

## 2016 Global health care outlook Regional & country perspectives

Public and private health care systems in 2016 will not only face challenges emanating from an increasingly global marketplace, there will also be region-specific issues to address.

### Americas

Per-capita health care spending (WHO, 2013, USD unless otherwise stated)<sup>142</sup>

Brazil — \$1,085

Canada — \$5,718

Mexico — \$664

United States — \$9,146

Health care spending growth in North America is projected to rise by an average of 4.6 percent annually during 2015-2019, driven, in large part, by expanded insurance coverage in the United States under the Affordable Care Act (ACA), which will boost that country's spending by an average of 4.4 percent a year in 2015-2019.<sup>143</sup> Canada is projected to see even faster spending growth during the same period — 4.8 percent annually — reflecting its older population.<sup>144</sup>

Latin America's health care spending tells a more subdued story: Spending slowed sharply in 2014 and is expected to enter a decline in 2015 as economies remain under pressure, particularly in Brazil and Colombia. Even so, several governments are trying to improve public health care systems as much as their budgets allow; as a result, spending across Latin America is expected to rise by an annual average of 3.1 percent in 2015-2019.<sup>145</sup>

### Country-specific issues

- **Brazil's** current economic slump may extend well into 2016. According to EIU forecasts, Brazil's GDP will contract by around 2.5 percent in 2015 and recover only moderately in 2016, the result of political instability, declining consumer and business confidence, and monetary tightening.<sup>146</sup> These factors combined with impending fiscal austerity measures and rising taxes may limit spending growth<sup>147</sup> in a country that already lacks sufficient health care infrastructure. In addition to a shortage of health care professionals — 1.3 doctors per 1,000 people in 2014<sup>148</sup> — In 2015, Brazil had 1.95 doctors per 1,000 inhabitants.<sup>149</sup> The poor state of Brazil's public health system is boosting the use of private health care and employer-subsidized private health insurance among those who can afford it. Private health care accounted for 51.8 percent of total health care spending in Brazil in 2013, according to WHO data, and anecdotal information suggests this has grown since. The country's financial constraints are driving cost management efforts across both public and private health care sectors. Preventive medicine programs are growing in number and reach; hospitals are establishing networks to gain scale efficiencies and negotiating leverage; providers are pursuing licensing agreements with hospitals that have centers of excellence for second opinions in high-cost surgical procedures; and the focus on population health management is increasing. Recent legislation to allow foreign investment is spurring companies like UnitedHealthcare (UHC) to buy insurance companies in Brazil, and boosting the rise of private insurance for the middle class. One consequence is the rise of a shadow/parallel system of care.
- While public health care spending in **Canada** has risen quickly over the past decade, the rate of growth has slowed in the last five years — partly as the result of cost-cutting efforts — and the trend is expected to continue.<sup>150</sup> Still, the overall cost structure of Canada's health system and its increasing share of provincial revenue is a concern across the country. Pressure is on the government and providers to make better use of available resources and reduce the annual escalation

of health expenditures. There are two different trends occurring within the provinces: The first is consolidation to create larger entities governing health systems, and more localized delivery focused within regional hubs of care. The other trend is a shift to community-based care with an emphasis on integrated care across the sectors on a population basis. Innovation, patient engagement, outcomes management, and technology investments are viewed as critical enablers of reform and sustainability in Canada's health care system.

- The aging of **Mexico's** population and an increase in chronic diseases such as diabetes and cancer (at 219 percent and 56 percent, respectively, between 1980 and 2011)<sup>151</sup> are driving up demand for health care services. This demand, in turn, is putting financial pressure on Mexico's National Health System, which accounted for 6.2 percent of GDP in 2014.<sup>152</sup> Although recent budget cuts have resulted in various investments being put on hold,<sup>153</sup> improved public health system sustainability, quality, and transparency remain a government priority. To accomplish this, the government is focusing efforts on the portability of rights and the compatibility of health information systems such as EMRs among health institutions. Implementing health care reform may be an important issue in 2016 because doing so would open the market to non-government competition, boost private health care and insurance coverage, and create new opportunities for the sector at large.
- The **United States** is likely to see increasing demand for branded and generic drugs and medical devices in 2016 as the number of insured individuals continues to grow under ACA and Medicaid. According to a study by the Rand Corporation, between September 2013 and February 2015, 22.8 million Americans became newly insured and 5.9 million lost coverage, for a net gain of 16.9 million more insured.<sup>154</sup> Although new, substantive health care-related legislation in 2016 is unlikely, several parts of the ACA legislation that will affect health care costs and benefits will continue to roll out over the next few years. Among these, states will have permission to form health care choice compacts allowing insurers to sell policies in any state participating in the compact (January 2016);<sup>155</sup> insurance exchanges may open to

larger employers in states that allow it, and states may seek Innovation Waivers to alternative coverage models (January 2017);<sup>156</sup> and the federal government will institute the "Cadillac" tax, an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed \$10,200 for individual coverage and \$27,500 for change to family coverage<sup>157</sup> (originally scheduled for January 2018 but delayed for two years).<sup>157</sup> See more about the outlook for the U.S. market at [www.deloitte.com/us/healthcare](http://www.deloitte.com/us/healthcare).

## EMEA

### Per-capita health care spending (WHO, 2013)<sup>158</sup>

Germany	— \$5,006
Middle East (SA & UAE)	— \$1,473
Netherlands	— \$6,145
South Africa	— \$593
United Kingdom	— \$3,598

Economic pressures and a decline in the euro will continue to limit health care spending in Western Europe, despite the health needs of an aging population. The EMEA region is projected to see the world's slowest growth in health care spending in 2015-2019, at just 1.4 percent annually. Spending in Germany, the United Kingdom, and Sweden is expected to fare better than in Greece, Italy, Ireland, Portugal, and Spain — the countries most impacted by the Eurozone crisis.<sup>159</sup> In contrast, the Middle East and Africa region is expected to post the fastest health care spending growth globally, at around 9.3 percent annually in 2015-2019,<sup>160</sup> but these projections might change due the decline in oil prices. It is expected that growth will be driven by government policy changes, the expansion of health care systems, and rising populations.

### Country-specific issues

- The gradual aging of **Germany's** population — more than 20 percent is aged 65 or older (behind only Italy and Japan among OECD countries) — is expected to increase demand for treatment of conditions related to old age and for elderly care<sup>161</sup> in 2016 and successive years. Although the public system will continue to play the most prominent role in health care provision and spending, the share of private spending is expected to rise as the German government continues its efforts to reduce public health budget expenditures.<sup>162</sup> These efforts also affect hospital infrastructure. Many hospitals

— especially in the western part of Germany — are in need of renovation and have large investment bottlenecks. Due to the reduction of public subsidies many hospital managers have to deal with new financing models which they have not needed in the past. The latest legislation (“Krankenhausstrukturgesetz”) was more positive than many market players expected. It will provide more money for specific areas of the health system (e.g., for nursing care) and strengthen the influence of quality measures on hospital reimbursements. A newly established institute will define how to measure quality and formulate the monetary incentives and penalties. This is expected to have considerable influence on how hospitals think about improving the quality of their health care provision. Additionally, the current refugee crisis could increase the coverage pools in more socialized health care systems like Germany.

- Starting from a relatively low base in terms of GDP spend, countries across the **Middle East** are increasing health care system expenditures for local populations, although their central policies, standards, infrastructure, and services differ. In Saudi Arabia, for example, the government’s 2015 budget designated \$42.7 billion for health and social welfare — up 48 percent from 2014’s allocation — despite the worldwide decline in oil prices,<sup>163</sup> but 2016 could be impacted by the slump. In the United Arab Emirates (UAE), health care, education, and social services are key priorities in the federal budget. Rising life expectancy, high incidence of lifestyle-related chronic diseases, population growth, and rising consumer expectations are driving demand for health care services throughout the UAE.<sup>164</sup> While Middle Eastern countries now offer many specialist services locally, including through foreign investment (such as the Cleveland Clinic or Moorfields Eye Hospital), the region still sees large numbers of people travelling to the United States, United Kingdom, and elsewhere for treatment. Health care provision is variable for immigrants or foreign workers in most countries. There are examples of countries designing end-to-end health care systems but frequent political changes challenge the consistency which is required to complete delivery.
- The **Netherlands**, like other Western European countries, is grappling with the health care needs of an aging population. And while the Dutch health care system is successful in providing widespread coverage — the country tends to spend more in care (youth, elderly, mental, long-term, home-based care) than other countries — it is struggling to contain cost growth.<sup>165</sup> In response, the government is moving to more regional/ local health management solutions. The Netherlands has an obligatory health insurance system and bases provider and health professional reimbursement on a countrywide diagnosis-related group (DRG)-like system. Currently, government-funded population health experiments are taking place in which reimbursement is based on providers’ success at keeping a community healthy. Other initiatives include introducing dual models of public and private care delivery and funding; and enhancing patient data collection and sharing through electronic health records, wearables, and other technology advances.
- The biggest issue facing the health care sector in **South Africa** is cost constraints. The country’s overall economic environment in 2015-2016 remains challenging, which adds considerable pressure to the government budget and could lower its future spending on health care. South Africa is pushing ahead with plans to gradually introduce a National Health Insurance (NHI) system (over a 14-year period) which will be funded partly out of personal taxes and partly from mandatory employer contributions.<sup>166</sup> The white paper for the implementation of the NHI was published on 21 December, 2015. However, improving the patient experience in the public health care sector will require major investments in infrastructure, clinicians, and treatments. With high unemployment levels affecting tax revenues, the government’s ability to address issues is very limited. And while the “people costs” of delivering health care services will probably rise in line with local inflation, the infrastructure and health care-related services costs are anticipated to increase at a higher rate due to the country’s reliance on exports and a depreciating currency value. South Africa’s private health care sector, which accounted for an estimated 52 percent of total health care spending in 2013 but covers just 20 percent of the population,<sup>167</sup> is also under pressure to reduce costs in line with the reduced spending power of some sectors of the economy.

- Like most developed countries, the biggest health care challenge facing the **United Kingdom** is increasing demand of four-to-five percent a year compared to funding increases of less than one percent a year. In England, a relatively stagnant budget, the rising number of frailer, older people with multiple, complex, and expensive long-term conditions, and the increasing costs of drugs and other consumables, is expected to lead to a £2 billion funding deficit (on a £116 billion budget) in 2015-2016. Without radical change, the funding deficit is predicted to be £30 billion by 2020-2021. The new Conservative government, elected in May 2015, committed to adopting the NHS Five Year Forward View (5YFV) and to focus on prevention of ill health; giving patients more control of their own care; removing the silos between physical and mental health and health and social care; and delivering new models of care. The Government's November 2015 Comprehensive Spending Review committed to providing £8 billion additional funding in return for £22 billion efficiency savings by 2020-2021. Initiatives to bridge the funding gap include reducing spending on agency staffing; capping spending on management consultancy contracts; implementing the findings of Lord Carter's review of efficiency in hospitals;<sup>168</sup> and constraining public sector pay to only one per cent a year for the next four years. The additional £8 billion funding is to be front-loaded, with a £6 billion increase by 2016-2017 to support implementation of the new care models and tackle the growing deficit.

## Asia-Pacific

### Per-capita health care spending (WHO, 2013)<sup>169</sup>

Australia	— \$6,110
China	— \$367
India	— \$61
Japan	— \$3,966
Southeast Asia (Singapore)	— \$2,507

Although the Asia-Pacific region is experiencing an economic slowdown, the rollout of public health care programs combined with increasing private wealth is expected to boost the region's health care spending by an annual average of 6.6 percent in 2015-2019. The strongest anticipated growth, at a substantial 16.1 percent per year, will be in India, where the government has set a target of raising public health expenditure — primarily allocated to infrastructure improvements — from its current equivalent of 1.2 percent of GDP to 2.5 percent of GDP within five years. China's spending growth in 2015-2019 is estimated to be 8.8 percent a year, although given the current economic uncertainty that number could end up being far lower. Australia and South Korea are expecting growth of over four percent a year. Due to continuing currency devaluation, Japan remains the region's most depressed market; spending is not anticipated to recover until 2016, with an average growth in dollar terms of just one percent.<sup>170</sup>

### Country-specific issues:

- Health care spending in **Australia** continues to grow in response to the needs of the country's aging population, advances in medical technology and treatments, and the public's increasing awareness of health-related issues. The bulk of health care funding is provided through a longstanding, national health care system known as Medicare. Contributions are made through taxes and a levy based on taxable income. In addition to public funding, there are 35 private health insurance funds in Australia, the largest of which is Medibank Private. Together with its wholly owned subsidiary, ahm, Medibank provided health insurance for 3.9 million members — equivalent to 34.6 percent of the market — in fiscal 2014-2015.<sup>171</sup>

- Fueled by increasing consumer income, population aging, and government initiatives, **China's** health care market is growing rapidly, with annual expenditures projected to reach \$896.7 billion by 2019, up from an estimated \$579.7 billion in 2014.<sup>172</sup> In 2016, two major forces will be driving the evolution of China's health care sector. One is government policy focused on enhancing health care accessibility and affordability to the general public — China is shifting its focus from increasing health care service volume to enhancing provision efficiency. As a result, the government is initiating programs to promote a tiered health care system, reduce unnecessary drug usage, reform public hospitals, and channel private capital into health care provision and health insurance. Another force is the emergence of new technologies and care models such as mHealth and wearable devices, which are changing how care is provided. These and other innovations are strongly supported by the government as a way to improve efficiency. Given the health care sector's positive growth prospects, foreign companies and investors are keen on entering or expanding their presence in China; however, they face many challenges along the path to turning their high hopes into profitable realities. With strong competition from public hospitals and obstacles such as physician recruitment, reimbursement, and general lack of trust in privately run hospitals, investors should carefully assess each opportunity. Partnering with local companies will be important, as it not only can synergize brand strength and operational excellence but also help to secure an adequate supply of physicians and other medical staff. Meanwhile, opportunities to acquire private hospitals are becoming scarce due to inflated valuation and the generally small size of these institutions. Instead, private investors are looking into privatization of public hospitals or cooperative opportunities with local governments, which not only provide increased access to local capabilities and resources but also are beneficial in enhancing government relationships.
- India** is one of the fastest-growing economies in the world, as well as home to approximately 35 percent of the world's poorest people. The country's health care system clearly illustrates that dichotomy: Although India's health care sector is growing rapidly — driven mainly by private players — public spending has remained quite low and resulted in inadequate infrastructure and manpower in public health facilities, especially in rural areas. India's current spending on health care is expected to remain stable at the equivalent of 4.1 percent of GDP in 2015-2019. This is below the average of 6.5 percent expected for the Asia and Australasia region, and is seen by many (including the current government) as inadequate.<sup>173</sup> Health insurance coverage is low and India has one of the world's highest rates of out-of-pocket spending in health care.<sup>174</sup> Successive governments have tightly controlled public health spending — of note, the national government reduced its 2014-2015 health care budget and increased states' contributions for centrally sponsored schemes, including health. Looking to 2016 and beyond, health care organizations in India will need to turn to innovative business models to improve access, increase quality, and simultaneously maximize resource utilization to ensure growth. Some enterprises are already starting to move in this direction — emerging operating models such as hub and spoke have great potential to expand reach, especially in tier two and tier three regions, while asset-light models and other frugal innovations can reduce the cost of health care significantly. Health care delivery models such as day care and short-stay surgery are also revolutionizing the space by improving patient convenience and turnaround time. Finally, the innovative use of technology such as telemedicine is helping care providers maximize limited resources at a low cost.

- **Japan's** economy remains under duress, despite a huge bond-buying campaign, structural reforms, and central government stimulus.<sup>175</sup> Putting further pressure on the economy are Japan's rapidly increasing health care costs, driven by an aging society and increasing chronic diseases, as well as the emergence of innovative and expensive treatments. Japan's total health care spending reached an estimated \$478 billion in 2014, making it the third-largest spender on health care in the world, after the United States and China.<sup>176</sup> Since the country's current health care system was designed in 1961 on the basis of stable demographics, it is not surprising that the system is no longer sustainable in terms of financial and provider resources. In response, the government is looking ahead to 2025 and implementing a series of new policies aimed at establishing an efficient and lean health care system. The most symbolic initiative is reform in local health care systems. Every local government is required to estimate its health care needs in 2025 and report potential resource gaps to the national government. (The estimation is required to use the National Database, a national-level administrative database which consists of medical claims and health check data of all Japanese citizens.) One of the goals of local health care reform is to re-allocate hospital beds based on local needs — currently, beds for sub-acute and chronic care settings are not sufficient while there is a surplus in acute-care settings. Since the majority of health care facilities in Japan are privately owned and the daily in-patient fee is set based on the registered function of hospital beds — the fee is high in the acute-care setting — hospitals are reluctant to change their current registration. Although local governments cannot compel hospitals to change the function, the new data is expected to support a smooth transition from the current acute-centered situation to one that expands bed allocation among other settings (e.g., sub-acute and long-term care) to optimize local health care resources.
- Governments in **Southeast Asia (SEA)** continue to roll out universal health care systems amid rapidly growing demand for services — Indonesia, for example, implemented its coverage plan, Jaminan Kesehatan Nasional (JKN) in January 2014, later expanding and rebranding the program as the Healthy Indonesia Card (KIS).<sup>177</sup> Philippines and Vietnam are also implementing universal public health care schemes that will be run as mandatory health insurance systems. However, most countries in the region face ongoing funding constraints and are looking for ways to reduce health care expenditures. One market trend that could reduce costs and improve care delivery is consumer engagement — patients are growing in number and spending power in the SEA region and health care organizations are prioritizing consumer communication strategies, especially for new product or new service launches. Additionally, innovation is playing a bigger role in augmenting traditional care management approaches. The region is seeing the emergence of new, patient-centric, collaborative business models, wellness and lifestyle-themed health services, telehealth initiatives, subscription care models and more.

For global perspectives, please visit [www.deloitte.com/healthcareoutlook](http://www.deloitte.com/healthcareoutlook). Please visit [www.deloitte.com/healthcareoutlook/sources](http://www.deloitte.com/healthcareoutlook/sources) for a complete listing of sources referenced in this report.

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