

Health Economics 2020 Market Analysis

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The European **healthcare** market is expected to grow from around \$2080 billion in 2016 to around \$2125 billion in 2020. This region has not witnessed a significant increase in the market size due to decrease in government expenditures due to weak economic conditions in many countries. The report covers market characteristics, size and growth, segmentation, regional and country breakdowns, competitive landscape, market shares, trends and strategies for this market. It traces the market's historic and forecast market growth by geography. It places the market within the context of the wider healthcare market, and compares it with other markets.

Aging population poses a threat to the economy as it impacts the economy and increases government spending on healthcare and pensions. The estimates show that the population aged 65 and above in the European region is set to rise to 224 million in 2050. Italy has the highest percentage of elderly (above 65 years) population in Europe at 22%. Europe's total GDP was \$19.9 trillion in 2016 accounting for 26.7% of global GDP. Europe is one of the major global economic blocks. Many of the leading European countries form part of the European Union, a free trade and movement block with a single currency.

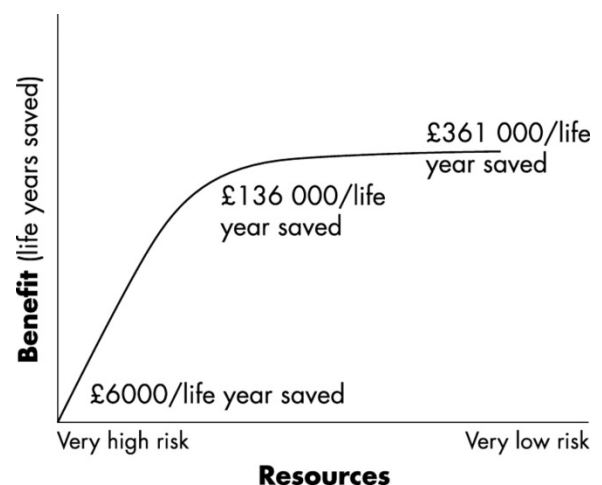
The European healthcare Market is expected to exceed more than US\$ 224 Billion by 2022 at a CAGR of xx% in the given forecast period. The European healthcare Market on geographic segmentation covers various regions such as North America, Europe, Asia Pacific, Latin America, Middle East and Africa. Each geographic market is further segmented to provide market revenue for select countries such as the U.S., Canada, U.K, Germany, China, Japan, India, Brazil, and GCC countries.

The Federal Republic of Austria is a relatively sparsely populated country with 8.7 million inhabitants. In 2016, Austria's gross domestic product (GDP) amounted to €40 000 per capita, placing Austria 6th among EU Member States. Austria's overall growing population and labour force and its relatively low level of **unemployment** have substantially contributed to the growth of its domestic economy in the last two decades.

Austria is a parliamentary republic with nine states (Lander). Decision-making powers are shared between the federal government and the Lander. Legislative processes primarily take place at the federal level in the national parliament, which consists of two chambers, the National Council (Nationalrat) and the Federal Council (Bundesrat). State parliaments (Landtage) have legislative power at the Länder level. A distinctive feature of the Austrian political system is that formal representatives of employers and employees (and other interest

groups), which are collectively known as the Social Partners, have significant influence on legislative processes, especially in the area of social policy and health policy. Life expectancy at birth in Austria remains above the European Union (EU) average (80.9 years) and has increased by more than three years since 2000, to 81.6 years in 2016. Healthy life years have not significantly changed over recent years and remain below the EU average. Diseases of the circulatory system such as stroke and **myocardial infarction** together with malignant neoplasms are the causes of around two thirds of all deaths in Austria. With stable smoking rates among adults that are above the EU average (24% versus 21% in 2014) lung cancer represents the third leading cause of death in Austria. Also, alcohol consumption is among the highest in the EU. However, seven out of 10 Austrians (70%) report being in good health, which is slightly higher than the EU average (67%).

The relationship between resources invested into an intervention and the benefit that is incurred is rarely linear. As decisions in health are usually whether to expand or contract existing services, it is important to consider how increments in benefit change with increment in resource allocation and not the average benefits that are incurred by average costs. This is known as a marginal analysis. Where the benefits in terms of years of life saved are plotted against resources invested in statin treatment. Three points are highlighted for cost/life year saved where resources are invested into very high risk, low risk, and very low risk patients.



Importance and Scope of Health Economics

The importance of the economic model is that it provides useful insights into how health care can be organized and financed

and provides a framework to address a broad range of issues in an explicit and consistent manner. Organizational changes such as the development of the National Institute for [Clinical Excellence](#) and the devolution of decision making to primary care organizations have led to an increasing interest in the subject and its influence on health care organization and decision making.

Thirty years ago there were limited options for doctors making treatment choices and patients did as they were told. Any values that contributed to the decision making process were implicit and determined by the [physician](#). However, against a background of limited health care resources, an empowered consumer and an increasing array of intervention options there is a need for decisions to be taken more openly and fairly.

The global landscape has changed drastically since HAS was founded nearly 60 years ago. Around the world, people are living longer and healthier lives. More children than ever are attending primary school. Maternal mortality has nearly halved over the last two decades. However, with 1.4 billion people living on \$1.25 a day, poverty eradication remains the greatest global challenge facing the world today. There is much work to be done.

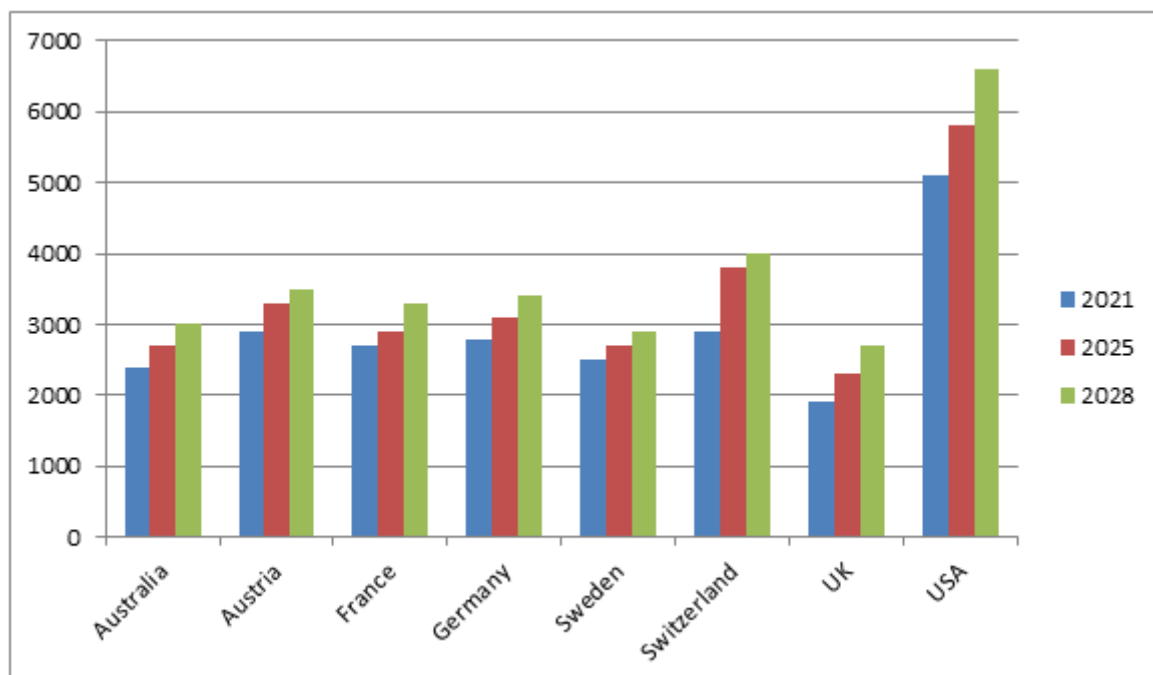
Indeed, many [non-health](#) goods (services and products) and activities can be enjoyed and produced more effectively by healthy people than by unhealthy ones. It is little wonder that limitations of current health service access and effectiveness remain controversial. A study of HE, itself no stranger to controversy but established as a sub-discipline of Economics, can help you to explain the controversies or even to resolve them. You can find graduate jobs and career opportunities in HIM around the world, in both private and public sectors. In addition, many more careers in health service organizations and in various companies or government services can be enhanced

by the distinctive perspective and ways of resolving policy questions that extended study of HE yields.

Modules and programmers in HIM vary considerably. On many such courses, however, you will be able to study how, in different regions of the world at different times; resources have been allocated to health-related goods. You will also be able to see how limits to resource use in the name of human health can be decided and what the consequences for various interested parties, intended and unintended, could be.

It is likely that you will be able to apply various techniques drawn from introductory market economics (on many courses, mainly microeconomic ones) to the particular case of health-related goods of various types. The effect of risk and information on decision-making about investing for health, by private individuals or organizations and by the state, is also likely to be a prominent feature. Courses vary considerably in their use of quantitative methods and in the extent of their inclusion of alternatives to the perspective on health derived from mainstream economic theory.

Your course in HIM might include a detailed investigation of particular types of health service institution or organization, from an economic perspective. Individual hospitals, pharmaceutical or health insurance companies, regulators appointed by government and professional groups such as clinicians or health service managers could all feature; so could the Economics of professional relationships between them within a particular health service system, such as the National Health Service (NHS) in the UK or Medicare in the USA. Most importantly of all, perhaps, you can study the relationship between service provider and individual patient from an economic perspective while remaining ever-mindful of human aspirations and vulnerability where the risk to health is concerned.



Total Health Expenditure Per Capita, USD\$ PPP

Target Audience:

1. Health policy-makers
2. Health care administrators
3. Health care professionals
4. Ministry of Health staff at the policy, operational decision-making levels in central and decentralized units
5. Ministry of Planning staff working in the health sector
6. Health economists
7. Clinicians
8. Researchers who have the on-the-ground skills of health care delivery and want to understand the logic of health care as an industry
9. Graduates from health sciences and social sciences
10. IT professionals who are interested in structuring practical research that measures the impact of proposed programs and health policy changes
11. Students participating in the Master Health Sciences
12. Medical health officers - They will be able to provide better services to the consumer
13. Paramedical students - They manage various medical situations and economies of it and can be able to better advise the customers
14. Individual hospital facility is benefited as this facilitates them of the hospital and perceives what services are needed by the customers of the hospital and the way will they be funded.
15. Pharmaceutical and health insurance corporations will be benefited as this may facilitate in understanding the demand and provide varied health and insurance products and evaluate the economic viability of the same for the company.

Related Companies/Industries:

1. UnitedHealth Group
2. Medtronic
3. Abbott Laboratories

4. Thermo Fisher Scientific
5. McKesson Corporation
6. CVS Health
7. Cigna Corporation
8. Stryker Corporation
9. Cardinal Health
10. AmerisourceBergen
11. Express Scripts Holdings
12. Walgreens Boots Alliance
13. Johnson & Johnson
14. Anthem
15. Aetna

Related Associations and Societies:

1. American Society of Health Economists
2. The International Society for Economics and Social Sciences of Animal Health
3. Canadian centre for Health Economics
4. Canadian association for health services and policy research
5. Australian Health Economics Society
6. LSE Health Society
7. International Health Economics Association
8. African Health Economics and Policy Association
9. Athens Institute for Education and Research
10. Asia Pacific Health Economics Network
11. Asociación de Economía de la Salud - AES (Spanish Health Economics Association)
12. AcademyHealth Health Economics Interest Group
13. Associação Portuguesa de Economia da Saúde - APES (Portuguese Association for Health Economics)
14. Associazione Italiana di Economia Sanitaria - AIES (Italian Association for Health Economics)
15. Canadian Health Economists' Study Group - CHESG-GECES