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ECONOMIC STRATEGY IN SUPPORT OF HEALTH FOR ALL: THE WORLD ECONOMIC SITUATION AND FINANCIAL PLANNING FOR HEALTH

Report by the Director-General

The deterioration in world economic conditions described in section 1 of this report has had a very bad effect on many Member States in the developing world. Some countries have managed to cope better than others, but they were stronger economically to begin with. Certain measures for health and well-being have suffered setbacks and in many Member countries health conditions have substantially worsened. Progress in planning the finances and resources required for health for all has also been interrupted in many Member countries by emergencies.

The economic picture is thus not a bright one, but that should not prevent countries from continuing to progress towards health for all. On the contrary, since health-for-all strategies may be less costly than conventional health systems, Member States would do well to re-examine them in a context of financial and economic realism. Section 2 of this report gives some indications as to how this might be done. Internal resources will have to be used rationally and fully before recourse is had to external support (this is and will remain limited). Options for countries to generate resources internally range from new revenue to reorganization of resources so as to pursue health-for-all goals. Financial planning with adequate attention to intersectoral action remains essential.

If health for all is to be attained by the year 2000 the next few years are critical for Member States and WHO as a whole. Member States will have to re-think and re-shape their priorities and policies and undertake sounder financial planning for their strategies for health for all, possibly with WHO collaboration as outlined in section 3 of this report. WHO must take appropriate action to ensure that the relations between world economic conditions and health-for-all strategy are established on a technically valid basis for debate in the world economic community. Training in the relevant economic disciplines will be promoted and supported.

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INTRODUCTION

Resolution WHA38.20 requested the Director-General "to prepare a report on the repercussions of the world economic situation on the national, regional and global efforts undertaken by Member States in order to achieve the goal of health for all by the year 2000". This report, together with document EB77/INF.DOC./2, "Repercussions of the world economic situation", puts together such information as is currently available on the effects of the widespread economic crisis on health.

The Executive Board at its seventy-fourth session had agreed that the subject of "Economic strategies to support the Strategy for Health for All" should be placed on the agenda of a future session (document EB74/1984/REC/1, page 38). This report links the world economic situation and financial planning for health in countries. It draws the conclusion that planning the finances for health for all must now take much higher priority. Further background material is provided in document EB77/INF.DOC./1, "Planning of the finances of health for all".

1. WIDESPREAD ECONOMIC CRISIS[1]

Since the target of health for all by the year 2000 was decided by the World Health Assembly in resolution WHA30.43 in 1977 much has been accomplished; much yet remains to be done. Economic prospects have deteriorated in many parts of the world since 1977, and this has threatened not only existing health services but strategies for health for all.

The major recession began in 1981 after the sudden rise in oil prices for the second time in a decade. In the previous five-year period (1977-1981) economic growth had been steady and considerable in both developing and developed countries. By 1983 the growth rate in the developing countries had dropped to 1%[2] this figure concealed wide differences between regions: in Africa and the Middle East there was no growth and a decline in per capita income. In Latin America by the end of 1984 average GDP per head had fallen to the level of 1976; growth in Asia was still 5% but was much lower in the seven least developed countries of the region. In the western hemisphere output dropped by 1%, except for the economies of Eastern Europe, which were generally sheltered from these trends.

The sharp rise in oil prices in 1981 led to acute balance-of-payment problems for most developing countries that import oil. The value of the United States dollar rose by 45% between 1979 and 1984. Commodity prices were depressed and the terms of trade between developing and developed countries fell by some 20%. These facts brought out the alarming rate at which developing countries were accumulating debts in order to finance the deficit in their balance of payments. In 1983 debt service payment consumed 27% of Africa's export earnings, and total debts were estimated at 59% of GDP. The equivalent figure in the Americas was 28.3% of exports in debt service payments. In 1984 the external debt of Latin America and the Caribbean was US$ 360 000 million, about US$ 24 000 million greater than the combined GDP of the Region.

The position of sub-Saharan Africa began to deteriorate in the 1970s. Income per capita in 1983 was 4% below what it had been in 1970. The worst drought in 15 years hit large parts of sub-Saharan Africa in 1982, extended in 1983, and has continued until recently. Food production in the 24 most seriously affected countries declined by 15% between 1981 and 1983. The devastating drought brought to light vividly the long-term adverse trend in food production in this area. One person in five in sub-Saharan Africa was being fed from imports, a significant increase over the past decade.[3]

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[1] Most of the data in this document were drawn from: International Monetary Fund, World economic outlook, 1985, Washington, D.C., p. 205. United Nations Economic and Social Council, Report on the world social situation, 1985, New York.

[2] International Bank for Reconstruction and Development. World development report, 1984, Washington, D.C., Table 2.1, p. 11.

[3] International Bank for Reconstruction and Development. Toward sustained development in sub-Saharan Africa, 1984.

1.1 Economic growth and health

Economic growth does not always help the poorest in a country where health is at risk, but economic decline certainly has adverse effects on health. Economic stagnation and decline endanger the health of those most at risk. The effects of the widespread recession on health are imperfectly documented because substantial evidence is often lacking. Yet the full effects of greater and more widespread poverty on morbidity and mortality seem obvious since the economic crisis has been most serious for the poorest and those whose health is at greatest risk. In countries most seriously affected - in most of Latin America, Africa, and parts of Asia - it would appear that progress towards health for all has already been seriously affected.

While precise measurement is impossible, the presumption is strong that two kinds of effects have occurred as a consequence of deteriorating economic conditions: individual and family health have worsened; revenue for existing health programmes and services has diminished and the possibilities for new programmes have been severely restricted. Special problems have to be added because of the severity of the drought in Africa, where health has suffered noticeably, with increases in morbidity and mortality especially among children.

1.2 World economic conditions and health for all

The widespread economic crisis has made realistic financial planning of health-for-all strategies more urgent as the developing world has experienced a decline in real income per head, and the prospects for recovery of the world economy in ways that would help developing countries are not promising. Export earnings have fallen drastically with the world prices of primary products and commodities. Terms of trade between developed and developing countries have worsened: developing countries pay more for their imports than they can earn from their exports. The developing world's debt and its servicing costs add yet another burden.

The above-mentioned economic situation has had an impact in many developing countries on the overall resources available for health-for-all objectives. Moreover, claims on resources for health-for-all strategies and primary health care must now compete with more directly compelling aspects of survival and efforts for socioeconomic development.

Further setbacks in health have resulted from intersectoral effects of the crisis; e.g., malnutrition has been aggravated by failures in agriculture, food production and distribution, and the lack of hard currency has made it difficult to purchase drugs. Aid to the developing countries has not increased sufficiently to alleviate these problems; indeed it has remained virtually constant.[1]

1.3 Responsiveness of the health sector

The economic situation has a direct bearing on what countries can affort to spend on health services and health-related activities as compared with other sectors contributing to socioeconomic development.

It also affects the extent to which developed countries will transfer resources to help promote health in the developing countries. Better health not only results from socioeconomic development, as distinct from economic growth *per se*, but it is also an essential investment in real economic development. Health development policy and socioeconomic development policy mutually reinforce each other, which explains the extent to which health goals are determined by policies that lie outside the health sector, and why other sectors must recognize how health goals affect their own. A country's policy should ensure that investments in economic development result in improvements in the quality of life and standard of living of the people. These principles have been clearly enunciated in the report of the International Conference on Primary Health Care held in Alma-Ata in 1978 and in the Global Strategy for Health for All by the Year 2000.

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[1] De Farranti, D. *Paying for health services in developing countries*, World Bank (Population, Health and Nutrition Department), Washington, D.C., 1984, pp. 94-95.

How far, if at all, has the health sector been able to respond to the increased health needs created by the economic recession? From the insufficient data available for a full answer to this question, several generalizations can be made: in the developing countries hardest hit by the crisis public spending on health has declined, in some cases by large, in others by small amounts; in only a few countries did it rise.[1]

The vast majority of countries do not know exactly how much is currently being spent on health and related services or how the costs are distributed and financed by public or private funds. In the first monitoring of the Global Strategy (in 1983) only 61 out of 120 countries were able to attempt an estimate of the percentage of GNP, or GDP, spent on health, and about one-third of these could only report on public expenditure or - more narrowly - the expenditure of the ministry of health. Estimates of private expenditure were usually guesses. The evaluation of the Global Strategy (in 1985) indicates a similar situation in spite of certain improvements in some countries.

2. FINANCIAL AND ECONOMIC STRATEGIES FOR HEALTH FOR ALL

The moment is critical if WHO's Member States are to attain health for all. They would do well to re-examine their resources and strategies in the light of economic realities, and realistic programmes and objectives will have to be supported by pragmatic financial planning. Deteriorating economic conditions should not be made an excuse for Member countries to sacrifice the longer-term goals of health for all. The challenge is to find more creative uses of resources and to explore to the fullest all existing sources of finance so as to plan realistic and attainable goals.

The recent evaluation of strategies showed the need for emphasis on financial planning because results to date show that essential financial elements are missing in most countries' plans. Many Member States have expressed concern about the prospects for health for all because of the widespread economic crisis. It is no doubt a major setback; others include inadequate coordination of health and socioeconomic development activities. A national health-for-all strategy is most likely to succeed if it is in harmony with the country's total socioeconomic development process. Progress towards health for all requires stability and continuity of policies and above all integration of health and other social and economic development policies.

In the first monitoring of health-for-all strategies, as well as in the subsequent evaluation, it became clear that financial planning for health for all is not easy. Since 1977 the health budgets of many countries had been cut, and priorities had to be radically revised. The difficulties in financial planning for health for all have in some, if not most countries, been primarily due to lack of basic data and lack of experience among staff of ministries of health. Sometimes the plans have been over-ambitious and thus fiscally unattainable.

2.1 Problems in the financing of health-for-all strategies

Why have so few countries costed their strategy for health for all and worked out how to finance it? Among the reasons one finds the inertia caused by existing structures for the organization and budgeting of the health systems. Some countries have been so severely hit by the economic crisis that ministries of health are living from month to month, or from day to day; the focus is on managing today's crisis, not planning future financing, which seems an unrealistic exercise. Some ministries of health may fear that revealing the full cost of a plan will make it difficult to secure approval.

The whole idea of producing costed plans for health for all may challenge traditional attitudes. There are those who believe that financing is the concern only of the ministry of finance, not of the ministry of health; and sometimes taxes and external aid are looked upon as the only sources of finance for health-for-all strategies and primary health care. Added to the fact that costing the plans presents certain policy hazards and risks, staff in ministries of health may often be inexperienced in financial planning and unfamiliar with the economic concepts involved.

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[1] International Monetary Fund. Government Finance Statistics Yearbook, 1984, Washington, D.C.; and De Ferranti, D. "Strategies for paying for health services in developing countries", World Health Statistics Quarterly, Vol. 37, No. 4, 1984, pp. 428-450.

Finally, in some countries the narrow view has been taken that the health sector is the only one involved in achieving health for all. This is not the case. To attain that goal, the involvement of all relevant sectors has to be ensured, their resources mobilized, their activities coordinated, and the impact evaluated.

2.2 The process of financial planning

The process of financial planning forces a government to face up to difficult choices. Few decisions are supported by all groups in the country, because any policy decision helps some group but hurts another. All countries will have to commit themselves to seeking alternatives. Those seeking external financial support wil have to rely first of all on internal sources of finance for health for all in order to underline their real intention to bring primary health care within the reach of the whole population. Doing that will strengthen their case for foreign aid. They will also have to promote greater efficiency in the use of resources so as to make the most of what is available. And, last but not least, they will have fully to re-examine all plans, including health-for-all plans, to ensure that they incorporate only technology that the country can afford and, if conditions require it, prepare less costly plans. A balance between alternatives must be struck; that balance can only be decided at the national level.

The primary challenge is to plan health for all within realistic estimates for all possible sources of finance. A secondary challenge is to stretch the resources available by an imaginative and bold search for ways to increase efficiency. The Global Strategy calls on ministries of health "to present to their government a master plan for the use of all financial resources", and WHO has provided guidelines in the past two years.[1]

2.3 Mechanisms for financial planning for health for all

Financial planning should consist of four steps:

(1) determining the base-line - what was spent and how it was financed;

(2) the expenditure estimate - broad estimates of the cost of health-for-all plans;

(3) The income estimate - projecting existing sources of finance;

(4) reconciling income and expenditure.

The vital creative activity to which the whole process leads and which is the central purpose of the exercise is the fourth and final step. Few if any developing countries will have all financial gaps filled by outside donors; most of them will have to find creative ways to generate internally most of the finances necessary to achieve a costed health-for-all plan before turning to outside help.

The process of drawing up health-for-all plans for financing health for all brings out the difference between what is desired and what can be financed from existing resources, and forces planners to examine all possible alternative sources of finance and face painful choices. If politically and administratively acceptable sources of finance cannot be found, it will be necessary to generate funds internally by finding ways to use existing resources more efficiently. If all such contingencies fail, revised plans will be needed that are less costly and that still reach every person even if much simpler technology must be used. Much can be done, for example, to promote the community-based primary health care approach to prevention, self-help and self-care at relatively little cost.

3. WHO RESPONSE

This is a critical time for Member States to call on WHO for cooperation in financial planning for health for all, and for WHO to call attention, within and outside the United

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[1] Mach, E. P and Abel-Smith, B. Planning the finances of the health sector: A manual for developing countries, Geneva, World Health Organization, 1983; and programme budgeting as a part of the managerial process for national health development (document MPNHD/84.2).

Nations system, to the effect of deteriorating economic conditions on the health of people in the developing world. If this is to affect policy, more concrete and quantitative assessment must be made of the relation between declining economic conditions, deteriorating living standards, and poor health. Distinguishing cause and effect is not a simple task. Numerous studies have been made of the effect of economic ills on mental illness and social deviance, but fewer of the effect on overall health.

It is thus important that in the coming year WHO should use the greatest technical expertise to document the extent to which deteriorating economic conditions in many parts of the world affect health, health development, and the potential success of health for all and primary health care, particularly in developing countries. It might show, for example, how balance-of-payment deficits affect supplies of drugs and equipment, and manpower; how high interest rates and large external debts affect health parameters; how falling commodity prices and adverse terms of trade in the developing world reduce the resources available for measures to improve health and well-being. Such econometric studies, where the dependent variables are health and well-being and the independent variables are changes in major economic parameters such as external debt, balance-of-payment margins and export earnings, would establish the proposed quantitative framework. While it will not always be possible to quantify effects with great precision, it should be possible to show more definitively that adverse movements in macro-economic variables are paid for in terms of health and well-being in the developing countries.

For WHO to argue on the world platform that current international economic and financial policies have consequences for the chances of success of health for all in the developing countries, it must engage the audience in a debate that is informed by hard, analytically sound and quantitative data. It would therefore be premature to transfer the report on the repercussions of the world economic situation on the Strategy for Health for All to the United Nations Secretary-General as requested in resolution WHA38.20 of the Thirty-eighth World Health Assembly. It is suggested that this should be done as soon as sufficient information is available.

At the same time, WHO must collaborate with Member States in formulating realistic and financially feasible health-for-all plans, as envisaged in the Global Strategy. As has already been noted, data are often lacking to establish even a base-line of existing resources and expenditure in countries, let alone to re-plan health for all in the light of the smaller resources available. However, neither Member States nor WHO can wait for all the data to be available before choosing a course of action. If necessary, ways must be sought of re-shaping and re-costing plans so that they cost less. There will never be enough data; the challenge is to plan with limited data, and here WHO technical support to Member countries may be essential.

Finally, to overcome some of the contraints identified in section 2.1, training of health administrators at all levels in the relevant economic disciplines would appear to be indicated. WHO should promote and support training related to the financing of health-for-all strategies, whenever necessary.

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