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**Recession, Structural Adjustment and Innovative Health Financing**

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During the 1950's, 60's and early 70's the world's economy achieved high rates of growth, often with a side effect of high rates of inflation. During that period the developing nations grew more than five percent per year, a rapid pace. With such growth, standards of living could be increased, and such services as health care were expanded.

Over the past ten years, however, growth has not been so robust. According to the World Bank's World Development Report of 1987, growth in the developing countries from 1965 to 1973 (in Gross National Product (GNP) per capita) was approximately 4.0 percent, fell to 3.1 percent from 1973 to 1980, was actually negative (approximately -0.7 percent) in 1982, was essentially zero (0.1 percent) in 1983, and seems to have averaged only about 2.8 percent over the period of 1984 through 1986. If the economies of India and China are excluded, the low-income economies had GNP per capita growth of only 0.4 percent per year for the whole period from 1965 through 1985. During the same period, the middle-income developing economies performed better, but themselves experienced growth in GNP per capita of only about 3.0 percent per year. The extended period of slow growth has caused governments and individuals in developing countries to confront difficult financial constraints.

Government budgets, from which many funds for both continuation and growth of health programs come, have generally grown either slowly or not at all (or actually decreased) in the last several years. Although government expenditures began to grow more rapidly about 1983, from 1972 to 1983, expenditures, on both government in general and health in particular, tended to decrease as a percentage of GNP for the poorest countries. For the low-income countries (GNP per capita of \$400 or less in 1985)

expenditures of the central governments fell from 18.2 percent of GNP to 16.3 percent from 1972 to 1983. During that same period the middle-income developing economies (GNP per capita greater than \$400 in 1985) saw growth in government expenditures from 20.0 to 26.2 percent of total GNP. It appears, therefore, that total central government expenditures declined mainly in the lowest-income nations.

During this period, that saw negative growth in central government expenditures as a percentage of GNP in the lowest income nations, health expenditures tended to fare even worse. In these poorest nations, health expenditures by the central governments fell from 4.6 percent of GNP to only 2.7 percent, a reduction of over 40 percent of the 1972 figure. The middle-income developing nations, even though their overall central government expenditures grew as a percentage of GNP, nevertheless also saw large reductions in health budget shares. These less poor nations, which spent 6.3 percent of their budgets on central government health services in 1972, were spending only 4.5 percent in 1983. Health budgets of the central governments declined even where total government expenditures were growing as a percent of GNP.

Two questions interject themselves on the reader of such statistics. "Why have government budgets for health fared so poorly in the developing nations?" and "What should and can be done?" I will return to these questions as a major focus of this paper, but first let us review ways to raise funds for the health sector when additional government revenues cannot readily be acquired.

The case can be strongly argued that in such circumstances as most developing countries find themselves, significant added budget funds for

health services will not be likely to be forthcoming from the government. I and my coauthors at the World Bank believe the likelihood of little added health budget to be a reasonable assumption, and have spent considerable time and effort describing alternative ways to finance needed health services, especially curative care.

I will here discuss the other possible sources for funds for health care listed in that Bank document. Even if the case for government funding is well documented and well presented, it is unlikely that direct government funding will (or should) be sufficient to provide for the health needs of the population. Other sources of funds not only can help to pay the cost of health services in the developing countries, but also can help to increase the efficiency, fairness and long-term sustenance of the overall health system.

Especially in the curative care area a strong case can be made that a large part of the burden should be borne by those who directly benefit from the services. If practical methods to protect the very poor can be implemented, charging for curative care, mainly via fees and insurance plans, can remove a large burden from resource poor governments.

The arguments in favor of these other innovative approaches are made in detail in the World Bank's Health Finance Policy Paper. (See Financing Health Services in Developing Countries: An Agenda for Reform, A World Bank Policy Study, 1987.) Borrowing heavily from the document, of which I am one of the principle authors, I will summarize here.

The article proposes that developing countries reduce government responsibility for high-cost health services for treatment of individuals and redirect resources

toward basic health services, such as immunization, that benefit society as a whole. Such a shift would relieve government of the burden of providing costly health care for economically better-off, largely urban populations, freeing government resources for basic, less costly services that are more likely to benefit the urban and rural poor.

#### Financing reforms

Obviously, the problems of health sectors cannot be solely attributed to the approach governments have taken to financing health care. Nor will a change in the financing of health services alone solve the problems. Change in financing will not, for example, eliminate the need to improve management, training, and supervision in the public delivery of health services. But financing reforms do deserve consideration as one part of an overall effort to improve health systems. Four policies constitute an agenda for reform:

- \* charging users of government health facilities;
- \* introducing health insurance programs;
- \* encouraging provision by the nongovernment sector of health services for which households are will to pay; and
- \* decentralizing certain government health services.

These financing policies are closely related and complementary. They would shift some of the burden of financing health care from the public sector to the beneficiaries, and they would move some decision from central planning agencies to local health authorities that are better aware of conditions and needs of patients in their jurisdictions.

**Charging users.** Some countries have had user charges for decades, and some others, particularly in Africa, are now beginning to introduce them. But in most countries, government health facilities charge no fees or very low ones for services, drugs, and other supplies. The government health system, therefore, cannot collect revenues from many patients who may be able and willing to pay for health care. The entire cost of health care ends up being financed through frequently over-burdened tax systems.

In these countries, modest charges (amounts that would constitute, even for poor households, one percent or less of annual income, assuming four treatments a year at a government health post) should be considered at government facilities, especially for drugs and for curative care. (Most preventive programs would remain free and be financed directly by government.) A system to protect the poor, such as lower fees in rural areas and at lower-level entry facilities, should be simultaneously introduced. Where there is currently no charge for health services, modest fees could generate revenues covering 15-20 percent of most countries' operating budgets for health care (excluding administrative costs associated with charging fees)--enough to cover a substantial part of the costs of currently underfunded inputs such as drugs, fuel, and building maintenance.

In the longer run, user charges can provide a way not just to raise revenue but also to help improve the use of government resources. Curative services, mainly for better-off urban populations, currently account for 70-85 percent of all developing country health expenditures, and probably 60 percent or more of government expenditures on health. Once mechanisms to exempt the poor from burdensome charges are working well, charges for

curative services for most patients could be raised to levels that more accurately reflect the cost of providing them. This would free as much as 60 percent of government expenditures on health for reallocation to basic, largely preventive programs and to simple curative care for the poor. . . .

One practical way to protect the poor is to reduce or eliminate charges in predominantly poor rural areas and urban slums. Another option is to issue vouchers to the poor, based on certification of poor households by local community leaders (a practice that appears to work well in Ethiopia). Other options include allowing staff discretion in collecting charges (although this is difficult to do in the government sector) or, in middle-income countries, the use of a means or income test. . . . Finally, in a well-functioning referral system (in which patients enter the system at a low-cost, low-level facility and, only if they cannot be treated there, are referred to more complicated care in a higher-level facility), a schedule of low fees or free care at the lower level, and referrals at no additional cost, also helps protect the poor.

**Insurance programs.** A modest level of cost recovery is possible without an insurance program. But in the long run, the widespread availability of health insurance is necessary to relieve the government of subsidizing the high costs of hospital-based curative care.

Currently, insurance programs cover only a small portion of low-income households in most developing countries, especially in Africa and South Asia. Excluding China, where the majority of urban residents are insured, no more than 15 percent of the people in developing countries take part in any form of risk-coverage scheme (other than free public health care provided with tax revenues). Most of these are covered under government-

sponsored social insurance plans in the middle-income countries of Latin America and Asia. Private insurance, prepaid plans, and employer-sponsored coverage are all still relatively rare.

An effective way to encourage insurance in developing countries is for the government to make coverage (whether provided by government or the private sector) compulsory for employees in the formal sector. Then at least the relatively better-off will contribute to the costs of their own health care. A few low-income countries and most of the middle-income countries in Latin America and Asia have taken this step, using payroll taxes to fund social insurance that also covers health care.

Insurance programs in industrial countries and in Latin America have undoubtedly contributed to rising health care costs. When insurance plans cover most or all costs, and patients and health providers perceive care as "free," some unnecessary visits and procedures are likely, leading to escalating costs in the system as a whole. To avoid such escalation, compulsory insurance plans in low-income countries should not cover small, predictable costs (for example, low-cost curative care); they should cover only "catastrophic" costs (defined, where possible, in terms of household income). Cost escalation in such systems will also be less likely if consumers pay an entrance fee (or deductible) and share the costs for treatment of each illness. To protect the poor, the cost of insurance premiums can be subsidized through vouchers, and deductibles and copayments can be reduced. When catastrophic illness strikes, and even a small charge per service adds up to a heavy financial burden as a proportion of income, payments above a specified level can be forgiven.

Competition among insurance providers will also help prevent cost escalation. Without effective competition, insurance providers will have little incentive to keep costs and premiums low. Wherever possible, therefore, government should avoid crowding out private insurers. Finally, government-run insurance programs should avoid subsidizing the insurance system with general tax revenues; this allows costs to rise in the health system and eventually means the insurance program will benefit the better off, while being financed, in part, by the poor.

Cooperate with and make use of the nongovernment sector. Government is an important, but by no means the sole, provider of health services in developing countries. Missionaries and other nonprofit groups, independent physicians and pharmacists, and traditional healers and midwives are all active in the health sector. Direct payments to these groups account for up to one half of all health spending in many countries.

The appropriate size and roles of the government and nongovernment sectors is bound to vary among countries. However, governments reduce their own options for expanding access to health services when they actively discourage nongovernment health care, or fail to seek efficient ways to encourage it. Expansion of nongovernment health services can reduce the administrative and fiscal burden on the government and broaden consumers' options. For some types of health care, especially simple curative care, nongovernment services may be more efficient than the government, providing comparable or better-quality services at lower unit costs. Competition from the nongovernment sector can also encourage improved efficiency in government services

Decentralizing certain government services. Since the government's role in the provision of health care will remain large, it is important to improve the efficiency of public health services. In countries where managerial resources are scarce, communication is difficult, transportation is poor, and many people are isolated, decentralization of the government health service system should be considered as one way to improve efficiency.

Decentralization is appropriate primarily for services provided directly to people in dispersed facilities, where user charges for drugs and curative care are implemented. Some health programs, such as control of vector-borne diseases, are more logically managed centrally.

By keeping revenues as close as possible to the collection point, decentralization improves incentives for collection and increases accountability of local staff. Within certain limits, decentralization helps assure that local expenditures reflect local needs, and fosters development of managerial talent at the community level.

Decentralization and greater local financial control by no means imply complete financial independence of each individual facility. Government facilities that provide integrated curative and preventive services in rural areas and to the urban poor will continue to require central support. In fact, in rural areas the appropriate unit for planning and budgeting is likely to be a regional or district office, not each of many small health posts.

### Problems and pitfalls

Implementation of these financing reforms will not solve all the problems of the health sector. User charges in public facilities, for example, will not generate foreign exchange to pay for imported pharmaceuticals. Insurance programs will not necessarily assure better quality. Decentralization will not eliminate the need for difficult political decisions at the center regarding new investments, training subsidies, and wage scales for public workers. Even a high-quality nongovernment health sector will not fill such critical needs as environmental disease control, and is unlikely to adequately serve the poor in remote rural areas.

Moreover, financing reforms will have little impact without a political commitment by government to making the health sector more effective. User charges and other reforms alone will not assure that freed government resources will be well spent. Political decisions will largely govern whether freed revenues are used to improve access to and quality of services sufficiently to attract fee-paying and insurance-buying customers, rather than to build urban hospitals and buy expensive, nonessential equipment. Only government action can bring necessary changes in management and training programs--for example, in the medical education system so that training of doctors is more appropriate to needs and training of paramedical personnel is strengthened.

### Obtaining Government Funds

Now we return to the question of why Ministries of Health (MOH) have

fares so poorly in attempts to attain more funds for health services in recent years.

I have a straightforward and simple hypothesis--the case for health (rather than alternative government spending programs) being the best use for a large part of the scarce government funds in a poor and developing country, has been poorly made. The rigorous scientific case for the value of health programs to the nation is rarely existent, and the arguments made in political competition for scarce government funds often are ineffectively presented.

The overall objectives of governments in poor countries may cause health expenditures to be given relatively low priorities. The government of any nation should attempt to allocate funds toward those governmental activities having the greatest net value to the society. In this allocation process the long-term view must be considered. Generally, only governments can have the foresight and patience to put money now where it will only (or mainly) produce benefits that occur in the far away future. The value over the long-term of such uses of resources may be very great. Economic development is almost certainly one such long-term goal that takes high priority for essentially all developing country governments.

In neither the "value now" nor the "long-term" sense do health expenditures tend to be winning many political competitions for scarce resources of governments. The agriculture, transportation, education and energy sectors all make strong cases that investments now will lead to a better life for all in the future, i.e., development. Health tends to feel itself above such mundane arguments. Demands often are made in terms of inherent "rights"; and often the requests for health funding almost amount

to veiled character denigration of anyone who could vote against the control of "death and illness," especially of women and children. Health ministries and health professionals speak of the absolute necessity of funding each and every program defined under the banner of "Health for All by the Year 2000," irrespective of the cost or of the other non-health programs that must not be funded in order for this health funding to occur. Emotions are stirred; legislators make speeches about the needs for the health of the people; the executive branches of government vow to help as much as possible; and when the MOH officials leave (or even without their leaving), officials in budget and planning departments make the difficult resource allocations. It is not really very surprising that these decisions often support the less emotional (but more growth and development oriented) funding requests from the other sectors.

The policymakers could be interpreted as taking the view that transportation, energy, education, et cetera must be supported in order that the economy develop. The decisionmakers may regret putting less into health than they would like, but also may sincerely believe that they are making the best decisions for the long-term good of their countries and their people. And in fact, such decisions often may be the best choice given the many needs and the few funds of the societies.

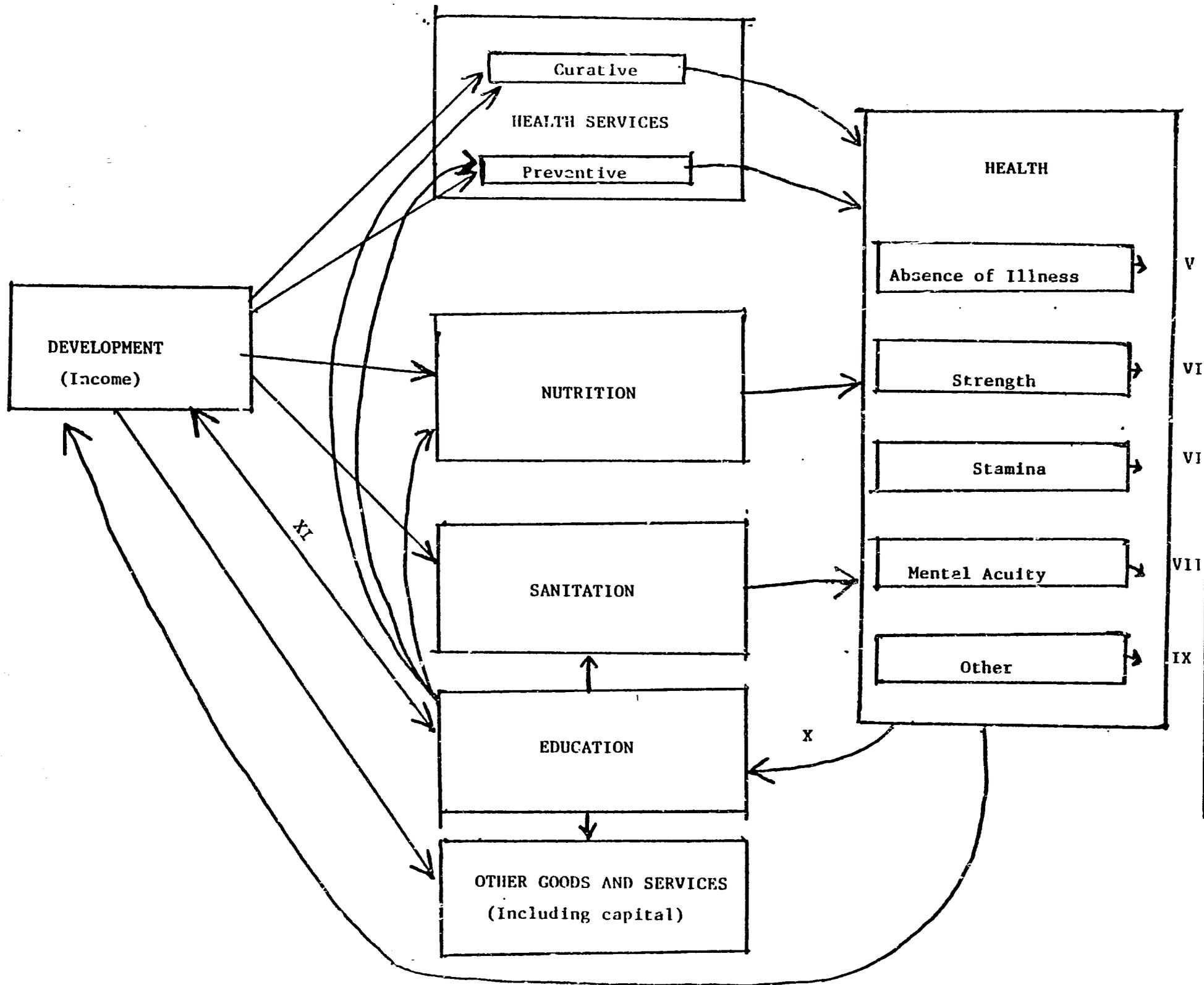
The reasoning in favor of the development emphasis in government programs is more or less, "Once the country reaches sufficient income levels, such 'luxuries' as better health care will be affordable." It continues, "If the precious resources are used for health now, development may never occur; and without true development actual health levels will

always be low, even if a relatively large percentage of GNP is spent on health services."

The argument is both logical and compelling. The health sector must rebut this argument directly, avoiding emotionalism and implicit (or explicit) notions of the moral superiority of health expenditures relative to other development oriented spending. It must also accept the reality that when all such competing cases are correctly made by all parts of the government, the decisions that result about health's proper funding levels may be for lower levels than advocates of health programs and the health sector in general believe to be needed.

Health proponents must document and present the case that health expenditures do lead to development, and that for exactly that reason, they are an efficient use of the precious resources of the nation. That health services also directly reduce suffering and death in the short-run only adds weight to this development oriented argument for a fair share of the overall government budget.

I will not go into great detail as to how I think the health funding case must be made, but I will describe it briefly with the aid of the figure. Health benefits from very specific types of health expenditures (i.e. nutrition programs for children, vaccination of children against specific ailments, health education programs emphasizing ORT, etc.) must be carefully documented and their magnitudes estimated (paths I and II, III and IV). These health outcomes resulting from the health-related expenditures must then be shown to lead to changes in the productivity of the society. The value of a healthy work force must be measured in economic growth terms; the added productivity in the future of children who



do not suffer specific ailments during infancy must be hypothesized and estimated; the added ability to learn in school or other training of healthy well-fed children and adults must be documented and valued, (X and XI); and the value in alternative productive activities of the actual human resources that can be shifted out of the health sector as health problems are reduced must be determined and added. All other such development related benefits of better health status must be identified and their value to society estimated; while at the same time it is made explicit how specific health expenditures can increase these health status outcomes.

Once the links from health expenditures, to health status, to measurable development outcomes, are documented and valued; the added case for other benefits of health services can be added to the argument. The point can also be made that as development occurs, as a result of the more healthy population; incomes will increase, the society will be willing and able to spend even more money on health inputs, and the development process will continue to escalate. Once the link from health to development is documented, the link from development to health is generally well believed. The total picture becomes one of ever increasing, sustainable, levels of both health and development, resulting from increases in health expenditures that can be shown to be efficient uses of the scarce resources.

How to fully make the political development case for health expenditures is conceptually straightforward. It follows the pattern of correctly done cost benefit analyses. Levels of development (i.e., of GNP) for all years in the foreseeable future must be charted out under each alternative pattern of spending of government resources. The overall

economic growth patterns under each possible pattern of spending each feasible total amount of health expenditures must be separately traced and compared to alternative scenarios tracing out the development results from spending the same resources on alternative government services, such as specific programs of energy development, agricultural support, and education.

Even if the development benefits over time from the most valuable health expenditure programs turn out to be less than those for some alternatives, it may be possible to secure budgeting for certain programs by pointing out the value to the people of those health benefits that cannot necessarily be shown directly to add to development. The policy makers are much more likely to be willing to give up some development for added present health status (and the reduction of illness and suffering) if they are shown in a believable fashion exactly how much growth must be given up in order to obtain the specific health benefits. Obviously, reasonable decisions must be made with consideration of more than the direct development benefits of government spending decisions. Even though the poverty of the developing nations may lead to an extreme emphasis on development-causing activities, reductions in development are at times accepted when the benefits of the alternatives (such as better health for the ill) are considered to be of high social value.

One action which this group of scientists could take is to determine to push with greater energy and resolve to produce the research findings needed by the health sector to make its correct and fair political case for governmental support. Scientific studies of the link among health expenditures of various types and health outcomes are few; and studies

making the needed further links, from the health outcomes to development related productivity (and possibly to the reduced need for scarce resources in the health area as health status increases) are almost nonexistent.

Education and population are two areas in which the researchers have done a much better job of providing the needed research backing for the political debate than have those in the health area. Obviously health research is different from research on population and education, but much can be learned by health researchers from examination of the research that has been done in these two mentioned and other fields.

Obviously, I look at the problem of lack of research from my own perspective, but I am astonished at the few economic researchers with advanced training who have specializations in health and development, and also are qualified by experience to help carry out the needed research agenda. I fear that similar lacks of people capable and motivated to carry out this research effort exist in the other relevant disciplines.

The problem of shortages of trained personnel is made much more serious in its impact because of the additional need in the Ministries of Health, Planning, Finance and Budget for economists and other personnel who can both relate to the non-government researchers in these areas and carry the burden of fighting the actual political battles within the government.

In many countries the MOH suffers more than other government agencies partly because budget making arms of government are dominated by economists and financial planners. Because of the nature of their training these personnel often are not easily convinced by arguments organized in the manner of the health professions. Health ministries need personnel who speak the budget language, so that the budget agency personnel can be

conversed with both in their own specialized terms and on the basis of research carried out with methods they understand and in whose validity they believe. Ministries of Transportation, Agriculture, Energy, et cetera, often have significant numbers of personnel trained in financing, budgeting and economics; and as a result are better prepared to fight the budget battles, using the tools and arguments of the disciplines in which the agencies in control are trained.

More personnel simply must be forthcoming, both to carry out the basic research and to work in the government sectors. International organizations and governments should consider how best to facilitate the training and recruitment of such specialists.

#### Summary

For the reform of health care financing in developing countries there are several specific actions that governments can take. All governments can rapidly begin to make use of the four non-budget options described in this paper where they prove to be beneficial.

Health researchers also can begin very quickly the task of providing evidence with which decisionmakers can deal in attempting to build a political consensus for increased or perhaps better targeted governmental expenditures in the health sector. The legitimate case that can be made will probably be especially strong in promotive and preventive areas, where the present research findings provide evidence that the returns relative to costs are large.

Researchers and representatives of international organizations need to take actions to facilitate the training of personnel to carry out research,

to aid in the financing and implementation of such research efforts, and to increase the breadth and depth of the dissemination of the results.

While the efforts toward health finance reform have accomplished much, especially in recent years, the task still before us is mammoth.

## POLICY RECOMMENDATIONS

- (1) Development and implementation of research agenda on the impact of alternative health interventions in developing countries:
  - (a) on health improvement .
  - (b) for specific population groups.
- (2) Development and implementation of research agenda on the impacts of the health outcomes identified in (1) above, on productivity and economic development.
- (3) Development and continued support for a training program (for U.S. and developing country nationals) for high-level researchers and research-method-trained government personnel in health finance and development.
- (4) Reorientation of present health finance research efforts toward rigorous tests of hypotheses about the impacts of alternative finance activities. That a diverse set of changes carried out in the context of a given situation "works" or "does not work" tells us little about which elements had impacts, what these specific impacts were, and whether failures (or successes) were due more to specific situations than to the specific types of interventions and their magnitudes.