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Commentaries

ECONOMICS AND HEALTH: BEYOND FINANCING[1]

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Introduction

The World Bank's publications, among them the reports issued on the economic and social indicators of the developed and developing countries, together with those on which the Bank's policies are based, exercise an immense influence upon the decisions of governments. These decisions reflect the quality of the documents, particularly as regards the information they analyze. In this respect, the Bank has made itself into a true university in that it disseminates ideas, describes situations, suggests solutions, and justifies solutions with the best data and references available on economic and social problems and the progress of development. The documents are valuable because of their intrinsic content and the soundness of the analyses made for guiding decisions in the countries and influencing teaching and research. They may also acquire greater significance when they establish the Bank's lending policy in particular sectors that the governments concerned have to consider. This is true of the publication *Financing Health Services in Developing Countries: An Agenda for Reform*, which forms part of the World Bank Policy Studies series.

The authors of the study are explicit regarding their intent: "The Bank is one of the few institutions able to press strongly for greater attention to health financing. It is doing so aggressively through routine meetings, through special conferences on the subject, and through interaction with other lending agencies with respect to specific countries."[3]

Our practical interpretation is that governments accepting the diagnosis and reforms contained in the study would be able to get loans from the Bank and from other multilateral or bilateral agencies for implementing those reforms. Hence, the ministers of health bear the great responsibility of examining the proposals and reporting to the decision-makers, especially the president of the republic, regarding the accuracy of the diagnosis of the country's health situation and the possibility of progressively resolving the problems with alternatives differing from

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[3] World Bank, *Financing Health Services in Developing Countries: An Agenda for Reform, a World Bank Policy Study*, Washington, DC, 1987, p. 50.

those indicated by the Bank or else by applying the measures it recommends.

For these reasons I believe it most appropriate for the *Bulletin of PAHO* to be publishing the foregoing summary of this study with commentaries written by public health figures of the Hemisphere, since this will help to ensure wide dissemination in the Americas. The language used by the study, which places heavy emphasis on considerations of an economic nature, is not always easy reading; those not familiar with its special terminology may well have some difficulty following it.

The document is almost solely devoted to examining the financing of health services, an approach that calls for a critical observation by the authors: "The concentration on financing in the present study by no means reflects a diminution of concern with the full range of issues. It does reflect the belief that the reform of financing deserves serious consideration as one part of an overall renewed effort to improve the health status of the populations in developing countries."[4] However, decentralization, the only one of the four reforms proposed not concerned solely with financing, is given no more than partial treatment. Therefore, the governments will have to examine the health sector as a whole and not separate the economic aspects from the other components of a national health policy and corresponding courses of action. Neither should the significant loan and other possibilities be the criterion that dominates the decisions. Rather, the decisions should emerge from a thorough examination of the problems and their priorities based on the information available. This approach will provide a basis for determining measurable objectives with regard to each individual problem that are commensurate with the resources available. This process constitutes the start of the programming cycle. The objectives determined make it possible, in turn, to identify actions for raising the productivity and quality of preventive and curative services and for stimulating active and informed participation by the communities, participation that constitutes the richest potential the countries possess for establishing primary health care.

Ideally, the function of external capital should be to speed the reform process deriving from this examination, for the purpose of reducing morbidity and mortality (especially among the highest-risk groups), extending health services coverage, and improving the population's nutritional status.

Health Sector Diagnosis in the Developing World

The World Bank study's description of the health sector and analysis of its problems are based on methods and a

[4] See page 420 of this issue.

wealth of data that are not commonly used in the Region, a circumstance that serves to underscore the quality of the study. The problems identified are not new ones, of course, but they are very well documented.

Background. We have long known that the investments of both the public and private sectors fall short of apparent needs and real demand. The study makes no reference at all to the deeper causes of this situation. These causes can be found in the countries' economic and social development policies. In a good number of countries the funds exist but are badly invested and woefully administered, waste being the rule rather than the exception. It is a problem of priorities, rational programming, and efficient management that looks beyond the present day. We have referred on other occasions to the spending on arms throughout the world, including the developing countries; this spending greatly exceeds the investments that would be needed for comprehensive primary care, including timely treatment of the diseases occurring with greatest frequency among the high-risk groups.[5] However, even if this in-depth reform in development policy is not possible, a circumstance that is certainly lamentable, there are many possibilities in the health sector for augmenting the resources available and the yield obtainable from them, by reducing waste and duplication of services and by stimulating intersectoral actions and contributions by both urban and rural inhabitants of labor, materials, and also funds.

The economic crisis. The study does not say anything about the consequences of this decade's economic recession and of the adjustment policies recommended by the International Monetary Fund, consequences that have most heavily impacted the social sectors—especially health and nutrition. There is evidence that malnutrition, morbidity, and mortality are on the rise among mothers and children under five in a number of countries—the result of health and nutrition budget cutbacks, unemployment, and, in general, more widespread poverty. In Latin America and the Caribbean this process of social deterioration is still taking place. It is essential, therefore, that any proposed health sector financing system that calls for larger contributions from the people and increases in recurring costs be examined most carefully.

Distribution of the investment in health. We have also known for a considerable time of excessive investment in curative institutional care—sometimes in buildings that are more luxurious than functional—to the detriment of disease prevention and health promotion activities. Also, as the World Bank study notes, there is little doubt that the cost per life saved is much higher in hospitals than in the preventive services and community programs. Moreover, both the curative and hospital care approaches, whatever their levels of financing, are inefficient and produce a low return.

We also know that the public sector health services in some countries lack the elements essential for appropriate

[5] Abraham Horwitz. Reflections on the Effects of Economic Restrictions and Scarcity on Health. Hugh R. Leavell Lecture given at the V International Congress of the World Federation of Public Health Associations, Mexico City, March 1987.

diagnosis and treatment, while the private sector (with the exception of empirical medicine) is more effective but more expensive. This explains to a large degree the low demand for the former.

Nevertheless, we are convinced that the solution cannot lie in eliminating or reducing hospitals, because hospitals are a vital part of the system for timely referral of patients from the peripheral levels of the health infrastructure. "It is the financing of expensive hospital care that needs change, not the existence of the care as such."[6] We would like to add that both in terms of infrastructure and of operating and investment budget, what is needed is a better balance between preventive and curative care in both urban and rural areas.

In the countries with low health services coverage, extension of this coverage needs to be programmed with great care. Building hospitals without at the same time including preventive and curative primary care services and making provision for referral from the hospitals' catchment areas—a mistake commonly made until not very long ago—is something that the governments and financing agencies cannot accept. Conceptually, it is equivalent to separating health promotion and disease prevention from treatment. The consequences of this separation are those that the study describes and that we have to accept, but always with the firm intention of bringing about the changes that are essential for enhancing the efficiency and effectiveness of the available services and reforming the health sector, its priorities, and its resources before investing huge sums in it.

The points made by the study regarding health service supply and demand are known but are presented with a wealth of examples and arguments to justify them. As regards supply, we would emphasize overcentralization and the cost of the services, the known logistics and poor quality problems of the public sector that the study acknowledges as being hard to quantify but that definitely exist. On the demand side, there is inappropriate resource use. People tend to overuse urban hospitals, especially those practicing third-level medicine (in theory the highest quality) while those facilities outside the urban centers have many empty beds.

We would have preferred to read something about the relationship between needs and demand (which are not synonymous) and the supply of health services. To obtain an understanding of this relationship, well-formulated operations research is needed in each country. This would serve to better explain the urgency of health sector reform designed to make the sector more efficient and productive, and the justification for investing funds to strengthen and extend coverage.

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[6] World Bank, *Op. cit.*, p. 18, box 3.

The Remedy Proposed by the Study

The study affirms that "When public budgets must be cut, it is easier, especially in the short run, to cut spending on fuel, drugs, and vehicle and building maintenance than on salaries. Because these inputs are usually a small portion of total costs (typically less than 20%), they must be cut drastically to reduce total spending significantly. The price of a small financial saving is a large drop in the effectiveness of workers.[7]

This statement brings us to consider the remedy proposed by the study, which consists of four components grouped under the heading "Four Policy Reforms." Briefly, they are as follows: (1) charging users of public sector services for curative care; (2) encouraging risk coverage programs, including health insurance; (3) making effective use of nongovernment resources for which people are prepared to pay; and (4) decentralizing the public health services.

It is asserted: "The thrust of the argument throughout this study is that certain health programs with public benefits are now underfunded. As revenue collection in public facilities makes large curative services with private benefits financially self-sustaining, the freed government funds should be absorbed in truly public health activities and in subsidizing curative care for the poor. The situation in every country will be different, but this principle implies that the overall central budgetary allocation to health should be protected for a time when user charges are introduced. Only if and when there is adequate provision of health activities with public benefits and of critical curative care for the poor should a reduction in public funding for health be considered."[8]

In other words, the aim is to progressively increase the payment required for treatment of diseases and, with the exception of the neediest, to allocate the "savings" that the government would make to prevention. To do this, the first step is to start charging a majority of the users of medical care services something. The object is laudable if the approach is feasible. The study identifies a number of latent problems and dangers of the reforms.

Private services. The World Bank study shows a preference for use of private sector (i.e., nongovernment) services. The private sector consists of philanthropic institutions and other nonprofit groups, physicians and pharmacists exercising their professions privately, and the informal sector based on traditional empirical medicine. Direct payments to these providers amount, in some countries, to half of all spending on health.

In principle, private sector participation by the institutional private sector in the functions and actions of disease prevention and treatment is acceptable—provided that the national health policy and its priorities are followed and the relevant standards and proce-

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[7] World Bank, *Op. cit.*, p. 20.

[8] World Bank, *Op. cit.*, p. 45.

dures are applied. An equally important requirement is that the health ministry and regional services should exercise systematic supervision for advisory and educational purposes.

It must be recognized that the private practice of medicine has been increasing in the Americas with the rise in household incomes. What is more, the poor turn to private services at great sacrifice when the care available from the state services does not satisfy them. This situation unfortunately appears to be quite common and becomes worse in times of economic crisis such as the developing countries have been experiencing with marked severity this decade. Nothing is more moving than to observe the immense efforts made by a laborer or peasant who literally sells all that he possesses in order to save the life of his mother or father. This is a reflection of unchanging human values that the government must respect while, at the same time, taking steps to offer efficient services, either free—by means of a prepayment system—or at a minimum cost that the poor are able to pay.

In Haiti, the country with the lowest per capita income in the Americas, the World Bank estimates that spending on health in 1985 averaged US$23 per capita. Approximately 43% of this figure was accounted for by family payments to private professionals.

Decentralization. Reform with respect to decentralization of the health system is essential. However, we have the impression that the World Bank study places emphasis on the financing process and on the use made of the funds obtained from payments to the services providing care. We agree that this is necessary, but we would point out that true decentralization of the health services must be integral and must not dissociate but rather complement the leading normative role of the health ministry and the executive function of the local bodies.

Social Security in Latin America. The pace at which health insurance is introduced will depend on how quickly payment for curative care by those who are not classified as poor is instituted and increased, up to the point where the entire cost of these services is financed. As the tariffs become higher, the need for risk-coverage plans will become more evident. This statement is logical, but it does not coincide with the history of social insurance in Latin America, where, in specific circumstances, political decisions have adequately interpreted the urgency of satisfying one of the population's vital needs.

Moreover, Latin America has a history of 63 years of social security systems aimed at achieving equity—affording fairer distribution of national income—legality, and financing of various ser-

vices including health. Generally speaking, these systems are funded by contributions from workers, employers, and the State. In the best cases, the workers pay in accordance with their income on a proportional scale, but everyone is entitled to the same benefits.

Social insurance systems have been established with the contributions of urban wage earners and have not covered the lower-income rural dwellers such as peasants and other agricultural workers. The study under review refers to the 16 Latin American countries that have organized social security systems for some proportion of the population. This proportion has been growing in parallel with rising incomes, generally ranging from 11% to 71% of the inhabitants and from incomes of US$410-480 to US$1,120-2,660 as of 1977. There have undoubtedly been changes since then (the use of 1977 data underscores the need for updated information) caused by declining household purchasing power due to inflation or by increased unemployment, both of which are consequences of the continuing economic recession. In these circumstances, the need for social security that covers at least loss of employment and health is all the greater, especially for the poor.[9]

The case of Chile. It is surprising that the data presented in the study do not include Chile, which was the first country in Latin America to promulgate a law on compulsory insurance in 1924, a law that adapted to Chilean conditions the system introduced in Germany at the end of the last century by the Bismarck Government. This system was designed to provide insurance against the natural risks inherent in social existence, such as catastrophes and diseases. Operationally, it was designed to utilize the Ministry of Health's establishments for provision of curative care. Organization of the Chilean National Health Service, which brought together under one service all the institutional and community resources available to the State, facilitated fulfillment of the spirit of the law. This also served to prevent duplication and competition between the Ministry of Health's services and those of the social security system, as well as concentration of the latter in the urban areas with an emphasis on curative medicine, including high technology, to the detriment of disease prevention and health promotion activities. This point is mentioned by the study. We prefer social security as a doctrine and a shared right of the people who pay the contributions—and these must include all who are producers and consumers—while the state institutions provide the services according to the benefits assigned by the law. Under this arrangement, social security is a financing mechanism, with the services being organized and administered by the State.

A Rational Approach for Financing Health in the Americas

The study points out that, with the exception of China, there is little experience in Africa or Asia with social insurance and other health care systems based upon prepayment. But that is not

[9] World Bank, *Op. cit.*, pp. 36–38.

the case in the Americas where, we believe, such systems offer the rational approach to follow—an approach that entails learning from the mistakes of the past, including abuse of the services as noted by the study, in order to obtain the greatest possible return from the resources available. In some countries private insurance schemes have developed; these should be considered as complementing and not competing with state schemes, provided that the State verifies the quality of the services provided. Such private services should constitute an incentive to ensure that the government services satisfy the natural demand for preventive and curative care, especially when there is evidence that the public services are underutilized. We are convinced that the Health Ministry should perform the same directing function for the health sector as it does in those countries where the constitution or the law has assigned the social security system responsibility for curative care and rehabilitation. At the same time, the State should guarantee the insured all the benefits that the law assigns them and not oblige them to purchase these benefits in the private sector—as is happening, for example, with medications, a development that causes demand to decline.

These considerations point up the need to progressively complete the coverage provided by the health services, especially in countries where this coverage is presently low, whether the services are provided by the Health Ministry or through prepayment systems. A tripartite social security system, i.e., one based on contributions by the State, employers, and urban and rural workers, can contribute toward an essential extension of the infrastructure. Loans from the World Bank and the Inter-American Development Bank (IDB) may always be needed, so long as they are not intended solely for hospital construction without including community, preventive, and ambulatory services for the population served by the hospitals in question. It must be borne in mind that efficient maintenance of the new services made available by such loans will create recurring cost obligations. We recognize that, given the costs entailed, the less interest the Government has in improving the health and nutrition status of the population, the longer the objective will take to achieve. In general, decisions evincing little interest characterize a society that prefers to devote expenditures to arms or the financing of economic infrastructure (the latter being possibly necessary and valuable) while neglecting the investments in human development upon which the progress of the country will depend.

Nevertheless, the negative impact of the recession and the payment of vast interest on external debt mean that governments with the best of intentions are unable to carry out their responsibility to provide essential health services for their people. As a result, large

segments of the population only have available to them the care obtainable from practitioners of traditional or empirical medicine, care that generally does not include the measures needed to promote health or prevent disease. High morbidity and mortality rates, certainly higher than the rates given on account of the underrecording of cases, are therefore not surprising.

Resources for Priority Groups

Some considerable time may be needed to cover 80% or more of the accessible population in certain countries. Meanwhile, the governments have recognized the need to concentrate resources on the priority problems that affect vulnerable maternal and child groups exposed to the greatest risks of sickness and death that could be prevented or given timely treatment by means of primary health care. Of course, significant reductions in morbidity, mortality, malnutrition, and low birthweights effectively reduce hospitalizations and the cost of care. It is also necessary to reform the health sector so as to improve the quality and return obtained from the resources used. Such reform goes beyond the executive decentralization recommended by the study, since it should include the normative and supervisory function, among others, of the Health Ministry. Specifically, the Health Ministry must deliberately promote joint actions with the ministries and agencies of the other economic and social development sectors that have a direct impact on the incidence and prevention of diseases.[10]

If it is not possible to redistribute the funds available to both the Health Ministry and the social security system, so as to allow for greater investments in community care (i.e., in disease prevention, including nutrition) than in institutional care (i.e., treatment in hospitals), any increase in the budget should be used for community care until useful coverage has been achieved with respect to specific problems. To this end, systematic introduction of payment for curative services could be included, applying tariffs that are proportional to household incomes and specifically differentiated to protect the poor. To the extent possible, people in a state of extreme poverty (which would have to be defined) would pay nothing. The study suggests methods for identifying such people, methods that would have to be tried out and modified on the basis of experience. Disease prevention and health promotion services should be free of charge and should include food supplements for pregnant women, lactating mothers, and children under five shown by growth monitoring to be undernourished. The study supports this approach, although it does not refer explicitly to the problem of malnutrition.

At the Technical Discussions of the 40th World Health Assembly in May 1987, reference was made to using payment for hospital care as a means of funding the hospitals, a practice that is followed in some countries in various guises. Some felt this would give rise to

[10] World Health Organization, Technical Discussions of the 39th World Health Assembly, WHO Working Document A39/Technical Discussions/1, Geneva, March 1986.

increased inequality in health. However, there was a consensus that various policy options were open within each system for increasing health resources. One differing opinion asserted that charging a tariff for health services would heavily impact the poorest users and would fail to bring about any substantial increase in revenue unless the charges were set very high.[11]

The study maintains that experiences in a number of countries show that up to 20% of the health budgets, excluding wage and salary expenditures, is funded in this way. If these financing methods do not include specific provisions for subsidizing care for the poor, however, they may aggravate social inequality, which would be contrary to the aims of modern health systems and also contrary to the doctrine of equity that sets forth the right of all to the opportunities and services that a society offers.

Concluding Remarks

To sum up, we reiterate that the World Bank has made a valuable contribution to analysis of a problem that is of vital significance in the developing world: the financing of health services. We suggest that governments examine this study carefully and consider whether current policies and programs are dealing with priority problems, whether the available resources are producing what is expected in terms of cost and effect, and whether the tremendous potential represented by community participation is contributing to the execution of the health actions involved. This review should lead to the reforms needed to serve the people better before resorting to international borrowing. In Latin America, which is becoming progressively urbanized and which has extensive experience using the social security system as a mechanism for prepayment of health care, an approach utilizing such a system should be further developed.

We have allowed ourselves to make some comments on this point. There is, moreover, a trend toward payment for curative services, even among very low-income households. Therefore, this trend should be systematized, with those living in extreme poverty being required to pay nothing insofar as possible, and with the charges being differentiated by household income and the nature of the services provided. Disease prevention and health promotion services should be completely free.

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[11] World Health Organization, Technical Discussions of the 40th World Health Assembly, WHO Working Document A40/Technical Discussions/4, Geneva, May 1987.