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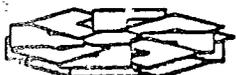
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ISSUES IN DEVELOPMENT OF A HEALTH FINANCING STRATEGY FOR THE BUREAU FOR ASIA AND NEAR EAST

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ISSUES IN DEVELOPMENT OF A HEALTH-FINANCING STRATEGY FOR THE BUREAU FOR ASIA AND NEAR EAST

In this paper we identify the central issues of health care financing in the countries for which the Bureau for Asia and the Near East (ANE) is responsible, and we suggest several policy options for both the countries themselves and the Agency for International Development (AID). The paper is intended to stimulate thought during the development of an ANE overall health-sector strategy for the 1990s; it does not purport to be either a specific, detailed health-financing strategy for ANE or a scholarly discourse on the subject of health care financing or health economics in general.

1. GOVERNMENTS INVARIABLY HAVE DIFFICULTY IN MEETING THEIR CITIZENS' HEALTH CARE NEEDS

The fact that there are substantial unmet health care needs in ANE countries has been well documented elsewhere. The specific needs that are most urgent vary from country to country, but they include in most countries unacceptably high infant and child mortality rates, high maternal mortality rates, low use of modern contraceptive methods (with some notable exceptions), and inadequate nutrition, particularly of women and children.

To the extent that these needs are addressed, it is almost always through a combination of public- and private-sector services. National data concerning health care are almost entirely about government expenditures and activities, and often only about the expenditures and activities of the ministries of health; little is known in most countries about the private health care sector, and data about health-oriented expenditures and activities of other ministries and government agencies often are buried in higher-level aggregations. These data lacunae are serious problems in development of health-sector financing strategies.

Nevertheless, the available data suggest that most ANE governments¹ commit a relatively small part of their total expenditures to health care. Figures for 1982 for ANE countries for which data are available show these levels:

	Health As % Of 1982 Total Government <u>Disbursements</u>
Egypt	2.6
Jordan	3.9
Morocco	2.9
Tunisia	6.7
Turkey (1981)	2.4

¹The term "governments" is used in this paper to refer to all government agencies, at all levels of government, that have any responsibilities related to the health care system. In most countries, this definition encompasses many entities in addition to the ministries of health: typically, decisions concerning governmental health care expenditures are made at state, district, or municipal levels in addition to the national level; the Ministry of Education most often is responsible for training health professionals and other health care personnel, and other ministries may be involved in other aspects of health care, such as health care of armed forces or police personnel.

India	2.3
Pakistan	1.2
Nepal	4.7
Bangladesh (1976)	5.1
Sri Lanka	3.4
Thailand (1983)	5.2
Indonesia	2.5
Papua New Guinea	9.6
Philippines	5.6
Fiji	8.8

A few of these countries have increased the share going to health since 1982, but the overall situation has not changed substantially. The prospect of further substantial increases in government health care expenditures is politically remote in ANE countries, even though some of these nations are moving rapidly into the class of Newly Industrialized Countries.

Part of the gap between government expenditures and needs is filled by funding from bilateral donor organizations (such as AID and its counterparts in other industrialized nations), multilateral donor and lending agencies (World Health Organization, United Nations Development Programme, World Health Organization, World Bank, Asian Development Bank, and others), and Private Voluntary Organizations (PVOs).

Even when funding from these sources is combined with government expenditures, however, funds are never entirely sufficient to respond to important current and projected health care needs in any ANE country. Although population growth rates are falling in most ANE countries, the absolute numbers of people added to these countries each year are staggering--and health care needs grow apace. As just one example, the best contraceptive prevalence rate in the ANE region now is the 65 percent rate achieved in Thailand; if the entire ANE region were to be brought to this level by the Year 2000, 140 million women would have to become new acceptors during this period, considerably more than doubling the 1985 number of acceptors in the region (117 million). Just to maintain the 1985 contraceptive prevalence rate, more than 52 million women would have to become new acceptors by the Year 2000.

2. RESOURCE SHORTFALLS FORCE GOVERNMENTS TO MAKE DIFFICULT CHOICES

Faced with the fact that available resources cannot meet all the legitimate health care needs of their people, governments must engage in a difficult and often politically sensitive process of priority setting. Some of the choices that must be made are quite obvious. Others are more subtle, and corresponding priorities often are determined by default rather than deliberation--sometimes with disastrous results.

The scope of this resource allocation problem is demonstrated in the next several paragraphs, in which six major parameters of the health financing dilemma of any nation are discussed. Although each parameter is stated as an "either/or" choice, the actual choice to be made is where the health care system should be positioned on a continuum between two extremes. Each of the parameters also contains several secondary choices, further compounding the difficulty of the decision-making process.

- **Development or operations?**--Governments must choose how they will balance expenditures between the direct provision of service and the development and maintenance of the health care infrastructure. The difficulty of the choice is compounded by the fact that responsibility for funding various aspects of development and operations typically is divided among several ministries,

each with its own agenda, even though the government ultimately adopts a single, aggregate budget. The decision process is complicated further by the tendency of donor agencies to focus on particular aspects of the health care system.

Broadly speaking, however, a decision to cut back on development is almost always more palatable politically than a decision to cut back on services. In times of economic stringency, governments consequently tend to postpone maintenance of existing facilities. In many nations deterioration of the health care infrastructure already is nearly irreversible.

- **Urban or rural emphasis?**--As governments develop their health care infrastructure, they almost always concentrate facilities and specialized personnel in the most densely populated areas--a logical decision on the face of it. As countries become increasingly urbanized, a current phenomenon in several ANE countries, this tendency is reinforced and the disparity in access to quality health care between urban and rural areas becomes even greater. Only a deliberate decision to address the needs of rural areas more equitably can reverse the trend.
- **Preventive or curative emphasis?**--Both developing and developed nations tend to neglect preventive health care. The need for curative services is normally more visible, more certain, and more immediate. Yet, there is ample evidence that the communicable and debilitating diseases so prevalent in ANE countries (and in many other parts of the world), especially among infants and children, occur precisely because effective preventive health programs are not in place. There are few good models that show the synergistic impact of a health system in which preventative and curative services have been well balanced.
- **Emphasis on sophisticated tertiary care or on primary health care?**--The lure of medical high technology is nearly irresistible. Both government officials and the public (and often health professionals as well) tend to measure the quality of the health care system of their country by how far it has advanced in sophisticated tertiary care. But high technology that usually benefits only a limited number of patients can be acquired only through the sacrifice of expanded primary health care that benefits many. More broadly, the choice between heroic procedures that save a few otherwise terminal patients and simple procedures that achieve small but definite improvements in the health of many is one of the cruelest choices health planners must make.
- **Provision of "free" care, imposition of user charges, or establishment or expansion of health insurance schemes?**--In most ANE countries, health care traditionally has been provided "free" (i.e., without direct, out-of-pocket payment from the patient) by the government. Once established, as it has been for decades in these countries, this approach is seen as difficult to change. Nevertheless, some ANE countries have been experimenting with user fee schemes of various types; results have been mixed, although it is too early to judge many of these programs fairly. Health insurance, either publicly or privately sponsored, is not common in ANE countries, although, again, there is some recent, limited experimentation.
- **Public-sector or private-sector providers?**--Many ANE countries have a vigorous and growing private health care sector, consisting of both traditional healers (of enormous importance in some countries) and allopathic

practitioners. These private-sector providers are well patronized by both the rich and poor strata of society; surveys in several countries reveal that people at all economic levels are making out-of-pocket expenditures for private-sector care far greater than had been suspected previously--dramatic evidence of the value people place on health. Paradoxically, many people judge the quality of the care they are receiving by how much it costs--leading to the consistent but usually inaccurate conclusion that care from private-sector providers is better than care from government doctors and hospitals. Where significant private-sector activity is occurring, there is seldom any effective regulation by the government. Furthermore, few governments have studied seriously how public and private health care resources can be combined synergistically to meet more of the total population's health care needs. This point is expanded upon later in the paper.

Each nation must make these choices for itself, and shoulder the consequences. Generic prescriptions do not work. When donor organizations or others attempt to influence the choices or augment the resources available to government, they take care not to concentrate so heavily on one or a small combination of parameters that they unbalance the other parameters.

3. GOVERNMENTS ARE RARELY WELL EQUIPPED TO MAKE THESE CHOICES

The central problem to which this discussion points is not that there are many difficult choices to be made. This is true, but there are many other areas of government in which the choices are equally complex and far-reaching.

Rather, the problem is that few, if any, governments have the technical capability to deal with the choices on a rational, analytical basis. First, they rarely have a clear perception of the many dimensions of the resource allocation task and the trade-offs involved. Second, few people trained in the analytical concepts and techniques involved in resource allocation are available in the ANE countries. Third, and perhaps most devastating, the basic data essential to rational resource allocation are simply not available. So few countries have developed even rudimentary health care data systems that the possibility of allocating resources to this purpose is not even listed as a choice in the preceding section of this paper. Yet, better health data is one of the most urgent needs throughout the ANE region. (Again, the ANE region is not unique in this respect.)

Two particularly important and interrelated needs in all ANE countries are for:

- Better data on utilization of the services of private-sector health care providers, and on the flow of funds into and through the private health care sector
- A fuller understanding of the people's perceptions of their health care needs, their current methods of satisfying these needs, and their attitudes toward the existing health care system--public and private, modern and traditional

The latter need reflects the fact that, historically, government-operated health care systems have tended to define needs in terms of the services they wish to offer. The existence and sometimes rapid growth of the private health care sector while government health care facilities are underutilized is tangible evidence that this view of health care needs is no longer accepted by the public.

4. GOVERNMENT RESOURCE CONSTRAINTS ALSO MAKE OPTIMUM ENGAGEMENT OF PRIVATE HEALTH CARE RESOURCES IMPORTANT

The last of the choices discussed earlier--the choice between public and private providers--needs some elaboration. In most countries, the public and private health care sectors are seen as separate spheres, each serving part of the health care needs of a portion of the population. As government allocations to health care fall increasingly short of need, however, there is growing interest in ANE countries in coming somewhat closer to the target by harnessing public and private resources together, by forming public-private partnerships in health care.

The term "privatization" often is used for this process, but this term has some limiting and misleading connotations--most particularly that it means total retreat of government from its responsibilities in the health care arena. Rather, what public-private partnerships strive for is a realignment of responsibilities so that each sector--public and private--does what it does best.

Furthermore, there is a misconception that the driving force for public-private partnerships is the desire of the private sector to make profits from financing or providing health care. Although private sector organizations do expect to be compensated for more than their costs of providing services--in the form of profits to for-profit organizations and fees to not-for-profit organizations--this is really not the central issue if these organizations deliver services of the same or better quality (broadly defined) at the same or lower total cost. The fact that the private sector organization benefits does not mean that the government or the public loses; to the contrary, the only public-private partnerships that work well in the long term are those based on a "win/win" philosophy.

In many people's minds, moreover, privatization is equated solely to contracting out various support services. Actually, this is only one of at least 19 forms public-private partnerships can take. The rich variety of choices is discussed in the balance of this section of the paper.

Five of the 19 options involve explicit shifts of responsibility for certain aspects of the health care system from the public to the private sector:

- **Transfer Responsibility For Providing All Curative Services To The Private Sector--**In contrast to traditional public health services--preventive health care, communicable disease control, and health education--curative services are not public or social in character. Therefore, it is entirely conceivable that the government could withdraw entirely from providing curative services (except perhaps to its armed forces and other special populations), transferring this responsibility to the private sector. In most countries, a change this profound would have to be accompanied by a change in the way health care is financed, as discussed in the next group of options.
- **Allow Private Doctors To Admit To Public Hospitals--**In countries where public hospitals are underutilized, either generally or, say, in rural areas, private doctors could be allowed to admit patients into these hospitals, paying the government a flat sum or daily rate for this privilege. The rate charged by the government could reflect the degree to which the government desires to encourage this practice, possibly being below cost in rural areas where it would improve access of the local population to health services.

- **Permit Private Practice For Public Physicians--**In other circumstances, it may be appropriate to allow government physicians to conduct private practice at fee-for-service or capitated rates, on or off the site of government health facilities, during or after regular scheduled civil service working hours.
- **Deregulate And Decentralize Authority--**In countries where management of the government health care system is highly centralized, as is the case in most ANE countries, government hospitals could be given varying degrees of autonomy--in some cases even becoming financially self-sufficient and thus essentially private institutions. This would relieve them from having to adhere to the many bureaucratic guidelines, rules, and procedures that typically exist in developing countries, and also would free them from various government procurement regulations, placing them on a footing equal, or nearly equal, to that of private institutions. This option is at the heart of the profound changes currently being made in the United Kingdom's National Health System.
- **Stimulate The Private Sector To Pay A Greater Share Of The Costs Of Professional Education--**Both developed and developing nations almost always subsidize the cost of professional education for physicians and other health care professionals--often to the point of absorbing the entire cost. Graduates often are committed to a specific period of public service in return for the training subsidy. In most countries, however, the number of years of required service is considered insufficient to compensate for the medical training subsidies. In some cases, individuals can buy out of the responsibility of public service by paying a lump sum that is often below the value of the subsidized training. To correct this situation, students could be required to pay a larger share of the cost of their education, or the length of required public service could be lengthened and the cost of buying out could be increased, or private institutions could be induced to assume part of the subsidy burden.

The largest group of options, consisting of six possibilities, change the way health care services are paid for:

- **Establish National Health Insurance, Financed Partially By Private-Sector Funds--**A national health insurance scheme could be established, financed through assessments on wages in the case of wage earners and on earned income in the case of the self-employed. The poor, and possibly public service employees, could be included if the cost of their care is subsidized by the government. Assessments might be levied on marketing organizations, agricultural and fishing cooperatives, and other such organizations in productive sectors of the economy where workers' income is irregular. Health care could be provided to members of the insurance scheme by public providers, private providers, or both.
- **Stimulate The Growth Of Private Health Insurance--**Governments could stimulate growth of private health insurance schemes through special tax considerations or direct subsidies. Private health insurance could be used to purchase basic health care, or, where government already provides basic health at no charge to the patient, private health insurance could be used to "top up" (i.e., to pay for services and amenities beyond those provided by the government). As private health insurance becomes more widespread, government's financial burden in providing health care presumably becomes less.

- **Encourage Expansion Of Managed-Care Plans--**Experience in both developed and developing nations suggests that managed-care approaches can yield an appreciable reduction in the cost of health care, regardless of who pays for the care. Government could stimulate the growth of preferred provider organizations (PPOs), health maintenance organizations (HMOs), and other types of managed-care plans through several approaches: enabling legislation, provision of start-up and working capital costs, or contracting with managed-care plans to care for patients who are under government charge and responsibility.
- **Provide Tax Subsidies To Employers And Consumers--**In a reversal of the direction of responsibility shifting, government can assume a greater share of the burden of health care costs by granting tax deductions or exemptions from national income taxes to employers who provide health benefits to their employees and to consumers who pay for their own health care.
- **Impose User Fees--**Collecting user fees or copayments from patients shifts some--usually a quite small part--of the cost of providing health care to the private sector (the consumer). Depending on the level at which user fees are set and the services on which they are imposed, they have the additional benefit of discouraging overutilization of various parts of the health care system, such as emergency departments of hospitals.
- **Stimulate Community Financing of Primary Health Care--**AID has experimented in a number of countries with schemes in which communities gradually assume the full cost, or at least a major portion of the cost, of providing primary health care services to their residents. Results of these experiments have varied but have been, on balance, positive. Admittedly, however, not all have been completely and satisfactorily evaluated.

Five options are based on contracting out:

- **Contract Out Selected Services--**Using the commonest of all forms of public-private partnerships, public hospitals could engage private vendors to provide a wide range of supportive and ancillary services, particularly to hospitals, such as laboratory and radiology services, housekeeping, laundry, security, maintenance and repair, waste disposal, food services, and data processing.
- **Contract With Private Physicians To Care For Government Charges--**Government invariably has responsibility for underwriting the cost of care of various groups of citizens: the poor, police and military personnel, other public service employees, prisoners, and usually the mentally ill. Rather than itself providing health care directly to these people, government could contract with private providers to do so. This could be done with managed-care plans, discussed earlier, or with individual physicians or groups of physicians who could be reimbursed on any of three bases:
 - **Fee-For-Service--**Government could reimburse the private physicians on the customary fee-for-service basis (the commonest practice, until recently, in the U.S.) or on the basis of a government-imposed or negotiated fee schedule.
 - **Public-Sector Cost--**Alternatively, government could base reimbursement to private physicians on the cost of providing services of equivalent type and quality in public-sector facilities. This assumes

that government has a reasonably detailed and precise knowledge of the cost of providing services in its own facilities, which is seldom the case.

- **Sessional Basis**--Government could contract with physicians, particularly in remote areas, to provide services to patients at specified rates per session.

- **Contract With Private Hospitals To Care For Government Charges**--In similar fashion, government could contract with private hospitals to provide inpatient services to a specified number of government charges over a year or some other time period, paying the hospitals prospectively on a per capita basis. This technique is used in Canada and several European nations.

A final set of three options is directed at changes in the health care infrastructure:

- **Sell Or Lease Public Hospitals To The Private Sector**--Various private sector health care provider organizations, such as medical syndicates and group practices, health maintenance organizations, and other such entities, might be willing to buy or lease components of the public hospital system at district or state levels, particularly if they are now underutilized, and operate them as private facilities.
- **Lease Components Of Public Hospitals To The Private Sector**--Rather than lease entire hospitals to the private sector, government could lease just portions of government facilities (entire services or even individual beds) to private providers.
- **Lease Facilities Constructed By The Private Sector**--In situations where the existing government-owned health care infrastructure is inadequate or obsolete, private investors could construct new facilities and then lease them to the government on a long-term basis. This could be done on a turnkey basis, and it might involve short- or long-term contracts under which the private sector would manage the new facility for the government.

Evaluating these options is a task for which, like resource allocation, few governments are well equipped. The greatest danger is that a government will gravitate immediately toward one option without a full appreciation or examination of the other alternatives. Before choosing among them, every alternative under consideration should be evaluated in the context of the country, against eight criteria:

- Equity
- Allocative efficiency
- Operational efficiency
- Administrative feasibility
- Operational and financial feasibility
- Consumer acceptability
- Provider (public and private) acceptability
- Political acceptability

Competent evaluation thus requires the combined skills of the economist, survey researcher, management analyst, and politician.

5. THE SITUATION POINTS TO SEVERAL CONSTRUCTIVE ROLES FOR AID

The discussion above suggests that AID/ANE could strengthen its impact in the health-financing arena by action on several fronts simultaneously. Although these actions are not totally interdependent, ANE will be most effective if it undertakes at least a major part of the program described under the next seven headings.

(1) Understanding The Private Sector

To facilitate greater interaction with the private health care sector, HPN officers would benefit from better understanding of how the private sector thinks and acts. This could be accomplished through several approaches:

- HPN officers in both AID/W and the field could begin active networking with private sector executives and technical specialists.
- ANE could encourage its HPN officers to participate in private-sector conferences on health care financing topics.
- AID could institute an executive exchange program, in which an HPN officer gains direct experience in a private health care insurance or provider facility while a private-sector executive contributes his or her expertise as a temporary member of the HPN staff.

ANE could commission monographs on health care financing subjects, to serve as groundwork for discussion of these subjects at ANE mission directors' conferences.

ANE could increase emphasis on health care financing at the HPN officers' conferences and in the State-of-the-Art course.

ANE could plan and conduct a global or additional regional conference on health care financing, patterning it after the successful ICORT series of conferences and the recent conference on private-public partnerships in Kuala Lumpur.

(2) Strategy Development

Developing a comprehensive health care financing strategy for a particular country is a major, highly technical undertaking. The ANE countries would benefit from having two or three well-done projects in this area as models. ANE could support such projects, which would be particularly timely now in the Advanced Developing Countries.

(3) Tools For Policy Dialogue And Training

ANE could continue to support development of analytical tools that would be useful in policy dialogue and training activities, such as the financial simulation model currently in the late stages of development.

(4) Training And Technical Assistance

Possibly the most important activity in the health care financing sphere is the provision of training and technical assistance to the managers and technical staffs of host country ministries of health.

With respect to training, this could take the form of short-term regional or country-level training courses in health care financing concepts and related topics, such as health data systems. Training might well include also long-term training of a limited number of

participants in the U.S. or third countries, study and observation tours, and preceptorships, or any combination of these.

Technical assistance in health care financing also could be provided to specific projects or, more broadly, to ministries of health in ANE countries.

(5) Data Systems And Surveys

Effective financial planning will continue to be hobbled in ANE countries until there is a significant upgrading of health data systems. Improvement is needed urgently in two data areas:

- Data about the private health care infrastructure, utilization of private-sector health care services, and the flow of money into and through the private health care sector
- More comprehensive and much more reliable epidemiological data

ANE could support projects designed to address either or both of these needs.

It is evident that ANE should be undergoing a major shift of perspective, from the exclusively supply-side view of recent years to a more balanced view of both supply and demand for health care. To support this shift, it will be important for HPN officers to gain a much better understanding of demand for health services, which undoubtedly varies in significant ways from country to country. This could be accomplished by commissioning additional demand surveys of the type recently completed in Bangladesh.

(6) Donor Coordination

USAID is no longer the dominant health-sector donor in many ANE countries. From a point where ANE could develop health-sector strategies bilaterally, the situation has moved to a point where ANE will be fully effective only if it coordinates its strategy more closely with other donors. This is discussed in greater detail in another of the papers in this series, *Development Assistance To The Health Sector In Asian And Near East Countries From The Agency For International Development, Other Donors, And Private Voluntary Agencies*.

(7) Infrastructure Financing

As AID stimulates ANE countries to restructure their health-financing mechanisms, a critical element almost invariably will be substantial restructuring of the incentives to key providers in both the public and private sectors. In many cases, the most powerful incentives may involve an upgrading of the facilities and related resources available to these providers. In view of this, AID may wish to reconsider its current posture with respect to funding of infrastructure projects.