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OIC OUTLOOK

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HEALTH SYSTEMS AND EXPENDITURE IN THE OIC MEMBER COUNTRIES

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INTRODUCTION

The well-being of humanity is based on the development of health which is commonly and widely accepted as the ethical principle of equity. Over the recent decades, the issue of health has gained great importance as a major driver of socio-economic progress around the globe, with more resources than ever being invested in this sector. In a general overview, people are healthier, wealthier and live longer today than 30 years ago. According to the 2008 issue of the World Health Report, if children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006 (where the actual figure was 9.5 million). This difference of 6.7 million means that 18,329 children's lives were saved every day.

However, the Report also mentions other issues that should gain serious attention: First, the substantial progress in health development over the recent decades has been deeply unequal, with convergence towards improved health in a large part of the world, but at the same time, with a considerable number of countries increasingly lagging behind or even losing ground (Inequality). Second, the nature of health problems is changing in ways that were only partially anticipated, and at a rate that was wholly unexpected; Ageing and the effects of ill-managed urbanisation and globalisation accelerate worldwide transmission of communicable diseases and increase the burden of chronic and non-communicable disorders (Nature). Third, health systems are not isolated from the rapid pace of change and transformation that is an essential part of today's globalisation; Economic and political crises challenge state and institutional roles to ensure access, delivery and financing of health care (Externalities).

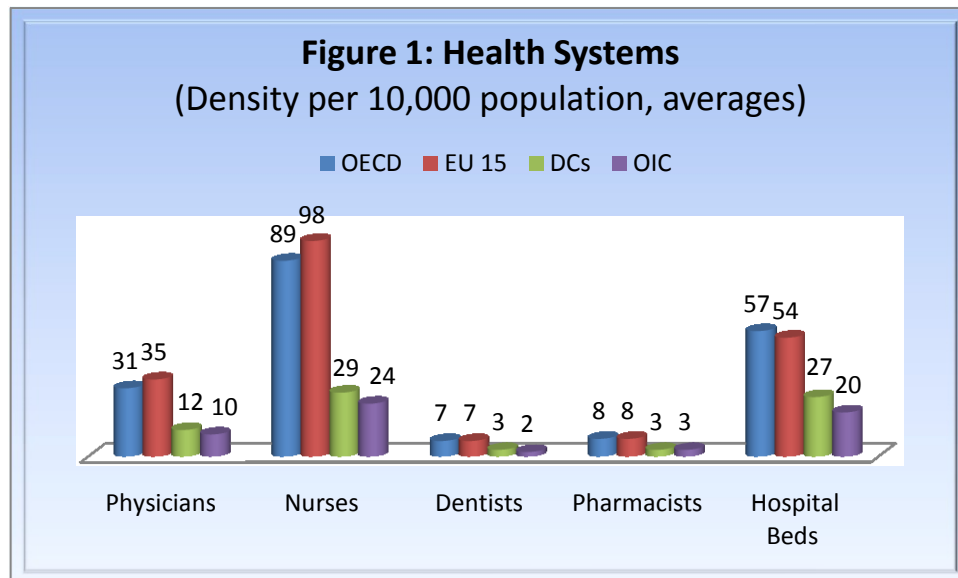
Moreover, the Report draws attention to five important shortcomings of health care delivery. First, people with most means and least health problems consume the most care, whereas those with least means and most health problems consume the least (Inverse Care). Second, weak social protection leads to extremely harmful expenses; Over 100 million people annually fall into poverty because they have to pay for health care (Impoverishing Care). Third, health services for poor and marginalized groups are often highly fragmented and severely under-resourced due to the excessive specialisation of health care providers (Fragmented Care). Fourth, poor design of health systems that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, medication errors and other avoidable adverse effects (Unsafe Care). Fifth, resource allocation mostly focuses at high-cost curative services neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden in addition to lacking the expertise to mitigate the adverse effects on health from other sectors (Misdirected Care).

The issue of health development gains greater importance when the OIC Member Countries are considered. Their mixed nature and high levels of heterogeneity and divergence in the economic structure and performance call for urgent action needed for the enhancement and utilisation of the allocation of resources.

HEALTH SYSTEMS

The concept of Health Systems focuses on health services provided for the population of a country. It is commonly measured by the number of physicians, nurses, dentists, pharmacists and hospital beds available per 10,000 humans of the population. The data used for calculations is the latest available country data which ranges from 1997 to 2007.

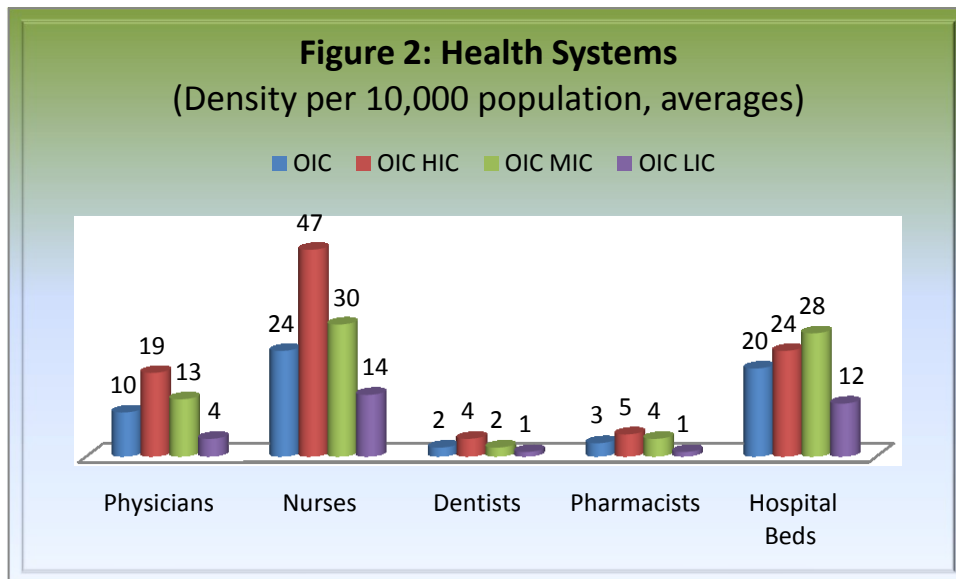
Considering the four compared country groups, namely; OECD, EU 15, the Developing Countries¹ and the OIC, it is clearly recognised that the group of the OIC is far behind both of the OECD and the EU 15 for all of the five categories (Figure 1). Roughly speaking, the average level of Health Systems in the group of the OIC is around one-third of that in the OECD and the EU 15. And, when compared to the group of the Developing Countries, the OIC is again below the average for all of the categories except for the number of pharmacists per 10,000 where it is at the average level of the Developing Countries. That is, the average level of Health Systems in the group of the OIC is also behind that of the Developing Countries.



Source: World Health Organization (WHO), Statistical Information System (WHOSIS).

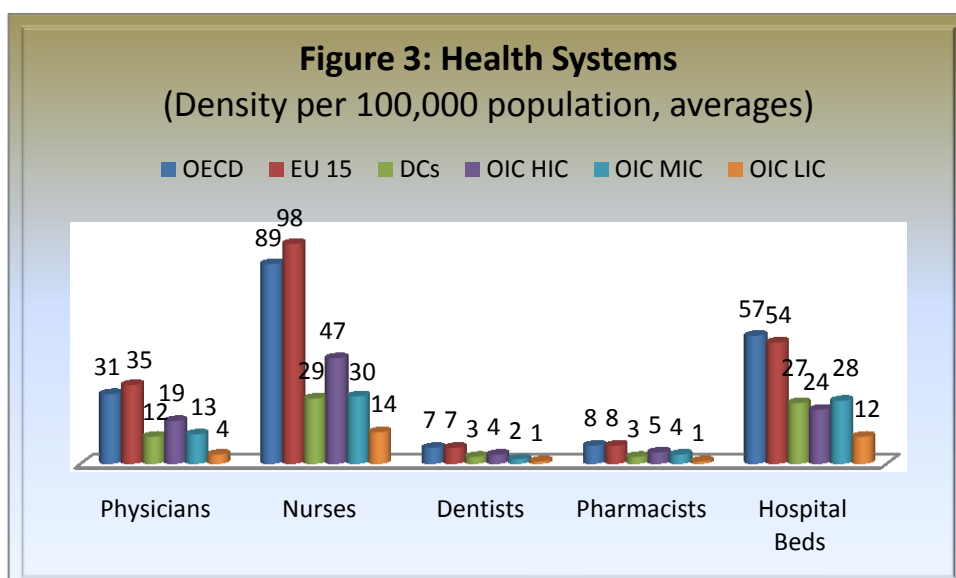
When the income sub-groups of the OIC are considered, it is clearly recognised that, while both of High Income and Middle Income OIC Member Countries (OIC-HIC and OIC-MIC) are performing well above the average of the OIC as a group for almost all of the five categories, the Low Income OIC Member Countries (OIC-LIC) are suffering much with respect to their average level of Health Systems figures (Figure 2). When comparing the “good” performers of the OIC sub-groups (OIC-HIC and OIC-MIC) with the average levels recorded by both of the OECD and the EU 15 groups, both OIC sub-groups average levels of Health Systems are significantly far behind those recorded by both of the OECD and the EU 15 groups.

¹ The group of the Developing Countries is classified according to the IMF’s Country Composition of World Economic Outlook Groups, World Economic Outlook Database, April 2008, <http://www.imf.org/external/pubs/ft/weo/2008/01/weodata/groups.htm>



Source: World Health Organization (WHO), Statistical Information System (WHOSIS).

Comparing the income sub-groups of the OIC with the country groups of the OECD, EU 15, and the Developing Countries shows, as expected, that all of the three income sub-groups of the OIC are far behind both of the OECD and the EU 15. But compared to the group of the Developing Countries, the OIC-HIC and OIC-MIC both performed better than the average of the Developing Countries with respect to the number of physicians, nurses and pharmacists. The OIC-LIC sub-group is far behind the average of the Developing Countries for all of the five categories. Regarding the category of hospital beds, surprisingly, the OIC-HIC recorded an average below that of the Developing Countries while the OIC-MIC recorded an average above that of the Developing Countries (Figure 3).

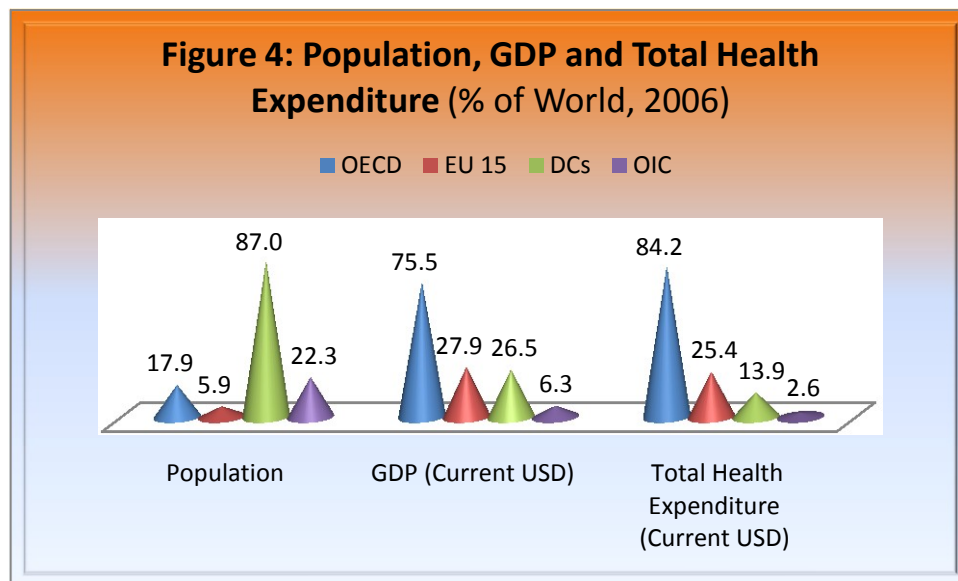


Source: World Health Organization (WHO), Statistical Information System (WHOSIS).

HEALTH EXPENDITURE

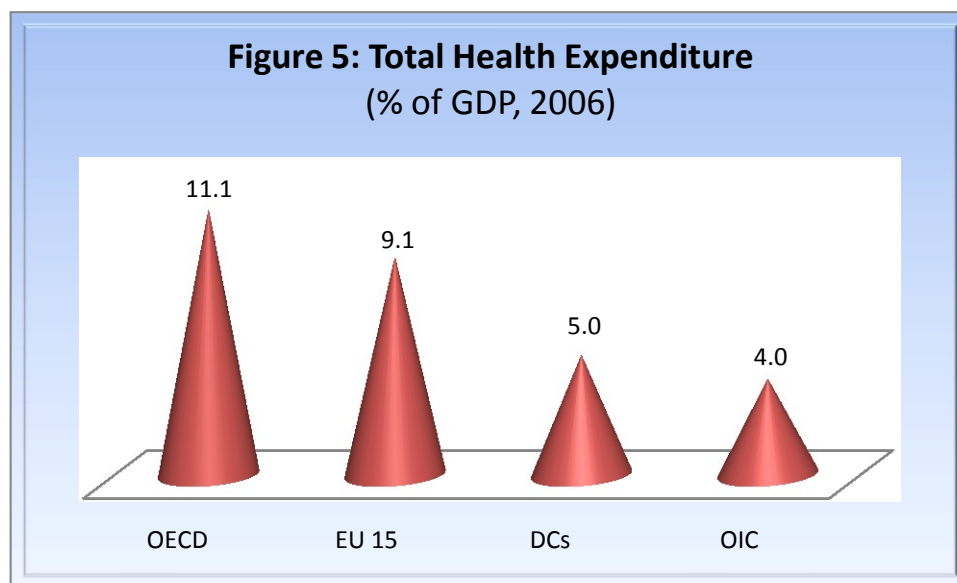
The concept of Health Expenditure focuses on the financial side of health development with respect to the population of a country. It is analysed here through comparing the population, GDP and Total Health Expenditure for the country groups in question for the year 2006. The Health Expenditure analysis also provides explanation and reasoning for the above-mentioned situations with respect to the Health Systems analysis.

At the global level, with 17.9% of the world population, the OECD gains 75.5% of the world GDP and spends 84.2% of the world Total Health Expenditure. In the same manner, the EU 15, with 5.9% of the world population, gains 27.9% of the world GDP and spends 25.4% of the world Total Health Expenditure. But, the picture is reversed when considering the group of the Developing Countries, highest population percentage of the world but lowest GDP and Total Health Expenditure compared to both of the OECD and the EU 15. In the same manner as for the group of the Developing Countries, the OIC group with respectively higher population percentage of the world recorded lower GDP and Total Health Expenditure compared to both of the OECD and the EU 15.



Source: United Nations Statistics Division, National Accounts Main Aggregates Database.

This gives an idea about global trends of health development in these four groups. But what about caring for health development? How much do these four groups care for health development? This issue can be explained through analysing their Total Health Expenditure as percentage of their own GDPs (Figure 5).

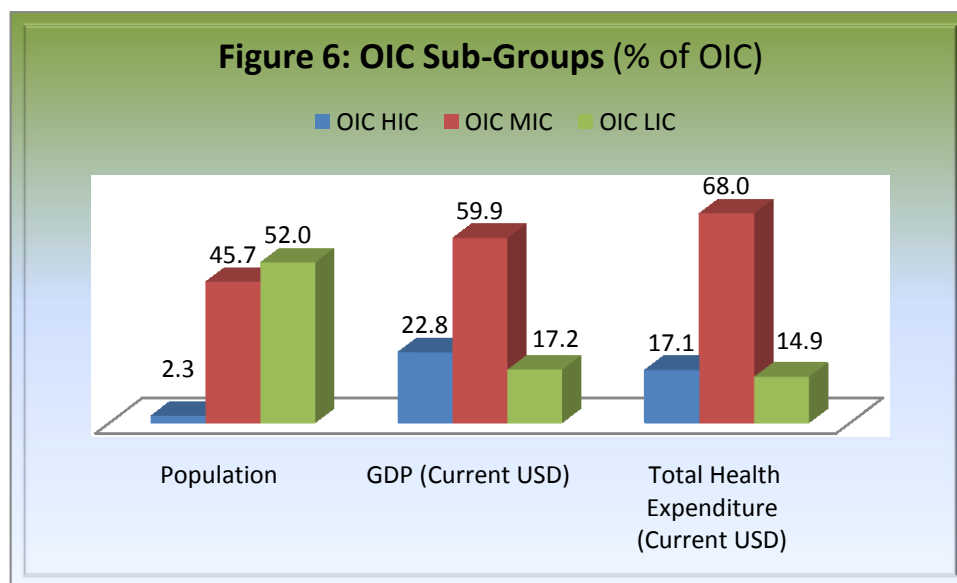


Source: World Health Organization (WHO), Statistical Information System (WHOSIS).

While the OECD and the EU 15 spend 11.1% and 9.1%, respectively, of their GDPs on health development, both of the groups of the Developing Countries and the OIC spend only 5% and 4%, respectively, of their GDPs on health development (Figure 5). Taking into consideration the mixed nature of the OIC group which reflects high levels of heterogeneity and divergence in the economic structure and performance of these countries where, out of the world's 50 least-developed countries, 22 are OIC Member Countries, and remembering that, by the end of 2006, the total external debt of the group of the OIC amounted to 752.6 Billion USD, and that, according to the 2008 World Bank classification, 22 OIC Member Countries are considered Heavily Indebted Poor Countries (HIPC)², the issue of health development becomes a major challenge and an urgent area of concern that needs serious planning and policy reforms for more allocation of resources.

The picture of the group of the OIC becomes clearer when considering the income sub-groups of the OIC. With 2.3% of the OIC population, the OIC-HIC gains 22.8% of the OIC GDP and spends 17.1% of the OIC Total Health Expenditure. In the same manner, the OIC-MIC, with 45.7% of the OIC population, gains 59.9% of the OIC GDP and spends 68% of the OIC Total Health Expenditure. But, the picture is reversed when considering the OIC-LIC, highest population percentage of the OIC but lowest GDP and Total Health Expenditure with respect to both of the OIC-HIC and the OIC-MIC (Figure 6).

² SESRIC (2008), Annual Economic Report on the OIC Countries.



Source: United Nations Statistics Division, National Accounts Main Aggregates Database.

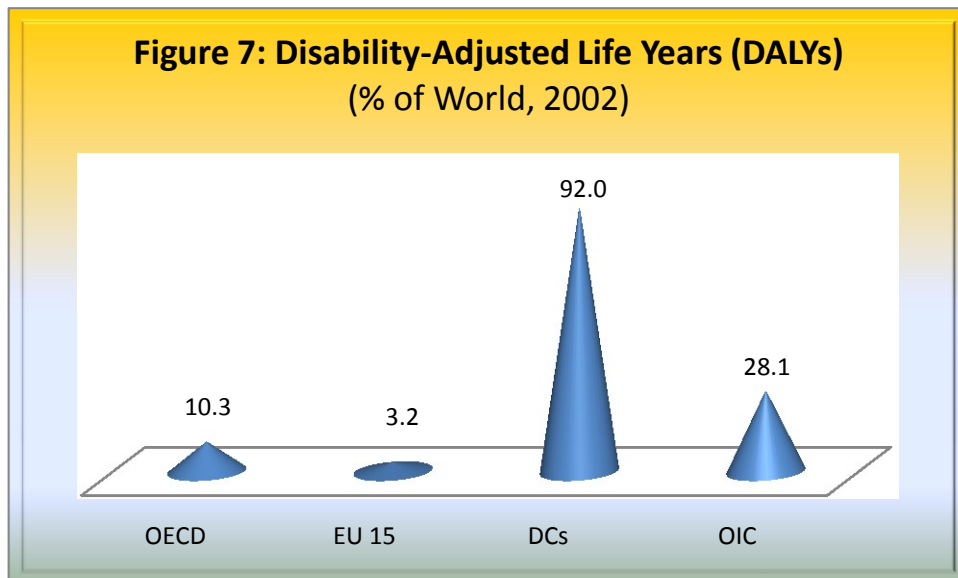
DISABILITY-ADJUSTED LIFE YEARS (DALYs)

The Disability-Adjusted Life Year (DALY) is a newly introduced measure that constitutes the basics of the World Health Organization Global Burden of Disease (WHO GBD) analysis³. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of “healthy” life lost by virtue of being in states of poor health or disability. The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of “healthy” life. The results of the DALY analysis can be understood as a reflection of the above-mentioned situations with respect to the Health Systems and Expenditure analyses.

Considering the OECD, EU 15, the Developing Countries and the OIC country groups, it is clearly recognised that the group of the OIC is much far behind both of the OECD and the EU 15. While the OECD and the EU 15 recorded 10.3% and 3.2%, respectively, of the world’s DALYs, the group of the OIC recorded 28.1% of the world’s DALYs (Palestine is not included in this analysis because of its non-available data). The worst picture is that of the group of the Developing Countries; recording 92.0 of the world’s DALYs (Figure 7). Remembering that the group of the Developing Countries makes 87% of the world’s population, its DALYs record is not surprising because of its significantly low world GDP percentage (26.5%) of which only 5% is dedicated to Total Health Expenditure. One would not be mistaken when saying that the “world” is urgently in need for serious enhancements in the issue of health development. This is

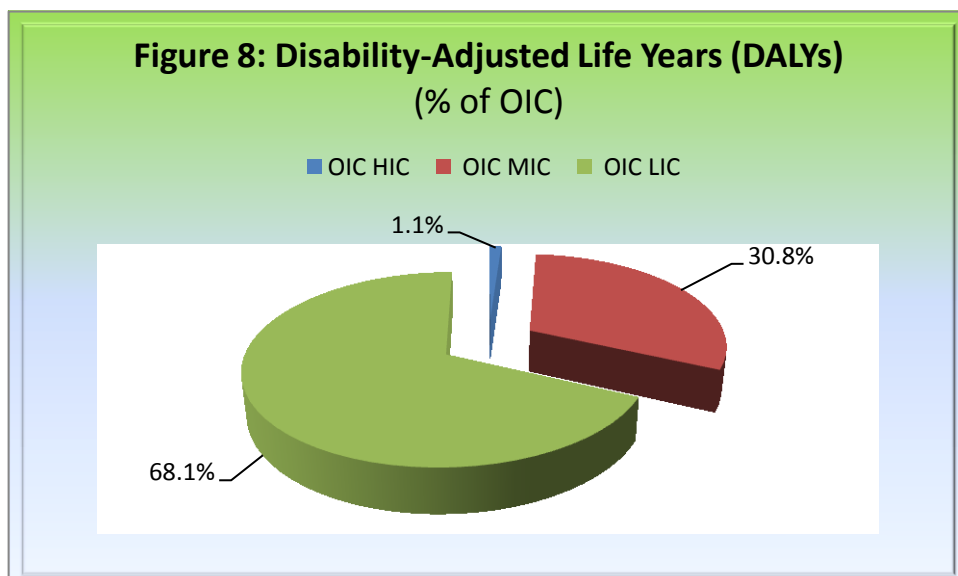
³ The (WHO GBD) analysis provides a comprehensive and comparable assessment of mortality and loss of health due to diseases, injuries and risk factors for all regions of the world. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. The first GBD 1990 study quantified the health effects of more than 100 diseases and injuries for eight regions of the world in 1990. It generated comprehensive and internally consistent estimates of mortality and morbidity by age, sex and region. This study was updated for the year 2000-2002 and included a more extensive analysis of the mortality and burden of disease attributable to 26 global risk factors using a consistent analytic framework known as Comparative Risk Factor Assessment (CRA).

also true for the group of the OIC as it is a sub-group of the Developing Countries. The figures of DALYs reflect the situation of the Health Systems which, in turn, is a reflection of the situation of the Health Expenditure-GDP relationship/ratio.



Source: World Health Organization (WHO), Deaths and DALY estimates for 2002 by cause for WHO Member States.

When the income sub-groups of the OIC are considered, it is clearly recognised that the OIC-HIC recorded the minimal (negligible) percentage of DALYs within the group of the OIC which is significantly better performance compared to both of the OECD and the EU 15. The OIC-MIC recorded almost one-third which is better than the OECD group but much worse than the EU 15 group, and the OIC-LIC recorded almost two-thirds which is significantly worse performance compared to both of the OECD and the EU 15) of DALYs within the group of the OIC (Figure 8).



Source: World Health Organization (WHO), Deaths and DALY estimates for 2002 by cause for WHO Member States.

When the DALY is age-standardised per 100,000 of the population, it is recognised that the DALY performance of the group of the OECD ranges from 8178 to 16246. In the same manner, the DALY performance of the group of the EU 15 ranges from 8178 to 16246. But, the picture gets much worse when considering the group of the OIC. Only Kuwait fits into the range of the group of the EU 15 with a recorded standardised DALY better than Portugal. Kuwait, Qatar, Bahrain, Brunei, Oman, United Arab Emirates, Malaysia, Albania and Turkey fit into the range of the group of the OECD (with Turkey having the least performance as an OECD member). The remaining OIC Member Countries fall far behind both of the OECD and the EU 15 of which 47 OIC Member Countries recorded standardised DALYs in the range of 16,384 (recorded by Tunisia) to 73,362 (recorded by Sierra Leone).

The group of the Developing Countries recorded standardised DALYs in the range of 9,768 (recorded by Monaco) to 84,594 (recorded by Lesotho). Comparing the standardised DALYs of the OIC Member Countries with those of the group of the Developing Countries, 22 OIC Member Countries recorded standardised DALYs in the upper half (15 in the top 50) while the rest is at the lower half (24 in the bottom 50) of the Developing Countries (Palestine is not included in this analysis because of its non-available data).

CONCLUSION AND POLICY RECOMMENDATIONS

In many regards, the responses of the health sector to today's globalised world have been inadequate and ineffective. Inadequate as they not only fail to anticipate but also to respond appropriately. Ineffective as a system's failure requires a system's solution, not a temporary relief. Problems with human resources for health care, finance, infrastructure and information systems extend beyond the narrowly definition of the health sector. This raises the crucial importance of working effectively across governments and stakeholders.

The 2008 issue of the World Health Report structures the reforms needed in the health sector in four groups that reflect the convergence between the evidence on what is needed for an effective response to the health challenges of today's world, the values of equity and social justice that constitute the basic of the health development movement, and the growing expectations of the population in today's modern societies: First, reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, mainly by moving towards universal access and social health protection (Universal Coverage Reforms); Second, reforms that re-organise health services as primary care so as to make them more socially relevant and more responsive to today's globalised world while producing better outcomes (Service Delivery Reforms); Third, reforms that secure healthier communities, by integrating public health actions with primary care and by engaging healthy public policies across sectors (Public Policy Reforms); Fourth, reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems (Leadership Reforms).

In this respect, and taking into consideration the weak performance of the OIC group which call for urgent action needed for the enhancement and utilisation of the allocation of resources, it is worth mentioning that the First Islamic Conference of Health Ministers which was held in Kuala Lumpur, Malaysia (12-15 June 2007), has highly

emphasised the health development issue in the OIC. The OIC Member Countries are urged to cope with the Kuala Lumpur Declaration 2007 which has been signed by the OIC Ministers of health in the said Conference. The Declaration constitutes a very important stage of utilised cooperation among the OIC Member Countries on national, regional and international levels aiming at developing, strengthening and maintaining the health sector in the Islamic world.

The Ministers have drawn crucial attention, among other things, to: (1) The importance of health to human development and poverty reduction being an important economic asset for labour productivity and educational attainment; (2) The decision of the 3rd Extraordinary Session of the Islamic Summit Conference to establish a special fund within the Islamic Development Bank (IDB) for poverty alleviation and health issues in the OIC Member Countries; (3) That communicable diseases, in today's globalised world, can spread much faster and can lead to significant loss of lives and have negative impact on the economy of the OIC Member Countries; (4) The International Health Regulations (2005) adopted by all 193 WHO members have come into effect on 15th June 2007; (5) That more than one-third of unvaccinated children globally (9.9 million infants) reside in the OIC Member Countries; (6) That the exclusive breastfeeding rate (up to 6 months) in many OIC Member Countries is less than 20%; (7) That maternal mortality due to preventable complications of pregnancy and childbirth remains unacceptably high in many OIC Member Countries.

Accordingly, the Ministers, among other things, have urged and requested the OIC Member Countries to: (1) Further support the IDB fund through generous and urgent contributions; (2) Assess the existing national public health systems and develop, strengthen and maintain the core country capacities required under the International Health Regulations (2005) through the mobilisation of both domestic and external resources and expertise; (3) Support the implementation of the resolution of the World Health Assembly (60.28) on pandemic influenza preparedness plan sharing of influenza viruses and access to vaccine and other benefits; (4) Intensify their cooperation with the World Health Organisation and other international organisations to combat global health concerns; (5) Promote collective self-reliance in vaccine production and supply through strengthening National Regulatory Authorities and improving capacity for vaccine production and distribution in the OIC Member Countries; (6) Introduce stronger tobacco control legislation to protect present and future generations from the devastating health, social and economic consequences of tobacco consumption and exposure to tobacco smoke; (7) Invite the OIC general Secretariat, the Islamic Development Bank and the World Health Organisation to set up a tripartite consultative mechanism to combat diseases and epidemics.

SOURCES

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