Planning the finances of the health sector

A manual for developing countries

E. P. Mach & B. Abel-Smith

WORLD HEALTH ORGANIZATION

PLANNING THE FINANCES OF THE HEALTH SECTOR

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by

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PREFACE

Many countries, particularly in the developing world, are seeking to orientate their health services towards a more equitable and efficient utilization of resources. A detailed analysis of the financing of health services is an important step in such an undertaking.

This manual sets out a methodology for carrying out such an analysis, suggesting ways of collecting and organizing data on expenditure and sources of finance. It also suggests how this information might be utilized in policy formulation—to make a master plan for the future use of all financial and material resources. Particular attention is paid to primary health care in view of its high priority in current health policies. A series of tables presents models that provide an analytical framework for national planning, and summary tables have been devised for the use of policy-makers.

The manual is aimed at planners, economists, statisticians, accountants and researchers in the health and health-related sectors in developing countries, and at the staff of international and bilateral agencies concerned with development aid. It is hoped that the results of periodic studies undertaken with the help of this manual will assist policy-makers in taking decisions. It is also hoped that the methodology, or part of it, will serve for routine data collection and presentation and thus enable trends to be analysed over longer periods of time. Furthermore, the manual is intended to serve as training material for the different categories of personnel mentioned above, as part of the general policy of strengthening national capacities in all areas, including planning, management and the evaluation of the health system. National and international organizers of workshops, seminars and training courses in these fields, both in the health sector and beyond in general planning and national financial management, may find this manual, or an adapted version of it, of use in their work.

Many national case studies and a number of international workshops have contributed to the evolution of this manual. The basic assumption was made that, even with limited statistical data, useful estimates could be made of the main categories of health expenditure, sources of finance, and the flows of money within the health sector, and that this information could help policy-makers and managers to take appropriate action. It was suggested that data on expenditure and sources of finance should be collected by reviewing the finances of the most visible providers of health care, e.g., ministries of health, other ministries, local authorities, social security schemes, religious missions and private practitioners. This approach has been adopted and further developed. In particular, methods have been added for estimating the value of transactions in the private health sector, assessing the level and sources of foreign assistance, estimating the expenditure on safe drinking-water supply, sanitation and nutrition programmes, and classifying costs and finances of primary health care and analysing the findings.

The chapters on financial forecasts and on possible ways of taking corrective action give brief descriptions of options currently being chosen in some countries, and do not provide a complete list of possible solutions. In particular, Chapter 8 gives only an outline of projections of future expenditure and sources of finance. It is hoped that greater detail will emerge with descriptions of further national experiences.

This manual has been widely circulated for comments and the subject was discussed at a number of international workshops—among others, in Mexico (interregional, 1979), India (for countries of the South-East Asia Region, 1979), Colombia (for countries of the Americas, 1979) and the Philippines (for countries of the Western Pacific Region, 1982). Teaching material was also developed for an intercountry training course in Botswana on techniques of surveying health finance.

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CHAPTER 1

Introduction

The development of health policies

In the early 1950s many developing countries were concentrating their efforts on the eradication of diseases through mass campaigns run outside the main structure of their health services. As early as 1953, WHO was stressing the need to strengthen basic health services "to meet the most urgent problems affecting large sections of the population" (*23*). During the 1960s a number of developing countries integrated their special programmes with their basic health services.

Progress in developing basic health services—particularly in rural health services—has been slow and uneven. A joint UNICEF/WHO study reported in 1975 that, despite great efforts, the basic needs of vast numbers of people throughout the world were still unmet (*7*). Too often the pattern of health services has been modelled on those in industrialized countries—relatively sophisticated services staffed by highly qualified personnel. These services have been concentrated in the cities and towns, have been predominantly curative, and have catered for only a small minority of the population. It has not proved possible to expand effective access to services of this type to anything like the entire population.

Several World Health Assemblies have stressed that an alternative approach can be practicable and relatively successful if:

(1) The emphasis is switched from urban to rural populations and to the underprivileged.

(2) Services are integrated, combining both curative and preventive strategies as part of wider socioeconomic development.

(3) The importance for health of sanitation, housing, nutrition, education and communication is given full recognition.

(4) The use of services is promoted where local populations take a

major responsibility for them both in providing manpower and facilities and in participating in decisions on local health policies.

(5) Locally recruited primary health care workers, supported by their communities, can form the front line of the health care system.

(6) The work of indigenous healers is given full recognition.

Health for all by the year 2000

In 1977, the World Health Assembly decided that the main social target of governments and WHO should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (resolution WHA30.43). In 1978, a conference held in Alma-Ata, USSR, declared that primary health care was the key to attaining this target (*27*).

The conference defined primary health care as essential health care made universally accessible to individuals and families by means acceptable to them, through their full participation, and at a cost that the community and country could afford.

These services were to include as a minimum:

(1) education concerning health problems and methods to prevent and control them;

(2) promotion of food supply and proper nutrition;

(3) an adequate supply of safe water, and basic sanitation;

(4) maternal and child health care, including family planning;

(5) immunization against the major infectious diseases;

(6) prevention and control of locally endemic diseases;

(7) appropriate treatment of common diseases and injuries;

(8) provision of essential drugs.

In 1979, the World Health Assembly invited the Member States of WHO to formulate national, regional and global strategies, a health strategy having been described by the WHO Executive Board as "the broad lines of action required in all sectors to give effect to health policy". The Global Strategy published in 1981 (*22*) started from country strategies and was built up through regions to the world level. It is a synthesis of ideas derived from national and regional strategies.[1] The main thrusts of the Strategy are:

— primary health care to deliver programmes that reach the *whole* population;

[1] The Global Strategy is referred to throughout as "the Strategy".

— action to be taken by individuals, families and communities as well as by health services and health-related services in other sectors;

— technology that is appropriate, scientifically sound, adaptable, acceptable to users, and within the capacity of the country to afford;

— a high degree of community involvement;

— international action to support national action.

Action is also specified to promote and support the Strategy:

— by disseminating information to maintain population support;

— by ensuring political commitment at every level;

— by enlisting the support of the relevant professionals;

— by strengthening the health arm of government;

— by developing the managerial process;

— by reorienting the national research effort;

— by mobilizing human resources;

— by generating the necessary finance, including transfers from developed to developing countries;

— by creating the necessary international cooperation.

A list of indicators has been prepared to monitor progress in implementing the Strategy at every level (*20*).

WHO will provide coordination and promote technical cooperation and the Organization will be restructured accordingly. Its programmes of work will give high priority to the support of the Strategy. WHO will use the Strategy to support the International Development Strategy for the Third Development Decade, thus contributing to the New International Economic Order.

For this manual, the following sections of the Strategy (*22*; pp. 67–68) are particularly relevant:

> "Just as the successful implementation of the Strategy will mean mobilizing all possible human resources, it will also depend on mobilizing all possible financial and material resources. This implies first of all making the most efficient use of existing resources both within and among countries. At the same time, additional resources will undoubtedly have to be generated.
>
> In this context *ministries of health* will:
>
> (1) review the distribution of their health budget and in particular allocations to primary health care and intermediate and central levels, to urban and rural areas, and to specific underserved groups;
>
> (2) reallocate existing resources as necessary—or, if this proves impossible, at least allocate any additional resources—for the provision of primary health care, particularly for underserved population groups;
>
> (3) include an analysis of needs in terms of costs and material in all consideration of health technology and of the establishment and maintenance of the health infrastructure;

(4) consider the benefit of various health programmes in relation to the cost, as well as the effectiveness of different technologies and different ways of organizing the health system in relation to the cost;

(5) estimate the order of magnitude of the total financial needs to implement the national strategy up to the year 2000;

(6) attempt to secure additional national funds for the strategy if necessary and if they are convinced that they can prove that they have made the best possible use of existing funds;

(7) consider alternative ways of financing the health system, including the possible use of social security funds;

(8) identify activities that might attract external grants or loans;

(9) in developing countries take action so that their governments request such grants and loans from external banks, funds and multilateral and bilateral agencies;

(10) in developed countries, take action to influence the agencies concerned to provide such grants and loans;

(11) *present to their government a master plan for the use of all financial and material resources, including government direct and indirect financing; social security and health insurance schemes; local community solutions in terms of energy, labour, materials and cash; individual payments for service; and the use of external loans and grants.*" [1]

The analysis of national health expenditure and sources of finance

How should a master plan be prepared for the use of all financial and material resources? The first step is to obtain a clear picture of the use of current financial and material resources, identifying allocations to primary health care, to intermediate and central levels, to urban and rural areas and to specific underserved groups. The full costs of various health programmes are not always known, as support costs (such as transport, the maintenance of buildings, and supervision) may fall on other budgets or other parts of the budget. A master plan of all financial and material resources will normally involve data stretching far outside the ministry of health budget into the budgets of other government departments, compulsory health insurance agencies, industry, voluntary bodies and the private sector. Extremely few developing countries, and by no means all developed countries, know all that is spent on health services and health-related activities and how these services are being financed.

The budgets of ministries of health, in their conventional structure, are not suitable for policy analysis since they normally consist only of

[1] Authors' italics.