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FEATURE

FINANCING HEALTH SERVICES IN DEVELOPING COUNTRIES: AN AGENDA FOR REFORM[1]

The following World Bank presentation and "round table" commentaries by Abraham Horwitz, Julio Frenk, David Tejada de Rivero, Antonio Ordóñez Plaja, and Guido Miranda Gutiérrez seek to provide a wide-ranging overview of proposals for improving health services financing in the developing world.

Developing countries have achieved remarkable reductions in morbidity and mortality over the past 30 years. But continuing gains depend largely on the capacity of health systems to deliver basic types of services and information to households that are often dispersed and poor. At the same time, rising incomes, aging populations, and urbanization are increasing the demand for the conventional services of hospitals and physicians. These competing needs have put tremendous pressures on health systems at a time when public spending in general cannot easily be increased—indeed, in many countries it must be curtailed.

In most developing countries, public spending in all sectors grew rapidly in the 1960s and 1970s. But slow economic growth and record budget deficits in the 1980s have forced reductions in public spending; public spending on health has increased more slowly since 1980 and in some countries has declined on a per capita basis. A case certainly could be made for more public spending on health in developing countries. Public and private spending together in developing countries is on the average less than 5% of that spent in developed countries; even if this money were spent as cost-effectively as possible, it would probably be insufficient to meet critical health needs. But in most countries the general budget stringency makes it difficult to argue for more public spending. For the foreseeable future, government efforts to improve health are unlikely to rely on

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increases in public spending financed by debt or taxes, or on the reallocation of public expenditures from other sectors, even though such increases or reallocations would be economically as well as socially justified.

What can be done? An alternative approach to financing health care is proposed here. Even as governments continue to grapple with questions of the appropriate level of funding for health and the appropriate allocation of total government resources to health, this alternative approach deserves consideration. Indeed, it makes sense even in countries where the overall budget problem is not severe.

Simply stated, this approach would reduce government responsibility for paying for the kinds of health services that provide few benefits to society as a whole (as opposed to direct benefits to the users of the service). More government (or public) resources would then be available to pay for the services that provide many benefits to society as a whole. By relieving governments of the burden of spending public resources on health care for the rich, this approach would free resources so that more could be spent for the poor.[2]

Individuals are generally willing to pay for direct, largely curative care with obvious benefits to themselves and their families. Those who have sufficient income to do so should pay for these services. The financing and provision of these private types of health services (which benefit mainly the direct consumer) should be shifted to a combination of the nongovernment sector and a public sector reorganized to be financially more self-sufficient. Such a shift would increase the public resources available for the types of health services which are "public goods"; these include currently underfunded health programs such as immunizations, control of vector-borne diseases, sanitary waste disposal, health education, and in some circumstances prenatal and maternal care, including family planning (see box). The benefits of these largely preventive programs accrue to communities as a whole, not just to individuals and their families. They will not be paid for willingly by individuals and should be the responsibility of the government. But most curative care, whether provided by the government or nongovernment sector, should be paid for by those who receive the care. Shifting this responsibility would also increase the public resources available for government provision of basic curative and referral services to the poor, who currently have only limited access to services of this nature.

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[2] The categories of "rich" and "poor" need to be defined in each country and will depend on a country's income structure and social objectives.

Private and Public Benefits of Health Care

Goods and services provided by the health system can usefully be classified with respect to who receives the benefits of them. At one extreme are purely private goods, for which all benefits of use are captured by the person who consumes the health service, and at the other extreme are purely public goods, for which all benefits are equally received by all members of society. An aspirin taken for a headache is a good example of a purely private health good. Spraying to protect all residents from a vector-borne disease closely approximates a purely public health good. Many actual health services are of a mixed type; the consumer captures some purely private benefits, yet others also benefit from that person's consumption of the service. The person who is vaccinated receives a private benefit of protection, but others benefit as well because they are less likely to be exposed to the illness.

Consumers are almost always willing to pay directly for health services with largely private benefits. But they are generally reluctant to pay directly for programs and services which benefit society or communities as a whole. Consumers tend to wait and hope that others will provide the funds needed for the adequate provision of the "public" type of service—the so-called free-rider problem. That is why in most societies the health services with largely public benefits are funded by general revenues rather than user charges. Only public involvement will provide sufficient public goods (and mixed goods with a significant public benefit).

Health services with mostly private benefits, for which there is therefore great willingness to pay, are often equated with curative care, while those with mostly public benefits, for which there is little willingness to pay, are equated with preventive care. (For ease of exposition they are also discussed in these terms in this study.) But the correspondence is not exact. For some preventive care, such as monitoring the growth of infants, much of antenatal and perinatal care, and screening for hypertension, most benefits are captured by the recipients of the service and their families. Well-informed patients are likely to choose to pay for these services rather than forgo them. For some curative care, such as the treatment of the carrier of a contagious disease (tuberculosis is an example), there are public or social benefits to others as well as private benefits to the patient.

Health Sector Problems

The characteristics and performance of the health sector vary tremendously among developing countries. In most cases, however, the sector faces three main problems. It is argued here that each of these problems is due in part to the efforts of governments to cover the full costs of health care for everyone from general public revenues. The three problems are:

- *Allocation: insufficient spending on cost-effective health activities.* Current government spending alone, even if it were better allocated, would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities, including both the truly "public" health programs noted above and basic curative care and referral services. Although nongovernment spending on health is substantial, not enough of it goes for basic cost-effective health services. As a result, the growth of important health activities is slowed despite the great needs of fast-growing populations and the apparent willingness of households to pay at least some of the costs of health care.

- *Internal inefficiency of public programs.* Nonsalary recurrent expenditures for drugs, fuel, and maintenance are chronically underfunded, a situation that often reduces dramatically the effectiveness of health staff. Many physicians cannot accommodate their patient loads, yet other trained staff are not productively employed. Lower-level facilities are underused, while central outpatient clinics and hospitals are overcrowded. Logistical problems are pervasive in the distribution of services, equipment, and drugs. The quality of government health services is often poor; clients face unconcerned or harried personnel, shortages of drugs, and deteriorating buildings and equipment.

- *Inequity in the distribution of benefits from health services.* Investment in expensive modern technologies to serve the few continues to grow while simple low-cost interventions for the masses are underfunded. The better-off in most countries have better access both to nongovernment services, because they can afford them, and to government services, because they live in urban areas and know how to use the system. The rural poor benefit little from tax-funded subsidies to urban hospitals, yet often pay high prices for drugs and traditional care in the nongovernment sector.

Obviously, these problems are not solely attributable to the approach governments have taken to financing health. Nor will a change in approach to financing health alone solve these problems. In the short run, for example, change in the way resources are mobilized will not by itself correct the gross misallocation of health resources between high-cost hospital-based care and low-cost basic health services. Change in financing will not eliminate the need to improve management, administration, training, and supervision in the public delivery of health

services. Similarly, in its work on health, the World Bank is concerned not only with financing but with a wide array of issues associated with the design of sustainable and effective health programs.[3] 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.

Four Policy Reforms

Four policies for health financing are proposed below. They constitute an agenda for reform that in virtually all countries ought to be carefully considered. The four policies are best thought of as a package; they are closely related and mutually reinforce each other. Most countries could benefit from adopting only some parts of the package, and some countries might wish to move more quickly on some parts than on others. But in the long run, because the policies are complementary, all four merit consideration.

Charge users of government health facilities. *Institute charges at government facilities, especially for drugs and curative care. This will increase the resources available to the government health sector, allow more spending on underfunded programs, encourage better quality and more efficiency, and increase access for the poor. Use differential fees to protect the poor. The poor should be the major beneficiaries of expanding resources for and improved efficiency in the government sector.*

Some countries have had user fees for decades; and others, particularly in Africa, are now beginning to introduce them. But the more common approach to health care in developing countries has been to treat it as a right of the citizenry and to attempt to provide free services to everyone. This approach does not usually work. It prevents the government health system from collecting revenues that many patients are both able and willing to pay. Thus the entire cost of health care must be financed through frequently overburdened tax systems. It encourages clients to use high-cost hospital services when their needs could be addressed at lower levels of the system. It deprives health workers in government facilities of feedback on their success in satisfying consumers' needs. It makes it impossible to reduce subsidies to the rich by charging for certain services, or to improve subsidies to the poor by expanding other services.

[3] See World Bank, *Health* (Sector Policy Paper), Washington, D.C., 1980, which deals with the health sector as a whole.

In the short run—that is, as soon as administrative mechanisms can be put in place—countries should consider instituting modest charges, focusing initially on charges for drugs and other supplies and for private rooms in government hospitals. Where the current price is zero, even modest increases in charges could generate enough revenue to cover 15 to 20% of most countries' operating budgets for health care—enough to cover a substantial part of the costs of currently underfunded nonsalary inputs such as drugs, fuel, and building maintenance. By "modest increases" is meant amounts which would constitute, even for poor households, 1% or less of annual income, assuming two visits per person a year to a government health post for curative care.

In the longer run, user charges provide a way not only to raise revenue but also to improve the use of government resources. Curative services, most of which can be viewed as "private goods," currently account for 70 to 85% of all health expenditures in developing countries and probably 60% or more of government expenditures on health. Over a period of years, and once mechanisms to protect the poor are in place (along with insurance systems to cover catastrophic costs for all households), consideration should be given to increasing charges for curative services to reflect the cost of providing them. This would free resources equivalent to perhaps 60% of current government expenditures on health for reallocation to basic preventive programs and first-level curative care for the poor. (At the same time, most preventive programs should remain free of charge and be financed directly by government.)

Capturing the benefits of a policy of user charges requires attention to three complementary steps by the government. First, user charges will not work unless services are accessible and of reasonable quality; if they are not, the problem of underutilization discussed below will only be exacerbated. Second, user charges will not help improve the overall allocation of government health spending unless the freed revenues are actually funneled into currently underfunded health programs that provide public benefits and into increasing the number and quality of facilities to serve the poor. This redirection of freed resources requires a strong political commitment. Third, the poor who cannot afford new or higher charges must somehow be protected.

How can the poor be protected? Lower or even zero charges in clinics located in urban slums and in rural areas are a simple, practical step. Combined with higher charges for hospital care, they would not only protect the poor but also improve the targeting of existing government health spending. Another option is to issue vouchers to the poor, based on the certification of poor households by local community leaders (a practice that appears to work well in Ethiopia). Other options to protect the poor include allowing staff discretion in collecting charges (although this is difficult to do in the government sector) or, in middle-income countries, using means tests (which often already exist for other programs). In a well-functioning system of referral (in which patients enter the system at a low-cost lower-level facility and, only if they cannot be treated there, are referred to a higher-level facility), a schedule of low or even zero fees at the lower level

and referrals at no additional cost also provide protection for the poor. The most appropriate option will depend on each country's situation; experimentation with different approaches is likely to be required.

Provide insurance or other risk coverage. *Encourage well-designed health insurance programs to help mobilize resources for the health sector while simultaneously protecting households from large financial losses. A modest level of cost recovery is possible without insurance. But in the long run, insurance is necessary to relieve the government budget of the high costs of expensive curative care; governments cannot raise government hospital charges close to costs until insurance is widely available.*

Insurance programs cover only a small portion of low-income households in most developing countries, especially in Africa and South Asia. Outside of China, where the majority of urban residents are insured, no more than 15% of the people in the low-income developing countries take part in any form of risk-coverage scheme (other than free health care provided by tax revenues). Most of these people are covered under government-sponsored social insurance plans in the middle-income countries of Latin America and Asia. Private insurance, prepaid plans, and employer-sponsored coverage are all still relatively rare.

A starting point for insurance in most low-income countries is to make coverage (whether provided by the government or the nongovernment sector) compulsory for employees in the formal sector. Then at least the relatively better-off will be paying the costs of their own care. A few low-income countries and most of the middle-income countries in Latin America and Asia have already taken this step, often through payroll taxes to fund social insurance that covers health.

Insurance programs in industrialized countries and in Latin America have undoubtedly contributed to rising health care costs. When schemes cover most or all costs, and patients and health providers perceive care as free, some unnecessary visits and unnecessary procedures are likely, and costs will escalate in the system as a whole. To avoid such escalation, compulsory insurance plans in low-income countries should avoid covering small, predictable costs (such as for low-cost curative care); they should cover only costs that might be termed catastrophic for an individual. (Where practicable, the definition of the catastrophic expenditure level can be related to household income.) In reimbursable systems, costs will also be less likely to escalate if consumers pay an entrance fee (or a deductible) and make a copayment for each illness, and if there is competition among insurance providers. Without effective competition, insurance providers will have little incentive to keep costs and premiums low, and higher costs will be passed through in the form of higher wage bills for employers who provide coverage and higher consumer prices.

Avoiding cost escalation in government-run insurance programs is especially critical to avoid a related problem: political pressure to subsidize the insurance system from general tax revenues. If this occurs, it makes the insurance program a benefit for the better-off, paid for in part by the poor.

Use nongovernment resources effectively. *Encourage the nongovernment sector (including nonprofit groups, private physicians, pharmacists, and other health practitioners) to provide health services for which consumers are willing to pay. This will allow the government to focus its resources on programs that benefit whole communities rather than particular individuals.*

Government is an important provider of health services in developing countries, but by no means the only one. Religious missions and other nonprofit groups, independent physicians and pharmacists, and traditional healers and midwives are all active. Direct payments to these nongovernment providers account for up to half of all health spending in many countries. There is no "correct" size for this nongovernment sector; its role in relation to that of the government sector is bound to vary among countries. However, governments reduce their own options for expanding access to health care when they actively discourage nongovernment suppliers or fail to seek efficient ways to encourage them.

Community-run and privately managed cooperative health plans should be encouraged. Capitalizing such plans, providing temporary subsidies, and providing administrative support should be considered. Any prohibitions or restrictions on nongovernment providers should be reviewed. Unnecessary paper work and the regulations relating to nonprofit providers should be reduced. To provide better care for the poor, subsidies to make existing nongovernment facilities more affordable should be considered as a cost-effective alternative to direct provision of these services by the government.

Only the public sector can oversee and guide the activities of nongovernment providers of health services. In every country the government needs to take the lead in training health workers, testing them for competency, and licensing nongovernment facilities. Governments must play a central role in research and development. They must set standards and regulations to protect the populace from untrained or unethical practitioners, especially in countries where professional associations and standards of professional conduct are not yet well established. Governments need to develop the legal framework for prepaid health systems, and they must disseminate information about pharmaceuticals and health insurance options to help consumers deal effectively with nongovernment providers.

In some countries, including much of Latin America and the middle-income countries of Asia, it may be possible for the nongovernment sector to provide most or even all curative care as long as risk-coverage plans and subsidies for the poor are implemented. In others,

including those in Africa and the poorer countries of South Asia, where much of the population resides in rural areas and where basic curative and preventive services are closely and appropriately integrated, the government will need to continue to provide curative care in conjunction with its preventive care (for example, combining treatment of a sick child with immunization). Ideally, these services should complement existing nongovernment services, including those provided by traditional healers and religious missions. In all countries, in most areas of preventive care where social benefits are large, the role of government will remain predominant and indeed ought to expand.

Decentralize government health services. *Decentralize planning, budgeting, and purchasing for government health services, particularly the services offering private benefits for which users are charged. When setting national policies and programs, use market incentives where possible to better motivate staff and allocate resources. Allow revenues to be collected and retained as close as possible to the point of service delivery. This will improve both the collection of fees and the efficiency of the service.*

The government will have a continuing role in providing health services in most nations. Efforts to increase efficiency in the provision of these services cannot be neglected. In countries where managerial resources are scarce, communication is difficult, transportation is slow, and many people are isolated, decentralization of the government service system should be considered as one possible way to improve efficiency.

Decentralization is appropriate primarily for services provided directly to people in dispersed facilities, where there are user charges for drugs and curative care. Decentralization is less likely to make sense for tax-supported public goods, such as immunizations and control of vector-borne diseases. These programs are more logically administered centrally, although they can be, and sometimes are, contracted out to local governments. Decentralization gives local units greater responsibility for planning and budgeting, for collecting user charges, and for determining how collected funds and transfers from the central government will be spent. (It often also implies greater responsibility for personnel management and discipline.)

Decentralization of financial planning should include the general principle that revenues collected in the form of user charges should be retained as close as possible to the point at which they were collected. This improves incentives for collection, increases accountability of local staff, within limits ensures that the choice of expenditures

(whether to fix the well or purchase drugs) reflects local needs, and fosters the development of managerial talent at the community level. The conventional public finance argument is that all public revenues should revert to the center for allocation where most needed. But this reasoning fails to take account of a critical factor: the system of collection itself affects the amount and use of revenues collected. In general, the higher the transaction and information costs of collecting fees and administering revenues—that is, the smaller the amounts collected and the more frequent the collection, as in the case of charging for drugs and simple curative care—the stronger are the arguments for placing control over revenues at the point of service delivery.

Decentralization and greater financial control, however, by no means imply the complete financial independence of each individual facility. Government facilities that provide integrated curative and preventive services in rural areas and to the urban poor will continue to require central support. In fact, in rural areas the appropriate unit for purposes of decentralized planning and budgeting is likely to be a regional or district office, not a small health post. Eventually government hospitals in urban areas could transfer some collected revenues to the center to supplement general revenues and help finance other government health programs.

Control of revenues at the point of service delivery also reinforces a more general principle: as fees collected in government facilities make largely curative services with private benefits financially self-sustaining, the freed government resources should be retained in the health sector (but not necessarily at the individual facilities) until health programs with public benefits and care for the poor are adequately funded.

Decentralization of government health services will not be easy, and of the four policy recommendations it is probably the least tried. Where other parts of the government are highly centralized, there will be considerable obstacles to decentralization. But there will be considerable benefits as well, since perhaps no other government service except agricultural extension is as highly dispersed. Where overall administrative systems are weak, the quality of staff in remote areas is poor, or positions are unfilled because of long-standing difficulties in attracting staff away from large cities, decentralization will have to be planned and introduced gradually. In some countries, where staffs of regional agencies, local hospitals, and clinics have little experience in managing revenues and expenditures, training in such skills and a trial period to test these skills will need to precede decentralization.

The Policy Package and Health Sector Problems

Table 1 summarizes the potential effect of each of the four recommendations on the problems in the health sector. User charges for government-provided services can help solve all three problems. User charges increase resources for the system as a whole and allow government resources to shift to more cost-effective (generally preventive)

TABLE 1. Effects of policy reforms on three main problems in the health sector.[a]

Policy	Allocation	Internal inefficiency	Inequity
Keep the present system	0	0	0
Institute user charges	+	+	+
and use freed government revenues to expand cost-effective services	+	0	+
and use new revenues to finance nonsalary costs	0	+	+
and use differential charges to protect the poor and reduce existing subsidies for the rich	0	0	+
Provide for risk coverage	+	0	+
Use nongovernment resources effectively	+	+	+
Decentralize government health services	+	+	+

[a] 0 indicates no effect; + indicates alleviation of the problem.

programs. This shift alone will tend to benefit the currently underserved poor more than the rich, since the poor tend to suffer more from the kind of health problems that can best be addressed by preventive programs. If revenues from user charges are channeled directly into underfunded nonsalary expenditures—that is, into drugs, fuel, and maintenance—the efficiency of the existing government services will increase. User charges can also play a direct role in making the health system more equitable: the rich, who benefit most from government-provided services, will now have to pay; the government resources thus freed can be redirected into programs and facilities targeted to the poor.

Risk-coverage programs can provide more revenue to the system as a whole and allow the diversion of freed government resources to cost-effective programs. By tapping the ability of the better-off to cover the major costs of their own care, risk-sharing schemes improve the overall equity of government health spending.

Using nongovernment resources effectively helps mobilize resources from families, communities, and voluntary groups and allows government resources to be redirected to programs that produce many benefits but for which individuals are reluctant to pay. The result of this redirection of funds is both more efficiency and greater equity.

Finally, decentralization can help mobilize more revenue. Consumers will be more willing to pay and providers more willing to collect charges because of the link between revenue collection and better services. Decentralization can also help improve the use of government resources by making government-provided services more responsive to the needs of their clients.

The parts of this policy package rely on each other for their positive effects. Charging fees at government facilities will not be effective in raising revenue unless competitive incentives in both the nongovernment sector and the decentralized government sector orient the system toward providing quality care at affordable prices. The tendency to allocate too much of the government health budget to high-cost hospital

care, with negative effects on overall cost-effectiveness and on equity, will be difficult to change until charges come close to reflecting real costs. But charges at hospitals and other government facilities cannot be raised to reflect costs and recover larger amounts unless much of the population is insured. At the same time, insurance and other forms of risk coverage will collect little revenue and in all likelihood will fail if free services remain available at government facilities. In the long run, the diversion of government resources to cost-effective basic services will be easier if an active nongovernment sector is providing the bulk of curative care. An active, high-quality nongovernment sector requires the availability of insurance.

Reforms in Financing

Implementation of these reforms will not by any means solve all the problems of the health sector. User charges in government facilities will not generate foreign exchange to pay for imported pharmaceuticals. Insurance programs will not by themselves raise the quality of government services. Decentralization will not eliminate the need for difficult decisions at the center regarding the geographic allocation of new investments and health personnel. A strong nongovernment sector may not adequately serve the poor in remote rural areas.

Reforming the finance policy will have little impact without a political commitment by the government to making the health sector more effective. As noted above, user charges (and other financing reforms) alone will not ensure that the government resources thus freed will be used wisely; decisions made largely in the political arena will determine whether the freed funds are used for the poor and for services with public benefits, rather than for building urban hospitals and buying expensive nonessential equipment. Political decisions will largely govern whether the freed revenues are used to improve service accessibility and quality sufficiently to attract fee-paying and insurance-buying customers. Only government action can bring necessary changes in management and training programs—for example, by instituting more appropriate training of doctors and placing greater emphasis on training paramedical personnel.

Without reforms in financing, however, the necessary revenues may not be available to carry out the political decisions for reallocation both within and outside the health sector. Although reforms will not automatically take care of political decisions, they will help to provide the resources that make political decisions feasible.

Nor is the finance policy package itself a simple one to implement. In countries where administrative capability is

weak, the introduction of new approaches will take time. Moreover, each of the four parts has potential drawbacks if implemented without due care. User charges could deter those who would benefit the most from seeking care. Risk-sharing schemes could raise costs and augment existing disparities. Deregulation of the nongovernment sector and administrative decentralization could increase geographic inequality and decrease the quality of services.

Avoiding the pitfalls requires that political and social boldness in innovating policies be complemented by systematic and sustained attention to monitoring programs. In each country, specific approaches to implementation need to be monitored as they are tried; flexibility in such areas as the size of user charges and the approach to decentralization needs to be maintained.

Need for Further Analysis

As the reforms in finance policy are tried, monitoring and operational research in each country should focus on the following kinds of questions:

- How accessible are services now and how good are they? What are nongovernment expenditures on health care? How much do people now pay? How much can they afford? How would utilization of services be affected if prices were raised? Would demand fall for important health services? Would utilization by the poor decline?

- What fees should be charged and how much revenue can be raised from them? What are collection costs likely to be? What is a reasonable schedule of charges at different levels of the system?

- What health insurance programs now exist? Who is covered at what cost? Are there informal insurance systems within extended families?

- How equitable is the existing health system? What groups now benefit from what services, at what cost to the government purse? What are practical means of identifying and protecting those unable to pay for health care?

- How active is the nongovernment health sector? Is the for-profit sector competitive? Are there private physicians, pharmacists, and other trained health practitioners in rural areas? What income groups does the nongovernment sector serve? What are alternative means, and their relative costs, for improving information to consumers about the quality and prices of private health services? How can both public and private health providers be regulated and supervised so that their clients are protected from ill-advised and overpriced services?

- How can the management of government health facilities be organized and overseen so that resources are used efficiently and workers perform

well? What steps can be taken to ensure sustained political and popular support for the reform of health financing?

The Role of the World Bank

The World Bank began direct lending for health in 1980, and by 1983 it had become one of the largest funders of health programs in developing countries. Lending operations in more than thirty countries have focused on the development of basic health care programs, including expansion of primary health care, provision of drugs, and support for training and technical assistance. Lending operations have generally been preceded by systematic studies of the health sector as a whole. These studies have enabled the Bank to carry on a policy dialogue regarding systemwide health issues with government officials.

In its sector work and lending in health, the Bank has been concerned not only with health financing, but also with a wide array of systemwide issues, including the appropriate allocation of investments in the sector given the criterion of cost-effectiveness, the design of sustainable health programs, and the need to improve management and training. Although this study concentrates on financing, this is no indication that concern with these other issues has in any way abated. But there is mounting concern in the Bank and in member countries about the resource problem in health, and a conviction that the Bank, itself a financial institution, can make a useful contribution to improving health in developing countries by encouraging innovative health financing policies.

The Bank is currently making renewed efforts to contribute in this way. A strengthened program of country sector work includes attention to the health financing issue. General reviews of overall government expenditures increasingly include special attention to the health sector. Innovative lending programs include assistance to countries in the development and implementation of new health financing approaches. Dialogue with other lending agencies is more active, and a program of research and operational evaluation on the effects of new approaches is planned.

The Bank has advocated consistently that overall economic policy be grounded in sound principles of finance and project selection; the agenda for the reform of health financing proposed here is consistent with and reinforces those principles in the health sector.
