-burn linear things but big planned reforms led by charismatic politicians—[Clement] Atlee in the UK, [Paul] Kagame in Rwanda, Tedros [Adhanom] in Ethiopia. Politicians of all hues recognise this is very powerful stuff.”

### **Universal coverage does not mean universal access**

Efforts to introduce universal health coverage, or UHC—defined as fully covering a population for all services and protecting it against financial distress resulting from medical costs—have a long history. As early as 1978 the Alma-Ata Declaration identified primary healthcare as the key to extending access to healthcare across populations.<sup>17</sup> In 2005 a World Health Assembly Resolution declared sustainable health financing, universal coverage and social health insurance to be key criteria for achieving “equity in access”.<sup>18</sup>

<sup>15</sup> WHO, Global Health Observatory data repository, Health expenditure ratios, by country, 1995-2014. Available at: <http://apps.who.int/gho/data/view.main.HEALTHEXPRATIOWA?lang=en>

<sup>16</sup> “In Private, Republican Lawmakers Agonize over Health Law Repeal”, *The New York Times*.

<sup>17</sup> WHO, “WHO called to return to the Declaration of Alma-Ata”. Available at: [http://www.who.int/social\\_determinants/tools/multimedia/alma\\_ata/en/](http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/)

<sup>18</sup> WHO, “Sustainable health financing, universal coverage and social health insurance”, World Health Assembly Resolution 58.33 (2005). Available at: [http://www.who.int/health\\_financing/documents/cov-wharesolution5833/en/](http://www.who.int/health_financing/documents/cov-wharesolution5833/en/)

A number of co-operative initiatives are sharing best practice in working towards UHC, including the Joint Learning Network for Universal Health Coverage, a network of global health practitioners that co-ordinates workshops and learning exchanges between countries to help to experiment with new ideas for expanding health coverage and access to healthcare.<sup>19</sup>

But while the term UHC is often bandied about in government policy papers, achieving such universality can be elusive.

In Africa, the stronger role of the private sector in providing care offers both unique challenges and innovative models for provision. Some 50-70% of health services on the continent are currently provided by the private sector, including faith-based organisations, according to Dr Thakker. Other funding comes from foreign aid budgets, non-governmental organisations and multilateral institutions such as the World Bank. However, these funds remain uncertain from one year to the next. A significant remainder of healthcare expenses is covered by out-of-pocket spending, with a smaller share—often in single digits—coming from prepaid insurance or employee and group self-funded mechanisms. “Coverage should mean financial access not being a barrier,” Dr Thakker says, although he notes that this goal will have to be reached in different ways, given that less than one-third of healthcare is funded through taxation in many parts of Africa.

In Latin America, too, innovative uses of private and public co-operation have helped to bridge coverage gaps, according to Ricardo Bitrán, an economist and president of Santiago-based Bitrán & Associates, which designs and implements public-health projects. Some countries, including several in Central America, have relied on awarding public contracts to private healthcare providers to expand access to healthcare for low-income populations in rural areas where public healthcare providers do not have a presence, he says. Others have adopted commissioning systems and provider-payment mechanisms that make payment conditional on performance, which acts as a financial incentive for providers to achieve public-health objectives.

Other experts argue that only health systems that move convincingly to public financing are likely to succeed in ensuring access. “Countries that have shown big improvements are those where there has been a dramatic switch towards a European-style system,” says Mr Yates. He adds that such systems have generally seen better outcomes than those in which private expenditures of various sorts were in effect used to patch gaps in public financing.

Countries which have made this switch include Brazil, Ecuador, Mexico and Argentina in Latin America and Thailand, Malaysia and Fiji in South-east Asia. By contrast, according to Mr Yates, regions such as Sub-Saharan Africa and South Asia continue to lag behind. “I do think that when it comes to financing UHC, looking at evidence from around the world, it’s all about public financing.” Efforts to design smaller insurance-cover systems, such as prepaid community insurance initiatives, tend to be less effective overall, he adds.

Others believe that mixed systems can provide more benefits. “From what I’ve seen in Colombia and other countries, especially in Latin America, insurance should be provided by just one organisation, nationally, but provision—hospitals and clinics—should be free-market and competency-based on

<sup>19</sup> Joint Learning Network. Available at: <http://www.jointlearningnetwork.org/>

merit and results,” says Jorge Alejandro García Ramírez, a trained general practitioner (GP) and CEO of Bive, a Colombian social enterprise that provides access to private doctors for a membership fee.

Centralisation of insurance and payments, something that does not exist in many Latin American countries, could help to encourage competition over results and productivity rather than over tariffs, says Dr García. By comparison, the current division in Colombia between those with publicly funded or subsidised care and those covered by contribution-based health insurance plans leads to inequities in access to services and around 125,000 legal actions against insurance providers each year, he adds.

“It is one thing to say that people have access to services and another to see people actually receiving the healthcare services they need,” says Mr Yates. “China is claiming 96% health coverage through insurance schemes, but due to things like big co-payments, it means people aren’t necessarily consuming the health services they are entitled to.”

Organisations such as the WHO and the World Bank are increasingly measuring health results, including whether patients are getting malaria drugs, whether children are being immunised and whether mothers are delivering in birthing centres. “Health services coverage indicators are a much more rigorous test of whether access is really being realised,” notes Mr Yates. “A country can say that their constitution says everyone should get healthcare, but it’s nonsense if there are no health centres. You need to measure actual consumption of health services rather than inputs.”

### ***Improving data collection and quality of outcomes***

At the local level, the best approach to gaining knowledge about actual access to care should come through community surveys, not from the data produced by individual institutions, according to César Gattini Collao, assistant professor at the School of Public Health at the University of Chile and executive director, Chilean Observatory of Public Health. Places with poor access can contribute to a lack of data about health trends, which can make it difficult to inform decision-making and, in turn, undermine access—a vicious cycle. “If there are no healthcare centres in rural Peru or Bolivia, it’s not possible to have access, and you have no health records.” Healthcare facilities in poor and isolated areas tend to have limited resources and performance, including a lack of information reported to other administration, he adds; this can mean a lack of reliable information about key public-health targets, such as levels of vaccination coverage.

Meanwhile, levels of investment in health systems do not always reflect quality or appropriateness of care, those interviewed say. “It is kind of obvious that what matters is not just more spending, but also the quality of spending and universal access,” says Professor Jha. “The US is the best example. It spends nearly double that of many other comparable countries but achieves lower results.”

Better and increased use of HTA tools will be a crucial component of evaluating outcomes and improving care, according to the experts interviewed for this paper. “Health systems are all structured around what providers are able to do, including survival rates etc,” says Ms Colombo, adding that the OECD is looking increasingly at value measures in healthcare. “But from an individual perspective, have the particular interventions made a difference to [the patients]? We need to measure performance differently. If a service doesn’t make a difference, it doesn’t deliver.”

The Health Consumer Powerhouse in Stockholm includes a separate rating for performance outcomes relative to expenditure, Mr Hjertqvist says, adding that even middle-income countries such as Estonia and the Czech Republic have done quite well in this area, demonstrating again that levels of expenditure are not the only factor contributing to good access to care.

Several interviewees point out that because many lower- and middle-income countries already operate on a low-cost basis, they have the potential to focus immediately on value. They can move from out-of-pocket-funded systems to new systems where the risks are pooled and services are purchased by a third party, allowing new information-technology systems to be brought in. Value-based care requires information systems and governance structures that low-income countries can establish from scratch with the right leadership. “Many OECD countries have existing systems with in-built inefficiencies, where incentives are not aligned with improvements in health outcomes. These existing systems and cultures can be hard to change”, observes Sofi Bergkvist, founding managing director of ACCESS Health International, a non-profit organisation dedicated to improving access to high-quality and affordable healthcare. “If you go from a system built on out-of-pocket expenditures to a value-based care system, you have great opportunities to leapfrog.” She notes that developing countries already operate on low costs and are comparatively efficient, without complicated incentive systems that characterise health systems in wealthier countries. “By putting in new structures, you can emphasise quality of care.”

In Africa, some inefficiencies result from problems related to capacity-building, according to Dr Harakeye. “We encourage countries to build capacity for institutionalising, standardising and strengthening National Health Accounts (NHAs).” Ensuring that there is accountability over how money is spent by ensuring the regular, systemic and routine annual implementation of NHAs can increase transparency and trust, but can also reduce perceptions of corruption, she adds.

## **CHAPTER 3: HOW DO ACCESS TO HEALTHCARE AND HUMAN DEVELOPMENT CORRELATE?**

Although the Global Access to Healthcare Index highlights some notable exceptions such as Cuba, for example (see Chapter 1), many of the most developed countries are also among the top performers both in the scope and in the level of care they are able to provide for their populations.

In parts of Europe, North America and East Asia there is a long-term trend of improving access, broadening the output of services available to patients, and in some cases cutting waiting times, those interviewed say. And while advances in technology and innovation are often contributing to higher expenses, they are also helping to streamline services.

“The user-friendliness of the system has improved,” says Mr Hjertqvist of the Health Consumer Powerhouse. “There is better transparency and better access to information. In 2005, when we started comparing [European countries], it wasn’t a given that you would have access to a second opinion or your medical records. Now a lack of access to these is the exception rather than the rule.”

While access to healthcare is improving and becoming more sophisticated, the link between healthcare access and human development is an interesting one to explore. Analysis of our data shows that there is a close correlation between the results of the Global Access to Healthcare Index and the Human Development Index (HDI). (See chart 15.) The HDI provides a good snapshot of a country’s social and economic level of development, combining three broad indicators: 1) health (measured by life expectancy at birth); 2) education (mean and expected years of schooling); and 3) income (GNI per capita).<sup>20</sup> The HDI is predicated on the assumption that human development is not only influenced by infrastructure but also by education, poverty, ethnicity and gender—the same factors that also underlie the social determinants of health.

“You won’t decrease maternal mortality rates or adolescent pregnancy if you don’t invest in the education of women,” explains Dr García. “In Latin America, you won’t improve health outcomes if you don’t create equitable outcomes for rural and urban people. In Europe, you won’t have good health outcomes if you don’t make healthcare equally available for European residents and refugees.”

### ***Prioritising preventive and primary care***

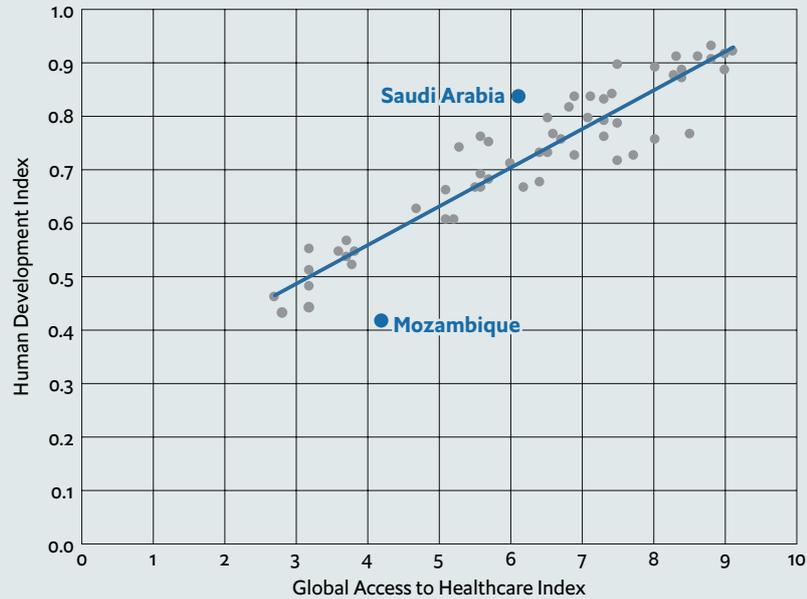
While improvements in health, education and income should ideally work in tandem, countries—especially in lower-resources settings—can make great headway on improving access to healthcare by focusing on preventive and primary care.

Preventive care, such as improved lifestyles through better diets and a reduction in sedentary behaviour, can help to save money in the long run. “Making young people do daily exercise is probably worth hundreds of billions [of euros],” Mr Hjertqvist says. At the same time, he adds, countries need to choose the system that works best for them.

<sup>20</sup> United Nations Development Programme (UNDP), Human Development Index (HDI). Available at: <http://hdr.undp.org/en/content/human-development-index-hdi>

Chart 15<sup>m</sup>

**Correlation between the HDI and the Global Access to Healthcare Index**



Sources: The Economist Intelligence Unit, Global Access to Healthcare Index; United Nations Development Programme (UNDP), Human Development Index (HDI).

But Europe’s healthcare model, with its emphasis on secondary over preventive care, is not necessarily one that developing countries should be following as they look to extend access to coverage, says Dr Bengoa. “Access to what? Access to an acute care model that we all want to get away from, because it is unsustainable in a chronic disease environment with the demographics we have?” he asks. “[Developing countries] should be structuring a system based on primary care, possibly home care, community nursing and much more preventive logistics. All of these are not present in the European and American model.”

In Africa, the focus has naturally been on improving access to basic care, such as vaccinations, malaria nets and AIDS medicines, which are “mainly provided for free, but not financed in a sustainable way”, says Ewout Irgang, technical director for Tanzania of the non-profit PharmAccess Foundation in Amsterdam. “It’s very effective from a health outcomes perspective.”

Other regions, such as the Middle East, have had more mixed results, in part due to unstable political systems. Iran has had some success in improving health indicators among those living in smaller cities and rural areas, following the establishment of a health network system in the 1980s to reduce health inequities, according to Hassan Joulaei, head of the HIV/AIDS research centre in Shiraz. He adds, however, that the system has remained underdeveloped and is largely limited to primary care, and that efforts to invest in a “Western-style curative sector” (hospitals, private-sector healthcare and health insurance) have generally been ineffective.

In Indonesia, where the government is in the process of rolling out a UHC programme, one observer argues that the health system would be better off concentrating on primary care and care for the

<sup>m</sup> The vertical axis shows the HDI and the horizontal axis shows the Global Access to Healthcare Index. Each country is represented by a dot. The closer the dots align along the line, the stronger the correlation between the two indicators.

poorest, rather than trying to extend even a basic package of services to all of the country's 250m people. "We need more money, but we need it for community health," says Yaslis Ilyas, professor at the University of Indonesia's School of Public Health in Jakarta. Compared with some high-ranking countries in the Global Access to Healthcare Index, such as Colombia, he says, Indonesia's population is not only large but also widely dispersed across an archipelago of islands, many of them remote. "The most important thing is the quality of primary care."

In neighbouring Philippines, Professor Ilyas adds, the government invested according to a different set of priorities, covering inpatient care first before extending to outpatient care covering only the poorest in society, and only for specific diseases (including tuberculosis and haemorrhagic fever). "The government could determine which provinces needed a higher level of support from the central government," he says. "But it's not easy to do that because of the political problems; [in Indonesia] they are already committed to cover the programme for all the people."

Professor Ilyas notes that countries such as Cuba and Thailand rank highly in the index because they offer a model of care based on a good primary care infrastructure, rather than delivering most of the care through hospitals. "If you lean on a hospital model, you are waiting for patients to come to the infrastructure when ill, and when they do come, you are overusing a lot of both medicines and technologies and patient beds."

## INNOVATIONS TO FACILITATE ACCESS

Innovation is an important route to extending access. Many countries are experimenting with different ways of extending access and are finding that it pays political dividends.

The governments of Iran and Indonesia, for example, have explicitly committed to increasing funding for healthcare coverage by cutting fuel subsidies, says Robert Yates, project director for the Universal Health Coverage (UHC) Policy Forum at Chatham House, a London-based think-tank. "The best innovations are within the confines of recognising that you should better finance your health system. Raise it in an innovative way and spend it in an innovative way. Rwanda started with *mutuelles* that were private, community-based and voluntary, but rapidly moved to them being compulsory, progressive and subsidised." *Mutuelles* are community systems in which premiums go into a local risk pool and are administered by communities.<sup>21</sup>

More localised health management, whereby municipalities are given greater responsibility for healthcare choices, is an approach that has also been used with varying results in countries such as Kenya and Brazil.

Other innovations have emerged from existing gaps in service. In Colombia, Bive, a social health enterprise, aims to provide low-income families with access to primary care.<sup>22</sup> It is part of the Innovators in Healthcare Network, an umbrella organisation of 60 social healthcare businesses around the globe working to provide access to services that governments cannot meet. It was created to address a lack of access to healthcare, not a lack of

coverage, according to Jorge Alejandro García Ramírez, Bive's founder and a trained general practitioner (GP).

He adds that access to GPs through Colombia's traditional health maintenance organisations (Entidades Promotoras de Salud, or EPS) can be especially difficult. "If you have a breast mass, if you went through standard healthcare it would take you between eight and ten months to receive a mammogram and a diagnosis. What we promote in Bive is early diagnosis and treatment of diseases by giving access to private doctors, faster than HMOs and with more quality and less expense than if you went on a private basis."

Elsewhere, MicroEnsure is a micro insurance programme operating in Kenya, Ghana and Tanzania. North Star Alliance runs a programme whereby shipping containers are repurposed into mini-clinics (Blue Box clinics). AYZH is a "customisable" US\$3 clean-birth kit that can be used by birth attendants in resource-poor settings in India. Le-Nest has trained volunteers and professionals who provide non-communicable disease management skills as well as physical and psychological interventions in China.<sup>23</sup>

Other organisations are looking at the area of health outcomes and value of care, including the Choosing Wisely programme, an initiative of the American Board of Internal Medicine (ABIM), which aims to spark discussion between patients and providers over whether care is necessary, free from harm and supported by evidence.<sup>24</sup>

<sup>21</sup> T Rosenberg, "In Rwanda, Health Care Coverage That Eludes the U.S.", The Opinion Pages, *The New York Times*, July 3rd 2012. Available at: [https://opinionator.blogs.nytimes.com/2012/07/03/rwandas-health-care-miracle/?\\_r=0](https://opinionator.blogs.nytimes.com/2012/07/03/rwandas-health-care-miracle/?_r=0)

<sup>22</sup> Bive. Available at: <http://bive.co/>

<sup>23</sup> Innovations in Healthcare. Available at: <https://www.innovationsinhealthcare.org/>

<sup>24</sup> Choosing Wisely. Available at: <http://www.choosingwisely.org/about-us/>

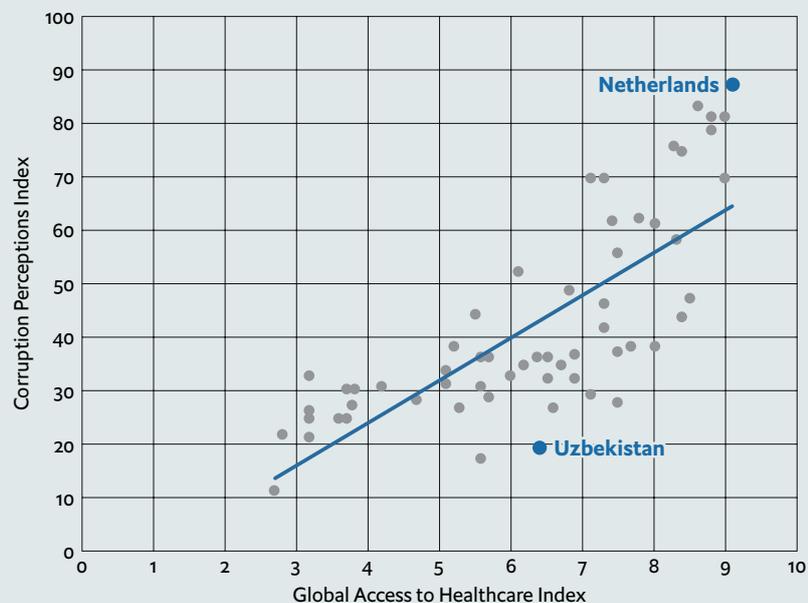
## CHAPTER 4: POLITICAL COMMITMENT AND TRUST AND THEIR IMPACT ON ACCESS TO HEALTHCARE

The interplay of human development, a politically committed leadership and social trust is the foundation of an effective healthcare system. Many experts argue that the strong correlation between the Global Access to Healthcare Index and the Human Development Index, discussed in the previous chapter, is due to the fact that high HDI rankings are a proxy for levels of trust within a population.

Indeed, there is also a strong correlation between the Global Access to Healthcare Index and the Corruption Perceptions Index (CPI), published by the global anti-corruption movement Transparency International. This correlation is weaker than the correlation with the HDI, but stronger than the correlation with income per capita (see chart 16). As a result, even additional resources from multilateral institutions or donors cannot on their own enable countries to vault to a higher level of development. Significant levels of World Bank and EU funds directed to south-eastern Europe have failed to close the gap, in health terms, between the Netherlands and Romania, for example, Mr Hjertqvist notes. According to Dr García, good health outcomes can only come from

Chart 16<sup>n</sup>

Correlation between the CPI and the Global Access to Healthcare Index



Sources: The Economist Intelligence Unit, Global Access to Healthcare Index; Transparency International, Corruption Perceptions Index (CPI).

<sup>n</sup> The vertical axis shows the CPI and the horizontal axis shows the Global Access to Healthcare Index. Each country is represented by a dot. The closer the dots align along the line, the stronger the correlation between the two indicators.

an environment that also includes equitable outcomes for rural and urban people and investment in education for women.

### ***The importance of trust***

Strong political leadership and public faith in the institutions of the state and civil society are important elements of good access to healthcare, as reflected in the healthcare systems domain of the index (see Chapter 1). “Sustainability, for both developing countries and OECD countries, is to a very large extent determined by the willingness to pre-pay, which is determined by the trust that people have in the state,” says Dr Schellekens. He adds that trust is in effect synonymous with the social compact that is the necessary precursor to both better access to healthcare and improved sustainability of healthcare systems. “The higher the trust, the lower the cost, the greater the willingness to pay for each other in the future.”

Dr Schellekens notes that a large, homogenous and centralised country such as China will ultimately find it easier to establish such a system than countries such as Brazil and South Africa, where there is less trust in the state. “There is also a difference between political commitment and trust, which is not the same. In Cuba, political commitment is high, but the trust that people have in government is low, and therefore political sustainability of the system in the long term suffers big time.”

Political leadership and commitment are also crucial, given the role of the state in regulating healthcare in systems that are often mixed between public and private, and in which information asymmetry is especially complex, says Ms Bergkvist of ACCESS Health International. Government institutions often do not have enough capacity to manage systems in which the private sector plays a significant role, or to assure quality in such mixed systems. “If you look at India, even today, the Department of Health, which should be the steward of the healthcare system, is focused on managing a public healthcare system that is serving less than 30% of the population. There is a need for governance structures to effectively oversee the entire healthcare system, with new and integrated health information systems.”

Some countries have developed other ways of managing complex systems, she observes, pointing to the example of the Philippines and other countries, where different entities are responsible for providing and paying for services, and South Korea, where separate institutions deal with national insurance and with managing the review of costs and benefits of healthcare services provided by the medical institutions. In addition, these systems allow the integrated surveillance of acute issues, such as outbreaks of communicable diseases or higher rates of mental illness in particular regions.

Even comparatively underdeveloped health systems can achieve progress with enough political will behind them. Some African countries, such as Rwanda and Ethiopia, have decided to strengthen human resources for promoting their health strategy through community-level provision. In Ethiopia, political commitment has helped to deploy more than 42,000 new well-trained health extension workers since 2004, Dr Harakeye notes. They work at local health posts, closer to the population, and provide a package of essential interventions to meet needs at this level, she adds. In part as a result of this initiative, Ethiopia cut child mortality by more than half from 72 per 1,000 population to 31 between 2005 and 2015.

In Africa, regional co-operation has been a key part of improving access to healthcare. The African Union is working with other bodies to harmonise regulatory systems for medicines, so that those approved in one country can be distributed more widely. In addition, ministers regularly meet to monitor and collect data on the status of individual diseases, as well as their prevention and treatment.

## CONCLUSION

The Global Access to Healthcare Index provides a snapshot in time of the way in which health systems around the world are coping with the most pressing challenges they are facing. The results of the index suggest that many countries at all income levels have made more progress in extending basic primary healthcare to their citizens than in building sustainable health systems.

While lower-income countries are more likely to struggle in this regard, there are notable exceptions of middle-income and less wealthy countries, such as Colombia, which are showing progress in providing sustainable healthcare. We have seen that political commitment can make the difference between sustainable and unsustainable healthcare provision, regardless of a country's income level.

Good governance and the extent to which a population has faith in civil society and government institutions are key components of the successful expansion of access to healthcare. At the same time, it seems clear that policymakers need to be asking more nuanced questions about what good access to healthcare really means. Promises of universal coverage or specific services are of no use if they fail to materialise or require an out-of-pocket outlay that is unaffordable.

Similarly, access to more expensive hospital care—but not to preventive and primary healthcare—is unlikely to have a significant impact on the growing burden of chronic diseases on all governments. In this regard, many lower- to middle-income countries, which have focused on this area and do not have healthcare cultures focused on tertiary care, may have lessons to share.

Finally, as many of the experts interviewed for this paper have argued, it is not enough to provide access to care: people must have access to the care that is relevant and right for them. This means a greater emphasis on value-based care, a willingness to discontinue expenditure on medicines and treatments if evidence shows they are not helpful, and above all, a focus on health outcomes that benefit patients.

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