INVITATION TO A DEBATE ON FINANCING AND HEALTH[1]

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By reason of the extensive information it presents and the many options it offers, the World Bank study *Financing Health Services in Developing Countries: An Agenda for Reform* deserves to be discussed and analyzed by all who have any responsibility in running the health sector.

Discussion by a number of groups is desirable because, as the study itself observes, even if all the proposed reforms were successfully implemented, this would still not solve all the health sector's problems. One probable reason, among others, is that the study concentrates overly on financial matters. A full and detailed discussion between the Bank, the United Nations, and the specialized UN agencies (such as the World Health Organization and the International Labor Organization) would help to place the proposed financing changes within the conceptual framework of universally accepted principles (such as the basic right to health, the social causality of disease, and the desirability of studying these problems in the light of a humanitarian economy). Such discussion would also provide an opportunity to choose between the biomedical and biosocial model or, better still, to strike an adequate balance between the two.

Most of the proposed reforms are not analyzed against the backdrop of the growing number of people with severe economic constraints, and while it is a sensible move to seek new sources of resources, this search has to be linked with a clear policy decision to provide care for the great mass of the poor, who are quite unable to pay for anything beyond the most basic medical care. In the same way, it is evident that the availability of money in itself is not the solution to such complex and variable problems as those presently prevailing in the health field—most acutely in the countries of the Third World.

The study advocates transferring services to the private sector and transferring medical care costs to the users as a possible solution, but it does not present a conceptual framework for doing so or an analysis of the relative roles to be played in our countries by the public and private sectors. In addition, it asserts that the four reforms proposed, to be effective, should be applied as one whole; but it also states that because of the difficulties involved in their application, a start could be made with small-scale trials that would offer greater viability and meet with less resistance—a position that is manifestly contradictory.

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Neither is it clear whether the suggested reforms would entail changes in the structure of the health sector, to the extent such changes are possible, and whether legal and administrative reform of the public sector as a whole would be necessary in order for these changes to come about.

Since it is impossible to make a detailed analysis of all the possible reforms proposed in the very limited space available, we will restrict ourselves to comments on a few aspects. It is quite true that the financial area has been insufficiently studied; however, a basically monetarist approach would be useless if not combined with efforts in other equally important areas at the time action is taken. Without funds very little can be achieved; nevertheless, the other side of the coin is that an excess of resources creates serious distortions, as has happened in some postindustrial countries and also, paradoxically, in many Latin American countries where the sum total of available resources has clearly not been excessive.

Curriculum Changes

As the study notes, it is possible that some governments may, by their own authority, succeed in introducing changes in the training of medical personnel so as to make that training more suited to their countries' needs and better able to prepare paramedical personnel. However, it should also be noted that a large number of public and private universities have sufficient autonomy to take such decisions by themselves.

Many Latin American universities have now been working in this direction for 20 to 30 years, with results that are variable but not generally very promising for a number of reasons. One reason is the prestige factor affecting leaders of medical education, who feel they have grounds for pride when comparing their learning centers with those of postindustrial countries in the teaching of basic sciences, which are universal. This positive way of thinking has negative effects when it is extended to the clinical sciences and allowed to create a situation in which the student is rarely exposed to the epidemiologic research performed in his or her own country, and even less to pertinent socioanthropologic and economic studies—without knowledge of which it is very difficult to successfully carry out promotional, preventive, curative, and rehabilitative actions. The students, for their part, strive to gain admission to universities where they will be able to learn and use the latest advances in technology, regardless of the relevance these may have for treating ailments prevalent among their people. Society, in general, shares these views and demands that the most advanced services and facilities be available for the small number of patients who need them. It is not superfluous to note that although the foregoing is accepted in

theory, in practice high technology is not available to those who need it but to those who have the money or influence to obtain access to it. This minority uses, and often monopolizes, the available third-level facilities with ailments that could and should be treated in second-level or even local hospitals. This brings us to the problem of the lack of equity and one way to cope with it: sharing the risks, which is one of the central subjects of the World Bank study.

Risk-sharing

Sharing risks is a simple act of human solidarity that is not very widespread, so it is worth considering what the study has to say about it. Many people, it asserts, are opposed to risk-sharing, arguing that they should not have to help pay for those with "bad life-styles" (smoking, drinking, lack of exercise, bad eating habits). It is appropriate to note here the findings of the classic study by Rollo H. Britten in 1934 and of the United States Public Health Service's *Health and Depression Studies* of 1935, in which it is stated that unemployment or bankruptcy prevents a person from practicing good habits, and that the risk of a person in this situation falling sick will be equal to or greater than that experienced by people who for years, and at times generations, have learned to live with poverty.

On the other hand, smokers with lung cancer or alcoholics with cirrhosis of the liver who have contributed all their lives to the financing of the health sector by paying high taxes on alcohol and tobacco, could argue with the same logic or, to be precise, the same lack of logic, that it is unfair for those with these diseases contracted from other causes to receive treatment financed with common funds. It should be borne in mind that in many countries it is precisely such taxes that are used to fund health and education.

Of course, this is a *reductio ad absurdum,* but on occasion such a device can help to demonstrate the fallacy of arguments that are purely selfish and have no thought for the future, since even an individual who lives most prudently cannot be certain that he will never suffer an accident or be struck down by a catastrophic illness.

The World Bank study describes various forms of risk-sharing; but whatever the system or combination of systems that a country adopts, it must be borne in mind that when large sums of money are available for a particular purpose, neither the user nor the provider of services will think in terms of cost control. The World Bank suggests that free competition among private insurance organizations can help prevent waste. This is possible and might even be achieved in some societies; however, in general the laws of free competition do not appear to function well in poor countries, and it is not unusual for the end result to be more or less disguised monopolies.

The study further points up, in general rightly, the shortcomings of compulsory state and private insurance schemes and speaks of private nongovernment insurance as offering the best alternative—overlooking the pronounced likelihood that such insurance

would quickly be managed in the same way as other insurance—in the sense of preferring least-risk situations and eliminating excess risks to the extent possible, thereby negating the principles of equity and risk-sharing.

In any event, whatever system is selected will have to seek every possible way of rationalizing costs and controlling both the quality of the services and the equity with which they are provided.

Cost Control and Quality Control

The study refers to the need to find effective mechanisms for reducing costs without affecting the quality of medical care. Many attempts have been made along these lines, with very limited results. It might be more viable, more significant, and more attractive to begin controlling cost by controlling quality, an equally difficult alternative but one with a more far-reaching potential.

In this regard, for example, health care providers should be made aware of four features of the medications that they use: (1) the risk entailed by their application; (2) their utility and cost; (3) the fact that they are redundant if too many are used; and (4) their possible side-effects. Undergraduate and graduate students, as well as professionals in continuing education courses, could usefully read certain very thought-provoking documents on this subject. These include the publications of the Office of Technology Assessment of the United States Congress and a selection of reports on the best research done on iatrogenics.

Such reading would work to the benefit of both patients and finances, since professionals would learn ways of reducing costs while simultaneously improving quality and reducing the future costs of treating iatrogenic problems. Even more important, discussion of these topics in universities would stimulate a far-reaching and desirable change in the training of health providers and in management of the technological environment wherein they have to operate.

Something similar can happen with paraclinical examinations. Here the physician, in order to make up for the very little time he gives or is allowed to give each patient, commonly orders an indiscriminate array of examinations, using these as a means of compensating for poor records, inadequate data, and a superficial clinical examination that, if performed correctly, would be sufficient for making a diagnosis.

While it is true that medicine also relies on other sciences and disciplines, the physician's decisions and actions have to be based fundamentally on a good doctor-patient relationship, accurate and sufficiently detailed records, and observation of the patient. Besides

reducing costs, any changes that help to ensure that these requirements are met will improve the image of the health services and prove a source of satisfaction for both the health professional and the patient.

Primary Care and Paramedical Personnel

For more than 20 years in fact, but on a formal basis ever since the Alma-Ata meeting, the concept of primary care and utilization of properly trained nonprofessional personnel has been universally accepted. This is a concept that can be applied to any medical care system, and when it is properly applied it clearly and quickly helps to reduce costs and achieve the goal of providing minimum care for all. Unfortunately, the concept has been debased in some areas so that there is a risk of it being turned into "second-class medicine." This must be avoided, first by adequate supervision, and second with flexible administration that ensures that personnel always have available everything needed to care for patients efficiently and swiftly up to the limits of their training. Something else of equal importance in an effective primary care system is round-the-clock availability of rapid communications and efficient transportation for transferring all patients who need care to a higher level. Indeed, without reliable communications and transportation the system will easily become discredited.

In view of the serious crisis besetting the health sector, alternatives of this kind that place emphasis on health self-care and disease prevention and management have to be given priority in the countries of the Third World in order to prevent excessive consumption of medical care that is either not widely available or is beyond the reach of large groups of the population. The World Bank study does not give this alternative the importance that it manifestly warrants.

The Crisis of the Eighties

The financial crisis in which the health sector presently finds itself did not come about in a vacuum; rather, it is part of a general crisis occurring on a disturbingly large scale throughout the Third World. Governments are overwhelmed by external debt and growing interest obligations, frustrated by their dependence on world prices for export products, crushed by the high prices they have to pay for essential imports, and burdened by the protectionist policies of the creditor countries. For all these reasons, they find it difficult to allocate the sums needed for acceptable and equitable health services.

The economic depression we have been suffering for years now is probably equal in magnitude to that of 1929. The prime difference is that it has been managed and disguised, almost always to the Third World's disadvantage. But it was true before and it is true now that when governments are in deep economic difficulties, the great majority of their people suffer the consequences acutely.

In the case of health, the problem assumes tragic proportions. Erosion of the currency's purchasing power, capital flight, and the resulting rise in unemployment help to aggravate the crisis.

The affirmation that individuals who can are going to "willingly pay" for direct health services for themselves and their families, and so help to ease the pressure on the general budget, is therefore open to question. It is questionable because those people have already been paying, and because their numbers are shrinking from day to day. The rise in the cost of medical care, which has been disproportionately greater than the rise in costs of other goods and services, has created a need to expand the concept of "catastrophic illness" used by United States President John F. Kennedy. Today, for the great majority of our people, any sickness that cannot be treated at the primary level constitutes a catastrophe if it has to be financed by the individual, even with the help of his family. Moreover, in the Third World the relationship between public and private health sector services is too complex and interdependent for one to expect that such an approach would resolve the situation to the benefit of the majority.

Timeliness of the Study

The foregoing comments are not intended to disparage the World Bank study, but on the contrary to arouse the curiosity of the people and entities directly or indirectly involved in financing of the health sector—in the hope that this will prompt many different forums of discussion from which positive results will ultimately flow. While it is true that adequate financing is not sufficient by itself to solve a complex and shifting problem with multiple causes, it is no less true that without funding even the most urgent goals are unattainable.

The study comes at an appropriate time, in view of the crisis that the health sector is experiencing, both within and outside the Third World. Accordingly, we suggest that it be read and analyzed to assist decision-making. This will enable it to serve as something more than just one World Bank policy document out of harmony with other agencies having the same end purpose—namely, health recovery and preservation. For the health system to which we aspire must be humane and effective; must have costs compatible with the State's resources; must offer real possibilities for equitable participation by the people; and, finally, must permit the overall costs of the health services to be covered and must include participation by the nongovernment sectors in provision of these services.