Draft Outline for Discussion Paper (v.1)

Allocating Resources for Health in Developing Countries: Coping with the Epidemiological Transition

Executive Summary

Main Paper

I. Introduction

A. The current burden of chronic, non-communicable disease

1. Large gains in life expectancy since WWII in all three developing continents, result in larger proportion of adults, more chronic and non-communicable diseases.
2. Even in countries with very low life expectancy (L.E.), L.E. at age five only approx. 9 years lower than in developed countries.
3. Chronic, non-communicable diseases highly prevalent in developing countries, with epidemiological profile (heart disease, stroke, cancer, respiratory disease) similar to developed countries.
4. Chronic, non-communicable disease disproportionately affects lower socioeconomic groups.

B. Allocation of resources for management of chronic, non-communicable disease.

1. Represents a substantial drain on health budgets everywhere (estimates in differing situations, e.g. China, SSA countries).
2. Resources disproportionately allocated to treatment of chronic disease, little attention to prevention, low-cost care, rehabilitation or primary care (examine the evidence).

II. Major Propositions

A. Failure to act now to prevent/manage chronic disease will mean major, avoidable burden on health system later since substantial proportion can be prevented/managed at low cost.

-- estimates of potential for preventing chronic disease or detecting early and orders of magnitude of implied savings; data from China-desk study and literature review.

-- ? need to collect data (if so, try to piggyback on sector work in China or elsewhere)

B. Examine alternative proposition that attention to chronic disease now, will dilute and delay PHC (child survival) efforts, given limited management capacity.

C. Examine proposition that developing countries should devote scarce resources to chronic disease prevention/management because:

1. some action does not create an unmanageable additional burden to health delivery system because it involves policy levers (e.g. fiscal policy on tobacco, safety belt legislation) or different levels of the system (IEC campaigns) or different institutions (e.g. patriotic health campaign in China, ministries of planning, finance, transportation, agriculture)
2. health system already heavily engaged in treating chronic disease (or paying for medical evacuations) but not in prevention or increasing the efficiency of treatment.
3. cost-effective strategies exist (specify evidence) or are likely (specify those that need validation/testing). E.g.'s hypertension screening in Shanghai/Beijing areas, early cancer detection in Shenyang area, Japanese stroke cost/benefit study, other examples (? Cuba). Also tools/models exist for developing strategies/choosing priorities (Eddy/WHO for cancer control strategy, other Duke work on chronic disease).

D. Examine Gwatkin proposition that allocating resources to chronic disease has negative effect on equity (? by diluting PHC and reducing priority of MCH)

III. Getting the balance right

A. How can the Bank assist countries to make reasonable resource allocation decisions? Look at:

1. country case studies, e.g. China
2. resource allocation models
3. projections of future disease burden/demand for health care (China exercise)

B. What research/analysis is ongoing and what more needs to be done
   1. by the Bank
   2. by others

C. What would it take to fill the knowledge gaps?
   in time, resources?

IV. Other issues/dimensions

? what is missing
? do we need to join forces with others (? WHO, Lincoln Chen, London School, developing country institutions)
? what resources do we need/have to get the analytical work done
? what are the opportunity costs
? do others assign this topic high priority
? should we seek additional resources for this analytical work

V. Implications for the Bank

for ESW; for projects; for analytical work.

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