

Health system and health funding policies: from PHC to stratified health systems

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Policy for health and development since WWII

- The colonial phase
 - making the tropics safe for the White Man (LSHTM)
 - improving the productivity of the slaves (hookworm)
- Magic bullets and vertical programs (DDT, MCH, FP, small pox, polio, tuberculosis and malaria)
- Developing an indigenous professional workforce
 - medical schools and big urban hospitals
- NAM, UNCTAD and the possibility of a fairer global regime (NIEO)
- Alma-Ata: Primary health care and barefoot doctors
- Selective primary health care (GOBI FFF)
- The debt crisis, the IMF and structural adjustment
- Legitimation crisis (WB to the rescue)
 - ‘Investing in Health’ - structural adjustment can be good for your health (PRSP, SWAs etc)
 - cost effective packages of interventions
- Rise of WB as premier health policy authority (and funder)
 - WHO Commission on Macroeconomic & Health: virtuous cycles and dark threats
 - GF ATM
- WTO: securing an unfair global trading regime
 - TRIPS and Doha
 - GATS and privatisation
- Global Fund for AIDS, TB and Malaria

Country	TotHlthExp /GDP (%)
Pakistan	2.4
B'desh	3.4
Nigeria	4.7
China	5.6
India	6.1
Russia	6.2
Cuba	7.3
UK	7.7
Brazil	7.9
South Africa	8.7
Argentina	8.9
Australia	9.5
France	9.7
Germany	10.9
USA	14.6

Country	PC THE (Int Dollars)	PC THE (USD at ave exch)
Nigeria	43	19
B'desh	68	14
Pakistan	48	13
India	96	30
Cuba	251	211
China	261	63
Russia	535	150
Brazil	611	206
South Africa	689	206
Argentina	956	238
UK	2160	2031
Australia	2699	1995
France	2736	2348
Germany	2817	2631
USA	5274	5274

Country	Gov share of THE (%)	Private pool share of THE (%)	OOP share of THE (%)
India	21.3	1.2	77.5
Nigeria	25.6	7.1	67.3
B'desh	31	10	59
Pakistan	27.7	1.5	70.8
China	33.7	2.5	63.8
South Africa	40.6	47.0	12.4
USA	44.9	41.1	14.0
Brazil	45.9	19.4	34.7
Argentina	50.2	18.7	31.1
Russia	55.8	16.1	28.1
Australia	67.5	12.4	19.7
France	76	14.2	9.8
Germany	78.5	11.1	10.4
UK	83.4	7.3	9.3
Cuba	86.8	0	9.9

International comparisons – health expenditure (WHR04,06)

Country	Life Expectancy (persons)
B'desh	62
Pakistan	62
Nigeria	46
South Africa	48
India	62
Russia	65
Brazil	70
China	72
Argentina	75
USA	78
Cuba	78
UK	79
Germany	79
France	80
Australia	81

Country	<5 Mortality (per 100,000)
Germany	5
France	5
UK	6
Australia	5
Cuba	7
USA	8
Russia	16
Argentina	18
China	31
Brazil	34
South Africa	67
B'desh	77
India	85
Pakistan	101
Nigeria	197

Country	Immunisation (% of 1 y/o with 3 doses DTP)
Nigeria	25
India	70
Argentina	88
Germany	89
China	90
UK	91
Australia	93
South Africa	94
USA	96
Brazil	96
France	97
Russia	98

Country	MMR per 100,000 (%)
Australia	6
Germany	9
UK	11
USA	14
France	17
Cuba	33
China	56
Russia	65
Argentina	70
South Africa	230
Brazil	260
B'desh	380
Pakistan	500
India	540
Nigeria	800

International comparisons -
health status (WHR04)

Health financing

- How is the money raised?
- How are funds pooled?
- How are services paid for?

Ways of raising money

- Government taxation
- Health insurance
 - contribution: through employment or individual/family
 - coverage: compulsory or voluntary
 - ownership: government, community or private
- Out of pocket payments
- Donor funding

Ways of pooling

- Taxation
- Enterprise-based welfare model
- Employment related insurance
- Community rating insurance
- Risk rated insurance
- Individual savings accounts

Pooling

- Contributing to and drawing from the same pool of funds
- Transfers through pooling:
 - from well to sick
 - low risk to high risk
 - young to old
 - rich to poor
 - across generations

Ways of paying for services

- Government provision (owns buildings and pays salaries)
- Contract between purchasers (government purchasers or insurance plans) and health service providers
- Patient payment and insurance reimbursement
- Out of pocket payment (not reimbursed)

'Purchasing' health care

- Item of service
- Episode of service (eg inpatient episode)
- Assurance of health care for a fixed period (individuals, families, enterprise staff, etc)
- Programs of services and activities
- Health outcomes?

One Contract



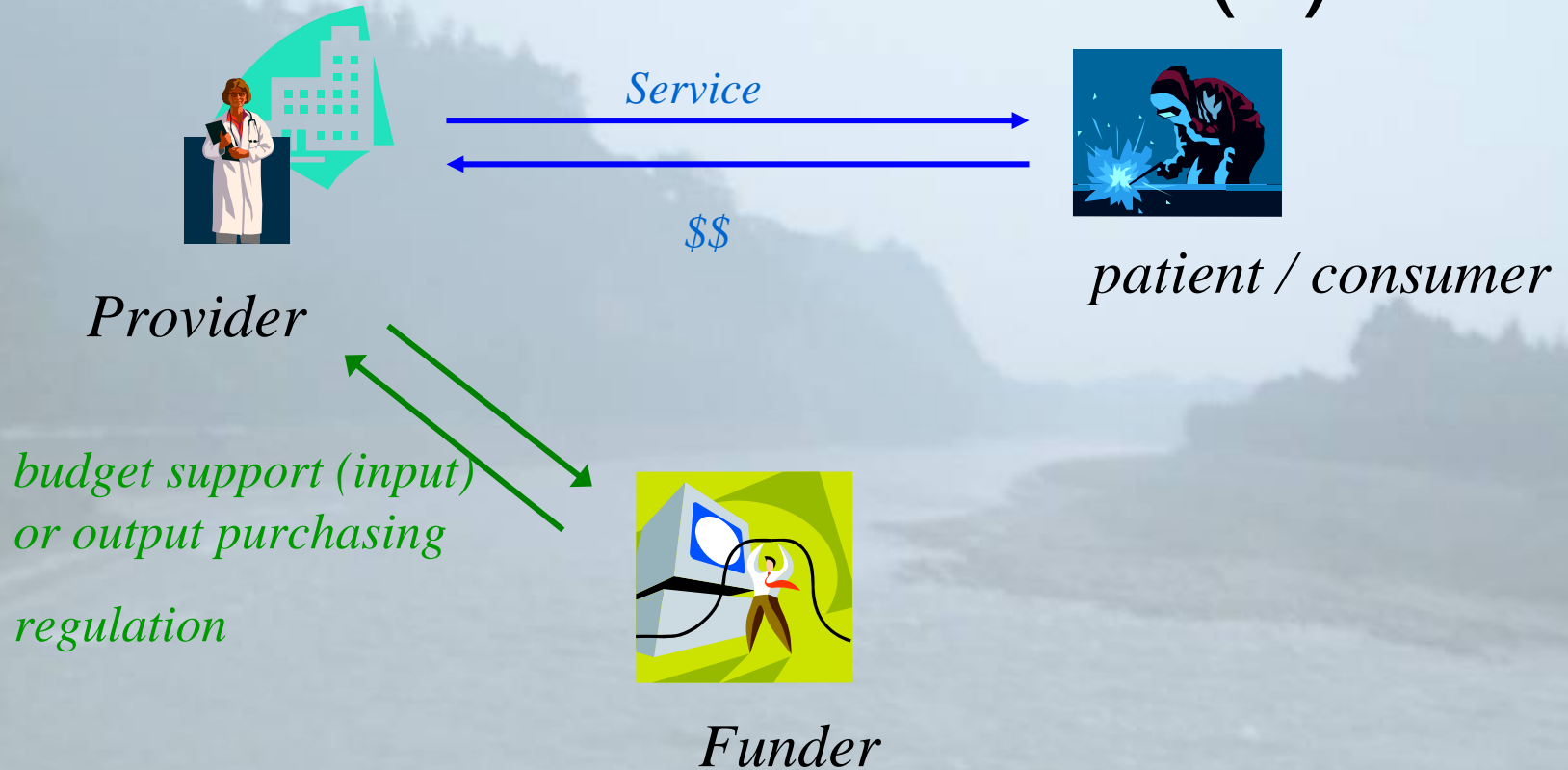
Provider



patient / consumer

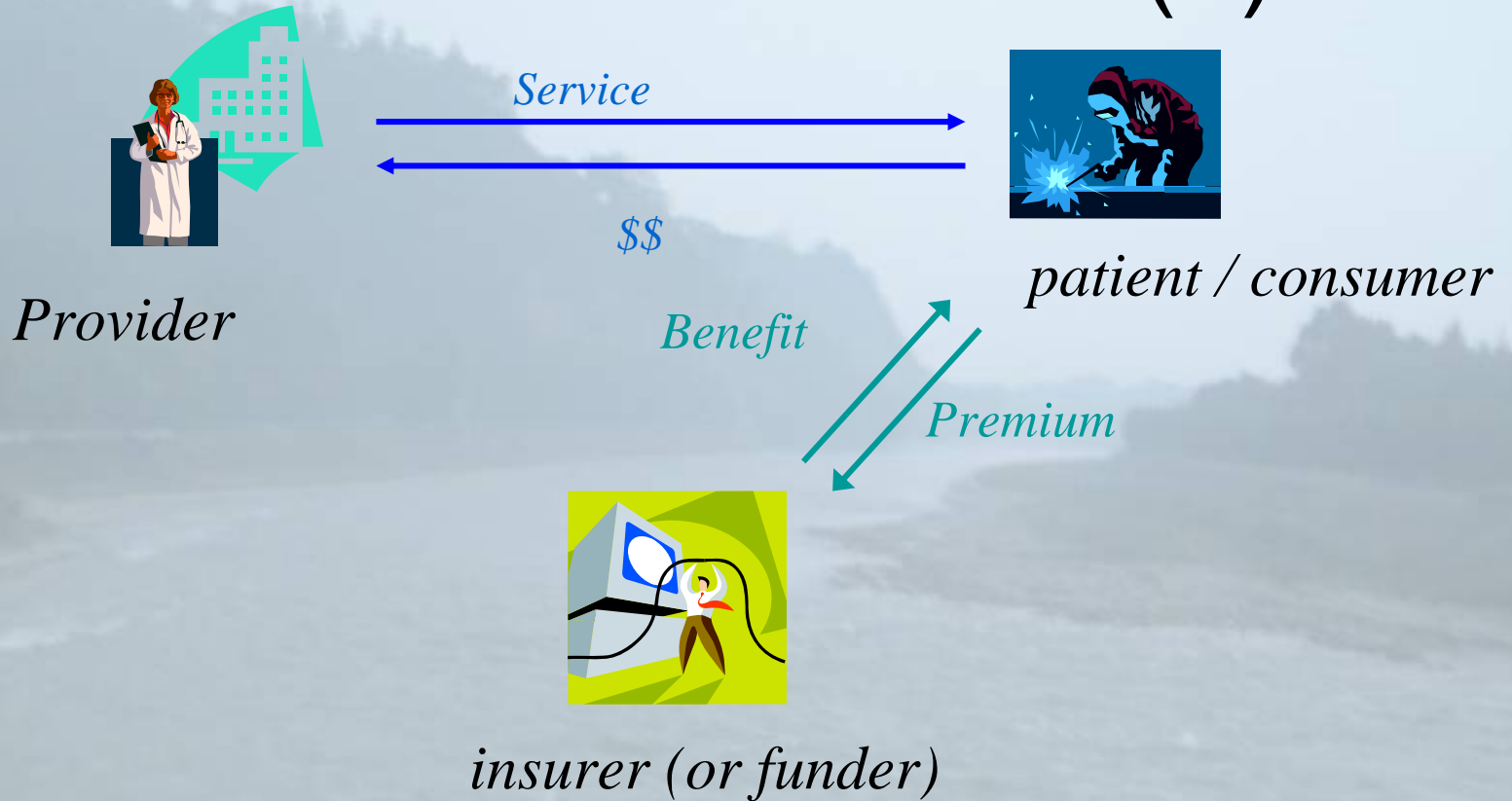
- user pays for service

Two Contracts (a)



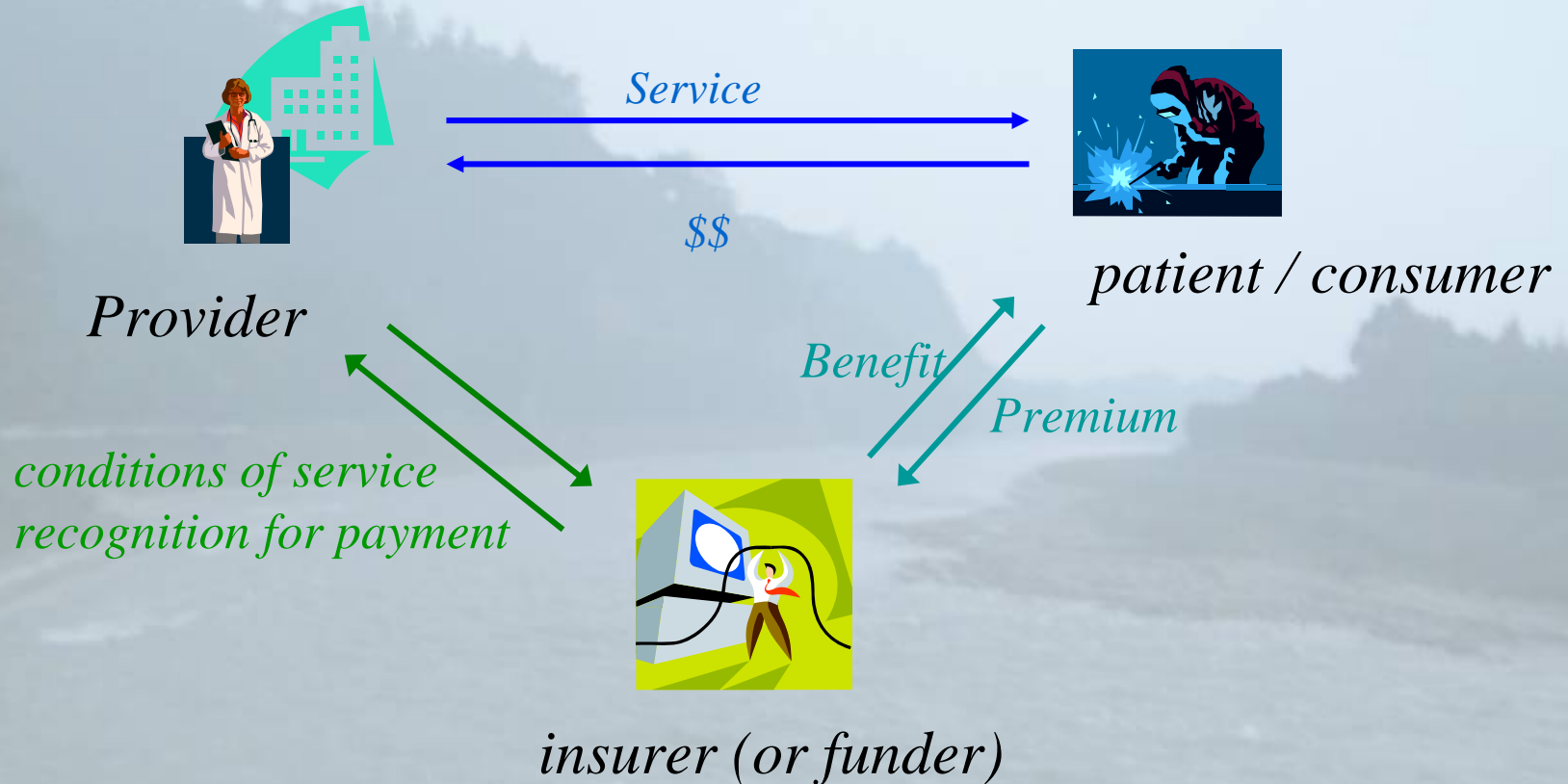
- provider provides service (+/- copayment)
- funder contracts with providers

Two Contracts (b)



- user pays for service
- insurer reimburses via benefit

Three Contracts



- user pays for service
- insurer reimburses via benefit
- insurer contracts with providers

US health insurance: the players

- Patients
 - procure care
- Providers (clinicians and facilities)
 - provide care (increasingly regulated by insurers)
- Plan managers
 - contract with and purchase services from providers on behalf of insured populations according to agreed plans
- Insurers
 - create a package of plans for sale to companies and public
- Brokers
 - assist employers to find the plans they want
- Employers
 - contribute to premiums
 - negotiate plan options with employees
- Unions
 - bargain with employers over plan choices
- Employees
 - contribute to premiums
 - hope to stay healthy

Insurance companies create different plans for different strata of the market

- High cost / high premium
 - unrestricted access
 - fee for service payment and full reimbursement
 - loose utilisation control
- Low cost low premium
 - restricted access (restricted number of providers, gatekeeping, etc)
 - capitation (provider takes the financial risk)
 - tight utilisation control

Managed care

- Active purchasing
- Plan managers contract directly with providers
- Plan managers regulate the provision of service to individuals according to the plan

Managed competition

- Market for health care
 - providers (hospitals and doctors) compete for consumers
 - competition increasingly ‘managed’ by health insurance organisations (‘managed care’)
- Market for health insurance
 - insurance companies compete for corporate contracts
 - not really ‘managed’ by anyone

Export of multi-tiered health care (including managed care)

- Africa, Latin America, Asia
- Direct leverage (SAP, PRSPs)
- Direct bilateral pressure to liberalise trade and investment
- Donor pressure (WB, USAID)
 - WB lending to private corporations
- Polished consultancy (especially WB, global accounting firms, leading academic centres)
- Creation of a new ‘consensus’ (‘pro-poor’ development assistance) eg through DAC of OECD
- The ratchet function of GATS

Three key documents

- Primary health care (Alma-Ata, 1978)
- Investing in Health (WB, 1993)
- Report of Commission on Macroeconomics and Health (WHO, 2001)

Alma-Ata, 1978 ([link](#))

- WHO and UNICEF building a case for a new approach to health policy in developing countries
 - priority to basic services where people live
 - appropriate workforce and technologies
 - intersectoral approach to prevention
- Borrowing from the experience of GK, China and other countries implementing the PHC approach
 - learning also from CH in the West and polyclinics in the East

PHC (A-A) – multiple meanings

- Sector of service delivery
 - first contact, continuing, generalist, comprehensive, essential services
- Policy model including principles for service delivery
 - community involvement (accountability, planning, prevention)
 - mutually supportive referral systems,
 - intersectoral collaboration,
 - appropriate multi-disciplinary workforce working as a team
 - appropriate technologies
- Social change
 - linked to vision of a NIEO
 - popular mobilisation towards health development **with and through** political sovereignty and self-directed economic development

PHC – contested from the start

- Selective or comprehensive?
 - 1978 – Alma-Ata
 - 1981 – ‘Selective PHC’ (Walsh & Warren)
 - 1983 – GOBI-FFF
- Place of vertical programs?
- Relationships with secondary and tertiary sectors
 - funding priorities
 - power relationships: top down or bottom up?
 - workforce policies remain contested
- Different economic policy agendas

Questions about selective PHC

- Evidence re effectiveness is mixed
 - compare small pox, onchocirchiasis and polio with AIDS, TB and malaria
- Efficiency in the provision of health care infrastructure
 - operational inefficiency and quality implications of having to provide a full infrastructure for each vertical program eg district health systems and AIDS/HIV
 - if some programs need comprehensive infrastructure then why not deliver all vertical programs in a partnership relationship with a comprehensive PHC sector?
- Sustainability
 - not sustainable as vertical programs because they do not create robust institutional capacity for sustainability (eg domestic smoke exposure, micronutrient supplementation)
- Shallow prevention
 - cannot get to the heart of the necessary transformations for deep prevention
 - difference between biomedical determinants and social/historical determinants
 - difference between public health pathways and historical pathways to better health
- Contradictions between priority setting at the national levels (best buys for donors) versus priority setting at the community level (best buys for families)
 - issues of allocative efficiency and equity (one size fits all)
 - why should the principle of allocative efficiency only apply at the level of donor choice and not at the level of community?

Questions about comprehensive PHC

- PHC practitioner as patient advocate and care coordinator
 - within and across the system
 - an issue of health system operations generally, not just the PHC sector
- Community accountability
 - a protection against corruption and a guarantee of diligence and commitment
 - mixed achievement; need to make hospital care accountable also
 - an issue of health system accountability generally
- Community participation in management, planning and policy making
 - difficult, mixed achievement, community people need support and pathways to participate
 - an issue for the health system generally
- ‘Essential care’ and appropriate technology
 - does this mean minimal?
 - what if consumers are looking towards ‘more professional care options’?
- Multi disciplinary teams
 - depends on sector-wide workforce policies and relationships

Case study: PHC in China

- Late 1950s to early 1970s
 - three tiered service system with resources for comprehensive basic care at the local level supported by referral network of secondary and tertiary hospitals
 - barefoot doctors
 - patriotic health campaigns
- Economic reform from 1978
 - move from collective farming to family farming
 - collapse of cooperative funding for PHC in rural areas
 - emergence of a hospital dependent user pays system in the country and cities
 - slowly putting in place health insurance
 - patriotic health campaigns just a memory
 - widening inequality and weakening social solidarity
- Lessons
 - the specific structures and workforce mixes which support the PHC model are highly context dependent
 - PHC development not independent of the development of the rest of the health system

Case study: PCTs in the UK

- PCTs in the UK
 - control of hospital induced demand (through gatekeeping and fund holding)
 - supporting GPs as coordinators of patient care
 - involvement of primary care practitioners and communities in accountability and priority setting?
 - possible role in social change (involvement in Health Action Zones)
- Lessons
 - options for PHC development arise within debates about HSR generally including health financing options
 - need to balance the model and the principles with the specifics of particular settings

The debt crisis and 'structural adjustment'

- 1973 OPEC oil price rises
- 1973+ Loan salemen on the loose (negative interest rates!)
- 1981 Reagan, monetarism and interest rates
- IMF 'structural adjustment packages'
 - Legitimation challenge (UNICEF, WHO, civil society)
- The World Bank joins the Fund (Investing in health, 1993)
- The WB takes charge of 'development assistance'
 - SAPs, PRSPs, SWAPs
- The Global Fund for AIDS, TB and Malaria
 - and other PPPs
- WB HSR orthodoxy: Vertical programs linked to multi-tiered systems (privatisation plus safety-nets)

Structural adjustment

- Cuts in public spending
- Removal of price controls
- Freezing of wages
- Emphasis on production for export
- Trade liberalisation
- Incentives for foreign investment
- Privatisation of public sector services
- Devaluation

Impacts of structural adjustment

- Widening of inequalities
- Reduced purchasing power for the poor (increased prices, withdrawal of subsidies, freezing of wages)
- Downsizing of public sector and safety net programs
- User pays in health care
- Reduced support for subsistence agriculture

Investing in Health 1993

- WB's 16th World Development Report
- Overview of world health
- Analysis of the conditions for better health
- Policy recommendations for health development

Investing in health

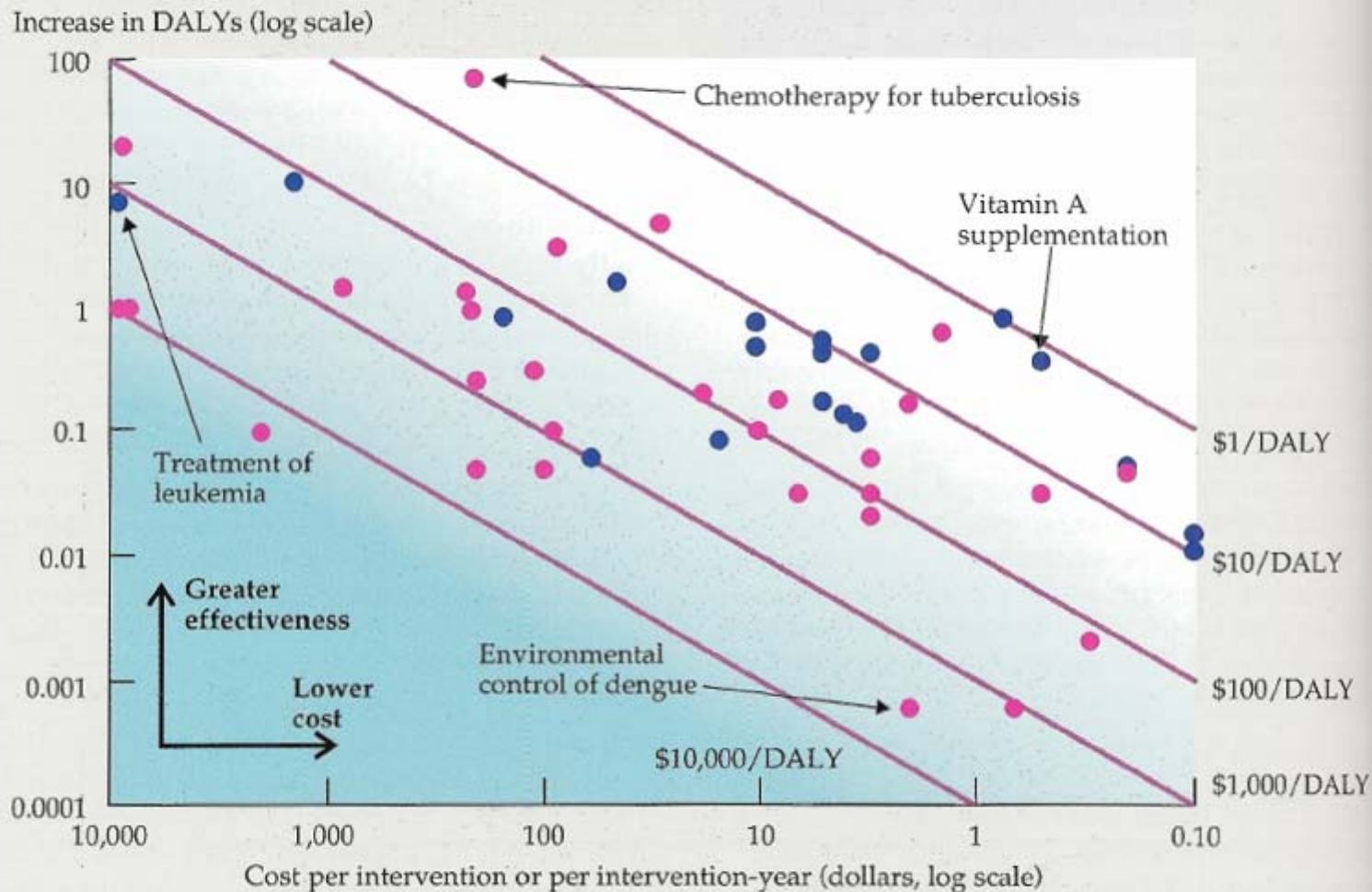
- Beautifully produced
- Clearly argued
- Useful source of data
- Innovative methodologically
- Useful review of some key issues
- Some sensible recommendations
- And potentially damaging to the health of poor people in developing countries?

The DALY

(Disability Adjusted Life Year)

- DALY as measure of global burden of disease (GBD)
- Cost-effectiveness of 47 'interventions' calculated (DALYs averted per dollar spent)

Figure 3.2 Benefits and costs of forty-seven health interventions



Target:

- Children under age 15
- Adults age 15 or older^a

The public health package

- Augmentation of the Expanded Programme on Immunisation (including micronutrient supplementation)
- School health programs to treat worm infections and micronutrient deficiencies and to provide health education
- Programs to increase public knowledge about
 - family planning and nutrition
 - self-care or indications for seeking care
 - vector control
 - disease surveillance activities
- Public health programs
 - to reduce consumption of tobacco, alcohol and other drugs
 - AIDS prevention programs with a strong STD component

The clinical package

- Tuberculosis treatment
- Management of the sick child
- Prenatal and delivery care
- Family planning
- STD treatment
- Treatment of infection and minor trauma
- Assessment, advice and pain alleviation

Contradictions and individualism in the public health package

- Periodic mass treatment for worms
 - "Treatment usually cures the current infection, but in endemic areas children will inevitably become reinfected."
 - "A return to pretreatment levels of infection typically takes about twelve months for roundworm and twenty-four months or more for hookworm."
 - "Rates of reinfection can be reduced by environmental improvements, especially sanitation, but where this is impractical or unaffordable, it is cost-effective to repeat the therapy at regular intervals."
- But but no subsidy for sanitation
 - "Health benefits alone do not generally provide a rationale for public subsidy of water and sanitation"
- No consideration of the experience of the industrialised countries during the 19th century with respect to market failure in the private supply of water, sanitation and refuse removal and the successful experience of publicly provided services

Micronutrient supplementation but deregulate food markets

- Micronutrient supplementation
 - Iodine - responsible for 20 million cases of mental retardation
 - Vitamin A - 13.8 million children with eye damage
 - Iron - 88% of pregnant women in India are iron deficient
- "A year of healthy life can be bought for less than \$10 with some micronutrient interventions"
- "There is a strong case for government intervention to improve health by improving nutrition, but not for interfering generally in food markets, except in extraordinary conditions such as famine."
- But protein and energy malnutrition?
 - 780 million people world wide suffer from an energy deficient diet; many are protein deficient also
 - The causes of malnutrition are linked to household income, female income, seasonal access
 - The main strategy suggested for addressing malnutrition is greater household buying power, associated with economic growth
- Land reform?
 - "In most societies providing health and education for the poor commands a degree of political assent that is altogether lacking for transfers of income or of assets such as land. Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences."

Structured discrimination against developing economies ignored

- Barriers to economic development facing developing countries and embedded in current global trading regime
 - dumping of cheap wheat
 - high import barriers in the North, especially agricultural produce
 - fluctuating commodity prices
 - falling terms of trade (continuing fall in prices for commodities compared with the prices of manufactured goods)

Public investment in water supply and sanitation is not cost-effective

- "... if publicly financed investments in these services are being considered for health reasons it should be noted that such investments generally cost more per DALY gained than other health interventions recommended in this report"
- That is, if the costs of an investment in water supply and sanitation are to be justified only in terms of improved health then it would be cheaper to pay for recurrent mass drug administration
- This comparison ignores the productivity and amenity benefits in other sectors of social activity. If the costs of the investment were apportioned across a range of other beneficial outcomes in other sectors the result might be different

A new 'health conditionality' as part of structural adjustment lending

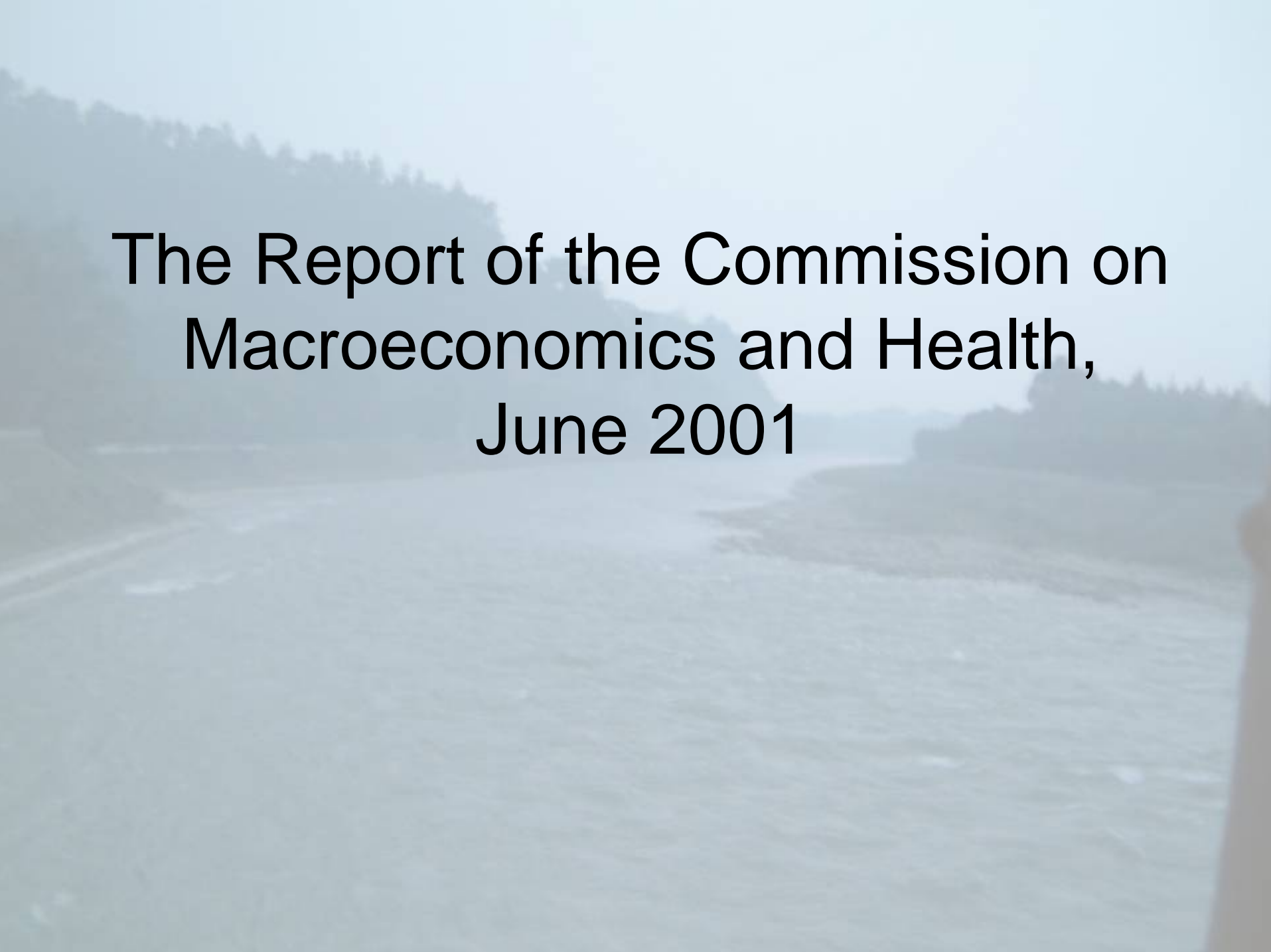
- Key outcome
 - guidelines for health policies under Structural Adjustment Programs
- The promise
 - "SAPs will be consistent with improving health if they are implemented in association with these policy packages"
- Is this promise credible?

SAPs with health conditionality

- SAPs would be consistent with health improvement, if World Bank policies followed
 - targetting of cost-effective public health interventions
 - transfer of funding from discretionary services (such as hospital funding) to development of primary health care services
 - establishment of efficient health insurance systems
 - increased efficiency in the delivery of health care and infrastructure for public health through the involvement of the private sector

The critique

- The credibility of the promise of 'health-promoting structural adjustment' depends on how you understand the global economy
- In terms of the growth and trickle down paradigm this report is a very positive contribution
- Evaluated in terms of the 'crisis of over-production' scenario the recommendations of this report will
 - help to stabilise the world economy and protect the living standards of people in the rich countries
 - at the cost of a continuing burden of disease carried by poor people in severely indebted less developed countries



The Report of the Commission on
Macroeconomics and Health,
June 2001

The basic message

- The health situation in many developing countries is insufferable
- These countries do not have the resources to provide basic health care
- Poverty and ill-health contribute to social and global instability
- Good health an input to economic productivity
- Globalisation is on trial (indicted on the grounds of poverty and health and under threat through social / global instability)
- Increased funding for health care in low income countries must be found through debt relief and increased aid

Commission on Macroeconomics and Health (June 2001)

- Commission required to "assess the place of health in economic development"
- Finds that better population health will contribute to economic development but resources available for health care in the low-income countries are insufficient and so donor finance will be needed to close the financing gap (in particular the GFATM)
- Endorses the PRSP process as mechanism for negotiating aid packages
- Identifies limited range of disease priorities, in particular communicable diseases, nutritional deficiencies, childhood illnesses, and a set of corresponding health care interventions
- Argues for health system development (universal access, subsidised community-based financing, 'close to client' (CTC) service development) and vertically organised disease focused programs
- Comments on developing country access to pharmaceuticals and argues for differential pricing backed up by provision for generic licensing (mandatory if necessary)

Features of the CMH Report

- Poverty and the threat of violence
- Health as input to economic development
 - no discussion of economic activity which creates profit through damaging health
 - no discussion of global barriers to economic development
- Interventionism and ‘scaling up’ (but also ‘CTC’ provision and health system development)
- Strong case for increased aid
- Reliance on Aid for financing (through PRSPs)

The virtuous cycle: better health creates economic growth creates better health

- *"Health is the basis for job productivity ... [G]ood population health is a critical input into poverty reduction, economic growth and long term economic development at the scale of whole societies. [...] Conversely, several of the great "takeoffs" in economic history - such as the rapid growth of Britain during the Industrial Revolution; the takeoff of the US South in the early 20th century [...] were supported by important breakthroughs in public health, disease control and improved improved nutritional intake ..." (page 32)*

Disease breeds social instability (and causes US intervention)

- The Commission is quite explicit in linking social and global instability to poor health as well as poverty:
- *The evidence is stark: disease breeds instability in poor countries, which rebounds on the rich countries as well. A high infant mortality rate was recently found to be one of the main predictors of subsequent state collapse (through coups, civil war, and other unconstitutional changes in regime) in a study of state failure over the period 1960-1994. The United States ended up intervening militarily in many of those crises. (Page 38)*

Role of PRSPs in the governance of the developing countries

- The Commission recommends that the IMF's Poverty Reduction Strategy Papers process be the main instrument through which ODA is to be directed to the 'up-scaling' of health systems. Debt relief would presumably also be conditional on satisfactory completion of PRSPs.
- Whether PRSPs are part of the problem or part of the solution remains a moot point. (See [Wemos, 2001](#)).

Acknowledge the hegemony of the Bank in return for more money for health (and Bretton Woods / G8 support for the WHO)

- WHO has been superseded by the WB as the premier health policy authority;
- WB is now the dominant development assistance donor globally;
- Confrontation with the Bretton Woods family (over the impact on health of economic policy prescriptions) jeopardises rich country funding of the WHO and the re-election prospects of the DG;
- A non-confrontational approach to the Bretton Woods family may be more effective, seeking to persuade them of the importance of health using arguments that they will respond to,
- In particular, advocating the instrumental value of health as an input to economic growth; and
- Endorsing the role of the WB through the PRSPs process as the disburser and coordinator of development assistance (including health sector assistance)

Pay up to reduce the risk of instability and delegitimation

- Perhaps the warnings about threats to globalisation are part of the substantive message of the report
 - Washington Consensus is under attack
 - Fraying legitimacy due to the failure of the Washington Consensus to deliver economic growth and the conditions for health development
 - Political stability globally jeopardised because of widening inequalities and the crisis of legitimacy
 - Governors of the regime must find the resources to ameliorate the worst of the health problems of the developing countries (more ODA)

WTO and health

- GATS, privatisation and safety nets
- TRIPS and access to pharmaceuticals
- Agriculture and small farmers' livelihoods

The rise of the Global Fund and the eclipse of the WHO

- Long standing efforts of G8 to weaken the WHO
 - US refusal to pay assessed contributions (but willing to support some projects off budget)
 - most recently in relation to trade and health and IP and health
- Emergence of the GF
 - outside the UN system
 - strong private sector and WB involvement in governance
 - dominant role of Gates and WB in funding
 - significance of delegitimation of big pharma (and TRIPS) following Thai and South Africa cases

Development assistance for health

- Increasing funds
 - Sachs, Bono, Gates
 - rationales: solidarity, rights, productivity, security, [legitimation]
 - new channels: WB, GF (and other PPPs)
- Pressures towards donor consensus and collaboration
 - the language of ‘basic’ and ‘pro-poor’ policies (locking in three tiered models)
 - PRSPs, SWAPs and Harmonisation (WB, DAC, Rome, Paris)

Discussion Topics

(design poster and present briefly)

1. 30 years after Alma-Ata the global context has changed dramatically
 - what are the implications of the new environment for how we approach primary health care?
2. Universalism or targetting and stratification?
 - PHM globally has argued for equity of access and of the standards of health care
 - The WB argues that low income countries cannot afford universal and unified systems; rather they push for multi-tiered health care funding with basic services safety net for the poor but health insurance and private sector provision for the rest
 - Is the PHM position financially sustainable or politically achievable? How?