

REMARKS  
OF  
M. PETER MCPHERSON, ADMINISTRATOR  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
AT  
CLUSA-NCIH WORKSHOP LUNCHEON  
WASHINGTON, D.C.  
APRIL 29, 1983

It is a pleasure to be here.

Let me say at the outset that I congratulate you on having this workshop. I believe that it represents an important step in expanding critical primary health care through more innovative and extensive use of the private sector.

In a recent speech observing World Health Day, I outlined the three key elements of this Administration's health policy at A.I.D.:

One .. to promote primary health care,

Two .. to support biomedical research in order to identify, prevent, and treat Third World diseases,

and

Three .. to seek ways to rely more heavily on the end user for covering the costs of primary health care programs.

I don't have to tell you that health care costs, the world over, are soaring. It is not possible, nor I would argue, desirable, to have government shoulder the growing costs of health care for its citizens.

It is, therefore, in all of our interests to seek and find innovative financing alternatives in primary health care -- alternatives that will offer new opportunities to increasingly use the private sector in meeting health care objectives.

We look to the institutions represented here to assist us in developing creative and sensible primary health care programs.

Our experience with primary health care over the past decade has convinced us that new technology can effectively deliver basic health information and care to both urban and rural populations. We know that people's health status can be raised through such efforts. We also know the demand for these services is there.

People have always purchased some sort of health care. Historically, they have purchased health services in the marketplace, relying largely on traditional health practitioners.

Why do they pay for these services? Clearly, they recognize the advantages of improved health:

- Adults can be more productive if their bodies are not racked with parasites and disease,
- Children are more alert and learn better,
- Babies are more likely to survive.

It is no wonder, then, that households generally spend a large proportion of their income on health. Even the very poor people in rural areas purchase health care.

But the questions we must ask ourselves -- is it the role of government, exclusively, to provide these services to people? Can LDC governments -- even with assistance from international donors -- realistically expect to sustain the costs of health programs for their entire population?

The answer to both questions is no.

I think we need to examine government's ability to handle the cost of health care within the context of LDC economic circumstances. And this applies to primary health care as well. Public sector budgets in most LDCs are hard-pressed.

The recent debt problems of many of the wealthier developing countries, and the upswing in requests for International Monetary Fund assistance, testify to the severity of the economic problems facing the developing countries. The high recurrent costs of health care, along with education and other priorities, could quickly bankrupt public resources for many of these countries, if free health care is made universal.

Given the costs of health care and the economic situation of most LDCs, governments, with or without donor assistance, simply cannot afford to be the exclusive providers of primary health care. We ask too much of governments by expecting them to continue to cover the costs of private goods consumers are willing to pay for.

We are pleased with the progress the international community has made in developing and promoting sound primary health care programs. It has become clear, however, that even low-cost health care becomes terribly expensive over the long term, because of high recurrent costs.

This logic dictates that governments should give priority to interventions and actions which the private sector cannot do -- such as investing in public health and promoting access to health care. And it should leave as much of the health care as feasible to market forces, wherever they can be applied.

I believe that government agencies primary role should be to promote a climate conducive to private sector involvement in the health field. For instance, governments can encourage experimenting with both community efforts and group practice options.

I see three important benefits of prepayment health plans for primary health care.

First, the orientation of prepayment health plans to preventive care makes them particularly appealing alternatives for primary health care.

Second, costs are kept under control through the direct involvement of communities in designing and maintaining unique health care services.

Third, despite concerns to the contrary, existing experience shows equity to be a major achievement of prepayment plans.

Government's most appropriate role then, might be ensuring the legality of such financing mechanisms, and providing seed capital and technical assistance to encourage development of community financing for health.

It is a model we have applied in using cooperatives in agriculture. It is one that appears promising for health.

A.I.D. is prepared to assist LDC governments define and adopt the role of health promoter, rather than health provider.

Community involvement in primary health care has obviously contributed importantly to its viability, especially in rural areas. Prepayment plans build on this success. They take it one step further, placing control of the health care system firmly in the hands of consumers. Under these plans, technology and costs become determined by users. Governments can help by assisting communities to design health programs which meet their needs and resource constraints.

It is my hope that A.I.D. will be a central player in promoting such a scenario. The talents and experience of this group can also be drawn upon in this effort.

A.I.D. has already begun to move in this direction.

We have begun to look carefully at the identification and testing of alternative health financing mechanisms. In addition to biomedical research, we are placing considerable emphasis on:

- 1 - Health economics research,
- 2 - The extent of consumer demand, and
- 3 - Alternative methods of shifting a greater percentage of primary health care costs to consumers who can afford to pay for them.

A.I.D. is also in the process of developing a technical assistance project aimed specifically at assisting our overseas missions to more thoroughly consider market options for health care. In that effort, we are placing considerable stress on the community generated prepayment plans. We are urging them to put greater reliance on market forces in determining how primary health care programs are to be designed and financed.

Documented evidence on the strengths and weaknesses of similar U.S.-based efforts offer valuable inputs to our current planning.

These efforts would very much benefit you, who are familiar, with prepayment health financing experiences.

We welcome your help in designing our experiments in health financing. Together, we can avoid the mistakes of the past, and better assist the developing countries in efficiently allocating their increasingly scarce health resources.

Our combined innovative approaches to financing primary health care programs offer real potential for meeting this goal.

Together, I believe we can achieve affordable, accessible health care for the poor in the developing countries.

I want to thank each of you for coming to this workshop to share your experiences and ideas.

I look forward to your suggestions.

Drafted by FHerder:S&T/HP:4/22/83:235-3619  
Cleared by PPC (per note of FHerder)  
Edited by DBorgquist:OPA:4/23/83:632-4200  
Edited by KSemerad:OPA:4/28/83:632-4200