Introduction: more of the same?

At first glance the future trajectories of hospitals in Low-and Middle-Income Countries (LMICs) appear very different from those presently in High Income Countries (HICs). After all, the scourges of communicable diseases such as AIDS, TB, and malaria are still responsible for a significant burden of disease and, along with the widespread and persistent shortfalls in the number and distribution of critical skilled health workers, makes it difficult to imagine an alternative future. For example, the Lancet Commission on Essential Surgical Care estimates a minimum of 143 million additional surgical procedures are necessary each year to save lives and prevent disability. Therefore, whilst the discourse in HICs is dominated by the opportunities that disruptive technology brings to the future of hospitals, in the rest of the world there appears to be a resignation to a state of perpetual catch up. This default setting could be a serious misreading of the LMIC trajectory.

Dysfunctions and funding challenges

Health care financing and delivery systems in LMICs have multiple dysfunctions that directly impact hospitals. The epidemiologic and demographic transitions are causing proportionately higher burdens of chronic non-communicable diseases. Primary health care systems in LMICs are chronically weak; over the period 2005 to 2015, for example, only 17 percent of mother-and-child pairs in the poorest wealth quintiles received at least six out of seven basic health interventions. Consequently, hospital care has become the default setting for treatment.

As countries transition from LIC to LMIC status, much of the increase in total health expenditure per capita comes from neither public financing nor Development Assistance for Health (DAH), but from increased private out-of-pocket expenditures. Without purposeful and successful policy reforms to ensure pre-payment schemes like insurance or general taxation, and to contain cost escalation, the treatment of chronic NCDs is likely to be on a high-cost trajectory, available disproportionately to the upper income quintiles, and thus inequitable. Regardless, financing of hospitals in LMICs will remain far behind those in HICs. In 2016, total per capita health spending averaged $40 in LICs, compared to $135 in LMICs, $477 in UMICs and $3,135 in HICs.

Inevitable reforms

In summary, hospitals in LMICs have no option but to reform and rationalize their business models if they are to cope with the massively increasing demand in the context of limited resources. We are already witnessing the future of hospitals not in New York or London but across India where hospitals such as the Aravind Hospital Group and Narayana Health are providing examples of what has been called reverse technology transfer. The advent and increased use of stationary and mobile digital technology will provide further opportunities for significant shifts in approaches to clinical diagnoses, provider-client communications, and treatment. This is especially so for the package of services in primary care that includes basic out-patient care at the first referral or “district” hospital; this is similar to that adopted by the Lancet Commission on

Investing in Health for the platforms required to deliver UHC services close to the population: population-based (public health) interventions, community-based interventions, health centers, and first-level hospitals.

Three axes: policy, transition, and experimentation

The optimal functions of hospitals will include serving as technical hubs in professionally managed primary care networks that deliver patient-centered, value-based care. Where current hospital capacities are poorly aligned with population needs and financial sustainability, rationalization or reorientation will be required. In practice, the evolution of planned and emergent responses to the combination of challenges noted above is likely to include: policy choices that pitch short-term expediency against reforms that require many years to mature; transitions from predominantly out-of-pocket payments to pooled pre-payments for hospital services; and experimental deployments of digital technology for remote diagnoses and management of illnesses. The extent of progress along each of these axes will be a product of strategic negotiations, tactical bargaining, and involuntary changes in response to exogenous pressures from disruptive technologies, social pressures, and fiscal constraints. We believe there is reason to suggest that LMICs will lead, rather than follow, the hospital revolution. Whether this leadership is by deliberate design or mostly emergent is secondary.

References


