

PROCEEDINGS
HEALTH OFFICERS' CONFERENCE

Bureau for Latin America and the Caribbean

Gettysburg, Pennsylvania

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Polly F. Harrison
Management Sciences for Health
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SUMMARY REPORT: HEALTH OFFICERS' CONFERENCE

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BACKGROUND AND RATIONALE

The 1984 Health Officers' Conference was focused on a single theme: financing and resource allocation for the health sector. There were several reasons for the selection of this theme. First, since the last Health Officers' Conference, held in 1982, there have been dramatic changes in the economic and political environments of the Latin American countries in which AID operates. The health sector of the 1980s is confronted with the persistence of adverse and deteriorating economic conditions which were only incipient and were not, perhaps, fully recognized when the health officers last met. Declining economic growth and swelling external debt have placed enormous pressures on public sector budgets. Economic stabilization policies have restricted financial allocations to ministries of health, so that normal growth of MOH budgets has been curtailed, where it has not been negative.

Second, AID has learned some lessons from its health sector experience which, together with these changes, have made attention to financing a virtual necessity. In the 1970, AID's involvement in primary health care delivery brought growing awareness of the importance of strong support systems; this, in its turn, generated a series of management improvement projects, ironically just as the financial and economic underpinnings of health delivery systems in LAC countries began to crumble.

Third and last, there are decisions to be made. Both in host countries and in AID, there is competition between the health sector and other sectors viewed as more productive, between health and alternative investment opportunities. Within the health sector, there has been a developing tendency to see that there are authentic choices to be made among the public, quasi-public, and private sectors. The private sector, viewed at the last conference as, at best, a subject for rhetoric and, at worst, a gimmick, is now perceived as offering real options. In host countries and in the donor community, there is continuing ideological divergence about the importance of health infrastructure relative to the importance of improving management and support systems; about the relative weights to be assigned to preventive vis-a-vis curative care; about the complementary and competitive roles of primary, secondary, and tertiary levels of health care; and about the ethical and economic connections between urban and rural client populations. Finally, there is, within AID itself, competition among categorical programs, special initiatives, and standing bilateral projects.

ORGANIZATION OF THIS REPORT

This report presents: the objectives of the Health Officers' Conference; a summary of the principal presentations; and discussion of three of the issues which emerged as most important, if not crucial. The last section of the report presents the consensus of the health officers, achieved both during their preparations for the plenary session and in that session itself, on recommendations for: policy objectives, intervention strategies, courses of action to address priority issues, AID's most appropriate responses, and necessary next steps.

CONFERENCE OBJECTIVES

The purpose of the Health Officers' Conference was to encourage a wider, holistic perspective on the financing and organization of the health sector and to work toward four major objectives:

1. to identify and prioritize the key issues in financing and resource allocation that confront the health sectors in the region;
2. to identify and develop policy objectives, intervention strategies, and courses of action which address these issues;
3. to determine what responses are most appropriate for AID assistance and susceptible to AID intervention; and
4. to recommend what steps should be taken next.

CONFERENCE FORMAT

The 1982 Health Officers' Conference focused on the newly approved AID policies and strategies and on problems of project implementation. In contrast, the single-theme, technical emphasis of this year's conference cut across the standard AID program groupings of planning, design, implementation, and evaluation, as well as across the standard health subsectors and project categories.

This orientation and the nature of the theme, itself, lent themselves well to the use of the case study method. Two cases, one from Haiti and one for Honduras, were taught by professors from Harvard. To extend the learning of the group beyond the customary AID horizon and in order to provide as much access as possible to the state of the art in health financing, the conference drew on a large number of outside resources. Presenters included not only representatives from PAHO and the World Bank and from the Near East and Asia Bureaus of AID but drew on universities in the United States and in Latin America; the Social Security subsector; and the private sector, particularly representatives of HMOs and the pharmaceutical subsector.

The conference was organized as follows:

- Day 1 Need versus the demand for health care in Latin America
Health financing issues and the role of government in the health sector
- Day 2 Social Security systems and medical care in Latin America
Management improvement projects: lessons learned and new directions
- Day 3 Prepaid systems of health care: status and potential
- Day 4 Pharmaceuticals: Issues and programs
- Day 5 Plenary session.

The complete conference agenda is included in the Conference Proceedings.

SUMMARIES OF PRESENTATIONS

Need Vs. Demand*

A theme which pervaded the conference and which struck the participants as being of real consequence was that health needs and health demands do not necessarily coincide. In other words, what clients want is frequently not the same as what is medically or epidemiologically identified as correct. Health is both a social and an economic good. Therefore, clients behave as consumers as well as patients. Need may not get perfectly translated into demand because clients are accounting for some real or perceived costs and/or because they have different perceptions about what need is.

The determinants of demand for health services are several and variable and some are more manipulable than others. These include -- and the order of importance will vary contextually -- incomes; prices; cost, not only in money but in time and effort; state of health, perceived or real; knowledge, attitudes, and beliefs; and accessibility and quality of service. Thus, not only do health service consumers (not healthplanners) define demand, but they also contribute their own definitions of need. These may be "incorrect" from a medical perspective and can be modified only through health education

*See P. Musgrove, PAHO. "Need vs. Demand for Medical Care in Latin America."

and/or the structure of costs. This is particularly true in the public sector. Unlike the private sector, the public sector cannot ethically respond to demand alone since that may be incompatible with public as well as individual well-being. For instance, interventions which benefit the society as a whole as much as they do the individual, e.g., vaccination, malaria control, tuberculosis therapy, may be essential to reducing mortality and morbidity in that society and yet not be perceived as a health need by its members.

The basic formula, as articulated by PAHO for defining health objectives in the public sector, includes the factors of equity (meeting needs with about the same likelihood for all), efficiency (trying to meet both demand and need without wasting resources), and efficacy (producing positive medical impact).

It is doubtful, however, that these can be achieved without a goodly measure of a fourth 'E', education, through which the suppliers of health in effect market their goals and attempt to achieve a better fit between need and demand and between demand and supply. This education must be predicated on a two-way, iterative process, in which suppliers "read" the market as expressed in demand, try to understand the nature and causes of demand, return to the market with messages which are scrutinized on a recurring basis for impact, and adjust supply in response both to the market and to larger health goals. For instance, it is clear that curative demand supersedes in consumer preference the demand for preventive services, and yet preventive services are of primordial societal importance. The public sector must be crafty enough to package its services so that curative services "lead" and may even subsidize preventive services. In the absence of this approach, it is difficult to see how overall public sector mortality- and morbidity-reduction goals can be achieved at a cost which is manageable for both providers and clients.

The problem arises of how to define and measure effective demand; how to build a medically, epidemiologically, and economically adequate package of health interventions; and how to charge appropriately for that package. The consensus among conference presenters and participants was that little is known about demand in the LAC context. Data available are unsystematic and not sufficiently precise or reliable. What information is available tells us primarily about what people spend on health and relatively little about the reasons for expenditures, the nature of costs, customers' own elasticity of demand, the dynamics of pricing, the meaning of quality of care, and differentials in willingness to pay. What is known is known mainly at the macro-level, e.g., that expenditures on health care go up faster than income; that, as health expenditures increase, overall relative expenditures at each level of service shift demand for public sector services change in the context of "lean" as opposed to "fat" economic seasons and fat economic times foster the generation of infrastructure which cannot be supported in lean times; poor people will spend more on drugs in lieu of services than do wealthier people; and price is only part of a constellation of variables that affect demand.

How can the necessary information be acquired? There appears to be some consensus that, while some rather large scale and costly surveys are under way or planned, satisfactory information can be gotten in other ways: through

surveys in smaller samples; through piggyback modules on projected surveys; and/or through well-considered analytical exercises, including the epidemiological and economic assessment of primary health care priorities and the definition of a more realistic set of mortality and morbidity objectives.

Financing and the Role of the Government in the Health Sector*

There are, basically, nine options governments can scrutinize when they are exploring health financing issues and alternatives: 1) improve the pricing of services; 2) adopt new approaches to revenue generation and risk-sharing; 3) alter the structure of public subsidies; 4) change the level of government spending on health services; 5) revise the level or content of external assistance; 6) use the resources already available to the health sector more efficiently through institution-building and through such strategies as permitting local management and retention of locally-generated funds; 7) change the public-private mix in the sector by pursuing such private-sector alternatives as transferring ownership/control of existing facilities from the public to the private sector, allowing or encouraging private or quasi-public services to grow or decline in parallel with public services, or introducing reforms within the public sector that have effects similar to transferring control, but without changing ownership; 8) expand or contract activities in other sectors that affect health conditions, e.g., water and sanitation; and 9) reorient health sector goals to conform to resource limitations, e.g., reduce targets for facility construction.

These options are not necessarily mutually exclusive and fall into three basic categories of concern: 1) cost cutting; 2) revenue generation; and 3) resource allocation. Most of the discussion within AID to date has focused on the first two categories. Assumptions have been that first, the major burden on public health sectors has derived from the recurrent cost of primary health care and second, that those costs cannot be met nor can the long-term financial viability of PHC systems be achieved by national governments. Furthermore, such costs are not appropriately assumed by donors.

Major financing solutions will be found in alternatives that control costs in some way and/or raise additional funds to support them. Either PHC services must be reduced or public-sector clients must pay, or assist in paying for those services. Primary importance is assigned to generation of revenues through such approaches as sales of medicines and curative services; local-level financing through a variety of mechanisms; and/or increasing the role of the private sector in provision of goods and services. Ancillary assumptions in some projects, e.g., the Sine Saloum rural health project in Senegal,

* See D. de Ferranti, the World Bank. "Financing Issues and the Role of Government in the Health Sector."

* See W. R. Goldman, AID/Asia Bureau. "Financial Viability for the Health Sector."

are that demand for preventive services will be created by the earned credibility of curative services, and that preventive services can be added once the viability of the curative service system is established.

Management Improvement*

An important component of the conference was a retrospective and prospective consideration of experience to date with management improvement projects spawned by AID in the 1970s. The underlying hypothesis for these activities was that more health services could be more effectively and economically delivered to more people, if only the systems supporting that delivery were managed more efficiently. The questions the conference asked, through substantive presentations and a panel discussion of field experience, were:

- 1) Have these projects had any success and what is the nature of that success?
- 2) What have been the impediments to progress through such projects?, and
- 3) Where do we go from here?

The context in which management improvement projects (MIPs) have had to operate is both their reason for existence and the source of many of the obstacles which such projects face in their implementation. The obstacles include: diminishing financial resources and rising demand; less willingness on the part of government to borrow for "non-productive sectors"; unpredictable and frequent staff turnovers; economic and political pressure on ministries of health to demonstrate success; and concentration of resources at the top of the health delivery pyramid, in inverse relationship to the concentration of need for primary health care at the base of that pyramid.

Ministries of health are short of the resources and absorptive capacity needed to carry out large and wide-ranging projects with ease and alacrity. There is, in some cases, lack of broad-based organizational commitment and ministries of health do not really have control over the two subsystems, finance and personnel, that are crucial to real and lasting change. On the AID side, management improvement projects have been too ambitious, inflexible, and complex, have emphasized rather sweeping systems reform instead of well-focused and measurable initiatives; and have stressed outputs instead of objectives. Particularly in the light of their very ambitious goals, AID project time frames have been woefully unrealistic given the order of change that is desired.

The importance of management does not make management improvement occur. While there have been accomplishments in planning and design, the primary achievements in implementation have been in training, perhaps the least threatening, and the

* See C. Crone Coburn, Management Sciences for Health, "Management Improvement Projects: Where Do We Go From Here?" This section also incorporates the major findings from a panel discussion among AID health officers on "Management Improvement Projects: What are the Results?"

most funded of all management subsystems. Unfortunately, the impact of training is limited when there is little or no follow-up supervision and systems support, and where no critical mass of similarly trained and supported personnel has accumulated.

Yet even in such contexts, management improvement projects have been able to display achievement in crucial areas; national health policies have been reoriented; training has been provided at all levels of the delivery system; management system bottlenecks and problems have been identified. There has been effective implementation of specific, focused technical innovations and efforts at system decentralization show promise.

This consensus on experience led to consensus on the criteria for the implementation and eventual success of management improvement projects. The essentials are:

- a) a critical mass of trained people, not necessarily very large in absolute numbers, but more importantly in adequate numbers in key subsystems;
- b) sensitivity to the political and institutional context and culture;
- c) the building of consensus through working groups and shared production of data that is quickly analysed, accessible, and concise;
- d) continuity and longer time frames;
- e) in-depth institutional commitment to change; decentralization and loosening of central control over resources;
- f) resource allocation that is in line with primary health care priorities;
- g) targeting of funds to regional and operational levels;
- h) selectivity among management systems and primary health care priorities; and
- i) specificity and focus on concrete objectives and outcomes.

Participants agreed that there was little point in management improvement or administrative reform projects undertaken in a vacuum. Such projects should be integrated with the delivery system, or at least with some of its components. Furthermore, there is little point in undertaking these projects if the ministry of health is not palpably serious about reform and does not foresee enough of a life span to get at least some subsystems operating well.

A final and critical criterion of potential success was the restructuring of incentives and rewards within the public health system. In most public sectors in the developing world, the incentives for institutional change are

either inadequate or the disincentives are irresistibly powerful. Perhaps because they are so embedded in the cultural and societal fabric and so discouraging by virtue of their strength and durability, existing structures of incentives and disincentives are, when addressed at all, relegated to the "assumptions" columns of log frames. A crucial question for health officers is, and will continue to be: how can such structures be brought into a better integrated and more honest position in the texture of projects; how can disincentives be reduced and what can be devised to drive the desire to modify management systems. Incentives for individuals can typically be characterized under the rubrics of power, recognition, money, and achievement and can be used as engines of change. The prospect of savings through cost containment or ability to retain revenue from new sources could constitute a potent incentive for health institutions.

Financing and Delivery Alternatives

A substantial portion of the Health Officers' Conference was dedicated to consideration of the potential of three alternative approaches to financing the health sector in ways other than through the customary public-sector strategies. The possibilities considered were: social insurance, prepayment schemes, and approaches based on or including sale of pharmaceuticals.

Social Insurance*

The role of social security in the health sector as a whole is substantial and is presently characterized in many LAC countries by high resource consumption low and skewed coverage, control and use of costly, sophisticated technology, large and growing financial problems, and real political implications.

Coverage under social insurance now exceeds 50% of the combined populations of the 16 Latin American countries that have mixed medical care systems, ranging from an average of 70% of the total populations of seven relatively high-income countries to an average of 11% in nine lower income countries. The range derives from the fact that population coverage for medical care under social insurance is strongly related to a country's level of economic development. Quality and cost are variable, depending in part on whether services are provided directly through a social security institute's own facilities and medical staff, or indirectly through financial arrangements with public health or private medical services. Extent of coverage varies primarily by employment residence, and the health risks against which coverage is provided. Social security does best at protecting fixed wage-laborers in urban environments and has made very little progress in coverage of medically indigent populations in

* See D. Zschock, State University of New York, "Social Security Systems and Medical Care in Latin America."

urban and rural areas or in rural areas in general. This has given rise to the accusation that medical care under social insurance is marred by exclusivity and is therefore regressive in its financing. Its supporters say that this exclusivity is more apparent than real, is not intrinsically irremediable, and has served to obscure the potential of social insurance for expanding coverage.

Social insurance, and its coordination with the public health system is an essential part of any rethinking of the health sector as a whole, most especially its financing. International efforts to stimulate such coordination began with a meeting of social security experts organized by the OAS in 1959. The consensus which has emerged since then is that any attempt to coordinate the two basic provider approaches must recognize that they appropriately serve different population segments and that patterns of service will vary over time as countries urbanize more and as they are able to offer more stable employment conditions. Areas where cooperation has been mutually beneficial include the construction and utilization of hospitals, and the production and distribution of pharmaceuticals. Coordination has been greater in higher rather than in the lower-income countries. The former have expanded coverage primarily through medical care under social insurance while the latter have tried to expand service delivery primarily under public health auspices. One constant throughout this variation is that coordination between social security systems and public health ministries does offer real opportunities for expansion coverage, increasing cost effectiveness of health services delivery, and reducing duplication of infrastructure and competition for scarce resources.

Panel presenters observed, however, that there are large obstacles to achieving closer coordination in the lower-income countries: vested interests of beneficiaries in the maintenance of privileged access to medical care under social insurance; their preference for the direct pattern of medical care delivery; and the tendency of medical care under social insurance toward technology-intensive, doctor-centered medical care and its primarily curative orientation. The culture of the social security institute was described by one presenter as a "patrimonial bureaucracy" predicated on a traditional populist, patron-client structure and on organization by fiefdom. Another basic issue that has stymied coordination is that in most countries public health services and medical care under social insurance are organized under different ministries and subject to different laws.

The current dilemma for AID is how next to proceed in the area of coordination and what options are there? While the specific objectives of health sector coordination will vary among countries, AID missions interested should consider the following:

- 1) Where equal access to services is not yet provided for dependents, social insurance can work toward providing full coverage. Public health experience in primary care delivery could be incorporated into social insurance plans for providing equivalent services,

- some of them jointly with public programs (e.g., immunizations and oral rehydration, and any of the components of the regional Child Survival strategy);
- 2) Where social insurance has not yet expanded coverage to include all "formal sector" employees and their dependents, such expansion could be accomplished in cooperation with public health programs under contractual arrangements which might eventually lead to the transfer of public health facilities to social insurance authorities;
 - 3) Social insurance programs could begin to provide medical services to non-covered individuals for specific purposes (e.g., emergency treatment, immunizations, etc.), financed on a cost-reimbursable basis through general tax revenue transfers, or communities, cooperatives, and groups of self-employed workers could be assisted in purchasing services by using social insurance mechanisms;
 - 4) Public health authorities could negotiate with social insurance programs for the latter gradually to assume direct or indirect managerial, financial, and/or staffing responsibility for secondary and tertiary levels of care at currently public facilities. Alternatively, joint planning of health personnel requirements, utilization, and remuneration may also be an area for technical cooperation. Even small improvements in personnel administration could yield substantial benefits for both sectors. Since public health and social insurance draw upon the same pool of manpower and tend to use the same sources and methods of continuing education, a basis for better coordination already exists. Opportunities also exist for cooperative approaches to pharmaceutical procurement, storage and distribution, and in the upkeep of health centers and clinics operated by both sectors.
 - 5) At some point, social insurance could become the principal provider of medical care, under either the direct or indirect pattern, with coverage for the medically indigent financed by general tax revenue transfers. Cooperative planning for the health sector as a whole will require a joint information system and medical record-keeping methodology that do not now exist. Cooperation at this technical level could be encouraged, starting at the level of basic health services and gradually including secondary and tertiary levels of care.

Prepaid Health Care Organizations*

Because the concept of prepaid care is new to AID, it is worth briefly defining it. Prepaid Health Care Organizations or Health Maintenance Organizations (HMOs)

* See H. Berman, Matthew Thornton Health Plan, Inc. "An Overview of Prepaid Systems of Health Care Delivery"; A Solari. "Development of Prepaid Systems of Health Care Delivery in Latin America." P. Zukin Health Management Group, Ltd. "Guide to the Assessment of Health Maintenance Organization (HMO) Feasibility"; C. Clellan. "Possibilities for HMO Type Organizations in Less Developed Countries".

as they are known in the US, are different from the traditional fee for service delivery model and from forms of health insurance. An HMO combines in one entity both financing and delivery of care to a subscribed population. Providers and the insurance company are thus part of the same organization. To maintain a financially viable and competitive business, the HMO managers must budget for an expected level of service utilization, and the participating physicians must impose tight controls on the health care system to assure that only medically necessary procedures and hospital admissions are ordered. Through this organized and managed system of health care, the per capita costs are reduced. Other benefits accrue as well. Due to the high cost of hospital care, disease prevention programs are not only a public health consideration, but also an economic necessity.

There are a variety of prepaid organizational or HMO forms. The variety of forms and the stages of their development are much greater in Latin America than in the United States. In Latin America, Prepaid Health Care Organization or HMO entity displays the following characteristics: it must be a private or semi-private legal entity; it must assume the financial risk and responsibility for organizing delivery and ensuring access to health care services; it must provide comprehensive coverage of health benefits; prepayment must be the sole or most important source of financing; health services may be provided directly through its own facilities or by contracted providers; physician services, except highly specialized ones, may be provided by physicians working as employees of the HMO or as a group of professionals that collectively share the financial risk for medical care with the HMO; continuity of care must be ensured by the organization; members cannot be disenrolled by the HMO because of their health status or utilization of services; and membership premiums may be paid by the member or by an organization.

The countries of Latin America share some characteristics which make it worthwhile for AID to think seriously about the potential of HMOs and HMO like schemes. These characteristics are:

- a) high percentages of the population (from 10-15% in the more-developed countries to 35-40% in the least developed) without access to modern health services;
- b) health facilities run by ministries of health and social security institutes that are, for the most part, of low quality, poorly equipped, offering little comfort, etc;
- c) an oversupply of physicians which is economically and politically troublesome;
- d) increasing demand by the middle and upper classes in recent years for better health services at more reasonable cost;
- e) a market already responding with a proliferation of traditional insurance approaches; and

f) an urgent need to contain the costs of health.

In other words, there are several sorts of very large populations with greater or lesser ability to pay who are either demanding or needing adequate health services, and there is an overall excess of providers in most LAC countries.

The basic set of issues that center on the establishment of HMOs anywhere derives from the criteria for their establishment. These are quite straightforward:

- a) marketplace characteristics (including ability and willingness to pay, a large enough population to provide an actuarially sound base, and a population that can be accessed in fairly simple fashion for the collection of routine monthly contributions;
- b) availability of financing to cover developmental costs and operating deficits incurred in the first years of operations;
- c) availability of technical staff trained and experienced in cost accounting;
- d) marketing information systems, and utilization control for whom incentives to join and adhere to such an organization can be provided;
- e) a hospitable legal environment;
- f) baseline data for estimating the cost and use of services within the proposed system (pricing cost, accounting, and final projections);
- g) health services delivery capability upon which a new system can be structured;
- h) existence of a sponsor willing to serve as the driving force in organizing and promoting the HMO-type organization; and
- i) an acceptable political environment.

These criteria constitute a checklist for assessing HMO feasibility and each criterion has the potential, if not the probability in the LAC context, for generating a small host of issues. They may all be resolvable, but resolution depends in a major way on the availability of solid data and a thoughtful series of marketing steps before implementation can even be contemplated.

A recent survey of prepaid health activity in South America, carried out under a Cooperative Agreement between AID/LAC/DR and the Group Health Association of America, intimates some of the issues that might be expected to arise, on the basis of experience to date. Among these are: a limited population base that can be recruited for prepaid health services; excessive domination by the

national social security system; economic recession, leading to zero growth or disenrollment; real competition from the public or quasi-public health sectors; an independent and resistant medical profession; and political considerations.

At the same time, there are a number of countries, where circumstances recommend that serious consideration be given to the HMO possibility. The survey flagged the following countries as fertile ground: Bolivia (through cooperatives); Jamaica; Colombia; Ecuador; Paraguay; Peru (through cooperatives and private firms); and Venezuela. A recent survey in the Eastern Caribbean, under AID sponsorship suggests some innovative possibilities for government involvement in HMO development.

Perhaps the most difficult aspect of such effort is the complexity of trying to set up HMOs in countries suffering from soft currencies, inflation/devaluation, foreign exchange problems, and capital flight. A key case in point is Jamaica, where a government whose health delivery system is essentially bankrupt is looking toward a private-sector, HMO solution for its problems. This is, of course, the same basic question with which AID is grappling in working with the private sector as a whole: what is needed for an outside enterprise to look at a Third World country and decide to invest in it, and how can AID help? No less important are the ethical implications of HMOs and the mechanisms and strategies that will have to be devised for the Agency to honor its commitments to preventive health care and to the Third World's most marginal populations. There are serious inherent strains between social objectives and business objectives, between image and profit.

The Pharmaceutical Subsector*

The questions of need versus demand and demand vis-a-vis supply are as germane to the specific subject of pharmaceuticals as they are to the general issues of health care provision discussed earlier. The bridge concept for both topics is the role and force of the market. It cannot be meaningless that the transnational pharmaceutical firms operating in Latin America and the Caribbean are most active in sales and packaging, less active in production, and least active in research and development. It is the market that matters.

Marketing can occur basically in one of two ways. Marketing experts either identify a need or a demand and respond to or are "pulled" by it. Or, they "push" it, that is, they create the need and in some fashion engineer the demand. Either way, the key dimensions are prices, product, place, technology, and promotion. Governments should assume social responsibility for marketing

* See G. Gereffi, Duke University, "The Pharmaceutical Industry and its Impact in Latin America"; and Enrique Feffer's comments.

practices through regulatory or other mechanisms to be sure that prices are appropriate to a target population's ability to pay, that products are compatible with epidemiological priorities and that the market is not used to dump unsafe drugs or that promotion and packaging do not favor inappropriate drug utilization by either the provider or consumer. It becomes an issue for AID and host country governments to be certain that they foster responsibility and, at a minimum, control irresponsibility within the marketplace.

Just as the structure of disease in Latin America has been traditionally affected by the lack of pharmaceuticals, we are beginning to see that same disease structure increasingly affected by availability. It is not clear that the effect is all positive. AID's concern, as it works in this subsector, is to be sure that it does not make things worse.

Pharmaceuticals have been increasingly perceived by health professionals in the developing worlds as a fungible resource which can support or subsidize not just curative health goals but preventive goals as well. The fungibility of that resource has a lot to do with the wisdom of pharmaceutical policy and legislation, as well as with the wisdom and skill with which a country's private and public pharmaceutical supply is managed. Frequently, the limited funds available are ill spent on ineffective, duplicative, or unacceptably dangerous drugs, or wasted on non-essential drugs which are used inappropriately. Since drugs have the capacity to harm as well as cure, the subsector generates a paradox. When drugs are not available, the patient does not get well or is given an inappropriate substitute or both. He/she becomes disgruntled with the entire health care delivery system, and not only may not appear for curative care but cannot be accessed for preventive care as well. On the other hand, if the drugs that are available are irrationally used, therapeutic failures and drug-induced illness add significant burdens to already overburdened health systems.

The solutions are to be found at all levels of the health system, the highest being that of national drug policies. These should be viewed as part of broader health policies which are, in turn, a key component of a country's (and AID's) intersectoral, overall development strategy. At lower levels, solutions are more likely to be found in the quality of implementation of drug programs. Solutions tried so far have included: 1) development of essential drug formularies based on prevalent morbidities, and utilizing criteria of efficacy, safety, and cost; 2) development of therapeutic prescribing information and standards of care; 3) improvement of inventory control systems; 4) establishment of management information systems; 5) improvement of procurement systems; 6) implementation of "level of use" standards; and 7) development of quality control procedures.

These measures do address the important logistical aspects of pharmaceutical programs, but do not adequately address patient-level pharmaceutical use concerns which play a similarly important role in the overall effectiveness of such programs. AID should be giving attention to the need for drug

utilization review activities. These activities begin with an understanding of the consumption of drugs and establishing realistic estimates of actual drug consumption which then become the basis for developing and adopting meaningful standards of use, so that suboptimal or irrational drug use can be identified and corrected. Drug utilization review procedures can provide benefits to patients, to health care practitioners, to drug program management, and to overall program costs.

Also to be addressed at the policy level are issues of centralization of procurement; the placement of pharmaceutical production, procurement, packaging, and distribution in the public and private sectors; use of multisource generics; the potential for joint ventures, particularly those which favor technology transfer and, possibly, labor intensity; and product registration and quality control. Each of these had local-level and international ramifications which can generate real issues, if not problems for AID when it is working in this subsector.

Below the policy level, or apart from it, are questions of implementation, the objectives of which are to manage limited resources efficiently, decrease costs, and increase availability and access. Improved pharmaceutical systems management is one of four basic strategies which AID can contemplate and which should, in fact, be considered before moving to more apparently innovative schemes. Such relatively simple interventions as rational procurement, improved storage, local formulation and repackaging, and generally good management of the supply system may, separately or together, go a long way toward producing self-sustaining and even profitable pharmaceutical enterprises for the public and quasi-public sectors.

USAID should also look at the potential for revolving drug funds (RDFs), drug sales programs, and pooled procurement, none of which are mutually exclusive. Each of these strategies has its advantages. RDFs offer opportunity for improved management of supplies and money, separate the activity from the government, assign value to inventory, force accountability, restructure incentives for proper management toward more businesslike procedures and, experience indicates, generally favor more efficient procedures and less political and market vulnerability. Drug sales programs increase cost-consciousness and improve patient compliance. Pooled procurement permits sharing of information for careful purchasing decisions and exerts positive influence on supplier performance. No single approach is necessarily the right answer for any given country and there is no right answer for all countries. The issue for USAID is to assess, without reference to what is currently fashionable, which approach will produce revenues and enhance health services.

Finally, real concerns for the conference participants continue to be the procurement of pharmaceuticals and the limitations of AID procurement regulations. Some AID officers had had good experience with AID procurement and found it adequately agile for their purposes, but most were worried about AID/W capacity for speedy response, especially in projects for which

pharmaceuticals constitute the engines or the financial heart. Access to waivers and solesource procurement are useful tools but not always sufficient or applicable. The growing complications due to multisource product components may further muddy already murky waters, although they may also engender a little more malleability in the regulations. All in all, the sense of the meeting was that procurement would continue to be a problem until AID learned from its own positive experience (for instance in family planning commodity procurement) and until the pertinent regulations are more flexible.

EMERGING ISSUES

Out of the formal presentations, case studies, and out of the panel and working group discussions, emerged principal clusters of issues, or themes. These themes constitute the thread which binds together the conclusions and recommendations which constitute the final section of this summary report. They are: 1) the complexity and breadth of health financing needs and implications; 2) the importance of resource allocation; 3) the importance of policy dialogue; and 4) the need for donor coordination.

Complexity

Health officers concluded that the subject of health financing was more complex and larger in its contours than the health officers had been wont to perceive it. This means that there are no single, simple, or pat answers in the area of health financing in general, nor in resource allocation, revenue generation, or cost containment. Not only is each of these areas internally complex, but each bears an intimate relationship to the others and there is a necessary and delicate balance among them. None can be fruitfully addressed in isolation and all should be addressed in the light of well-defined and clearly-ordered preventive and curative health goals.

Health financing has been plagued by some rather troublesome mythology: 1) that all countries are the same; 2) that highly simplified models are of broadly applicable utility; 3) that it is possible to think usefully about health financing without thinking about types of care and types of clients, or about questions of cost, equity, differential demand, and quality of services; 4) that health financing solutions are the first priority; and 5) that health financing "fixes" will automatically contain health costs in a future which will be marked by rising incomes and corresponding rising demand, by growing desire for more sophisticated health technology, by increasing elderly populations, and by changing health profiles.

Until now, an emphasis on recurrent costs and revenue generation has been the principal driving force for AID decision-making on whether, what, and how to invest in the health sector. There is, however, growing evidence

that revenue generation interventions such as user fees, revolving drug funds, and community financing schemes, even when they work and endure are only limited solutions which can obscure the larger issues. They are not appropriately an end in themselves. Beyond the limited financial impact of such schemes on national health budgets there is the risk that over-emphasis on such partial approaches will introduce unhealthy biases into AID Mission attempts to rationalize health portfolios.

Financing and financing solutions, cannot be considered in isolation, but must be related to well-defined and clearly-ordered preventive and curative health goals. These, for AID and for many other donors and the countries with whom they work, center on fertility and infant and young child mortality reductions through basic health services for the rural and urban-marginal poor. The growing feeling is that the issue of affordability, for the government and for the consumer, is a priority health policy issue. There are recurrent costs in all development sectors, and their dimensions and implications are part of a larger set of sectorwide issues and possible universe of solutions.

Resource Allocation

There was apparent consensus among presenters and participants that the area of cost effective use of health resources was of great priority and one on which AID has not focused sufficiently. There is good reason for this. The allocation of resources entails budgetary changes and major shifts in expenditures patterns which are decided at national policy-making levels. Consequently, they are less amenable to intervention than, for instance, efforts at supporting health services through community-level financing. Resource allocation is a matter which extends well beyond the health sector and the leverage that can be achieved with AID health projects has typically been limited. The officers agreed that it is not reasonable to expect health projects alone to resolve problems that are really government-wide or economy-wide problems. These need to be addressed within the context of an entire Mission program and as an integral part of country strategy. Tracking resource allocation is difficult because access to the necessary budgetary data is typically limited, much of the information hardly exists in useful form, and it is customarily politically sensitive. The consensus of the officers was that these constraints are best met through two main avenues: policy dialogue and donor coordination.

Policy Dialogue

Despite real and presumed difficulties, conference participants found, perhaps to their surprise, that there were already some examples of efforts at dialogue which might be termed successful or at least promising. One of these, the case of Honduras, was explored in depth as an instance where "good process brought about good substance." The most general conclusion of the case analysis was that, first, effective policy dialogue is, perforce and by

definition, dynamic, iterative and, while not necessarily rapid, a potentially exciting mutual learning experience. Secondly, there is no meaningful policy dialogue without the meaningful participation of all the major parties involved or affected. Furthermore, participation must be that of allies, not of patrons and clients nor of adversaries.

There was firm agreement that the essential ingredient for productive policy dialogue was good data, well analyzed, and presented in concise and easily accessible formats. In the Honduran case, the use of the Lotus 1-2-3 on a Compaq microcomputer was crucial to achieving a collegial understanding of the recurrent cost implications of contemplated hospital construction. Utilization of the same technology for a joint modelling exercise made it possible for the Hondurans to select an alternative solution that made sense to them, and to AID. Ministries can be helped to know what they spend and for what, what their alternatives are, and how effectively to decide on the basis of simply and actively shared facts rather than on the basis of rhetoric, habit, or imposed policy.

The observation was made that economic stringency may actually provide an opportunity through managerial improvement and careful husbanding of available resources, to restructure public health sectors which have become swollen and disorderly. Still, the changes that need to be effected cannot be accomplished by AID alone and there was considerable feeling that even bilateral approaches to decisions among the options had their limitations. There was agreement that the best opportunities for impact would be found by the community of donors, working together and in conjunction with host governments.

Donor Coordination

The much-battered topic of inter-donor coordination was discussed again, with some weariness and little belief that what was occurring in Washington, except for some appreciated efforts on the part of the LAC Bureau, was building a constructive working relationship with PAHO and the other multilateral lending institutes. In fact, there was virtually no knowledge about what actually constitutes the process of interdonor coordination at the central level. The perception was that there is a large gap between the traditional rhetoric about coordination and reality. By way of evidence, one officer noted that there is no single, accessible, up-to-date compilation of ongoing and forthcoming project descriptions for all major donors. The observation was also made that, while lack of coordination does place real administrative burdens on host countries, in some instances it is viewed as an opportunity for bargaining and even manipulation. Donors have not only failed in coordination but have effectively encouraged diversion and misuse of funds, as well as dilution and irrational deployment of human and economic resources. The officers concluded that fruitful coordination could and would occur primarily in the field and that AID missions should redouble their efforts, although some missions had made substantial progress in this regard since the 1982 Conference.

CONCLUSIONS AND RECOMMENDATIONS

The recommendations from the 1984 Conference fall into the following categories:

- 1) general sectoral and programmatic issues;
- 2) project design issues;
- 3) issues of human resource development and administration;
- 4) information needs;
- 5) information management issues.

These are presented below in that order.

1. General Sectoral and Programmatic Issues

- a. The productivity effects of good health are significant and worthy of AID's concern. This does not mean, however, that the social meaning of health for health's sake should be forgotten or that governments should not be helped to meet the social needs of their populations. There is also a significant political value associated with health and its delivery, both for governments and for those who work with them in the health sector. Concern for the economic dimensions of health should not obscure its other dimensions and other values.
- b. The LAC Region Health Officers vigorously concur that health financing issues are crucial and integral to overall AID health strategy, and should be given more explicit emphasis. AID health sector strategy, therefore, should be expanded to include overall improvement of resource allocation and utilization, with special attention to private and quasi-public/private providers, including social security and prepayment schemes, cost containment, particularly hospital cost containment and recurrent costs for the sector as a whole.
- c. There appears to be no agile and productive channel at the central level for coordination and health policy dialogue among donors, particularly bilateral donors. The Health Officers encourage fuller and more frequent coordination and dialogue at the highest levels of decision-making, between AID and those other international donor agencies involved in the health sector, so that the policies and programs of each complement rather than conflict with each other and so as to maximize utilization of resources instead of diluting and confounding their impact. Donors in the field should work collegially with each other and with host countries on the key issues of recurrent costs and cost containment, on resource allocation, and on the prioritizing of preventive and curative health interventions, especially in the areas of primary health care.

- d. The health officers suggest that, given the potential importance of pharmaceuticals in contributing to resolution of some health financing problems, AID policy for drug procurement be reexamined, with an eye to reformulation of that policy. Our pharmaceutical procurement policy may not be cost-effective for countries.

2. Project Design Issues

- a. The apparent shift in AID Policy toward longer time frames for projects is applauded by the Health Officers; it is doubtful that any durable and profound institutional change can occur in less than 10 years. It is also important that the time frame for achieving and assessing impact be extended substantially beyond AID's traditional thinking on that score.
- b. Flexibility is also crucial. Projects should be oriented toward objectives, rather than toward activities. Guidelines for changing projects and/or continuing them should be less rigid than is currently the case.
- c. Projects should be designed more realistically and with less complexity. Everything that is hoped for programmatically in a given sector should not be packed into one or two projects. There should not be, for example, bilateral projects which will address every single facet discussed in this conference, e.g., donor coordination, policy dialogue, regional project management, or every health financing option.
- d. Consideration should be given to the possibility of designing public sector institution-building projects which, instead of attempting to produce change on a broad but shallow basis across systems and institutions, are paced so that work proceeds sequentially in fewer subsystems more profoundly. Management improvement projects should be integrated with the health delivery system and advance serially, beginning with the subsystems that are more politically visible and susceptible to change, such as logistics and maintenance, and modifying the more difficult subsystems, e.g., finance and personnel, at a slower pace.
- e. For a number of AID missions, issues of health care financing are crucial. At the same time, it is not clear that financing alternatives have the same priority in Washington as, for instance, oral rehydration or child survival. Officers feel pressured at times to do "fashionable" projects which are not appropriate to their country's situation, which have counter productive implications for funding as well as for personnel, and which strain the rationality of health portfolios. The health officers request AID/Washington sensitivity to these implications.

- f. Health projects have not sufficiently emphasized the "softer" side of utilization, demand, user perspectives, and behavior in general. These will be important in a number of health financing activities, if not crucial (e.g. pharmaceutical sales, user fees, and prepayment schemes), and should be emphasized in project design and redesign.

3. Issues of Human Resource Development and Administration

- a. This year's Conference and their own recent experience suggest to the Health Officers new areas for professional development that they would like the Agency to consider. This development can occur through special training, site visits, workshops, seminars, and purposive dissemination of data, and can range from developing real expertise to generating minimum skills for intelligent production of scopes of work in new areas of health endeavor. Specific information needs are identified in the next section.
- b. The theme of this conference is applicable as well to population programs and nutrition activities. Because of this and because health officers, more often than not, are also responsible for activities in population and nutrition, there should be more practical integration of those subsectors. For example, when population and nutrition officers are different individuals, they should be included in such conferences as this one. There should also be explicit exchange of experience in selected areas. An important instance is the area of procurement; the officers suggest that S and T/Health study the Agency's experience in the procurement of family planning commodities to test its applicability to questions of health procurement in general, specifically the procurement of pharmaceuticals. As a broader matter, the health officers see themselves not just as health officers but as officers who combine responsibilities for health, nutrition, and population, and request that the Agency share and implement that perception.
- c. Each new project and new amount of money means more work, and the pace of these arrivals is outstripping the addition of new staff. In fact, technical positions overall have been cut, under the assumption that contractors can design, negotiate, and implement projects. At the same time, missions are losing contractors who are currently being financed by operating expense funds, since mission management in some cases wants technical contractors to be project-funded, even when these may be functioning as personal service contractors. The officers recommend that the Agency, and individual missions, recognize that this may be unrealistic in some countries, and permit the latitude for variation, and where appropriate, time for comparison of OE to project funding.
- d. The agency should seek, when hiring IDIs and mid-level health staff, individuals with background or skills in health financing and experience in the fields addressed in this conference.

- e. Health officers are given credit only for the bilateral project component of their portfolios, although they are asked to assume varying degrees of responsibility for centrally-funded projects. Either officers, especially regional officers, should be assessed on the basis of their entire portfolio, or the demands for responsiveness to S and T centrally-funded projects should be minimized.
- f. The health officers are concerned about career advancement in the health sector and would like to see some analysis of trends in promotion by sector and by gender. There is some sense that rural development/agriculture officers are promoted more often than health officers and that women are promoted less often than men. These differences are believed to be significant.
- g. At both central and mission levels, there should be closer and explicit linkages between private sector development officers and health officers. A potentially fruitful area is in the exploration of new and mutually interesting approaches to health financing and delivery, particularly HMOs and alternative pharmaceutical procurement and distribution systems. The health officers suggested integrated training of PRE officers, economists, and legal advisors in areas of innovative health efforts so that, at a minimum, the project committee system can function on a stronger knowledge base. This can be fostered through the distribution of information, involvement in seminars and workshops, and through "road shows."

4. Information Needs

- a. The consensus of the officers was that this year's conference had been productive, interesting, and useful, a significant element in their professional development. The case study approach was both utilitarian and stimulating and is recommended as a component of future workshops and conferences. Conferences for health officers should be held no less frequently than every two years, preferably every year, at a regular and fixed time. For purposes of economy these could be held, at least sometimes, in the field.
- b. The theoretical approach underlying the Health Officers' Conference, together with the individual presentations, suggested to the officers a number of subjects about which they would like to learn more. In no order of priority, these are: experience with management improvement projects, especially with regard to constraints; prepaid health care systems, and, particularly, financing strategies, marketing, and development of benefit packages; health delivery through cooperatives, etc.; the measurement of effective demand; setting user charges; the potential for systematic use of health PVOs; experience with community financing schemes; next steps in working with social security systems; issues of pharmaceutical utilization and medical prescribing practices;

experience with pharmaceutical revolving funds; AID's own experience with procurement; general management skills and use of micro-computers for general management improvement.

- c. AID/Washington centrally-funded resources are appropriate and should be made available to: conduct studies on the demand for health care; explore the social marketing of essential drugs; improve health management; explore other alternative financing schemes through technical assistance and "road shows"; explore cost-saving possibilities in the purchase of health commodities and new technologies; conduct financial analysis for improved resource allocation and utilization, to include looking at incentive systems; provide technical assistance in supply management and in mass media approaches to health practice; conduct preliminary assessments of the potential for use of HMOs and other prepaid schemes; conduct sensitization and marketing of such schemes; conduct feasibility studies for prepaid approaches; provide technical assistance for financial and feasibility analysis in the area of social security, especially concerning the potential for coordination/collaboration with ministries of health, perhaps in conjunction with PAHO; operations research in selected areas; arrange and finance study tours to visit programs in new and unfamiliar areas, for example, trips by Spanish-speaking HMO managers to assist ministries of health and mission personnel with the conceptual development or improvement in prepaid health care systems, or trips to U.S. based HMOs for education and training of LAC personnel. It may be possible to piggyback some of these activities onto ongoing efforts, e.g., the centrally funded GHAA study or PRITECH.
- d. In view of the reduced levels of direct-hire health officers and recognition of the value of centrally-funded technical assistance teams such as WASH and PRITECH, the health officers recommend that AID also consider the development of centrally-funded technical assistance teams in the area of alternative health care financing. Sources of funding for the foregoing sorts of activities can either be provided on a central or a regional basis. In either case, the existing restrictions on buy-ins should be eliminated or softened. The officers request that S and T sort out its procedures for buy-ins; these appear to be erratic and arbitrary.
- e. Because health officers will be working in new areas and dealing with new problems, particularly in the area of project design, it is suggested that more PDS funds be made available as in the case of the agricultural sector for technical assistance and research for PIDs and PP preparation. To make this possible, not only would more PDS funds have to be made available but schedules would have to be more flexible at the mission level and missions would have to ask for more funds earlier in the cycle.

- f. Continuation of the PRICOR activity should give more emphasis to management improvement projects and to health care financing in a wider context than has so far been the case.

5. Information Management

- a. Given the newness of the health-financing areas into which health officers are convinced they must venture, information-sharing must be substantial and proceed on a number of fronts. These can include, but not be limited to: technical and concept papers, case studies, personal and written exchange of field experience, road shows, centrally-funded activities, project document exchange, Sector Council minutes, and so forth. The officers requested that LAC/DR produce a very simple newsletter which would report briefly on current and forthcoming research and activities related to health financing.
- b. To make this possible, the Health Officers recommended to themselves, and committed themselves, to send to LAC/DR, consistently and as a matter of course, copies of scopes of work, PIDs, consultant reports, mission-reviewed PPs, questionnaires, working documents, and information copies of substantive memoranda of special interest in the area of health financing.
- c. S and T/Health should appoint a coordinator with a specific expertise and responsibility in the area of health financing.
- d. At the mission level, the discussion of health care financing should not just take place in the mission health office, nor should the dissemination of relevant data be limited to the health office. Health officers should assure maximum mission participation in briefings by health experts in general and by experts in the different dimensions of health financing in particular.
- e. The LAC Bureau should be more sensitive and responsive to the language needs of missions' country clients and should consider supporting translation of key documents, including technical and policy statements, for sharing at the local level.
- f. Policy dialogue on financing issues between AID and other donors must be through open channels and not through classified cables which effectively restrict such dialogue. Such classification should be kept to a minimum.