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Resources for Child Health



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REACH Cost Recovery by Government Hospitals in LDCs: A Key Element In Strategy to Increase The Commitment of Resources To Primary Health Care (PHC)

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Introduction

This topic will best be elucidated in the context of a broader set of issues --namely, those relating to AID's and, more particularly, REACH's, engagement with health-sector financing events in LDCs. The health-care financing system, the way in which the demand for health care is financed, is a central and in many ways crucial feature of any nation's health-services sector. It is only very recently, however, that AID's health-sector assistance activities in LDCs have begun to exhibit awareness of this and to contemplate project activity in this domain. At least at the level of health-financing-project design and implementation, AID may be regarded as at the outset of serious engagement with financing events.

One consequence of this is that we have as yet to establish a clear sense of direction in this domain. Another consequence is that attempts to develop health-financing strategies and projects are prone to hang up on various misunderstandings. A classic example is the topic of this paper. Historically, AID's health-sector-assistance focus has been upon primary health care (PHC). Few would quarrel with the appropriateness of this. In this context, however, "hospital" has become virtually a dirty word such that there is, in some quarters, an almost reflexive resistance to the proposition that it might be appropriate for AID projects to assist cost recovery by government hospitals--even though this

is put forward as a key element in a strategy to increase the commitment of resources to PHC. (The nature and content of this strategy will be spelled out in what follows.) The REACH project was designed and fielded with an explicit health-financing component. Owing to this development, there is now a greater sense of urgency about achieving some meeting of the minds on issues such as those alluded to foregoing. This paper is intended as a contribution to deliberations to that end.

The Impact of Health-Financing Systems on Health-Sector Performance

Health-financing systems (and I include here reimbursement mechanisms) are far from neutral in their impact on the performance of the health-services sectors of which they are a part. A brief review of some aspects of this relationship will contribute to our understanding of possible objectives, in health-services terms, of AID's engagement with health-financing events.

- I. Health-financing systems have an impact upon the efficiency (in various senses) of health-sector performance. Two examples:
 1. At-risk providers operating under prospective-payment systems may have a greater incentive to achieve production efficiency (to use least-cost combinations of inputs to produce outputs) than providers operating under conventional retrospective reimbursement mechanisms.
 2. Public funding of health activities which produce public-good-type services will probably be necessary to secure appropriate rates of resource allocation to such activities (i.e., to achieve allocative efficiency in this sense). Thus, the attempt to rely upon private financing of the demand for such activities will probably result in allocative inefficiency (too low a rate of resource commitment).
- II. Health-financing systems have an impact upon the equity implications of health-sector performance. Two examples:

1. An important dimension of equity in this domain is the way in which the burden for supporting the nation's health-care system is distributed among the persons comprising the population served. Systems in which this burden is income-related (e.g., as by sliding-scale pricing or different rates of contribution to insurance schemes), such that those with lower incomes bear a lesser burden than those with higher incomes, are regarded by many as more equitable than systems in which the burden is not income related. It will usually be more feasible to achieve income-related burdens where the demand for care is socially financed than where the demand is financed by out-of-pocket payments by consumers.

2. Social-financing schemes have many advantages over out-of-pocket-pay schemes as a way to finance the demand for health care. For example, individuals who are risk averse (most of us are) gain a great deal of satisfaction from being able to insure against the risk of large outlays for health care, i.e., rather than having to "go bare." Beyond these kinds of benefits, social-financing schemes have important inter-personal equity implications, e.g., the burden for supporting the nation's health-care system is shared by people in their role as well persons rather than being left (as under out-of-pocket-pay systems) just to people in their role as sick persons.

III. Health-financing systems have an impact of utilization rates and cost-containment. Two examples:

1. Social-financing schemes which feature substantial consumer cost sharing (as by deductibles and copays) may help to hold down utilization of services as compared with schemes featuring (virtually) zero user-charges to the consumer. Thus, cost sharing tends to be favored from a cost-containment point of view. On the other hand, consumer cost sharing may not be favored from an equity point of view or from a health-status impact point of view.

2. At-risk providers operating under prospective-payment systems (e.g., HMO-type capitation) may have a greater incentive to limit utilization of services by their patients than do fee-for-service providers operating under conventional retrospective reimbursement mechanisms. Thus, the former arrangement tends to be favored from a cost-containment point of view. On the other hand, under the former arrangement, providers may have a greater incentive to "under doctor" such that this arrangement may be less favored from an equity point of view or from a health-status impact point of view.

IV. Health-financing systems have an impact on the performance of the health-services sector in various additional ways. Two examples:

1. If the budget costs of planned health programs are not properly measured, health-budget-making decisions may inadvertently frustrate the intentions of the health planners, e.g., as by coming up with too little funding for operating expense for planned programs.

2. Related to efficiency point 1. 2, appropriate rates of resource commitment to public-good-type services (preventive/ promotive, public-health services) may be precluded because too much scarce fiscal capacity has been dedicated to the funding of private-good-type services (e.g., hospital services) which might more appropriately have relied upon private financing. In this case, the health-financing system exhibits a structural problem, faulty assignment of public and private sources of funds to health services in accord with their public-good/private-good nature.

AID/REACH Engagement with Health-Financing Events: What Should Be The Focus?

Cursory though it has been, the foregoing discussion of the relationship between health-financing systems and health-sector performance has perhaps said enough to make the point that there are a large number of ways in which

AID/REACH engagement with health-financing events might seek to improve the performance of the health-services sectors in LDCs. Hence, there is the question of focus.

One possibility would be an eclectic approach, mainly responsive (rather than initiative) in nature. As the USAIDs come in with requests for assistance with their health-financing projects, we might agree, within the limits of our resources, to assist any such projects which could make a credible case that there would be a favorable impact upon some relevant dimensions of health-sector performance--namely, efficiency, equity, cost-containment, plan implementation, more appropriate rates of resource allocation to public-good-type services (and perhaps other dimensions which may occur to the reader).

Another possibility would be a more selective approach, recognizing that our resources for assistance in this domain are limited and based on the notion that a narrower focus may enhance the prospect of having a significant impact. This approach would be less responsive, more initiative. One way to select a narrower focus would be to find ways to make our engagement with health-financing events clearly complimentary to our ongoing engagement with health-services events. Now, as in the past, in the health-services domain, our assistance portfolio (rural-health projects, urban health projects, ORT, EPI) has sought to enhance the performance of PHC delivery systems with a particular interest in preventive/promotive, public-health services. Our efforts in this health services domain have been considerably frustrated by chronic and pervasive shortfalls in the availability of host-country funding of operating expense for PHC. This has led to various problems with which we are familiar, e.g., failure to sustain programs initially fielded as projects, failure to generalize programs fielded as projects on a trial basis with the understanding that, if successful, they

would be replicated "nation wide" (as the colorful language of the PP is apt to put it), and others.

Responding to these problems a complementary AID/REACH engagement with health-financing events would feature support for health-financing developments which were intended to increase the commitment of resources to PHC and which showed promise of securing this result. Included here would be strategies to cope with the structural malfunction of the health-financing system discussed under IV. 2 above--namely, faulty assignment of public and private sources of funds to health services i.e., not in accord with their public-good/private-good nature. The title of this paper refers to just such a strategy and we may turn in what follows to a brief discussion of it. In terms of the dimensions of health-sector performance set out foregoing, we should note that those in favor of increasing rates of resource commitment to PHC usually believe that this does improve the efficiency and equity of the health-services sector. Service to these dimensions may be regarded as necessary, but not sufficient conditions for program support with the selective approach. That is, some programmatic approaches to serve efficiency and equity objectives are to be preferred to others--notably (with the selection suggested here) those which increase rates of resource commitment to PHC.

Cost Recovery by government Hospitals in LDCs: A Key Element in Strategy to Increase the Commitment of Resources to Primary Health Care

I will outline this approach very briefly, but with enough detail, I would hope, to provide grist for the mill of subsequent discussion.

This strategy will be most appropriate in LDCs in which: (1) There is little prospect in the foreseeable future of significant increases (in real terms) in the overall resources available from the government for the MOH. (2) The hospital sector now claims on the order of 60%-70% of the MOH budget with the PHC

share being on the order of 10%-15%. (3) Although there may now be little cost recovery by government hospitals, the policy makers are not, in principle at least, opposed to more significant cost recovery by these facilities. All of the LDCs in which I have worked conform to these provisos.

A general point to keep in mind is that this strategy is comprised of a number of interdependent elements, it is a "package" in this sense.

What is called "cost recovery" by government hospitals takes place when these facilities market their services (charge fees) and in this way recruit private funding to defray the cost of these services. In most LDCs currently, there is lively interest in establishing or increasing such fees (so called "user charges"), although not necessarily as part of a strategy to increase rates of resource commitment to PHC.

Preventive/promotive, public-health services are for the most part in the technical sense public goods such that public funding will be necessary for appropriate rates of resource commitment to them, e.g., they should be funded out of the MOM budget. If we cannot rely on significant increases in the overall MOM budget, then increased resources for PHC must be found elsewhere in that budget, i.e., must be diverted to PHC from other programs. The hospitals, claiming 60%-70% of the total budget, are the most likely candidates for this role (following the dictum to look for money where the money is). However, we assume that significant cost recovery by these hospitals will be a necessary (although not also a sufficient) condition for such diversion. This is, of course, why cost recovery by these hospitals is a key element in this strategy to promote resource for PHC.

In many LDCs, the policy makers are acutely aware of a major problem confronted by initiatives to increase fees and hence the rate of cost recovery by government hospitals--namely, the generally low quality of the services

provided by these facilities. If this strategy is to work (e.g., if collection problems are to be manageable), the quality of services must improve and, more generally, the efficiency of these facilities must be improved. Many factors may help to account for poor efficiency and, as part of this, poor quality of services in LDC government hospitals. The critical factors, however, are basic structural features of these hospitals as organizations, e.g., personnel policies that provide little or no incentives for efficiency, budget-making procedures which afford hospital management little or no discretion.

Thus, as a part of this package of interventions, new organization formats for the government hospitals will be called for--formats (such as certain kinds of prospective budgeting) under which hospital management will be at risk for failure, and, more important, has an opportunity to be at risk for success. Under a system such that government hospitals market services and retain (a part, at least) of the revenue from these fees (an arrangement not now permitted in most LDCs where, usually, revenue from such fees must revert to the exchequer), such organization formats can be devised.

At this point, in putting this package together, we arrive at an apparent impasse. We require increased efficiency and quality of output if significant cost recovery by government hospitals in most LDCs is to be a realistic, feasible approach. To accomplish this, we need a change in the organization formats for these facilities. But, to get this change, we need budget procedures which are based on a system under which the hospital markets services and retains revenue resulting from these fees, i.e., in which cost recovery is working successfully. But, to make this system work we need improvements in efficiency and quality--and so we come full circle.

It is at this point that a health-financing project may come to the rescue. Without attempting to spell out details, the central notion is that the project might

provide funding to simulate the system that would obtain if the hospital(s) selected for a trial run in this domain marketed services and retained an agreed upon part of the revenue thus generated, to be used by hospital management in accord with agreed upon rules. This would provide an opportunity for a trial run to test the proposition that the incentives and management-opportunities provided by the new organization format would result in improved efficiency of facility performance including improved quality of out put. It should be noted that, owing to the chicken-egg problem sketched foregoing, without project funding to run the simulation (as a kind of social experiment) this potentially important proposition might not be testable at all.

It is also at this point that certain distinctive features of this kind of health-financing project need to be remarked upon. It is critical to keep in mind that, from AID's point of view, the whole point in starting down this road is to end up with more resources for PHC. Pre-project, the host country may have rather less interest in this outcome. In most LDCs, the policy makers are very interested in enhanced cost recovery by government hospitals and, more generally, in strategies to increase the efficiency of these facilities. Pursuant to these interests, they may be willing to start down this road, but not, perhaps, with the primary intention of in this way making more resources available for PHC. Thus, if USAIDs and host countries are to start down this road together, certain good faith commitments must be made at the outset. For example, the Ministry of Finance would agree that if a trial showed that retention of (some stipulated part of) revenue from fees for services marketed by government hospitals enabled the implementation of organization formats which in fact did increase the efficiency with which these facilities performed, then such retention of revenue from fees for services marketed by these facilities would become a regular, legal operating procedure. Also, for example, the Ministry of Health

would agree that increased cost recovery by government hospitals would not result in simply larger budgets for these hospitals but that some part of what would have been the public budget provision for the hospitals would now be diverted to preventive/promotive, public-health services.

Conclusion

We have been over this terrain rough shod and in short compass, relying upon the prospect of discussion of these matters to spell things out. Prior to that, a couple of concluding remarks will be in order.

Whether or not a strategy such as that sketched foregoing can be implemented in one or more LDCs and, if so, whether it would work as contemplated remains to be seen. It seems likely, however, that at least some USAIDs and their host-country partners will want to start down this road--e.g., to the extent of serious engagement with cost recovery by government hospitals and, more generally, realistic efforts to come to grips with efficiency problems in these facilities. (Events in Kenya may now afford an example of this.) Even if the parties do start down this road, the enterprise may derail at any of various points, e.g., the good-faith commitments may not be forthcoming, or, if forthcoming, they may be disappointed in the event. Conjecture about the feasibility of the course of institutional events comprising this strategy will not get us far. The proof of this pudding has got to be in the eating--we must run some social experiments.

Given the uncertainties and rather complicated nature of this strategy, why favor engagement with it? One important reason is that there appear to be no realistic alternatives to this "diversion strategy" to promote a more appropriate rate of resource commitment to PHC in LDCs. For decades, AID has lamented the low rate of resource commitment to PHC in LDCs. In so far as the course of events has been concerned, these laments appear to have fallen

on deaf ears. For decades, well-meaning, itinerant health planners (operating under any of various sponsorships) have been trying to make the case that not only is an ounce of prevention worth a pound of cure, but a health-services system which recognizes this in practice will be more equitable into the bargain. It may be true that, in some LDCs, at the rhetorical level of "declaratory achievement," greater attention is being given PHC (see Pakistan's forthcoming 7th plan for health). But, at the budget-making level that counts, there is little evidence of progress. The strategy outlined herein may (not unreasonably) be regarded, in so far as prospects for success are concerned, as not very realistic. But, in my view, it is far more realistic than any alternative approach to recruiting more resources for PHC of which I am aware.

In any case, implementation of a full-blown version of this strategy will not take place all at once, it will come in a series of institution-building steps. USAIDs and host-country officials, planning in the longer run to implement the diversion strategy, might begin rather modestly in any of various places, e.g., cost studies (to determine how much diversion from the hospital budget would be necessary to make a significant contribution to PHC), interventions of various kinds addressed to the question of hospital efficiency, promotion of private social-financing mechanisms (to facilitate, from both an administrative and equity point of view, cost recovery by government hospitals), and others. If AID/REACH were, in important part, to focus engagement with health-financing events on promoting the diversion strategy, it might similarly find itself associated, in each short run, with any of these various activities/interventions. There would still be focus in the sense of a coherent, overall rationale for the engagement, however, i.e., promotion of the diversion strategy as a way to increase commitment of resources to PHC. With this approach, AID/REACH might, say, assist cost studies in the context of projects in which these were

explicitly seen as pursuant to informing development of the diversion strategy but not assist cost studies if these were essentially free-standing or no more than generally related to efficiency concerns.

October 16, 1985

MEMORANDUM:

TO: Anne Tinker, Cindy Clapp-Wincek

FROM: Carl M. Stevens

REF: AID SECTOR STRATEGY - HEALTH, USAID May 1984 (Sector Council for Health)
A.I.D. POLICY PAPER - HEALTH ASSISTANCE, USAID December 1982 (PPC)
A.I.D. POLICY PAPER - RECURRENT COSTS PROBLEMS IN LESS DEVELOPED COUNTRIES, USAID May 1982 (PPC)

SUBJECT: Some Implications of the Above Captioned Documents for the Financing Elements and Aspects of A.I.D. Health Projects and Hence for Resources for Child Health Project Activities

These documents contain a number of suggestions, recommendations and prescriptions directly addressed to health-sector financing. Other provisions of these documents have less direct but important implications for financing events. Initially we may consider the more directly-addressed material.

Fees vs. Subsidies

All of these documents address the issue of "user fees" vs. subsidies in this domain and each of these documents recognizes that the economically efficient choice will depend upon the health good or service in question -- this point being more or less explicitly rationalized in terms of economic theory (e.g., public vs. private goods, externalities, market failure -- see STRATEGY p. 7, POLICY pp. 6 et seq., RECURRENT COSTS pp. 6 et seq.). The following statement (POLICY p. 7) is exemplary:

"There are, it should be noted, certain public health measures, notably immunizations, which affect the community as much as the individual. Immunization of the bulk of the population is required to prevent epidemic spread of such communicable diseases as polio, measles, and whooping cough -- all major killers in LDCs. The costs of public provision of immunization services would be dwarfed by the potential costs of handling the epidemic that might result if immunization were dependent on individual ability or willingness to pay. A.I.D. must be careful to distinguish these public health measures from personal (especially curative health care, which all but the poorest people already pay for and should be expected to cover."*

*/ The recent memorandum from AA/PPC to the Administrator recommends:

"...that you send out a policy guidance cable stating that missions should assume that user fees are appropriate for ORT, immunizations, drugs and curative care..."

One may question the extent to which this recommendation is consistent with the existing policy in this domain. This same memorandum refers to "...the need to establish Agency goals in health financing." Have not, however, the above captioned documents (and others) already done this?

This quotation also reminds us that in calculating the cost of immunization programs we should take into account the savings in the form of reduced claims for resources by other programs which may result from successful immunization programs.

As the foregoing quotation suggests, A.I.D. policy is that, generally speaking, there should be user charges (fees) for personal, curative services.

For example:

POLICY p. 6: "People pay for personal health care already and should be expected to pay for at least some portion of PHC services (e.g., curative care). Preventive services are difficult to charge for, but curative treatments should require a fee or other user-based financing scheme which contributes to the support of the system."

STRATEGY, p.7: "The objective is a mix of host country public and private resources which, as part of an integrated system, delivers services most cost-effectively. This may involve government subsidy for certain services in the public good (e.g., immunizations), as well as key services (e.g., oral rehydration, family planning, nutrition monitoring) which the poorer members of the population could not otherwise afford. Generally, however, personal health services will be financed by the consumer."

The general proposition that there should be fees or more generally user-based financing for personal, curative health services is qualified by concern for distributional equity, viz:

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"To the extent possible, those most in need of health care should not be denied care by a schedule of fees, insurance payments, or other approaches that effectively discriminate against the poorest groups. Nevertheless, experience to date suggests that nearly all can and will pay something for medical care." (POLICY, p. 7)

This statement is, of course, vague--the meaning of the various concepts is not spelled out in operational terms (which, it may be remarked, is appropriate for a policy statement at this level of promulgation). Simply put, what A.I.D. policy on this point says is that individuals should not be denied access to health care because of inability to pay -- this being, of course, precisely the general prescription that we appeal to to guide our own health-sector financing arrangements.

What this means operationally will be reflected in actual health-care financing arrangements and these will in turn reflect the preferences and values of the social order participating in these arrangements. Thus, for example, in the U.S. the definition of what income level represents "medical indigency" to qualify for MEDICAID benefits differs greatly among the 50 state programs -- that income being set at a higher level in, say, New York or California than in, say Mississippi or Alabama. Presumably, in the design of A.I.D. projects, host-country preferences/values in this domain are carefully to be taken into account.

A major omission from A.I.D. policy discussion of the user-fee vs. subsidy issue is failure explicitly to recognize that, at the level of project implementation in the field, host country political considerations may well (and legitimately) be decisive for the financing arrangements. After all, for many years many

LDCs have been very publicly "on the books" with the proposition that all citizens are entitled to "free" health services as a basic human right. This is a politically very sensitive area for policy making and in many LDCs it is very difficult to introduce significant fees for health services delivered by government facilities.

However, in most LDCs, the facts of life are that implementation of national health-policy goals will require much greater resort to fees for government-provided health services, particularly hospital services, than now typically prevail. And, in most LDCs, health officials and others are very much aware of this. Thus, actual financing arrangements on the ground can be expected to move in the direction favored by A.I.D. policy and A.I.D. can provide important assistance to this development. We must understand, however, that progress in this domain is apt to be slow.

It should also be remarked that, as in the instant case, policy statements which simply provide that there shall be user charges or fees for government health services leave open the question of how the demand for these services should be financed -- that is, shall the demand for these services be financed by out-of-pocket payments by consumers or by the participation of consumers in some kind of private social-financing scheme (e.g., employment related health insurance, other health insurance, pre-pay schemes and others). Although POLICY and STRATEGY do not directly discuss this issue they recognize these various possibilities and appear to be permissive on this score. For well known reasons, where there are to be charges for health services, social financing of the demand for these services is to be preferred to out-of-pocket financing -- there would seem to be nothing in the existing policy and strategy statements that would disagree with this proposition.

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Sustainability (Financial Viability) of Health Projects/Programs

Each of the above captioned policy documents addresses this issue in one way or another. Thus, STRATEGY 9p. 7) alludes to the "A.I.D. strategy to promote self-sustaining programs (sic.) and provides that:

"New projects should reflect careful consideration of recurrent costs (including costs to consumers) and include steps to be taken to resolve identified cost and financing problems prior to project approval."

And POLICY (p. ii) states:

"A.I.D.'s health program assistance will concentrate in future years on:...Promoting self-financing of health programs...A.I.D. will place special emphasis on encouraging LDCs to modify policies that inhibit self-sufficient, cost-effective programs. The agency will stress private sector approaches to providing health care and health-promoting measures and private resources to cover the costs generated by health programs."

And RECURRENT COSTS (p. 18) provides:

"Where recurrent cost problems are due to LDC government policy, and where that policy is not likely to change, A.I.D. should seriously consider reducing the level of activity in the affected sector...It makes little sense to invest in programs that are predicated on a given level of recurrent financial support, if that support is unlikely to be forthcoming.

Clearly, the most direct method for alleviating recurrent cost problems is financing recurrent costs explicitly... Donors have open to them the option of...increasing the degree to which they are willing to finance recurrent costs...The recent decision to extend life-of-project funding to ten years makes more realistic the length of time needed for a project which will generate as much recurrent finance as it will recurrent expenditures...Any arrangements of this type will need careful stipulation of the way in which A.I.D. resources can be phased out and host country resources phased in."

The Implications of Sustainability Objectives for A.I.D.'s Assistance to PHC Programs

As explained foregoing, according to A.I.D.'s health-financing policy, user fees or charges would not be appropriate for most of the intended output of PHC systems -- for these public-good-type services, public finance is peculiarly appropriate. Thus, these programs cannot be expected to be "self sustaining" or "self-sufficient" in the sense of generating private revenue. Nevertheless, it is also A.I.D.'s health-financing policy that PHC programs assisted by A.I.D. must be financially viable over the long run in the sense that as A.I.D. resources are phase out, host country resources (in this PHC case, public finance resources) will be phased in. How can we achieve the effective "careful stipulation" on this score called for by RECURRENT COSTS? Or, what are "...steps to be taken to resolve identified cost and financing problems prior to project approval" called for by STRATEGY?

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It is not unfair to say that historically for project implementation the approach has been simply to include in the Logframe an assumption that these financing events would come to pass -- perhaps adducing as evidence on the point pronouncements by host-country government officials. And it is not unfair to say that, in most instances, this assumption has not been credible. It seems to me to be the clear intention of current A.I.D. health-financing policy (as set out in the documents we have been examining), with its strong emphasis on the sustainability and financial viability of health programs, that more serious attention be given to this aspect of health-program assistance now than has been characteristic in the past.

In the context of assistance to PHC programs, responding to these expectations will require a more "systems" oriented approach than has been usual in this domain. It does not, in any case, make much sense to look at the requirement for health-program sustainability and financial viability just on a project-by-project or program-by-program basis. Rather, all of the programs and activities which comprise the health-services system should be regarded as related and interdependent parts of that system.*/

*/ This is certainly the orientation called for by the policy documents we have been examining herein, e.g., that the government sector, the private western-medicine sector, and the private traditional-medicine sector be regarded as mutually interdependent and complimentary components of the nation's total health-services system. In the text discussion here, we are looking at this matter in a somewhat narrower frame of reference than suggested in this note.

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Thus, the most promising approach in most LDCs to recruiting an appropriate level of resources for PHC is to divert or reallocate public-finance resources from curative (mainly, inpatient hospital) urban services to primary health care in rural areas (one of the ways to improve the financial viability of PHC projects recognized, but not emphasized, in the Administrator's May 15, 1985 memorandum on this subject). And the best way to facilitate such a diversion of resources is to implement appropriately income-related fees for government hospital services.

If one accepts these propositions (we do not have the space to elucidate them here) then a scheme to implement fees for government hospital services must be regarded as a primary-health-care-financing strategy. More particularly, A.I.D. assistance to PHC programs may need to be accompanied by assistance to schemes for more private financing of the demand for government hospital services -- or some other accompanying financing scheme, if the A.I.D. PHC assistance activities are to be regarded as appropriately responsive to A.I.D.'s health-financing policy goal of the sustainability and financial viability of programs assisted by A.I.D.

The point here is an important one such that a restatement may be in order to make it clear. Operating under A.I.D.'s health financing policy and pursuant to what, in any case, makes economic sense, we do not expect the PHC programs assisted by A.I.D. to achieve sustainability and financial viability by themselves generating private revenue. These programs are, however, expected to be sustainable in the sense that host country resources will be there to carry the programs over the longer pull after A.I.D. assistance has terminated. In the nature of the PHC, public-good-type case, these host country resources will be public finance resources, the general tax

revenues that support the MOH system as a whole. Thus, the financial viability of the PHC programs must derive from the financial viability of, and appropriate resource allocation within, the MOH system as a whole. To achieve health-system viability in this sense in the usual case will require health-financing project assistance -- and this project assistance, which will usually be in health-services domains other than PHC, must accompany the project activity which represents A.I.D.'s PHC assistance -- that is, the financing project, which may be addressed, say, to the hospital sector, is in this real, function sense, a part of the PHC intervention, if, that is, the PHC intervention is to be responsive to A.I.D.'s policy objectives with respect to sustainability. It is for this kind of reason that the RESOURCES FOR CHILD HEALTH PROJECT has wisely made financing a major agenda item along with immunization and other PHC activities.

Health Economic Development

According to STRATEGY (p. 1) A.I.D. will assist developing countries to:

"Reduce disease and disability in infants and children, women of reproductive age and other members of the labor force. These combined efforts will enhance worker productivity and overall economic development."

This strategic emphasis upon the relationship between health and economic development is in line with such statements in POLICY as:

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"Economic growth and human capital development are closely related: sustained growth cannot be achieved without at least a minimally trained, healthy populace. More particularly, recent research has demonstrated a strong relationship between improvements in life expectancy, a widely-used health indicator, and economic progress." (p. 1)

"Real and sustained improvements in health are necessary for economic development and increased productivity in developing countries." (p. 11)

The attention directed to relationships between health and economic development in A.I.D.'s health-policy documents has potentially important implications for health financing events in LDCs. Thus, for example, my impression in various LDCs has been that if governments (as represented by Ministries of Finance and Planning, and the like) really believed that an additional investment in health services would make a significant contribution to enhance the rate of economic development, then additional public resources would be supplied to the health-services sector. Typically, however, they do not seem to be convinced of this because: (1) they are dubious that additional resources for government-provided health services will have much impact on health status and (2) existing high levels of underemployment in their economies seem to suggest that, whatever the case with (1), enhancing the effective labor force by improved health status will not make much contribution to economic development.

In spite of doubts such as those expressed foregoing, there is reason to believe that improved health status can in fact make a

significant contribution to economic development. Good evidence that this is the case might well influence budget decision-making processes such that more resources would be allocated to health services. More generally (and in a less partisan vein), good information on the relationship between improvements in health status and economic development is needed to inform inter-sector resource allocation decision.

According to POLICY, p.5:

"In order to develop and test alternative health intervention packages, A.I.D. is prepared to fund experimental programs when they are clearly part of a plan to improve the cost effectiveness of the health system. Missions are encouraged to initiate such experimental activities, especially in areas where programs in other sectors (e.g., to increase agricultural productivity) are planned."

In light of the foregoing, it seems fair to say that field trials or experiments to yield information (among other information) on the relationship between health services and economic development would be very much in line with A.I.D.'s overall health policy -- and, as has been explained, the findings from such investigations might well be important for health-sector financing events in LDCs.

Health Programs: the Efficiency-Financing Connection

In various places POLICY speaks to management and implementation problems in LDC health programs -- summarizing (p. ii):

"A.I.D.'s health program assistance will concentrate in future years on:

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Improving the effectiveness of health programs through improved program design, management and implementation.'

STRATEGY also addresses these problems, providing (p. 7):

"Health care projects will not be approved for A.I.D. funding unless management needs have been adequately assessed and actions identified to resolve deficiencies."

As we are all aware, however, it is far easier to assert that we will improve the effectiveness of health programs through improved management and the like than it is to in fact accomplish this. And while we may call for actions to resolve deficiencies in this domain it would be overly sanguine to expect that such actions can in fact be readily identified.

The basic problem is, of course, that the "organization failure" which characterizes many LDC health programs is owing to rather basic features of organizations structure -- most notably, a lack of incentives for efficient performance by the organizations members and a lack of opportunity for program management to be at risk for success. These basic features are not remedied by such actions as, say, more emphasis on planning, information systems, management and administrative skills and the like -- albeit these tend to be the focus of the typical A.I.D. intervention in this domain.

There are a number of close relationships between efficiency events and health financing events and policy. Consider, for example, A.I.D.'s policy in favor of (appropriately) reducing subsidies to government-provided health services in favor of greater reliance upon user fees. For many health programs in

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LDCs, it is probably not possible to successfully administer a user-fee financing scheme unless there is a dramatic improvement in the quality of services provided by the program, i.e., a dramatic improvement in program efficiency in this sense. The connection also runs the other way, the implementation of fees being, potentially, a central element in the design of organization formats which can afford the incentives necessary to increase efficiency along with this quality of output. That is, a strong case can be made that A.I.D.'s goal of increased health program efficiency will require appropriately designed health-financing strategies for its realization. This is another reason why the RESOURCES FOR CHILD HEALTH PROJECT has wisely made financing a major agenda item along with immunization and other PHC activities.

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