

ALTERNATIVE FINANCING FOR HEALTH SERVICES IN LDCs: IMPLICATIONS FOR AID
HEALTH-SECTOR ASSISTANCE PROGRAMS , 1982

Carl M. Stevens */

*/ Professor of Economics, Reed College. This report has been produced pursuant to Contract No. DPE-1406-S-1044-00 with S&T/HEA, AID/W.

Preface

During the past year, I have undertaken some investigation into the feasibility of developing alternative social-financing schemes for the basic health services in LDCs.*/ As a part of these investigations, three country

*/ For a general statement of what is entailed by this kind of feasibility assessment, see the author's "Assessing the Feasibility of Alternative Social-Financing Schemes for the Basic Health Services in LDCs," February 1982.

case-studies have been produced--for Egypt, St. Lucia and the Philippines. This document reports some of the more general implications of this work for AID's health-sector assistance programs in LDCs. I should note that each of the country case-study reports included some discussion addressed to the more general significance of health-sector financing systems. A major function of the instant report is to pull some of this material together in one place and to remark upon the implications of it for AID's programs in this domain.

LDC Health-Sectors: Systems of Mutually Interdependent Sub-Sectors

In many LDCs, the health-services sector is comprised of a number of mutually interdependent subsectors, e.g., the Ministry of Health (MOH) system, other government sponsored systems such as social-security-type systems,

delivery systems operated as part of medical-education programs, the modern (western) private sector and the traditional private sector. Historically, AID's purview of LDC health sectors has been confined almost exclusively to just one component of these systems--namely, the MOH systems and USAID health-sector assistance programs have been concentrated almost exclusively upon the MOH systems. However, frequently, the MOH system is itself a relatively small component of the total health sector. Moreover, and as will be spelled out to some extent in what follows, the subsectors comprising the total system are apt to feature important complimentary (as well as some competitive) relationships. This kind of mutual interdependence means that AID's purview in this domain logically must extend beyond the MOH systems to comprehend the health-services sectors as a whole. AID program planning in this domain should seek to identify, for each country in question, important complementarities among the subsectors comprising the health sector as a whole and should seek to develop assistance programs which can build upon such complementarities in improving the performance of the health-services sector as a whole, including but not restricted to, the MOH system components. In what follows, I will afford some suggestions exemplary of this approach.

Characteristic Health-Sector Configurations and Financing-System Problems

The health-services sectors of my case-study countries differed in many important ways. Nevertheless, very generally speaking, they all conformed in their major outlines to what may be regarded as a characteristic pattern for many LDCs. There is a Ministry of Health (MOH) system, financed out of general tax revenues which is supposed to deliver services to the population at large without user charge. To a greater or lesser extent, this system will have developed a facilities infrastructure. The MOH system will be,

however, severely underfinanced such that it cannot discharge its obligation to deliver health services "free" to all of the people--indeed, it effectively will reach only a relatively small proportion of the population. There is a large and flourishing private health-services sector (larger than the public sector) providing services on a fee-for-service basis and financed in the main by out-of-pocket payments by consumers. This characteristic pattern provides the context in which one may hope to rationalize health-sector financing by developing alternative social-financing schemes as potentially important components of AID's package of health-sector assistance programs. We may turn to a more detailed account of the characteristic pattern and of financing-system problems associated with it.

In the domain of health-services, preventive/promotive services tend to have public-good properties such that public financing of such services can be regarded as peculiarly appropriate. In various LDCs, the publicly financed MOH system is the logical provider of various such services.*/ And,

*/ Public financing of preventive/promotive services does not necessarily entail public-system delivery of such services. Thus, in some instances, public authorities may, in effect, contract with private parties for the delivery of such services. Also some preventive/promotive services, e.g., environmental surveillance, may be pursuant to regulatory programs which will mandate corrective action by private parties such that, in this sense, the preventive/promotive impact is a product of both public and private delivery of services.

typically, the MOH system delivers preventive/promotive services as well as curative services. The curative services, however, take the lion's share of the budget, personnel and attention of the MOH system, a circumstance which impairs the capacity of the MOH system adequately to discharge its preventive/promotive functions and responsibilities. This is a problem of central im-

portance. National health policy cannot rely upon (and, generally speaking, ought not to attempt to rely upon) private financing to secure efficient rates of resource allocation to preventive/promotive activities. Consequently, unless the MOH (or other public authority) can adequately finance these activities (and otherwise attend adequately to the provision of the outputs of these activities), there is a high probability that the output of preventive/promotive activities will fall far short of appropriate levels (from the point of view of impact on health status).

A part of the problem derives from the overall level of funding available to the MOH system from its share of general tax revenues. A significant increase in the level of funding for the MOH might permit the system to allocate more resources to preventive/promotive activities. Usually, however, there will be little or no realistic prospect that the MOH system will, in the foreseeable future, enjoy substantial increases in the funding available to it from general tax revenues. Realization of this is apt to provoke a call for alternative sources of funding for the MOH system. It is important to recognize, however, that even if there could be a substantial increase in the level of funding for the MOH system from alternative sources, this is unlikely to solve the problem of resource availability for preventive/promotive activities. There is a fundamental structural problem with these systems as they are now constituted. The MOH system is supposed to deliver curative services to the population generally without charge. The pressures from consumers (both directly and via the political process) for increases in the quantity and quality of the curative services delivered by the system are powerful and difficult to resist such that the curative-services claim upon scarce MOH resources tends inevitably to displace the claim of the preventive/promotive activities. Indeed, for any system which undertakes to deliver these services at zero price, the curative-services domain

tends to be a bottomless pit. Simply increasing the level of funding for the MOH system, even if it could be accomplished, is not apt to prove a remedy for the position. What is required is to relieve the MOH system of its major responsibility for financing curative services, to take the curative monkey off the MOH's back, so to speak, such that more of the MOH's share of scarce fiscal capacity can be conserved for the financing of those preventive/promotive activities which, if not financed in this way, are unlikely to be financed and delivered at all.*/

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*/ For every government, fiscal capacity is of course scarce in the sense that competing claims for financing from this source always add up to more than availabilities. Consequently, there is a general case for conserving fiscal capacity for those activities for which this kind of financing is peculiarly appropriate (e.g., public goods) rather than draining this capacity for the financing of activities which might more appropriately be assigned to alternative financing.

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The development and implementation of alternative social-financing schemes (e.g., general coverage under contributory health-insurance schemes) provides a socially acceptable way to relieve the MOH system of a major part of its responsibilities for curative services. This opens up at least the prospect that the MOH system can move in the direction of becoming more nearly a Ministry of Public Health with its major program emphasis upon preventive/promotive activities. Unless such a transformation can be achieved, the prospects of efficient rates of resource allocation to important public-health-type preventive/promotive activities are remote. And this means, of course, that the prospects for implementing a Primary Health Care strategy are likewise remote.

The considerations sketched foregoing have, of course, implications for AID's health-sector assistance programs in LDCs. In line with its legislative

mandate and for other reasons, AID has a special interest in promoting the implementation of Primary Health Care strategies featuring an emphasis upon preventive/promotive activities. The MOH system is (rightly) perceived as the logical delivery system for many such services. And, pursuant to this, projects are launched as part of MOH operations. This approach, however, may well fail to achieve the PHC and preventive/promotive objectives (particularly when it comes to "replicating nation wide") because it fails to recognize and cope with the fundamental structural problem discussed foregoing. Taking account of the interdependencies in the system as a whole, a better approach to achieving PHC and preventive/promotive objects might well be to assist the development and implementation of social-financing schemes (e.g., contributory insurance schemes) to finance the demand for mainly curative services delivered by systems other than the MOH. Such programs can provide a socially acceptable way to take the curative monkey off the back of the MOH and provide the possibility that the MOH system can concentrate its attention and other scarce resources on public-health-type activities. Thus, such alternative social-financing schemes can be regarded as integral parts of a PHC strategy. And, given that AID's objective in this domain is to promote the PHC concept and the preventive/promotive activities associated with it, the best strategy may be to assist the implementation of such schemes, rather than to launch projects which operate directly on the MOH system itself.

Although a program is needed to relieve the MOH system of enough responsibility in the curative domain to permit a major redirection of program emphasis in favor of prevention/promotion, under any likely configuration for the health-services sector in many LDCs, for the foreseeable future the MOH system will continue to be responsible for financing some curative services--

particularly, for some proportion of the population which cannot be included as contributing beneficiaries in alternative social financing schemes. Although the MOH system will not have the resources to discharge a putative obligation to deliver curative (and other) services without charge to the population as a whole, if the MOH system could concentrate its curative efforts upon a small proportion of the population, say 20 percent, its resources would be more nearly adequate to the task.

Again we have reasons why the beneficiaries of an AID assistance program, in this case to implement alternative social-financing schemes, may well include many who are not the direct targets of the program. Such possibilities should always be taken into account in evaluating health-sector assistance programs from the "who benefits" point of view.

Another major problem with LDC health-sector financing systems is the way in which the demand for services in the large and growing private sectors are financed--namely, by out-of-pocket payments. There is nothing inherently amiss in having a large and flourishing private sector. Indeed, there would seem to be no persuasive prima facie case that public agencies have a comparative advantage in the management and administration of health-services delivery systems such that governments should be impelled on these grounds to go into the health-services delivery business.*/ How the demand for health

*/ The propensity of governments to go into the health-services delivery business (e.g., as by constituting MOH systems) appears to be motivated more by distributional considerations than by comparative-advantage considerations (except insofar as public-health activities are concerned). In the health-services domain, distributional considerations are, of course, of prime importance. However, it may be possible to achieve acceptable distributional objectives without resort to large-scale public delivery of curative services.

services (however provided) is financed, however, is quite another matter. The disadvantages, from both the social point of view and from the consumers' point of view, of out-of-pocket financing as compared with health insurance are generally acknowledged. It may be argued that governments do have a comparative advantage in arranging social-financing schemes (e.g., contributory insurance schemes) and that they can make an important contribution to the welfare of health-care consumers by so doing, both by giving consumers an opportunity to insure against the risks inherent in these markets and by serving appropriate distributional objectives.

Extending coverage under health insurance also helps to rationalize health-sector financing in another important way. One of the big problems in the economics of the health-services sector is how to bring an appropriate willingness-to-pay test to bear upon the demand for health services (and hence upon the rate of resource allocation to the health services sector) while at the same time giving consumers access to an otherwise acceptable scheme for financing their demand for these services. Contributory insurance schemes, particularly if they incorporate modest consumer cost-sharing, are responsive to this problem. Under such schemes, if the beneficiaries want to consume more services they must contribute more (i.e., must be willing to pay). At the same time, such schemes spare consumers the financing burdens they would experience were they constrained simply to "go bare" in the out-of-pocket payment market.*/

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*/ However the demand for health services is financed, there is of course, always some kind of willingness-to-pay test, e.g., the governments fiscal capacity is constrained by the willingness of consumers of health services in their role as tax payers to pay general taxes. However, the connection between paying more general taxes, particularly where these are indirect taxes, and more or less of any given government service, e.g., health care,

is indirect and not visible. With contributory insurance schemes, on the other hand, there is a direct and visible connection between payment and receipt of health services resulting in a meaningful willingness-to-pay test.

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The foregoing discussion under the heading of characteristic health-sector configurations and financing-system problems has, in addition to the points on this score already adduced, a rather general implication for AID's prospective engagement with health-sector financing problems, namely, the approach adopted should be rather broadly rather than narrowly conceived. A few words of explanation are in order.

In various countries, pursuant to the national goal of "health for all by the year 2000," Ministry of Health (MOH) systems have embarked upon efforts to enhance their primary health care programs and activities, frequently at the local level and in a context of community participation. This approach entails, among other features, much greater emphasis upon preventive/promotive activities. Consequently, what has been for years a chronic problem for MOH systems--namely, how to make more resources available for preventive/promotive programs, has been greatly exacerbated. And, owing in large part to this circumstance, interest has been growing in finding alternative sources of financing for the health services--alternative, that is, to the general tax revenues available to the MOH. In my view, we have tended to take too narrow an approach to this problem, e.g., tending in large part to focus just upon the question how more money might be found for the MOH system. What is really required is to rationalize the health care financing system as a whole. This is so because, as I have attempted briefly to explain foregoing, such rationalization must be regarded as an integral component of the Primary Health Care approach, this in turn owing to interdepen-

dencies among the sub-sectors comprising the health-services systems. This is the point of view from which AID should approach the design of programs to assist health financing.

The "Project" Approach vs. "Structural" Interventions

In the course of the country case studies and the possible implications of them for AID assistance to help cope with health-sector financing problems, it became apparent that, in this domain at least, it may be advisable for AID to at least supplement its typical "project" approach with more program-oriented "structural" interventions. A few words of explanation are in order.

The performance of the health-services sector is manifest in various ways--notably, impact on health status. We may begin with the assumption that, whatever the overall strategy pursued, USAID assistance is intended to improve the performance of the health-services sector. There are, however, in terms of the overall strategy pursued, (at least) two quite different ways to go about this.

Traditionally and for the most part, USAID health-sector assistance has been cast in the format of health-program design and direct implementation--as by fielding projects. The typical project in this domain specifies the desired outputs of some health activity, the inputs to be used (various categories of health manpower, facilities, supplies) to produce the desired outputs, and how these are to be organized, managed and administered. A budget is specified, funds are provided, and a contractor is hired directly to implement the project (working in conjunction with USAID and the host country). Although projects differ in various ways, the project approach tends to exhibit certain features, viz:

- (1) Although the content of projects is negotiated with the host country,

a good bit (frequently, most) of the initiative for project design, etc. is supplied by USAID (often with the assistance of a consultant hired for the purpose).

(2) Although contractors are hired to implement projects, USAID's own project-administration role consumes virtually all of its professional staff time. Professional staffers, as project officers "backstopping" projects, become involved on a day-to-day basis with the details of project implementation, a task which frequently entails mediating conflicts between the contractor, the host country, and both of these and USAID.

It is owing largely to the circumstance that USAID health-sector assistance has typically been in the context of the centrally-planned (in principle), centrally-budgeted and centrally managed MOH system that the health-program design and direct implementation approach has seemed the natural way to go. As has been pointed out in the previous discussion, however, many LDC health-services sectors are comprised of a number of interdependent subsectors such that AID's purview in this domain logically must extend to the sector as a whole. A USAID health sector assistance program to engage this wider domain of events probably will want to include assistance activities in addition to those based on the traditional project approach, for example, what I here term the structural-intervention approach.

As with the traditional project approach, the structural-intervention approach seeks as its ultimate goal to improve the performance of the health-services sector (e.g., impact on health status). Under the traditional project approach, an attempt is made to operate directly upon the performance of the system. Under the structural-intervention approach, on the other hand, an attempt is made to operate on elements of the structure of the sys-

tem with the expectation (based on analysis) that improved system structure will yield improved system performance. For example, an important element of the structure of each health-services sector is the way in which the demand for these services is financed. A program to assist the widespread extension of coverage under health insurance (some of the implications of which were discussed foregoing) is exemplary of a structural intervention.*/ It

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*/ U.S. health-sector policy has featured a number of structural interventions, e.g., the 1972 HMO Act (variously amended in following years). The legislation was intended to encourage the growth of the HMO sector thus providing enhanced competition in the market for medical services and with the expectation that this would help to contain health-care costs. With the notable exception of PL 93-641 (National Health Planning and Resource Development Act, a program which never really got off the ground and has now been largely aborted), public policy in the U.S. health-services sector has not been based on central-planning-type approaches.

is not focused directly upon the performance of any given delivery system, e.g., the MOH system, but it may be expected to enhance the performance of that system and others. A structural intervention to promote the implementation and extension of health insurance might feature a number of components. For example (and as has been suggested for Egypt with respect to the function of the Health Insurance Organization there), USAID might capitalize a loan fund, to be managed, say, by host-country banking institutions, to help finance investment expenditures by organizations which would deliver services to be financed under the alternative financing scheme. Another component might be agreement to finance technical assistance requested by host-country organizations (e.g., agriculture cooperatives, consumers cooperatives, local government entities) interested in the design and implementation of health-insurance programs. Another component might include, in addition to assistance with planning activities, various kinds of subsidies to help defray

operating losses to be anticipated in the early years of attempting to implement such programs (analogous to some of the provisions of the 1972 HMO Act in the U.S.).

The point here is not to recommend any particular structural interventions but rather to afford an example to facilitate drawing attention to the fact that such an approach will have certain characteristics which differentiate it from the conventional project approach. For example, as previously remarked, under the traditional project approach, the initiative tends to be with USAID. Under the structural-intervention approach, on the other hand, the initiative will be much more largely with the host country. Take the exemplary capitalized loan fund proposed foregoing. The extent to which investment events result from this component would depend upon the extent to which host country organizations come forward to convince a bank's loan officers that they can in fact repay loans for these purposes. Under this kind of program, USAID affords an opportunity; it's up to the host country initiative to exploit that opportunity. The vexed subject of technical assistance (TA) affords another example. In the context of the traditional project, TA is put in, usually at the initiative and insistence of USAID, in the attempt better to control the outcomes under the project. And, frequently, TA of this kind is resisted and resented by the host country (they tend to regard it as a full-employment program for U.S. consultants). The TA component of the exemplary alternative-financing initiative is of a very different kind. Under this recommendation, TA does not appear as a line item in a project budget. Indeed, there is no "project" in the usual sense. Rather, the program calls for establishing a fund to finance technical assistance which might (or might not) be requested by various parties. Thus, the initiative is with the host-country. If the promoters of health-insurance schemes feel that

they would benefit from TA they can come forward and request it. Again, the TA funds affords an opportunity; it is up to host-country initiative to exploit that opportunity.

In the health-services sector, and in addition to the usual circumstance of working within the context of the MOH system, the traditional project approach, cast in a central-planning-type framework addressed to specific performance targets, has been encouraged by the belief that this approach is somehow more "rational" than other approaches and also exhibits an appropriate sense of stewardship for the tax payer's dollar. However, the structural-intervention approach is not properly regarded as in some sense less rational than performance-target planning incorporating program design and direct program implementation. Rather, it is a different approach based upon a different perception of what intervention strategies are most apt to in fact result in improved health-sector performance. Nor would it be correct to suppose that the structural-intervention approach somehow exhibits a less delicate sense of stewardship for the tax payer's dollar. Indeed, if analysis suggests that the structural-intervention approach is more apt, under given circumstances, than is the traditional project approach to yield improvements in health-sector performance, then both rationality and our sense of stewardship for the tax payer's dollar would urge that we adopt the structural-intervention strategy.*/

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*/ We may remark that since the typical project engages but a small subset of the events comprising the health-services sector of which it is a part, it usually is provided that, if successful, the project will "be replicated nation wide"--as the argot of the project community would have it. However, the analysis (especially the economic and financial analysis) supporting the expectation of such replication is usually not very convincing. This consideration, plus the notable failure of health projects to in fact

be "replicated nation wide" raise questions about the extent to which the traditional project approach itself may be regarded as in fact "rational".

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In various LDCs, in economic sectors other than the health-services sector, USAID is continually urging the government to abandon central-planning approaches (administered prices, performance targets, etc.) in favor of greater reliance upon properly structured markets and market-type incentives. And, vis-a-vis these other economic sectors, this approach and the assistance activities which seek to encourage such structural changes, are regarded as entirely appropriate and rational. In light of this, the extent to which, vis-a-vis the health-services sector, we appear to have become wedded to the notion that the central-planning approach represents rationality appears as something of an anomaly. It is true, of course, that the health-services sector differs from other economic sectors in important ways. However, in the design of USAID's health-sector assistance portfolio, there may well be room for greater reliance upon structural-interventions--an approach which would be very much in line with AID's general approach to development assistance.

Assisting Alternative-Financing Programs: Some Implications for USAID
Planning, Program Development and Staff Commitments

I may conclude this note with brief attention to these organization matters. The conventional USAID project goes through a series of familiar steps from PID to PP to signing up the contractor and thence to project implementation. USAID staffers as Project Officers then "back stop" the projects with all of the day-in and day-out attention to operating details that this entails. It has been my impression (perhaps a wrong one) that it is in their role as Project Officers that staffers are perceived as doing the work of the

Mission.

Partly because they tend to be structural interventions, but for other reasons as well, programs to assist alternative-financing initiatives cannot follow this time-honored route and will have very different implications for the commitment of staff time and attention. As I would hope that the country case studies which are a part of the instant research project have made clear, alternative financing programs of a potentially important kind engage the whole social, political and economic structure of the host country in ways that our usual health-sector projects do not. For the host country itself, the steps prior to actually attempting to implement an alternative-financing scheme entail wide ranging investigations, consultations and negotiations involving not only the MOH but also other relevant Ministries (e.g., Finance, Planning, Agriculture) and the representatives of private parties who have a genuine stake in the outcome. Similarly, AID's programs to assist such developments will entail at the outset such wide-ranging investigations and consultations as an effort is made to assess the feasibility of the programs which may be candidates for assistance. For staffers, a major output of effort and attention is required from the outset just to determine what the prospects for assistance might be. These activities are time consuming; it is not possible (nor should an attempt be made) to cram them into a typical, relatively brief, PP preparation stage. And, indeed, during much of this activity there may be a large amount of uncertainty whether there will indeed prove to be a "Project" at the end of the rainbow. What this means is that, if AID is seriously to engage the alternative-financing domain, staff time, attention and effort invested in protracted preparatory activities must be clearly perceived as doing the work of the Mission in as important a way

as Project Officer activities are now perceived and must be accorded similar credit. If the assistance activity is in fact undertaken, it is more apt to take the form of structural-intervention-type program assistance than to take the traditional project form. Thus, at this stage, one may anticipate that far less staff time will have to be invested in the traditional day-in and day-out attention to operating details that characterizes the back-stopping function. At this stage, "Program Assistance Officers" will be engaged in various thinking, researching and consulting (with host government officials in various Ministries and organizations) activities. And again, of course, these activities must be recognized as doing the important work of the Mission.