FINANCING AS AN INSTRUMENT OF PUBLIC POLICY[1]

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Point of Departure

Although largely omitted for many years from the central debates on health, the topic of financing is increasingly becoming a focal point for examining the economic feasibility, distributive effects, political desirability, and ethical implications of care programs. The importance of the subject is matched, in the case of the study under review, by the weight of the agency responsible for its publication. The fact is that ever since 1980 the World Bank has been exercising a growing influence on the design, planning, and financing of the health services of many developing countries, an influence derived in material terms from over US$100 million that the Bank lends each year for health projects.

Publication of the study *Financing Health Services in Developing Countries: An Agenda for Reform* is accordingly an event of the first order. In view of the economic influence of the World Bank and the thoroughness and depth of the study presented, the document needs to be examined with care and discussed in detail.

The purpose of the study is unquestionably ambitious: to propose an alternative approach for financing health care. In essence, this approach revolves around one central thesis—that permanent resolution of the health systems' financial and administrative problems requires reduced government responsibility for financing those services that, in the World Bank's view, offer limited benefits for society as a whole. This reduced responsibility would free up the resources needed to pay for services of demonstrated public utility.

This point of departure is pessimistic, since it notes that public expenditures on health will not be able to increase very much, notwithstanding the considerable current shortfall in most developing countries. However, the proposal is not a simple reaction intended to ease the effects of the present financial crisis on the health systems. On the contrary, it advocates an entirely new approach that, according to the authors, "makes sense even in countries where the overall budget problem, as such, is not severe."

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Basis for Analysis

One of the merits of the study is that it obliges us to recognize problems and contradictions that define dilemmas requiring difficult decisions. Thus, there is a potential contradiction between what we could term two "universes of health needs," defined by unequal development of the epidemiologic transition *(1)*. The study correctly observes that the prospects for continuing to reduce morbidity and mortality depend on the capacity to offer basic health services to the poor; but this capacity is threatened by the growing demand for costly hospital services resulting from urbanization, rising incomes, and aging of the population. To the extent that social inequalities lead to an "epidemiologic polarization" *(2)* of the population of our countries, there is a real risk that the diseases termed "post-transitional"—which are characteristic of the developed countries and linked with chronic degenerative ailments, mental health problems, accidents, and violence—will absorb a large part of the resources needed for care of pretransitional diseases connected with infections and basic scarcities of food, housing, and sanitation.

A prime analytical question concerning the World Bank study has to do with the assumption that posttransitional pathology is a problem of the "rich," while pretransitional pathology is a problem of the "poor." Reality is much more complex than this simplistic view might suggest. The epidemiologic polarization of society derives not so much from vague categories of "rich" and "poor" as from division into a rural world based on an agrarian economy and an urban world based on an industrial and service economy. No reasonable definition of "rich" can be stretched to include urban workers barely getting by on a minimum wage or the armies of underemployed who flock in from the countryside. These populations suffer the highest rates of accidents, violence, and mental illness. In other words, it is the poor who suffer most from both types of pathology. It is therefore the poor, both rural and urban, who tend to need more services, both of a simple preventive nature and a complex curative nature. It is not correct to presume that the latter services are mainly for the rich.

There is another incorrect assumption in the World Bank study, namely the idea that curative services only produce private benefits, i.e., benefits to the direct consumers of the services and not to society as a whole. This assumption is based on a very narrow definition of the types of health services that are "public goods," i.e., services whose benefits are received by all of society. The precise dividing line between individual and social benefits is not so clearcut as the study appears to suggest. According to the authors, only a few services (nonpersonal services and those aimed at controlling communicable diseases) generate external benefits. But can we really presume, for example, that curative care for a mother or a productive

worker benefits that person alone and is of no value to the rest of society? Can we presume that prevention of mental deficiencies by means of appropriate prenatal care is without social benefits? The fact of the matter is that, with the exception of a few cosmetic or trivial services, the great majority of health care activities generate positive external effects.

The two foregoing ideas serve to support the study's central proposal: Separate curative services, which are presumed to benefit solely rich individuals, from the "public goods" that benefit all of society. The first type of service would be paid for by the consumer, because in fact the collective society, represented by the Government, has no reason to foot the bill for services whose benefits are enjoyed by individuals. The Government would then be able to concentrate its limited resources on financing the "public goods" and certain basic personal services for the poor.

The authors of the study are quite right in emphasizing that governments should allocate highest priority to the preventive services, especially those intended for disadvantaged social groups. However, it is questionable whether this can be accomplished by separating personal from public services. This proposal, which the authors present as an innovative alternative, brings us back, in actual fact, to an old and artificial separation of responsibilities that has already been abandoned virtually everywhere in the world. That is, the proposal harks back strongly to the old division between a dominant curative services sector, located in the private domain, and a parallel government sector responsible for environmental sanitation services, control of communicable diseases, and prevention and basic treatment services for the poor, in accordance with the outdated definition of public health. Very few countries still organize their health systems in this manner. One of them, however, is the United States, which the authors appear to be taking as the model for many of their proposals, despite the multiple problems involving coverage, accessibility, cost, and financing that beset its health services system.

This is not the most appropriate place for making a detailed analysis of the historical reasons why most countries have been moving away from the fragmentary care model that the authors of the study are now dusting off. It is sufficient to note that the advantages of an integral organization are recognized in such fundamental documents as the Declaration of Alma-Ata; that the worldwide trend toward integration of services derives among other things from the difficulty of separating the needs of the population in accordance with the preestablished dichotomies of prevention *versus* treatment or personal *versus* nonpersonal services; and that the greater the degree of fragmentation, the more the population's chances for effective control over the services is reduced.

Moreover, mobilization of the State's powers to achieve health goals has not been based solely on utilitarian calculations concerning externalities or the free-rider problem, or on an effort to offset the many imperfections of the medical services market. Public participation has been spurred much more by a concept of the human being as a national resource *(3)* or a normative view of what every society ought to offer its members *(4)*. Thus, health protection can be seen as a social right that is

distributed according to the principle of citizenship *(5)*. As such, it is part of the "model of society" that defines the quality of life that the collective community aspires to guarantee for its citizens. What is more, health care cannot be considered part of a system of rewards for individual effort; on the contrary, it constitutes an essential part of the equality of opportunities that forms the ethical basis for distribution of goods in any society. Unfortunately, the World Bank document does not analyze or discuss any of these principles.

Four Policy Reforms

While the general proposal of the document is questionable, certain of the specific policies it suggests warrant detailed consideration because they represent interesting solutions, especially if they are examined from a pragmatic and nonideologic viewpoint. The Bank proposes four policies, which are conceived as one whole: (1) charging users for services; (2) providing insurance or other protection against risks; (3) making effective use of nongovernment resources; and (4) decentralizing public health services.

1. Charging the users of health services. As regards the charging of fees, this should not be seen exclusively, or even mainly, as a mechanism for extracting resources from the population and transferring them to the health sector, but primarily as a *policy instrument* that can be used to induce certain behaviors on the part of providers and users of the services that are considered appropriate for achieving socially desirable health objectives.

The efficacy of the different methods of applying charges to achieve these objectives is not equal. Providing services at no cost to users, which can be viewed as a form of charging, has the advantage of stimulating demand among the poorest groups—although, as the study notes, demand is also critically dependent upon the accessibility and quality of the services. Unfortunately, the cost to the population does not disappear if there are no monetary fees, but is transformed into a price that is paid by waiting, protracted bureaucratic procedures, and loss of control on the part of the users. In addition, the existence of free services may in effect subsidize provision of those services to segments of the population that do not need them.

The alternative, however, is not to institute indiscriminate charges for every service provided, as appears to be suggested by the study; for even if they are subsidized, such charges discourage people from seeking care early and reduce utilization of preventive services, while also being regressive in terms of income distribution. One attractive option is a system of differential fees that are charged only for some services

and to some patients. A system of this type has great potential as an instrument for prompting use of certain early and preventive services, and also for furthering equity to the advantage of the lowest-income and neediest patients. For instance, differential fees can be based on four criteria that are not mutually independent: the type of unit where the service is provided, the type of locality where the unit is located, the type of service provided, and the patient's socioeconomic status.

2. Provision of insurance or other risk coverage. Another option that offers many advantages is some system of insurance or prepayment, an approach that the World Bank energetically advocates in what is one of the most valuable parts of the document. Although the Bank appears to favor coverage only for financially catastrophic risks, more comprehensive coverage can be envisaged. Structured by means of a good system of deductibles, a scheme of this sort can stimulate utilization of preventive services and discourage excessive demand.

In any event, protective mechanisms will have to be put in place to prevent charges or insurance premiums from causing the central budgetary authorities to cut back health allocations from general public funds, since the charges would then simply increase the burden on the population and not the financing available for the health services.

3. Effective use of nongovernment resources. The third policy proposed by the study, promotion of private enterprise, involves a number of conceptual and strategic problems. In the first place, the question can be asked: What is the private sector? The study seems to view all nongovernment providers and establishments as somewhat homogeneous. But are cooperative health plans, religious missions, and big multinational hospital chains really comparable? Do small medical entrepreneurs who live off their private practices, empirical midwives, specialist proprietors of large medical diagnostic firms, and druggists warrant the same treatment from the State? It is very probable that the private nonprofit sector is more similar to the public sector than the private for-profit sector. And while there are many arguments in favor of encouraging private community and nonprofit organizations, the same arguments do not necessarily apply to for-profit organizations. In fact, it must be asked whether the latter *need* additional incentives over and above those they already have. For example, in many countries expenditures on private medical services can be deducted from income tax. This amounts to a net subsidy from all society to the segments that are economically best off.

Besides not differentiating between the various segments of the private sector, the study puts forward some proposals that need to be thought through in much greater detail. It is claimed, for example, that in many Latin American countries the private sector could provide a large part or even all curative care. What would then happen in such a case, with all the social investments in health care already in place in those countries? How could the abuses that have already occurred in many countries following large-scale contracting of private services by public funds

and social security systems be prevented? Would not the setting up of the necessary control mechanisms give rise to a bureaucracy even larger than the one presently employed in providing services directly?

Furthermore, there is no evidence that the private sector, especially if it is organized on the basis of monopolies, provides services of better quality, offers patients better treatment, or is more efficient; still less does it increase equity, as the study affirms. To achieve some of these objectives, the authors recommend that there be greater competition. The question is whether this is really feasible. It must not be forgotten that the market for medical services is, so to speak, perfectly imperfect; in other words, that it displays all the imperfections identified by economists. In addition to the many external elements to which we have already referred, there are marked asymmetries between the information possessed by the doctors and what the consumers know (which is one major reason why they go to the doctors), significant legal barriers to entry into the market by new producers, a considerable facility on the part of producers for inducing demand, very definite limits on rationality, the fact that expenditure on services is viewed not as consumption but as an investment in health, etc. Even assuming that competition is desirable and possible, there are no convincing proofs, not even in the United States, that it effectively contributes to bringing the cost of medical care down. It would appear more sensible to explore options—something that the study does not consider—for increasing the efficiency and responsibility of the public agencies. Rather than abandoning them, steps should be taken to link remuneration more closely to performance and to increase the organized participation of users in decision-making.

4. Decentralization of government health services. Decentralization, the last of the policies proposed in the study, has as one of its main objectives making the public services more sensitive to the users' needs. The advantages of decentralization have been demonstrated in countries such as Mexico *(6)*. It is sufficient to underscore here that there may be a potential conflict between the local efficiency promoted by decentralization and national equity. That is, the considerable inequalities that usually exist between different regions may be accentuated by decentralization if the richer regions—which are also the ones with the best health levels—are the ones that organize more efficient local health systems and receive the most resources. Accordingly, besides having local bodies, it is necessary that a national evaluation level be retained which will focus on assessing the benefits of the health system as a whole and weighing the equitable distribution of those benefits.

Conclusion

To sum up, notwithstanding the World Bank's insistence that its four proposals be considered as one whole, the fact is that some of them are very reasonable while others are questionable. Contrary to what the study suggests, it is likely that a large share of the problems besetting the health systems do not derive from hypertrophy of the public apparatus but from the weakness of that apparatus and its inability to resist the pressure of private interests that promote fragmentation of the health system, absence of effective controls, and cost inflation. Solving these problems will not result in weakening of the public sector, but rather will serve to strengthen it as a vehicle for promoting greater community self-sufficiency in the provision of health services.

In any event, it is clear that there are considerable gaps in what is known about the feasibility and real effects of different—present and future—financing formulas. The World Bank has recognized the need to support more research on this priority topic. To accomplish this, concrete measures will have to be taken to make it possible to develop national capabilities for research on health systems. Only in this way will it be possible to generate the knowledge needed to sustain new financing approaches consistent with the epidemiologic, political, and economic complexity of today's world.

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References

1 Omran, A. R. The epidemiologic transition: A theory of the epidemiology of population change. *Milbank Mem Fund Q* 49(4):509–538, 1971.

2 Soberón, G., J. Frenk, and J. Sepúlveda. The health care reform in Mexico: Before and after the 1985 earthquakes. *Am J Public Health* 76(6):673–680, 1986.

3 Foucault, M. La crisis de la medicina o la crisis de la antimedicina. *Educ Med Salud* 10(2):152–170, 1976.

4 Steiner, P. O. The Public Sector and the Public Interest. In: R. H. Haveman and J. Magolis (eds.). *Public Expenditure and Policy Analysis (second ed.)*. Rand McNally, Chicago, 1977, pp. 27–66.

5 Frenk, J. and A. Donabedian. State intervention in medical care: Types, trends and variables. *Health Polic Plann* 2(1):17–31, 1987.

6 De la Madrid, M., G. Soberón A., et al. La decentralización de los servicios de salud: El caso de México. Grupo Editorial M. Porrúa, Mexico City, 1986.