THE FINANCING OF HEALTH: CONDITIONS FOR EFFECTIVENESS AND EQUITY[1]

David Tejada de Rivero[2]

The World Bank study-proposal on financing health services[3] unquestionably constitutes an important agenda for urgently needed reforms in this field. Indeed, the World Bank's Population, Health, and Nutrition Department has opened the debate on propositions that have been needing the endorsement of international agencies for some considerable time.

Limitations of the Commentary

Commenting on this study is an interesting and difficult task. The problems analyzed, the examples selected, and the policies proposed are all developed with great thoroughness and yet in a clear and simple manner that evokes a response. This is a document that makes one think and obliges one to revise views and reconsider experiences. The difficulty resides in the fact that we would very much like to comment on each and every one of the points discussed and to develop others that are either implicit in the study or else do not feature in it. This could lead us to write a full-length book instead of a commentary; especially since we could draw on extensive recent personal experience concerning the same ideas. This commentary will, therefore, be unbalanced and incomplete, overselective in the topics on which it concentrates while omitting many interesting points.

A Political Commitment and an Essential Complement

The study asserts that for change to be accomplished there has to be a serious political commitment on the part of the governments involved. This requirement must also apply to the international agencies—which in the final analysis are nothing else but the governments acting collectively. However, political commitment requires an essential complement: "political courage." This is what is demonstrated by the study when it puts forward proposals designed to demolish old positions that have so far been dogmatically defended solely because at some particular time they constituted statements of principle—even though when attempts are made to apply them they generally produce results contrary to the principles in question. One example is the principle that "all health services should be free." In some countries this has even been enshrined as a constitu-

---

[1] This contribution has previously been published in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*, vol. 103, no. 6, 1987, pp. 725–733.

[2] Former Minister of Health of Peru. Mailing address: Av. Javier Prado 1445, Depto. 502, San Isidro, Lima, Peru.

[3] World Bank, *Financing Health Services in Developing Countries: An Agenda for Reform, a World Bank Policy Study*, Washington, D.C., 1987.

tional right, alongside other important social aspirations. No one questions that the original intent was to benefit the poor, but the end result in practice has at times been subsidization of the least needy.

The study also provides an excellent model of how topics of this type should be presented. It is thorough, objective, and based on the experiences of different countries. It does not dwell at length on an explanation of the problem, but puts forward specific action proposals. In so doing it will help to "demystify" certain dogmas that still haunt politicians and technicians dealing with a social entity that is as complex, unstructured, and open as the health system.

The Essence of the Problem

All countries—both the developing ones and those classified as industrialized—today face a problem with no apparent solution. On the one hand there is rapid and continuous scientific and technological development in the health field. This is applied mostly to the diagnosis and treatment of diseases, and not necessarily to protection of health or preventive medicine. There is also aggressive and effective commercialization of this development, and health services personnel who are eager to lay hands on the most advanced and complex of this commercialized technology. New devices and equipment, or else new versions or generations of what is currently available, are continually being brought out (which means that technological obsolescence occurs a number of times faster than wearing out from normal use). With very few exceptions, the technological improvement is marginal, but costs are growing exponentially. On the other hand, the financial resources allocated to the public sector health programs tend to remain static or get cut back—both in real terms and as percentages of total public spending, gross domestic product (GDP), income, or virtually any other yardstick.

What is most serious is that commercialization of scientific and technological advances is not being accomplished so aggressively to promote better ways of life (health in the positive sense) and disease prevention, perhaps because these are programs and services that the authors of the study classify as "low-cost and high-efficiency."

The interaction of these two situations deserves special attention in the study, which rightly asserts that in the foreseeable future it will not be possible for government efforts to improve the public health to be based upon increasing public expenditures funded by taxation or credit or reallocation of public funds, even in cases where such increases and reallocations are fully justified on economic and social grounds.

The study underscores the fact that somebody always has to pay the cost of health services. What has received

very little attention (beyond formal financing classifications) is who pays for them in the end and who winds up being the real beneficiary (beyond average and undiscriminating statistics of the production of services). Where there is regressive taxation, with a predominance of indirect taxes, and where there is significant tax evasion (very common in developing countries), those who have less and those who do not use the services pay relatively more.

An Interesting and True Hypothesis

The study also draws attention to an interesting point: the differentiation of health services according to their effect on the users. There are activities or services whose effects are direct and limited to the particular user, who will thus be the sole beneficiary. On the other hand, there are other activities whose direct or indirect effects benefit population groups or the community in general, although they act on individuals.

This working hypothesis appears true and can easily be developed by applying the criteria inherent in any classification. It would also explain, in part, the users' behavior in accepting or rejecting a requirement to make some form of payment for the services they use. In using this approach other factors could also be considered that would facilitate the necessary classification, even though they have a different effect—such as an individual's perception of a change in health. There are, for instance, serious pathologic processes that begin without any signs or symptoms, so that they do not generate a spontaneous demand for services.

Health Sector Problems

The list of three main health sector problems referred to in the study could be supplemented with others of equal or greater importance. However, the three selected are pertinent—among other things because they actually exist in a great majority of countries.

Allocation: insufficient expenditure on cost-effective health-related activities. The internal imbalance in health expenditures is an irrefutable fact that has to be recognized as a problem that demands immediate action. Public expenditure on promotional or preventive programs aimed at the general community or at special high-risk groups is continually being cut back. This is happening largely because curative care services for individuals are accounting for steadily increasing proportions of public health expenditure. The political decision-makers are reluctant (lack the political courage) to change this situation because the desire for curative medical and hospital care services evokes a "political demand" on the part of both users and providers of these services. Historically, this demand has grown and consolidated itself among users because of the incorrect association of sickness with health, of curative services with health services, and of effectiveness with complexity; and it has done so among providers because their training is technology-

dominated and because they get a sense of professional achievement from a high-technology work environment.

Internal inefficiency of public programs. It is a fact that health programs and services are generally inefficient, especially in the public sector. Indeed, efficiency is the exception. However, it could not be otherwise, given the sector's considerable resource constraints and lack of management capabilities. Also, while costs are soaring all the time, the funding allocated to health is steadily shrinking in real terms, and cuts have to be made somewhere. In countries with acute inflation problems, the wage and salary demands of the providers are a "political demand" that is generally satisfied by freezing or trimming expenditures for nonpersonnel inputs. This means that there are no appropriations available for maintenance, and also that the funds allocated for procuring medications and other critical inputs are insufficient.

It is also true that the hospitals are overloaded and congested, while there is chronic underutilization of peripheral services. We realize that "low-level equipment and installation" conveys a negative social message that contributes to underutilization of peripheral services. The fact is that virtually everybody who can go directly to a hospital prefers to do so—a preference encouraged by the manifest poverty of the peripheral services, and also by the functional and architectural design of the hospital.

The topic of hospitals warrants a digression. In practice the hospital is still viewed as a luxurious fortress (at least by comparison with other facilities) in which the staff is enclosed, incommunicado, and waits for patients to arrive. Accordingly, the very existence of hospital outpatient services provides one reason why users prefer not to employ peripheral services. The hospital does not operate as part of a decentralized system that could have its external outpatient facilities (in the real sense of the term), together with beds for preparation and follow-up care, in the peripheral services that are so much less expensive. Another fact is that referral and counter-referral of patients from the peripheral services to the hospital and vice-versa is something that exists in the technical guidelines and in official reports but that does not happen in fact in the great majority of cases. For these reasons, at the same time as they face up to the financing problems, the countries and international agencies also ought to grapple with the pressing question of the functional and architectural form that should be taken by a new hospital—a "support" hospital that should be part of a fluid and dynamic system, communicating both internally and with the outside, operating in conjunction with the peripheral services as part of one indivisible, functional whole. Developing such facilities will require the same political courage as the four proposed financing reforms. It is sufficient to read the

history of hospitals to understand that they were first of all intended as places for the incurably sick, and that up to the present they have been viewed in terms of equipment technology and instrument technology. Perhaps the time has come to design a hospital that can serve as a component of an integrated and indivisible system, perform promotional, preventive, and recovery functions, and be a facility in which the community has a real and active role.

Regarding lack of equity in the distribution of the benefits derived from health services, this is a consequence of the past accumulation of mistaken policies adopted to deal with health problems. It is also a reflection in the health field of the structural problems and social injustice prevalent in a great majority of developing countries. The reforms put forward in the study will not, of course, solve the basic problem; but they undoubtedly represent a positive and feasible step that deserves every support in order that it may be implemented.

Four Policy Reforms

The four policy reforms advocated in the World Bank study do in effect constitute a positive and feasible agenda. This is not to say that their application will be easy, as is acknowledged. They will require political commitment and above all political honesty and courage. Those who have the power and the capability to make political decisions will always have two possible courses of action. One is to wait or try to find the direction in which public opinion is moving (which in itself amounts to implicit recognition of the permanent instability and variability of public opinion) and then, on the basis of what the opinion polls say, to opt for what has already apparently received public approval. The other option is to place the proposed political decision before public opinion, justifying it and explaining it with supporting information and seeking in this way to obtain a consensus or majority approval. The latter course is the one that ought to be adopted in dealing with the problem of health services financing. For the developing countries, these four policy reforms are vital.

A strategy will be needed in each country. This must necessarily be a "political" strategy and not just a technically sound proposal. In addition to being based on appropriate economic, technical, and legal studies, this strategy must rest on a general political analysis and analysis of the health sector, and must take into consideration all the components of a political process: the different interest, influence, pressure, and power groups, and the different channels, mechanisms, and means for amplifying demands. Hence, there cannot be one single uniform model or one international scheme for carrying out the strategies in the countries. Rather, there will invariably be a need for political decisions and political will, together with thorough studies and a major effort to inform and educate the different segments of public opinion.

1. Charging the users of health services. The study suggests a number of options and methods by which user charges can be implemented; some of

these, such as differential fees, are quite difficult to apply. However, the most important thing is the principle that payment for these services will be required from all except those unable to pay. This principle, at the opposite end of the scale from provision of all services free of charge, is ultimately fairer—because in most cases free services end up benefiting those who can and should pay and always discriminate in practice.

2. Provision of insurance or other risk coverage. Expansion of social security—which is not the same as increasing the coverage of public social security institutions—is a pressing and immediate task. In Latin America, where there is tradition and experience in this field, reforms are also needed that will look into and change where necessary the principles upon which the financing of social security is based. This financing of social security is not the same as the financing of the health services. Thus, for example, experience shows that in countries with tax systems where indirect taxes not only predominate but are imposed largely on essential consumer goods, those who are really contributing to the financing of social security are not always the formal contributors—employers and employees—but are apt to be those who consume the goods taxed and in so doing pay taxes, especially since employers include their formal contribution costs in their production costs.

3. Effective use of nongovernment resources. A very important point, and another in urgent need of "demystifying," is the need to stimulate, promote, facilitate, and make better use of the nongovernment sector's resources and readiness to serve. State control of the social services is a false panacea that is still clung to in certain political and technical circles. The truth in practice is quite different: The public sector and government resources alone will never be able to handle the problems of health so as to achieve full coverage with efficient services that have a positive impact on the health of the entire population. Without private sector participation, especially through volunteers, no government will be able to achieve the goal of health for all.

The study cites different types of private sector participation but is timid about including the large nonpublic sector made up of informal and unofficial community organizations. While it does mention community-run cooperative insurance and health plans, it does not suggest, even in principle, that there should be direct and permanent participation by the informally organized community. We are referring here to community participation in the entire breadth of health development: in defining the needs felt by the community (which at times are very different from those determined by technocrats or bureaucrats); in prioritizing these needs; in determining the most appropriate and feasible ways of

meeting them, having first-hand awareness of resource constraints and other limitations; in selecting the technologies that will be used; in planning programs; and in executing programs; and in follow-up, supervision, and social control.

Within this context the Government must take the big step of initiating specific processes for transferring the running of the health services to the organized community. However, as the study also notes, the Government would retain an important oversight, guidance, promotional, and normative role that it is currently unable to perform as it should, owing to the constant pressure of day-to-day contingencies faced by the centralized and bureaucraticized management of the health services.

4. Decentralization of government health services. This policy is not only a prerequisite for achieving significant reform in financing the services but also for being able to make progress toward extending coverage to the entire population. There can be no doubt that in the more disadvantaged countries lacking good roads, means of communication, and transport, and commonly possessing scattered and isolated populations, decentralization of health services ought to be seen as one of the best ways of making the system efficient and effective.

However, this decentralization has to be real, not just a formal policy declaration that is never implemented. The countries that have still not included decentralization as a basic goal in their formal health policy documents are very few in number. Nevertheless, this virtually unanimous trend on paper is not matched by reality. In general, decentralization is declared but not put into practice. It must be acknowledged that there is still a fear of effective decentralization. The fact is that there is no real decentralization when decision-making power and authority to directly manage financial, human, and material resources are not actually transferred. It is claimed that the local levels are not prepared, but this should not be any reason for not preparing them as quickly as possible, and there is no better and more effective preparation than actual practice.

In countries that have seriously initiated genuine decentralization supported by legal instruments—an obligatory legal process laid down in an organic health law, concrete and specific provisions in the budgetary laws, and detailed rules and instructions—the decentralization process has nevertheless proven very difficult. This situation serves to demonstrate that at times a political decision, political courage, and even political will on the part of a government, are not sufficient unless other changes are promoted at the same time, especially changes in the mentality and daily behavior of those who work at all levels of the health system. Otherwise, in the central levels there will never be any shortage of arguments for not complying with the legal requirements. The same thing occurs at the local levels when it is found that the making of decisions and real exercise of authority inevitably affect interests, generate conflicts, or simply do not satisfy everybody. People then begin to think logically of the way things used to be done, when all such problems were passed back up to the central level.

Strengthening of the central level is indispensable for real and effective decentralization, but the central level itself has to be made into something very different from what it is now with its centralized and bureaucratic procedures. In addition, basic and in-service training that is both intensive and provided on an emergency basis, utilizing nontraditional forms and methods, is vital.

Other Reform Policies

In parallel with reform in the financing of the health services, other equally fundamental measures will have to be taken. The need for combined multisectoral action and such action's permanent influence on the policies of other sectors must not be forgotten. Nothing could improve the level of health more or do more to change the prevalent structure of pathology in the developing countries than provision of safe water, basic sanitation, refuse collection, adequate availability of foodstuffs, and other conditions that are the responsibility of other sectors, even though they constitute important parts of the health environment. In addition, the ability to make better use of the health services and, in the bosom of the family, to prevent a considerable number of diseases or detect them in their early stages will depend on information and education that have to be provided in a regular manner through the general educational system. It has been demonstrated that in some countries up to 40% of the patients requiring hospitalization would not have needed it if some member of the family had possessed basic information or had received elementary training.

However, as already noted, the main point on which the World Bank study is silent is active participation by the community or by organized people. By this we do not mean the traditional form of participation as labor or support for what the technocrats have decided, but rather participation in the actual running of the health services. It has been found that one cannot speak of real decentralization and more rational use of the services if the behaviors of the users are not changed. The community—the people—has been kept out of the decision-making and management process and has been conditioned to demand things as a result. Thus, the populace insists on more complex services without considering whether they are relevant and effective and without any concern about their cost. This should not surprise us, since when the State adopts a paternalistic approach, the people will always respond with "mendicant" or demanding behavior. Only when the community, through its natural grass-roots organizations, participates directly and effectively in the running of the services will it begin to act with a sense of responsibility, with direct understanding of the

financial constraints, and with realization that the services cost money and someone has to foot the bill.

In a majority of developing countries the people have been organized in multiple and superimposed basic groups, such as mothers' clubs, neighborhood associations, and social and cultural organizations.[4] These groups have been springing up of their own accord, without support from the State (or indeed despite the State), in response to centralist policies, stifling bureaucrats and their involved procedures, and lack of access to state social services. Hence, there is no need to organize the people. There is only a need to encourage their development and responsible action.

A Concrete Proposal

The World Bank document concludes by stating that further studies will be needed. By way of example it lists a number of areas where questions need to be answered, all of which are most valid and relevant, and repeats the Bank's interest in cooperating with the countries in this effort.

What ought to be developed is a non-traditional formula for combining these two points. While further studies will indeed be needed, these should be designed as a methodical and duly programmed follow-up to real and concrete experiments in a group of countries where there is a political commitment to approaching the problem of financing health services along the lines suggested in the study. A special program could be set up in which a number of countries would participate with the coordinated support of the Bank and other international agencies. The commitments of the individual countries would be greatly strengthened by the collective commitment made among themselves and with international organizations. The study would take the form of a carefully prepared follow-up—paralleling the financial and technical support furnished to the countries—so that this study would not be based on isolated and short-term data and experiments but on several national processes in which international support would strengthen, endorse, and empower the reform policies proposed in this vitally important field of financing health services.

---

[4] These organizations will enter into conflict on many occasions; however, conflicts are normal in any social organization. Technocrats and bureaucrats always fear conflict and forget that it is a symptom and sign of social life.