

# From Health Policy to Economic Action Financing, a Suitable Tool to Adapt Health Programmes to National Priorities<sup>1</sup>

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## Introduction

It is assumed that the reader is already knowledgeable of the need of clear health policies in developing countries, with such objectives as total coverage of the whole population and accessibility and acceptability of health services, at a cost which all citizens can afford. In order to achieve social justice, some underprivileged groups of the population, very often the periurban slum dwellers, or people living in remote rural areas, or mothers and children, or the aged are considered as deserving priority in respect of health care. One of the conditions to implement such health policies is the provision of economic support for the required health activities.

Many countries are planning to reorient their health services to make them play a more purposeful role in the unified plans for socio-economic development. The reorientation, subject to local conditions, has to consider as components the manpower, the facilities, the appropriate technology and the economic basis of the existing health services, which should support the most important level of care, i.e. the primary level.

The rate of progress in making improvements is at present severely limited by shortage of funds, maldistribution of health resources, rising costs, lack of coordination between sources of funding and inefficiencies in spending. Selected aspects of these problems are discussed as well as some alternatives aiming at their improvement.

## Major Problems in Financing Health Services and Some Alternatives for Improvement

### *The Lack of Funds and Maldistribution of Resources*

In many developing countries there is a shortage of human, material and financial resources to meet health needs.

Scarcity of money affects all parts of the health delivery system: it shows itself at the national level, both in the routine allocation of yearly budgets and in the distribution of funds to authorities responsible for national development plans. Although the per capita health expenditure is not strictly comparable among countries, the figure is low in most developing countries and lowest in the neediest areas [2]. The shortage

**L'argent est le nerf de la guerre, mais il est tout aussi indispensable aux services de santé. Un groupe d'étude de l'OMS a récemment discuté les questions et les problèmes qui se posent à ce sujet. Une fois de plus, il faut décider «Qui paie quoi?» et «Qui reçoit quoi?»**

**Geld ist der Nerv des Krieges, es ist aber auch unentbehrlich für den Gesundheitsdienst. Eine Studiengruppe der OMS hat kürzlich Fragen und Probleme in diesem Zusammenhang diskutiert. Es muss einmal mehr entschieden werden «wer bezahlt was?» und «wer erhält was?»**

of financial resources is felt throughout the health system, but it affects particularly the needier, rural population [4].

While «absolute» inadequacies obviously justify need for additional resources, claims for additional health funds in case of relative inadequacies should be supported by analyses of the efficiency, effectiveness and equity of the present health care delivery system. The health sector in developing countries is often hospital-based, relies on relatively sophisticated technology and places emphasis on specialized medicine. As a result, it may absorb an unduly large share of the health budget serving a comparatively small clientele. In many less developed countries over half of the national budget is spent on health care in urban areas, the home of no more than a fifth of the total population.

Besides the geographical inequity the linkage of certain funds to certain groups in the population, which can give them an advantage at the expense of other sections of the population is also a serious problem. There may also be health inequities among racial and ethnic groups in a country. Historical, political and economic developments lie at the back of these many forms of inequity.

The data analyzed for a WHO Study Group on Financing Health Services [7], show that the following characteristics remain true for many countries, in spite of government efforts:

- disproportionate concentration of expenditure on health services in urban areas compared with expenditure in rural areas;
- heavy concentration of expenditure on secondary and tertiary care services compared with expenditure on primary care services;

<sup>1</sup> This article is mostly based on the report of a WHO Study Group of Financing of Health Services (WHO Technical Reports Series, No. 625, 1978); however, the views expressed are not necessarily those of WHO.

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- heavy concentration on curative services compared with expenditure on preventive services;
- considerable expenditure by the rural population on traditional practitioners and medicines.

#### *Increased Taxation and Social Security*

Several approaches to extending existing sources of finance or developing new sources can be adopted. The most obvious solution is to increase government financing either by raising existing taxes or by cutting down on other public expenditure. This is the approach that public health administrators are, and have been, continually pressing. In some countries, however, the share of public expenditure devoted to the health sector has tended to go down not up if calculated in constant units of the national currency [6]. Faced with demands for expenditure from the different sectors of socioeconomic development, governments have tended not to give the health sector high priority.

One possible approach is to introduce some new type of tax, the revenue of which would be wholly devoted to the health service. For example, in the “funrural” scheme in Brazil, a special new tax was imposed on agricultural products at the point of marketing, which is earmarked for the improvement of rural health services [7]. Special sales taxes have been imposed in some Canadian provinces which are identified as a source of financing for hospitalization. In two regions of Senegal, 8 % of the rural taxes levied and spent locally, are reserved for health purposes [5]. Some countries have introduced lotteries and devote the profits to health services. But, as with the earmarking of existing taxes, it does not follow that there will be a net increase in resources devoted to the health sector.

A widely used strategy for increasing the allocation of funds to the health sector throughout the world has been the introduction of compulsory health insurance. Because funds are raised by new taxes on workers and employers (sometimes with a government contribution also), parliamentary bodies have generally been more favourable to this approach than to one that would make further claims on the general revenues of the nation.

From the workers point of view, this method of financing assures the employee, and often the employee’s dependants, certain health services as a “right” rather than a benefit dependent on the generosity of the government or charity.

In developing countries, however, the proportion of the national population with regular monetarized employment and thus with periodic wages subject to social security deductions is usually small. Therefore, the fraction of the population benefiting from such programmes has been correspondingly small. With relatively more abundant funds to use, the services provided for insured persons are generally superior in both quantity and quality to those available to the majority of the population, which is predominantly rural. With occasional exceptions, agricultural workers and peasants are not protected by this type of fund raising programme [10].

Consequently, serious questions have been raised as to the overall impact of the social security approach on national equity in the distribution of health services [8]. It is claimed that ministries of health who are attempting to serve the whole of their national populations are caused greater difficulties in recruiting the personnel they need; in addition, the entire national health effort may tend to become heavily weighted towards curative activities. Moreover, to calculate benefits for participants of the insurance system creates the need for a considerable number of skilled administrators and, therefore, a costly training effort is necessary to prepare and, later, pay administrative personnel. In addition, in many countries the government is either paying contributions as an employer or subsidising social security systems (for example health insurance schemes for civil servants). In the case of subsidies, there is a danger that the burden of government participation may weigh, in part, on the most under-privileged categories of the population given that by far the greater share of taxation in developing areas comes from indirect taxes, often levied on everyday necessities [9].

On the other hand, there is one undeniable advantage of the social security concept, namely that it provides extra funds for the health sector in situations where the government for different reasons is unable to increase its contribution.

Also, health funds spent under social security tend to be spent much more systematically and prudently than would occur in the private sector.

In spite of the arguments against the suitability of the social security/health insurance system for developing countries, every year additional developing countries appear to be exploring the application of the social security concept. These countries need to consider very carefully how and when such a programme can be established or expanded. It should not be introduced until the trained manpower is available and it is important that the pattern of care provided by compulsory insurance schemes should not diverge too far from the pattern of the care it is ultimately intended to provide for the whole population.

#### *Participation of Rural Communities in Primary Health Care Programmes*

Many developing countries are making efforts to promote maximum self reliance in local rural communities. In China, Tanzania, the Jamkhed area in India, Savar in Bangladesh and Maradi in Niger, local involvement ranges from the selection of primary health workers from among the population to the construction and maintenance of health facilities and help in the financing of the services through population based payments and other support to the health workers. The local self reliance approach has been especially effective in promoting preventive programmes and extending primary health care as a whole. With this philosophy, for example, a network of maternity centres staffed by locally trained midwives has been

launched in two regions in Senegal, supported substantially by the population [2, 5].

In a rural local clinic, small fees may be charged for services usually to pay for the necessary medicaments, or funds may be prepaid by families to form a health cooperative. Some successful local health projects have been initiated by foreign, religious missions.

Care should be taken, in the worldwide enthusiasm for maximum local participation or self reliance in health programme development, that this movement is not exploited to relieve national governments of their responsibility. Likewise, local efforts for construction of health facilities should be coordinated with the next higher level of government (provincial or central), especially if future assistance in operating costs or provision of drugs and supplies is expected.

The development of a proper relationship between the financing system of the "official" health sector and local health programmes is one of the crucial factors for the expansion of primary health care and should be subject to health services research.

Correction of maldistribution of health resources is a complex task requiring a strong political will, proper information on the existing situation and consistent action for many years. Senior public health managers often find a situation where the possibility for corrective action, even in the government health services, is very limited: the budget is tied up to a great extent by recurrent costs and only a small percentage of the available funds can be shifted towards new priority areas, e.g. rural health services. This state of affairs is often a heritage from previous administrators and, in more general terms, result of a certain evolution. Redistribution of funds might involve reduction of the number of personnel in public hospitals and other facilities in certain areas; freezing of new investments, slowing down the "manpower output" of training institutions and of course intensive search for economies through increased efficiency and effectiveness of health services.

One of the many alternatives is to make a charge for curative services, particularly in urban areas. This will bring revenue, which can be used to develop priority rural services. It should also cut down on the demand for the services for which charges are made. To many public health administrators the introduction of charges may seem ethically unacceptable and politicians may hesitate to take such unpopular steps. The acceptability of such measures may depend on quality of the public medical services and on the cost and practicability of operating a system of exemption from charges for the very poor and for cases of major medical need.

However, there are many measures and actions which may achieve redistribution of resources in the non-public part of the health sector. Such measures might include besides the taxation, already discussed, licensing policies (location of health facilities, practice of health providers, regulation of fees for services, approval of drugs for the market); or economic means

(government subsidies, loans, financial support to local community health programmes).

To influence the private health sector in countries with a free-market economy is even more difficult, as the proportion of a nation's total resources allocated to health services in this subsector is partly the unpremeditated outcome of countless individual decisions made by providers and recipients of services.

#### *Increasing Efficiency and Improved Coordination*

In many countries there is considerable scope for saving money by using resources more effectively. Tasks can be delegated to personnel with less training. Much greater use could be made in some countries of traditional practitioners, after appropriate further training, working in association with the organized public and semipublic services. Less elaborate hospitals can be developed, arranging for relatives to service patients by preparing their food and giving them basic care. Some countries still maintain hospitals for tuberculosis and leprosy, even though these diseases can be satisfactorily treated in the community. Similarly, much mental illness can now be managed without admitting the patients to hospital. There is wide scope for replacing inpatient care by ambulatory care, cheaper home care, day care and selfcare.

More use can be made of traditional methods in constructing health buildings. In some countries there is scope for much greater economy in the use of pharmaceuticals and for improvement in procurement and supply systems. Both developed and developing countries are constantly searching for ways of increasing the efficiency with which they use resources in the health sector; the economies made through better management practices can be used to develop services which are of the highest priority.

The most serious and common lack of coordination is usually between expenditure by ministries of health and bodies responsible for social security [3]. Since social security moneys are normally derived through special channels from workers and employers, they are typically spent along administrative lines quite separate from those of health ministries. Moreover, different social security schemes may not be coordinated with each other. A similar lack of coordination often characterizes expenditures by organized private agencies and governmental public health programmes in the same field. There can also be a serious lack of coordination within government services in the use of foreign aid. There can be lack of coordination between different levels of government, between government services and those provided for the armed forces, nationalized transport and other undertakings. In general, improved management, training of manpower for management and better administrative organization seem to be the responses to this problem.

#### *Foreign Aid*

Funds provided for health related activities by external aid agencies, bilateral or international, can be ex-

tremely important: in many developing countries this assistance even exceeds the governments' own health development budget. National health priorities may suffer if external assistance is not directed towards purposes defined by the countries themselves. While most already have coordinating mechanisms, the above principle is not always respected, particularly in the case of nongovernmental donors.

In certain situations the amount channelled to health projects depends not only on government priorities but also on the whims of the various donors. Therefore, although the health authorities may be able to plan an overall development programme, they have no control over the rate of its implementation.

A phenomenon seen far more often is that recipient countries do not have the required means to cover local recurrent costs of health services. For a long period it was the assistance policy of donors that running the national or local health services would require immense funds and therefore grants should be earmarked for investment in health facilities, equipment or training only. However, the primary health care approach requires only modest amounts for investment and, therefore, some OECD member states now intend to include grants for local recurrent costs of health facilities. Research aiming at finding out the order of magnitude of such recurrent costs as well as comparative studies might have a direct impact on the decisions of donors in this respect. These studies will collect data on the recurrent costs of local primary health care programmes, that is the cost of the work of village health workers, the communities' participation, and the proportionate cost of the next level, supporting facilities which serve for referral of seriously ill patients; this cost will be compared with the conventionally organized health services, that is that cost and coverage provided by a rural health centre and a network of rural dispensaries.

#### **Some Methodological Aspects of Surveying the Financing of the Health Sector**

Public health administrators in most countries are well aware of the funds under their known control. However, information is rarely available about total expenditure on health related activities—spending by organs of government other than the ministry of health itself, by social security agencies and by charitable bodies, and particularly expenditure in the private sector, including that of traditional services.

Only when all sources of finance are brought together and an analysis is made of what precise services are financed by what fund, in particular geographic areas, is it possible to consider what changes can be made in order to move faster towards policy objectives. Methodologies are therefore needed for classifying the relevant information and low cost methods for collecting it. Such information should help in examining how far it is possible to develop new sources of finance, to redeploy funds already devoted to health purposes or to relieve resources by more efficient methods of oper-

ation for use in areas of higher priority. Several publications deal with such methodologies [1, 11].

#### **Conclusions and Potential Areas for Action**

Studies of financing of the health sector, including the nonpublic part, can make several important contributions to the health planning process.

They can quantify the gap between the resources which can reasonably be expected to be obtained for the health sector and the resources necessary to achieve the country's medium term policies. Quantifying the gap can help the countries to assess the type of new technologies that they can afford.

Surveys on financing can focus attention on alternative ways by which further resources may be found for the health sector. Such means may include taxation for public medical care, so that the expansion of organized services can be expected to decrease private expenditure on health care. Establishment or expansion of social security or compulsory health insurance systems might also be considered as a step towards the provision of equitable health services coverage for the whole population. In some cases it may be practicable to establish informal "grass-roots" insurance at the local level. Organization of community effort may also be promoted, including contributions in kind.

When the establishment or expansion of local primary health care programmes is planned, resources from outside to support the local effort in an organized way are also needed, despite the characteristic of self reliance. Funds are required for logistical support, training of teachers, drugs and other supplies, a secondary level of services for referral, the cost of technical supervision, etc. Integration of primary health care programmes in the overall health system is desirable, and within this the development of links between the financing of the entire health sector on one hand and the primary health care programme on the other. For example, the establishment of regional or even national financial procedures for guiding local and central government contributions to primary health care programmes would certainly facilitate the spreading of these programmes in a country. It would also mean the earmarking of sufficient funds to enable the public sector to respond to local initiatives; thus promoters of PHC programmes would know what could be expected financially from the official health system and organize PHC accordingly.

Surveys can provide data to assist in allocating resources equitably. In the public sector this will often involve the redistribution of available funds, for example among certain population groups or among major categories of health services (from hospitals to other health facilities, or from institutional care to ambulatory or home care).

In the nonpublic sector, depending on the political and economic structure of a country, redistribution of resources might be approached by administrative or economic measures.

In summary, it would seem to be useful if countries would decide to undertake periodic surveys of financing and resource allocation in their health sector as an integral part of the country health programming or similar health planning processes, for programming and evaluation purposes. These analyses could be used also to examine financing and budgetary expenditure, applying the criteria of equity, effectiveness and appropriate technology. Research centres, universities and other educational institutions should collaborate with the health authorities of their country and undertake the types of studies described above.

#### Summary

Many countries are planning to reorientate their health services, in order to achieve such policy objectives as total coverage of the whole population by services which are accessible and acceptable to all people and at a cost they can afford. This reorientation, in the framework of overall developmental strategies, has to consider such components of the health system as manpower, the appropriate technology, the facilities needed for referral purposes, and the economic basis of the existing services, which should support the most important level of care, i.e. the primary level. Progress in making improvements is severely limited among others by shortage of funds, rising cost, maldistribution of health resources, inefficiencies in spending and lack of coordination between sources of funding. Periodic studies of financing of the health sector, including the private sector, are proposed, which will focus attention on alternative ways of finding further resources; data obtained through low-cost surveys may facilitate the redistribution of available funds; costing of alternative technologies might lead to the application of the most appropriate versions; comparisons of major categories of national health expenditure with the objectives of stated health policies of a country could improve the allocation of funds flowing from foreign sources. Low-cost methods for making the necessary estimates already exist and are being further developed. Dissemination of existing experience in this area and application of known methods is now a challenging task for health authorities, research centres and international organizations.

#### Résumé: De la politique de santé à l'action économique – L'allocation des fonds, un instrument qui permet d'adapter les programmes médico-sanitaires aux priorités nationales

De nombreux pays se proposent de réorienter leurs services de santé dans le but d'obtenir une couverture complète de toute la population par des services acceptables pour tous et auxquels tous puissent avoir accès à un coût à leur portée. Dans le cadre des stratégies de développement global, cette réorientation doit considérer les éléments du système de santé qui doivent appuyer le niveau de soins primaires, qui est le plus important: main-d'œuvre, technologie appropriée, établissements de soins, base économique des services existants. Tout progrès dans ce domaine est sérieusement limité par une série de facteurs dont les principaux sont l'insuffisance des moyens financiers, la hausse des prix, la mauvaise distribution des ressources sanitaires, une orientation fautive des dépenses et un manque de coordination entre les sources de financement. Des études périodiques du financement du secteur de la santé, y compris le secteur privé, sont proposées. Elles se concentreront sur les divers moyens permettant de dégager de nouvelles ressources; des données résultant d'enquêtes peu coûteuses pourraient faciliter la redistribution des fonds disponibles; une étude des coûts de différentes options technologiques pourrait conduire à l'utilisation de celle qui se révélerait la mieux appropriée; des comparaisons entre les catégories les plus importantes des dépenses nationales de santé et les objectifs de la politique sanitaire du pays pourraient permettre d'améliorer la répartition des fonds provenant de l'aide extérieure. Des méthodes bon marché existent déjà pour arriver aux estimations nécessaires et on continue à les développer. Il reste à faire connaître les expériences faites dans ce domaine et à appliquer les méthodes déjà connues; c'est là pour les autorités sanitaires, les centres de recherches et les organisations internationales une tâche passionnante et très importante.

#### Zusammenfassung

#### Von der Gesundheitspolitik zur wirtschaftlichen Aktion – Finanzierung, ein geeignetes Instrument, um Gesundheitsprogramme den nationalen Prioritäten anzupassen

Eine grosse Anzahl von Ländern beabsichtigen, ihr Gesundheitswesen auf die Erreichung eines Zieles auszurichten – die Gesundheitsdienste der gesamten Bevölkerung zugänglich zu machen, und dies zu einem Preis, den diese auch zu zahlen vermag.

Eine solche Neuorientierung im Rahmen von Gesamtentwicklungsstrategien hat die einzelnen Komponenten eines Gesundheitssystems zu berücksichtigen, wie Personal, angemessene technische Ausrüstung, Einrichtungen für Überweisungen zur Weiterbehandlung sowie die Finanzierungsmöglichkeiten der einzelnen Dienste, die ihrerseits den Grundpfeiler für die wichtigste aller medizinischen Versorgungsebenen, nämlich die primäre Versorgung, darstellen. Eine Verbesserung der gegenwärtigen Lage ist oft nur in sehr begrenztem Umfang möglich, sei es weil bei steigenden Kosten die finanziellen Mittel fehlen, sei es weil die Gesundheitsdienste falsch, das heisst ungleichmässig, verteilt sind, weil die Ausgaben der Wirtschaftlichkeit entbehren oder gar die Koordinierung der Finanzierungsquellen zu wünschen übrig lässt.

Es wird daher vorgeschlagen, die Finanzierung des gesamten Gesundheitswesens, also unter Einbeziehung des privaten Sektors, in gewissen Zeitabständen zu untersuchen, wobei das Hauptaugenmerk auf alternative Wege zur Beschaffung zusätzlicher Mittel zu legen wäre. Zahlenangaben, die aus Niedrigkostenerhebungen stammen, vermögen die Umverteilung der finanziellen Mittel zu erleichtern. Angaben über Kosten und deren Aufschlüsselungen für alternative Technologien tragen ebenfalls dazu bei, Entscheidungen über die geeignetsten technischen Einrichtungen zu treffen. Schliesslich vermögen aber auch Vergleiche zwischen den Hauptgruppen der nationalen Ausgaben für die Gesundheit, die gesundheitspolitische Ziele verfolgen, den Zufluss bzw. die Zuteilung ausländischer Finanzierungsmittel zu verbessern. Niedrigkostenmethoden zur Ermittlung der erforderlichen Schätzwerte bestehen bereits seit geraumer Zeit und werden laufend weiterentwickelt. Die Verbreitung der Erkenntnisse und Erfahrungen auf diesem Gebiet und die Anwendung der bekannten Methoden ist jetzt eine der Hauptaufgaben der Gesundheitsbehörden, der Forschungszentren und nicht zuletzt der internationalen Organisationen.

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