

Investing in Health: The 1993 World Development Report of the World Bank

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It might be expected that when a development finance agency like the World Bank devotes a major annual report to the subject of health, it would analyze primarily health's contribution to economic productivity and slight the non-economic value of health. While the Bank's 1993 *World Development Report: Investing in Health* recognizes that better health often means more productive workers (and more educable schoolchildren), and supports this view with considerable evidence and analysis, the focus of the *Report* is health valued for its own sake, as an objective and not only a means to development. This focus creates the need for a noneconomic unit of measure for ill health, which motivates one of the principal statistical exercises behind the analysis: the estimation of the Global Burden of Disease, or the total healthy life years lost to premature mortality and to disability. The "disability-adjusted life years" (DALYs) in which this loss is measured allow comparisons across regions, sexes, age groups, diseases, and risk factors. The world average for this loss amounts to about one-fourth of everyone's potential healthy life. The average for Latin America and the Caribbean is only slightly lower.

The decision to value health in its own terms means that the Bank does not put a dollar value on life or on good health.

This implies that health benefits cannot be compared to benefits in entirely different forms, such as increased income or more education. The links from income and education to and from health are explored in detail, but the *Report* does not try to tell countries how much to invest in health versus other objectives. When a given investment provides two or more kinds of benefit, decisions become more complicated. For example, piped safe water not only reduces many health risks but also saves much time and effort. The health gains alone may not justify the investment, but the total benefits often do. Societies regularly make choices among different objectives; what the *Report* offers is a more rational basis for choices among different investments or activities that improve health, leaving open the social choice of how to value health relative to other desiderata.

Given an estimate of the "burden of disease" from different causes, it might seem that a disease or condition should receive priority in proportion to how much early death or disability it causes. Unfortunately, we know how to reduce the burden from some causes much more easily than from others. When little or nothing can be done about a health problem, it may be a priority for research but not for action.

It also does not generally make sense to define priorities according to subsets of the population, even when they are clearly "vulnerable groups." Some of the problems to which the group is vulnerable have easy solutions, as with immunization against some diseases of young children. Others, such as congen-

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ital malformations, do not. And if a solution exists, it is unethical to deny it to people simply because the group in which they are classified is not vulnerable to poor health from other causes.

The *Report* admits one vulnerable group that should have priority—the poor. This is not only because they get sick and die more readily than the nonpoor, important though that is. It is because it takes resources to protect oneself from disease and injury, or to treat ill health, and the poor are by definition vulnerable economically. Governments have a special responsibility to the poor because they can do less for themselves. When subsidies flow from one income group to another, they should always run from the richer to the poorer; subsidies that discriminate against the poor are unethical and a misuse of public resources.

The only other sensible basis on which to choose among health-improving actions is that of *interventions*, where decisions on priorities result from taking account of the existence of both a substantial disease burden and an intervention that is effective against it, at reasonable cost. Ranking interventions by the cost incurred to gain an additional healthy life year provides a way to maximize the total health improvement from any level of expenditure, except for the problems introduced by interventions with mixed benefits. To insist on cost-effectiveness—properly understood—as the criterion for action is not in conflict with compassion or equity, but is actually a means to achieve these ends.

Since the Bank lends money and gives advice to governments, the *Report* naturally focuses on the question of what the public sector should do in health. Cost-effectiveness provides a criterion for choosing which interventions to finance with public money, and leads to the definition of an “essential package” of care, which includes both public health meas-

ures and clinical interventions. Such a package should vary among countries according to their disease burden and their ability and willingness to spend money on health. In every case, it should include a minimum set of interventions that could be provided for US\$ 12 to US\$ 22 per person per year. The Bank estimates that in a typical Latin American country, universal coverage with this package could eliminate 15% of the remaining burden of disease. Public resources spent in this way would both provide high value for the money and concentrate benefits on the poor.

It is clear that a government should not think like an individual doctor, and much less like an individual patient, concerned only with his or her immediate health problem. Only governments can think about the entire health situation of the country and the best means to improve it, even though—since the demand for health care is insatiable—there will always be some intervention which cannot be provided or some patient who does not receive all the care he or she would like.

In addition to the criteria of favoring the poor and of paying for cost-effective interventions, the *Report* makes three strong arguments for active public intervention in the health sector—arguments that depend on the fact that this sector is different in some important ways from other sectors. These arguments have nothing to do with the emotional freight of illness or of life and death: they arise from economic reasoning, and they justify more and better public intervention than many governments now undertake. One is that governments should provide those relatively few, but extremely important, health-related activities that are public goods. Chief among these is information, not only for the government's own use but to improve the ability of providers and individuals to take care of their own health. Another rationale is for

governments to subsidize or promote activities providing substantial externalities—instances in which the patient benefits but others do also. The control of communicable diseases such as tuberculosis and STDs is the clearest example. The third argument is that governments have a responsibility to control or offset the “market failures” that readily occur in health care and particularly in health insurance, failures that can lead simul-

taneously to higher cost, poorer health, and less equity. To do this requires that governments concern themselves less with providing health care and far more with regulating providers and insurers to assure quality and avoid inequities. They must also promote competitive provision and efficiency in the use of both public and private resources. These responsibilities cannot be left to the market; it is vital that governments discharge them well.



Good News on Injectables Contraceptives

The findings of two WHO meetings of experts provided encouraging news for women who use or would like to use injectable contraceptives. Meeting in Geneva in late May, a panel of epidemiologists, clinicians, and public health specialists concluded that the progestin-only contraceptive DMPA (widely known under the brand name Depo-Provera) does not increase the overall risk of breast cancer, is not linked epidemiologically to either cervical or ovarian cancer, and may protect against endometrial cancer. At another meeting in early June, international experts in human reproduction, gynecology, and contraceptive delivery research concluded that two combination injectable contraceptives, known as Cyclofem and Mesigyna, were highly effective (nearly 100%) at blocking pregnancy and had a relatively low incidence of side effects.

Unlike DMPA, which is administered every 3 months, these new preparations (which were developed by WHO's Special Program of Research, Development, and Research Training in Human Reproduction) are injected once a month. Because they combine an estrogen with a progestin, they rarely cause the menstrual cycle irregularities that are commonly associated with DMPA and can result in discontinuation of that method. Large-scale clinical trials showed their high efficacy and good acceptance by users.

Sources: World Health Organization, Press Release WHO/41, 1 June 1993, and Press Release WHO/43, 4 June 1993.