Wastes in Government Health Care Programs

Philip Stevens
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Introduction

Below are four articles by Philip Stevens, Director for Health Research, International Policy Network (IPN) in London, UK. These papers are:

1. Fake drugs and failed governance, January 2009
2. Fueling waste and corruption: US aid hurts poor more than helps, May 2009
3. Obamacare failed in Europe, July 2009, and
4. Better spending on AIDS, July 2009

The above papers discussed certains wastes and inefficiencies when a government comes in to socialize a service that is better left to individual, parental and corporate responsibility, except for a few diseases that have large social impact like an outbreak of contagious diseases.

Philip is a friend, he has been to Manila several times. In September 2007, we held the IPN-MG "Symposium on intellectual property, innovation and health" at Manila Hotel. Philip was one of our two speakers. The other one was Prof. Bibek Debroy from Delhi, India.

Nonoy Oplas
President
Minimal Government Thinkers, Manila
July 31, 2009

(1) Fake drugs and failed governance

By Julian Harris, Philip Stevens
16 Jan 2009

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The World Health Organization meets in Geneva this week to decide new measures against the exploding global trade in counterfeit medicines — up to a third of all medicines in Africa and a quarter in developing countries overall. While the WHO wrangles over an international treaty and how to define the term “counterfeit,” it is not addressing the real causes, including the failures of dysfunctional governments which prevent genuine manufacturers from protecting their brands.

Interpol co-ordinated some 200 raids and seized more than US$6.65 million of counterfeit medicines in November across Cambodia, China, Laos, Myanmar, Singapore, Thailand and Vietnam: the second massive strike in the area in three years. Governments in developing countries frequently promise “crackdowns,” enact new laws, propose stricter punishments and so on — yet counterfeits remain widespread.

Developed countries, by contrast, have counterfeit levels below one percent. Some suggest this is due to strong regulators such as the U.S. Food and Drug Administration (FDA) yet millions of drug consignments pass through U.S. customs every year to 9,000 wholesalers. The FDA does not and cannot monitor all this, so why don't more counterfeits slip into such a lucrative market?

Part of the answer lies in the foundations that underpin the economies of richer countries such as strong protection for trademarks, which allows consumers to be confident of the origin of products.

Some claim that brands are only important to expensive, patented medicines. The opposite is true. Most medicines consumed in poor and wealthy countries alike are “generics,” drugs whose patents have expired, which should create a thriving market of branded generics, competing not just on price but on quality too. But a lack of respect for trademarks in developing countries means that patients can rarely be certain that the generics they buy are the genuine item: off-patent drugs are among the most commonly counterfeited medicines.

Rich countries' civil liability law, meanwhile, ensures that injured consumers can obtain redress through the courts, discouraging the production of fakes and those who peddle them.

This can only happen with efficient legal systems, free of corruption or political influence. Sadly, the courts and police of most developing countries are a long

way from this ideal and they allow criminals to bribe their way out of trouble, making new laws futile.

Extra laws often simply create extra layers of bureaucracy which then create further opportunities for corruption. Drugs passing through customs, for example, face myriad regulations and tariffs, inevitably leading to “informal” payments to speed up the process. If the market is small, as in many African countries, many suppliers of legitimate medicines find the obstacles too expensive and do not bother supplying at all. Counterfeiters, unconcerned by regulations, gain even greater advantage.

A free media is also crucial to improving standards and defending citizens against fakes. In China melamine contamination killed four infants (and harmed thousands), yet the government banned news reporting. All three cases filed against the producer have been rejected by the courts. The same happens with medicines.

Additionally, many governments impose high taxes and tariffs as well as complicated regulations on imported medical products, adding an average of 68.6% to the final price in developing countries, according to a WHO study in 2003: taxes or tariffs alone are often around 20% - from 14% sales tax in South Africa to a combined 30% in Brazil and more than 50% in India for imports (and at least 19% on local drugs). This makes real drugs more expensive, creating yet more opportunities for counterfeiters to undercut them.

Although strengthening the rule of law is vital for tackling fake drugs, as well as for general economic development, such reforms are lengthy and difficult. In the short-term, technology can help manufacturers of genuine products protect their brands. In Ghana, a new service called MPedigree allows people to send serial numbers (embedded under a scratch-pad on drug packets they have bought) by text message: they then get a message back telling them if the item is genuine. Many similar schemes are under development. Even safe Taiwan, with only around one percent counterfeits, has had to introduce near-infrared spectrography (NIR) to protect consumers.

The WHO and its International Medical Products Anti-Counterfeiting Taskforce (IMPACT) are doing good work in publicizing the threat and pushing governments to react but the private sector has to be at the forefront of solutions, especially in developing countries: after all, it has a far better grip on drug production, storage and distribution. Governments can help by interfering less, taxing less and focusing on what would really help, like strengthening the rule of law.

Julian Harris and Philip Stevens are analysts at International Policy Network

(2) Fueling waste and corruption: U.S. aid hurts poor more than helps

By Philip Stevens
17 May 2009

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President Obama signalled this week a major shift in the way the USA tries to help poor countries. Whereas the Bush presidency spent enormous sums on individual high-profile diseases such as AIDS, Obama says he will broaden US aid to improve health more generally. But the $63 billion question remains (for that is the sum proposed by Obama): is it likely to help sustainably improve health?

Because far more people in poor countries die of preventable diseases like pneumonia than AIDS, the plan makes some sense. But, heartless as it seems, healthcare programs funded by foreign aid rarely – if ever – live up to the soaring rhetoric with which they are launched by politicians.

Recent years have seen a procession of failures. A recent internal evaluation of the World Bank revealed that one third of its health programs between 1997-2007 produced "unsatisfactory" results. Furthermore, 71 per cent of its AIDS projects had failed, mainly because they were too complex for local health bureaucracies to manage.

One of the biggest players in foreign aid is the Global Fund for Aids, Tuberculosis and Malaria, established in 2002 to finance the fight against these diseases. The Fund and its supporters trumpet its successes, claiming responsibility for over two million people on AIDS treatment, the delivery of 70 million bed nets and 74 million malaria treatments.

But these are all measures of inputs, not outcomes. Nobody knows if malaria has been reduced as a result of these billions spent. Neither does the Fund keep track of vital AIDS patient information, such as rates of drug resistance and compliance with courses of therapy. Without such crucial data, there is no way of gauging the usefulness of its activities.

Under President Bush, the USA made great fanfare of its work on fighting AIDS in Africa with the lavishly funded PEPFAR (the President's Emergency Fund for Aids Relief). While this has done some positive work in financing treatment, only 22 per cent of its budget is dedicated to actually preventing infections.

If PEPFAR had focused more on prevention, thousands of deaths could have been averted. Instead, the numbers of infected people pile up every year,

each of whom costs thousands in palliative care until the end of their days. As the director of the U S National Institutes of Health, Dr. Anthony Fauci, said in 2007: "For every one person that you put in therapy, six new people get infected. So we're losing that game." PEPFAR must therefore be counted as a major strategic failure.

Countries such as Britain are beginning to reject the US disease-centric approach to health aid and are increasingly handing over no-strings cash to health ministries in poor countries to subsidise the running costs of their health systems. As far as ideas go, this is a stinker.

While it may answer the accusation that donor governments have too much control over how money is spent locally, it is a massively profligate use of taxpayers' money. Many health ministries are simply not up to the task of managing state health systems, let alone spending effectively the millions sprayed at them from overseas.

It's also tantamount to inviting corruption - ranging from ministerial embezzlement to local officials selling donated drugs – which has been shown to render much development aid useless.

Study after study shows that health aid makes almost no difference to mortality rates and health outcomes, despite the expenditure of billions.

In happier economic times, indefinitely financing state healthcare in Africa may have imparted a warm humanitarian glow to US taxpayers. Now that times are harder, and it is clear such transfers rarely work, maybe it's time to pare them right back.

When governments become dependent on foreign sources to maintain their activities, it drives a wedge between them and their citizens and allows corrupt and repressive governments to remain in power. There are many of these in Africa.

It also discourages governments from enacting the politically difficult reforms needed to promote economic development – strengthening the rule of law, establishing property rights and opening markets. Without improving prosperity, you can't improve healthcare.

Fortunately, the recession has accelerated recent declines in foreign aid. Congress still has to approve the funds so it has a chance to end subsidies to corrupt governments and begin a new chapter for the world's poorest people.

(3) Obamacare failed in Europe

Guillaume Vuillemey & Philip Stevens* – July 28, 2009

http://www.institutmolinari.org/editos/20090728.htm

Different versions of this article were published in *The Providence Journal* (July 6, 2009) and in *The Washington Examiner* (June 30, 2009).

President Barack Obama's proposed "public insurance option" for universal health coverage seems logical: A large public insurance fund will provide quality coverage for the uninsured and force competing insurers to lower costs. In practice, though, one needs only look at what decades of government health care have done to ramp up the financial and quality problems endured by Britain and France.

The Obama plan is supposed to make health insurance more competitive. But heavy subsidies will give it a big advantage, pulling an estimated 118.5 million people from private insurers to the public system. This government-subsidized system will eventually dominate the market in a way that would overrule competition.

This is precisely what happened in Britain. The state provides most health care, via the National Health Service. Patients have almost no say over which physician, surgeon or hospital they can use, while professionals have to conform to government plans and targets.

After its birth in 1948, planners soon found that "free" health care multiplied demand. NHS founder Lord Beveridge predicted free health care would cut spending as health improved.

The opposite was true. Between 1949 and 1979, it tripled in real terms. The service now costs twice as much as it did 10 years ago, with productivity down 4.5 percent.

One way government tries to limit demand is to decree which new drugs can be prescribed. Many drugs, widely available in America and continental Europe, are denied to British patients.

State mismanagement has also created waiting lines for hospitals, on average causing 8.6 weeks of waiting. Once inside, budgetary cutbacks on cleaning and maintenance mean higher rates of an antibiotic-resistant variety of staph infection. This "superbug" has turned even routine surgery into a lottery of death.

Britain may be an extreme example. Many point to France as a better example of public insurance delivering high-quality, equitable care. While it's true that French patients do enjoy better care and shorter waits than the British, this is due to a far greater reliance on independent health care and greater freedom from government for doctors and patients.

Yet this plus side is expensive. The French government is trying to control costs by increasing regulation of the private sector, meaning it will soon become more similar to Britain.

In France, there are already "medical deserts," particularly in the suburbs and countryside. In some places, patients wait more than six months to see an ophthalmologist.

In 2004, 286 of the country's top hospital doctors signed a petition bemoaning the shortage of doctors and nurses and increases in waiting lists. The petition read, "In casualty units, sick people have to wait for hours, sometimes even days, on gurneys, because there are no beds."

Yet France hasn't saved money. Despite regular cost-cutting announcements, the books haven't sustainably balanced since the system started in 1945. Obama, who recently agreed with health professionals to reduce the annual growth rate of health spending by 1.5 percentage points, should take note.

America can certainly draw lessons from overseas about saving money on health care. But in the cases of France and Britain, these lessons are in what not to do. These countries show that nationalizing care damages care.

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(4) Better Spending On AIDS

By Philip Stevens
30 Jul 2009

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THE 5,000 researchers and activists making their way home from last week's International AIDS Society meeting in Cape Town are in fighting mood. For the past 10 years, AIDS has been the single biggest beneficiary of the hundreds of billions of dollars spent by wealthy countries to help Africa. This river of money is now under threat as donor governments begin to suspect that drowning a single disease in cash could be doing more harm than good to fragile health systems .

For most AIDS activists, this shift of thinking is unconscionable. After years of campaigning, they had convinced the world that AIDS was an exceptional disease that posed an existential threat all over the world, and therefore demanded an exceptional response.

This campaign gave birth to one of the biggest political mobilisations of recent history. Governments sat up and took note. New nongovernmental organisations started up by the hundred. In 1996, the United Nations took the unprecedented step of creating a dedicated agency , UNAIDS. Since 2003, AIDS programmes have tripled their financial support.

Nevertheless, it is increasingly clear that the leaders of the AIDS industry have not been good custodians of this largesse.

An early strategic blunder was the prioritisation by the UN of treatment over prevention. With the lion's share of funding going to buying and distributing antiretroviral drugs for those already infected, not enough attention was paid to educating people about the behaviours that transmit HIV. This led to far more infections than otherwise would have been the case.

Much of this treatment money has been badly spent. One study presented in Cape Town showed that global spending on AIDS has climbed to about 60% of the level needed to cover everyone in the developing world who needs treatment, yet only about 30% of infected people are actually receiving it.

This inefficient spending was entirely predictable considering the parlous state of the health infrastructure of the worst affected countries, such as Malawi or Zambia.

More egregiously, the AIDS community has until recently systematically mischaracterised the true nature of the pandemic, causing much wasteful spending. First, it claimed that everyone everywhere — young and old,

straight or gay, man or woman — was at equal risk. Prof Jim Chin, a leading expert on AIDS epidemiology, describes this as a “politically correct myth” propagated to ensure no AIDS patient is stigmatised. This myth has resulted in billions being wasted on spreading AIDS prevention messages to people at negligible risk.

UNAIDS also exaggerated the numbers infected worldwide in order to keep the disease — and the money — high on the political agenda. In 2007, UNAIDS was embarrassingly forced to revise down its estimates for dozens of countries.

It is now clear AIDS is not the global “emergency” claimed by the AIDS lobby. While still a serious problem in southern Africa, research shows that the rate of infection is declining and the global peak in new infections has been passed in the mid 1990s. Yet AIDS still receives a quarter of all health aid, despite accounting for less than 4% of developing country deaths .

Fortunately, donors are beginning to recognise that an AIDS-centric approach to spending is not an effective way of improving health in poor countries, which is better done by strengthening overall primary care .

Last year, the UN established the Taskforce on Innovative International Financing for Health Systems. In May, its report argued that strengthening health systems should henceforth be the priority. This change of thinking is long overdue.

Nevertheless, it is under attack from the AIDS lobby. Former UN envoy on AIDS Stephen Lewis accused critics of “naked bureaucratic envy” and wanting to pit different diseases against each other. Donors should not let such vituperative rhetoric derail them as they strive to improve health for everyone, not just a few.