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# *Progress in times of austerity*

Economic Support for National  
Health for All Strategies

A Summary of the 1987 Technical Discussions

World Health Organization  
Geneva

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# Introduction

The world economic situation has deteriorated over the last decade; the health budgets of many countries have been severely reduced at a time when additional resources are required to build and sustain national health systems based on primary health care (PHC) to meet the priority needs of all people, especially the underserved. How therefore can universal coverage through PHC be achieved and paid for? Unless answers to this question are found, the extension of PHC to all people is likely to remain a dream. While cutbacks present major problems in the short run, it is nevertheless true that over the longer term the search for resources for PHC can provide countries with fresh opportunities to look again at how they use their resources.

To respond to the need felt by Member States of the World Health Organization (WHO) to develop and improve their economic capability in the health sector, Technical Discussions on the topic of "Economic support for national health for all strategies" were held on 6-8 May 1987 at the Fortieth World Health Assembly. There were over 420 participants (including 40 Ministers of Health), many representing the health, planning, development and finance sectors, bilateral and multilateral agencies, nongovernmental organizations and academic institutions.

The aim of the Discussions was to clarify issues and identify options for action on ways of mobilizing and using resources optimally, when developing or reshaping health systems, to ensure a balance between the cost of effective and practical health plans and the resources likely to be available. A background document was distributed to the participants in view of supporting the Discussions.<sup>1</sup>

This booklet consists of a brief review of the keynote speeches, an

executive summary of the Discussions and the main conclusions shared by four working groups.

Making this widely known aims at supporting the call for action expressed by the participants of the Discussions, and at expressing WHO's will to collaborate with those who are committed to expanding economic partnership towards health for all.

Dr M. Jancloes  
Co-secretary

Dr S. Khanna  
Secretary

<sup>1</sup> Reference: Background Document of the Technical Discussions — Economic Support for National Health for All Strategies (A40/Technical Discussions/2, May 1987).

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## Progress in times of austerity

Ten years ago at Alma-Ata the Member States of WHO committed themselves to achieving the ambitious goal of health for all by the year 2000. The time is now half spent, and progress does not appear to have been commensurate. There are still countries in which large numbers of people are dying through lack of the most basic medical attention.

But appearances may be deceptive. Primary health care — the means by which the goal is to be achieved — represents a radical new approach requiring an overturning of traditional concepts. To achieve such a change of direction throughout the world will obviously take a considerable time. In addition, the economy of most countries has fallen into recession in recent years, reducing the funding that is the life-blood of health services. The outlook has become increasingly sombre. *Where is support now to be found for health for all?*

This was the most important question facing delegates to the World Health Assembly 1987. And to try to find an answer they made it the subject of their technical discussions. The aim was to determine the progress so far made by the health-for-all movement and to propose ways in which it could be sustained even in times of austerity.

## Economic tide recedes

In his keynote address as chairman of the technical discussions, Dr Aldo Neri of Argentina plunged immediately into the economic problems that present the greatest obstacle to better health.

Times are harsh for the developing countries. There has been an overproduction of commodities at a time when demand is actually shrinking because of the tendency of modern industries to use smaller quantities of the raw materials exported by the developing countries. Prices have consequently deteriorated. There is also a tendency for new industries to be knowledge-intensive and capital-intensive but not labour-intensive, so eroding the advantage hitherto enjoyed by countries that could offer a cheap labour force. As a result, national debt problems have expanded to an unprecedented size. In Latin America, every person owes about \$1000 to international financial centres, a sum that in some countries represents one to two years' income.

These problems are exacerbated by the arms race, which imposes a serious burden on the richer countries and has inevitably forced up interest rates.

The industrial countries are having to cope with crises of their own, brought about by the rapid progress of new technologies and the need to transform systems of production.

The recession, thought Dr Neri, tends to have a more drastic impact on essentials than it does on nonessentials.

The treatment of patients continues, as does the use of high-technology equipment and the prescribing of expensive drugs. What tends to suffer is environmental sanitation, maternal and child health services, and immunization programmes.

Institutions in many developing countries are in need of reform. The social security system, for example, far from having the

universal coverage found in both socialist and capitalist countries, often takes the form of coverage for much smaller groups, so allowing the formation of pockets of privilege.

Hunger continues to be one of the world's most pervasive problems, not so much because food is lacking as because it often fails to reach those in need. Latin America is a case in point. The amount of food available there has for many years been greater than the requirements of the population, but still 60% of children under five are under-weight for their age.

*This institutional anarchy in the health field is a sad example of the waste of scarce resources. Only with a comprehensive approach embracing the private sector, social security systems, and the public sector can there really be forward movement, and the whole issue must become the subject of a great public debate.*

The funds available to health authorities are unlikely to increase, but they will have a very much greater effect if they are used efficiently.

However, it is not just a question of doing "more of the same"; some creative and original thinking is required to see what *else* can be done and what new approaches can be made in the provision of services.

## Progress monitored

In 1986 WHO carried out an evaluation of the progress made towards health for all, which showed a high level of political will in the 147 countries responding. A positive start had been made in many of them, but the overall benefits were below expectations because of widespread political instability, natural disasters, armed conflicts, and high population growth. The economic recession since 1980, the deepest since 1929, had led to increasing poverty. The public health sector had not escaped, and *health budgets had been reduced at a time when additional resources were urgently needed to support primary health care.*

However, external economic factors were not solely to blame. Few countries had begun to carry out the strategic actions required to expand economic support for health for all. Very few countries had estimated the magnitude of resources required for their national strategies, let alone identified the source from which they could be financed. *Very few new initiatives had been undertaken to mobilize resources internally, and there was a continued inefficient use of health resources, with very little attempt to reduce waste or improve cost-effectiveness.*

It is clearly at this point that stimulus is most needed to translate political readiness into useful action.

In response to the challenge, the participants in the technical discussions focused their attention particularly on ways of increasing domestic resources and using them in the most efficient manner.

## Austerity tightens discipline

As an example of what could be done, the actions taken in Morocco were described by one of the panel of speakers in the opening session, Mr Taieb Bencheikh, Minister of Health of that country, who saw a certain amount of good blown by the ill wind of the recession. Budgetary restrictions forced his Ministry to rethink its methods of using limited resources. *Attention was first paid to the hospitals*, where a certain laxity was evident. Administration boards were established in the university teaching hospitals and given full financial autonomy. The boards were composed of representatives of all the parties involved in the hospitals and were empowered to discuss all aspects of their budgets, the recruitment of personnel, and the ordering of equipment. The boards were also able to revise hospital charges and to retain the income accruing from them. Seven 500-bed regional hospitals were also given financial autonomy and allowed to keep and use their income. But it was obvious that

the real problem was to find good managers who would be able to develop and implement a management plan and make rational use of resources.

The investigation also revealed that there was no reserve of properly trained maintenance personnel, so a general maintenance service was established and contracts signed with companies for supplies, training labour, and engineers.

The review team then turned to the better management of drugs and equipment. First, a reduction was made in the number of drugs used in the intensive care units in treating the most common diseases. Second, considerable savings were made by instituting computer control of expiry dates for central pharmaceutical supplies. Third, procurement procedures were tightened up to avoid the losses of up to 40% that had hitherto been incurred simply through failure to check the range of prices of the products available. Lastly, procedures were revised to ensure a better distribution of drugs from the producers to the consumers in the provinces.

A scrutiny of personnel management showed that far too many medical and paramedical personnel were concentrated in the towns, at the expense of smaller places, and this problem is still under study. The Ministry has now insisted that recruitment of medical specialists, general practitioners, and paramedical staff should be by competitive examination. Refresher courses have been started and will be compulsory for practising physicians. A general inspection system has been introduced for the continuous monitoring of hospitals, programmes, and personnel.

Much of the inefficiency discovered by the investigation team was attributable to poor information and limited analytical capabilities both in the Ministry and at district health centres.

To overcome these deficiencies, three new units were established in the Ministry covering data processing, statistical information, and methodology.

While increased efficiency and reduced wastage can greatly help in absorbing budget cuts, it is also necessary to consider ways of mobilizing new resources within a country.

Mr Bencheikh said that the first step his team considered in this respect was the greater participation of the public. Health services are available free of charge to the poor and will remain so, but there are many people who can make direct payment for services and many more who have social security coverage. These latter groups are able to pay for their care in both public and private hospitals. The medical profession operates a system in which drugs purchased by people who can afford them are set against those provided free of charge to the poor. Prescribed drugs are thus not a charge on the health budget.

Hospital charges had not been revised for 20-25 years and on examination were found to be insufficient even to cover the cost of water and electricity. A new scale of charges is in preparation and will to some extent relieve the budget of a particularly onerous burden.

A large number of private charities are very active in the health field in Morocco and are in a good position to help remedy the lack of budget funds. Doctors have proved to be very good at fund-raising in the private sector — mainly in the big cities with a well-developed economic sector — and help of this kind does permit the government to channel its limited resources into primary health care.

Increasing numbers of small but well-equipped clinics are opening in Morocco, especially in the big cities, and the government has relatively good control over their charges. In addition, doctors' offices are being established in all parts of the country by general practitioners who are prepared to accept relatively low salaries and even on occasion to be remunerated in kind. The government is encouraging this development in the hope that country practices will become a permanent feature of the Moroccan medical scene.

Many communes of about a thousand people are themselves proposing to take responsibility for the construction and operation of rural dispensaries and health centres and for the recruitment of doctors and paramedical personnel. While the Minister welcomed these initiatives he felt that the recruitment of medical staff should be left to the municipal health departments in the big cities.

Morocco does receive considerable assistance from sources outside the country. It is greatly appreciated and undoubtedly helps, but it cannot provide a definitive solution to the country's problems because it is subject to uncertainty. Foreign experts are often used, with salaries paid abroad, and products sometimes have to be purchased from the countries providing the assistance. But, it is the arbitrariness of the assistance that is its worst feature. A country can never make plans on the assumption that there will be a steady level of support; if the assistance falters, important programmes to which the public is beginning to respond might have to disappear.

Mr Bencheikh ended his dissertation by offering a suggestion that might be of general use to all developing countries — namely that international financial agencies should include as one of the con-

ditions they impose on recipient countries a stipulation that a certain percentage of the country's budget be reserved for health. The percentage would be related to the gross national product, as in the case of budget deficits or external trade deficits. A policy of that kind would arrest the steady decline in the share of the budget set aside for basic health care.

## Bringing in the community

Two of the panel of four speakers in the plenary session, Dr Suwardjono Surjaningrat, Minister of Health of Indonesia, and Dr A. D. Chiduo, Minister of Health and Social Welfare of the United Republic of Tanzania, had similar messages for the meeting — the importance of involving the community in the raising of health standards.

It has been estimated that 50% of the health care in any society is provided by the family. Communities are also capable of tackling the root causes of disease such as malnutrition, lack of sanitation, unclean drinking water, and bad housing.

The need for community participation has often been overlooked in national development, but within communities there are considerable resources of human ingenuity, labour, materials, and money, the creative use of which opens up dramatic new possibilities for the improvement of health.

Until now, however community participation has usually been limited to help during crises such as epidemics and outbreaks of cholera. Community awareness of the need for continued vigilance over health problems is not yet in evidence. But this is not to deny that spontaneous community action in support of health has been forthcoming — for example, communities bearing the cost of referral of some of their members to hospital and communities constructing dispensaries or digging trenches for water pipes *under self-help schemes*. What is required in future is to encourage people to maintain vigilance themselves and to make sustained efforts to deal with their own health problems, with the aid of health personnel.

Both Indonesia and the United Republic of Tanzania have a rural outreach programme, which is a good way of mobilizing people's participation in all social activities, and these would naturally include health activities. In Indonesia the programme takes the form of integrated health delivery posts organized by the local people

but under the guidance of health centres. One of their functions is to encourage and enable people to take their own measures to care for the health of the family.

For Dr Chiduo, *the litmus test for political commitment to the goal of health for all is not brave statements, resolutions, charters, or plans but the pattern of allocation of resources*. What is needed is to examine both the level of health resources and the way in which they are used. The issue is not just how much money is allocated but also how equitably the available resources are distributed. In this respect his country has made some spectacular achievements. In the 1960s and early 1970s about 80-90% of the total budget was spent on hospital services, mostly benefiting the urban population where the facilities were located. By 1980, however, less than 60% of the budget was being spent on hospitals. There has also been greater equity in the allocation of resources between urban and rural areas. In 1971-72, about 80% of the health resources were allocated to urban areas and 20% to rural areas. The corresponding figures today are 58% and 42%.

## Holding the costs down

The fourth speaker of the panel, Professor Brian Abel-Smith of the London School of Economics and Political Science, England, dealt with the situation in *Europe, where the key phrase today is cost containment*. From 1950 to the mid 1970s, health expenditure increased up to 10% more rapidly than the gross domestic product. It was then decided that this escalation could not be allowed to continue.

The method of cost containment has been stricter regulation of the health care system, both on the demand side and on the supply side.

There has been a trend towards greater cost-sharing or copayment throughout both Eastern and Western Europe and in some countries towards privatization — that is to say, more private insurance or more contracting out of functions to the private sector.

On the supply side, one of the main targets in Western Europe has been the hospitals, with rigorous control over both hospital budgets and new construction. In some countries the primary health care concept is being used consciously as a means of reducing hospitalization, particularly by shortening the length of stay and developing alternatives to traditional hospital care.

Controls are increasingly being imposed on the purchase of expensive medical equipment.

A second target has been expenditure on pharmaceuticals. Without going so far as the WHO essential drugs list, more and more countries have been reducing the range of drugs that can be prescribed under national health insurance systems or national health services. The commercial promotion of drugs is being more heavily regulated, the prescriptions issued by doctors are being increasingly monitored, and encouragement is being given to the prescribing of cheaper substitutes for more expensive drugs.

There has been an increasing tendency to impose ceilings on health expenditure, and some countries have been moving over from national insurance to a national health service so that central government itself can exercise direct financial control. But one of the most innovative developments has been government control over the size of the budgets of private hospitals. Countries that have long had budget control have been holding expenditures down. In a number of them the budget cuts have begun to hurt, with long waiting lists of less urgent cases.

There has been a general drive to increase efficiency and productivity and to calculate what different activities are costing. There is also a greater use of the market mechanism to reward efficiency and stimulate production. This is true throughout Europe.

One of the central planks of the European health-for-all strategy is health promotion. Preventing the need for treatment is certainly the best way of controlling costs over the next few decades.

The idea of bringing about changes in life style and the social environment has caught on, the important targets being smoking, accidents, alcohol, diet, and more recently AIDS. At least one Eastern European country has gone so far as to reduce the production of alcohol and tobacco, as well as limiting times of sale and opportunities for consumption.

Some countries have produced costed plans showing in quantitative terms the switch they intend to make from acute hospital care to less costly and more homely ways of looking after the aged, particularly by means of a strengthened system of primary health care with a heavy emphasis on health promotion. These proposals are of great importance in Europe because it has a rapidly aging population rather than a growing one. Old people need much more health care than people in their prime, and an aging population costs an extra 0.5-1.0% of health expenditure each year if the same standard of health care is to be maintained.

## Striving for equity

After the contributions of the four speakers, a general discussion took place on ways of obtaining economic support for the health-for-all strategy. It focused on *domestic resources*, which were regarded as being ultimately more reliable than foreign aid, especially at a time of financial constraint.

Equity forms the basis of the value system implied in the goal of health for all. Equity demands a redistribution of incomes and benefits, which is easier in periods of high economic growth than at times of recession. Currently the prospects for economic growth are not very bright, and

it is all the more urgent to find ways and means of maintaining the emphasis on equity.

With few exceptions, most poor countries are in the grip of a dilemma: they have to decide whether to invest directly in health or to invest indirectly in health-related sectors such as nutrition and water supply. Only the local conditions can determine the priorities here.

In most developing countries the budget authorities have the final say on resource allocation. Generally the allocation to the health sector is low compared to the requirements of the health-for-all strategy. Indeed, the highest political authorities do not always appreciate the principle of equity in health, and priorities are unlikely to change until they are convinced that this principle can form a solid basis for growth.

At present the great need is to ensure that resources for health are not drastically cut, and *health policies should be formulated in such a way that they can withstand the influence of short-term declines in economic activity*. Moreover, the public must be made aware of the importance of health services so that its opinion can influence budget decisions.

In many countries two trends are discernible — the government taking responsibility for primary health care and health promotion and protection while market forces deal more and more with curative services. However, while deregulation may increase efficiency it can also create privileged groups, which works against equity. Some participants thought that government responsibility should not be limited by market forces but should focus on setting health targets based on priorities.

From the experiences of various countries in mobilizing resources for health the following methods can be proposed:

- increase the price charged for drugs within the limits of affordability;
- provide essential diagnostic services free of charge while charging for nonessential services;
- continue the provision of free preventive health services;
- encourage the participation of the community in health activities; and
- make judicious use of available international cooperation while avoiding fragmentation of health policies and services.

Investments by sectors other than health should be encouraged. Employers, for example, are often willing to build health facilities for their personnel, and many communities are prepared to contribute either in cash or in kind.

The introduction of users' charges can raise additional resources for health, and a variation of this to introduce such charges only for hospital services and people who can afford them. However, some participants felt that would lead to further inequities and not only hurt the poor but fail to add any substantial sum to resources. It is clear, however, that within each socioeconomic system various policy options are available for increasing the resources for health.

## The financial plan

The preparation of a plan of action is an essential element in the strategy for attaining health for all, and the financial implications of each health policy must be clearly stated. Mapping the future profile of the health sector means forecasting the likely developments in a country's economic and social fabric. Changes in population, agriculture, industry, and employment patterns will influence both the needs and the opportunities for health for all. In all planning exercises it is essential to obtain the participation of the public, of health workers, and of people in other sectors in order to avoid overcentralization.

The major stages in financial planning include:

- identifying expenditures by all the agencies providing health services, both public and private;
- costing the capital and recurrent components of scheduled developments over the period of the plan;
- identifying all possible sources of finance and estimating the likely amounts involved and their acceptability and administrative feasibility;
- comparing expected revenues with predicted costs and revising targets and strategies to achieve balance.

Many countries still do not have such plans. They face real difficulties in financial planning owing to economic uncertainties, lack of expertise, and insufficient information. One way of approaching the problem is to carry out a retrospective exercise, estimating expenditures and sources of finance for the whole health sector over recent years, including its private, public, and social security components. This will give a good indication of the way ahead.

**The relating of health priorities to available resources is the basis of realistic planning.**

Complaints about lack of resources are often made in circumstances in which there is a conspicuous waste of facilities or

manpower. Several options have been given earlier in this report for closing the resource gap, but each one needs to be carefully examined with regard to its impact on equity. Countries would benefit from sharing their experiences in this area.

*Success depends* not only on good planning by the ministry but also on *good planning and management in the provinces and districts of the country*, and the local plans should be taken fully into account in the national plans. The abilities of local personnel in this respect usually need to be strengthened by special training. Moreover, if the national plan concentrates on the public sector and neglects the services provided by the private sector, the full capacity of the country for realizing health benefits will be underestimated.

Even in middle-income countries, the ministry of health often lacks adequate up-to-date information on the budget situation. Few countries attempt the use of programme budgeting methods in their resource planning. The lack of capabilities at all levels for the financial assessment of the proposed health plan is seen as a major constraint to the implementation of health for all.

Insurance and social security mechanisms diminish some of the uncertainty surrounding future revenue levels. *Insurance schemes also have the capacity to protect the vulnerable by subsidy from those in employment.* The scale and acceptability of such a transfer is a matter for political judgement.

The importance of flexibility in planning should be kept in mind, both to allow for revision of targets within the overall framework and to allow for the ready absorption of unanticipated windfalls. This was stressed by participants from countries with recent experience in improving their financial plans.

Sustained political commitment is essential. Participants gave examples of resistance to plans both from health providers and from the users of health services. Experience in developed countries has shown that unless providers are convinced that a financial plan serves the interests of their patients they will simply overspend, so undermining the plan. Similarly, plans resulting from little or no

discussion at the local level may be ignored by users — as seen in the common preference for hospital care rather than community care.

Making changes in the health system costs money, and estimates of the amounts involved should be part of the planning process. *The retraining and redeployment of manpower form the biggest component of the health sector's recurrent costs*, and such changes cannot be achieved unless the costs are allowed for.

Skills in financial planning and management need to be widely dispersed throughout the health sector. All health workers should be trained to understand the economic implications of diagnostic and treatment decisions. Courses in public health and health administration should include the subjects of health economics, financial planning, and management, and governments should ensure that they do. For more specialized work, such as in planning and budgeting, longer exposure to health economics is appropriate for administrative and management staff. Ordinary graduates in economics are not adequately equipped to undertake health system planning; they need special training in health economics. Better communication between economists and decision-makers in the health field would be highly desirable, and the latter must develop greater sensitivity to economic issues.

## Mobilizing resources

More and more governments are finding it difficult to provide free health services for all, and the discussion provided a clear consensus that new sources of funding must now be developed.

*The principal underexploited source is contributions from consumers, and virtually all countries are now exploring ways of developing this option.* Studies in many countries have revealed that families spend relatively high amounts on health in relation to their incomes and incur further costs for travel and loss of productivity. In place of this random payment for health care, contributions from consumers might take the form of fees charged directly for services or channelled to health insurance or social security schemes.

However, greater reliance on funds from these sources must be accompanied by exemptions for special groups such as the poor, children, women in their childbearing years, elderly women whose capacity to pay is severely limited, and victims of chronic diseases and devastating illnesses. These groups must be protected and cared for with funds from government revenues. In addition, services that control the transmission of diseases will usually continue to be provided by the government. These would include immunization and the monitoring of public water supplies.

Further resources might be realized from direct community financing of services through voluntary payments, informal insurance, voluntary labour, and revolving funds. The private health sector and nongovernmental groups also make substantial contributions to the overall health resources.

Monies collected from large numbers of people for financing health services must be carefully managed to ensure their proper application. This implies that any system for obtaining funds from the public should be well documented and overseen by an official local group such as a local development committee or a community health committee. These accounting and auditing

mechanisms should be kept simple so that the public can understand them and so keep a further check on the collection and use of funds. The effects on the providers of care should also be observed, and the methods of administering the funds should be modified if necessary to encourage greater efficiency and equity. Surveillance should extend to the setting of fees and rate structures, in cooperation with government representatives, as well as to choice of services that will be subject to payment through cost-sharing schemes.

**Patients are more likely to contribute funds — and providers to collect revenues — if it is clear that benefits accrue to them.**

Funds generated within the health sector should be used only to provide health care. They should be controlled by the health sector, not paid to the central government for allocation among public programmes. However, resources may need to be redistributed by health authorities among regions of the country or income groups in order to promote equity. The health authorities should at the same time provide the necessary subsidies to satisfy the budgetary requirements of the different parts of the health sector.

Fees for patient care, compulsory contributions to social insurance, and similar revenue-generating schemes are difficult to introduce if the government has previously provided free care. The problem is especially thorny where the quality or availability of care is judged by patients to be unsatisfactory. Direct charges might be introduced most readily for elective procedures or for services that are demanded by relatively few people. Since radical reforms in health care financing are likely to meet political resistance, a gradual introduction of charges appears most appropriate.

## Making better use of resources

There is a general concern in all countries that health resources are not being used in the most effective way. This matter deserves the most urgent attention because

making the best use of available resources offers the best option for improving the financing of health for all.

The first step is to identify the points that are likely to provide the greatest opportunity for improvement. They may include authority over finance, manpower use, and staff competence. A set of objectives must be formulated to guide the selection of the most effective entry points for improving resource use.

Certain common themes emerged from the discussion that are relevant for both the developing and developed countries. There was general approval *for the use of incentives in obtaining better performance of providers, workers, consumers, and the government*. It is likely that a wisely chosen system of financing health services can act as a major incentive, but the drive for efficiency must be tempered with concern for equity. It must be remembered that for every cost in a system there should be a benefit and for every benefit there is a cost. Optimizing the use of existing resources is a balancing act in which the administrator tries to minimize costs and maximize benefits. It does not matter whether resources are increasing or diminishing: good management of the health system still requires the optimum use of resources to get the best results at the least cost.

Most countries have so far made only limited progress in reorienting conventional systems of health care into systems firmly based on primary health care. This in itself causes waste owing to a continuing overemphasis on curative care, which concentrates resources on coping with sickness after it has occurred rather than on preventing it from occurring at all, which costs far less.

The reorientation of health systems under *the health-for-all strategy requires a revision of the roles and responsibilities of all*

*levels of personnel to include a strong emphasis on primary health care.* The functioning of health care institutions, particularly hospitals, must also be revised to improve the integration of services, avoid overspecialization, increase the outreach of health personnel, and provide a mix of curative, preventive, and promotive activities appropriate to the population. At the same time, in-service training must be strengthened both to improve the knowledge and skill of personnel and to incline them towards primary health care.

Weak infrastructure and poor management, especially in the districts, seriously impede the coverage of the population with primary health care, in both rural and urban areas. They also cause wastage and poor utilization of resources by placing too much emphasis on a few special services, so aggravating deficiencies at intermediate levels and failing to address the priority health problems of the area. As at present structured, government health organizations are not very good at coordinating with nongovernmental and private health institutions or with community organizations and sectors such as education, agriculture, and water supply, all of which can provide important resources for health. Competition between various health organizations and services may cause overlap and waste. All health resources, not just those in the public sector, should be used to improve the health conditions of the people. Since these resources are in the hands of different groups, governments must establish methods of cooperating with these groups.

Many participants saw a clear need to awaken a sense of urgency in governments to achieve a dramatic improvement in the performance of public services. Health care systems often operate below their optimum level owing to inappropriate institutions or lack of incentives. Health administrators must therefore have methods of evaluating the performance of the health care system so that they can make timely and judicious interventions. To do this they need to develop indices of efficiency and cost-effectiveness and measures of the quality of services. This is another field in which the sharing of experience between countries would be highly desirable.

The performance of a health system depends mainly on the quality of its staff, since manpower is the biggest consumer of funds.

The main issue in health manpower development is the level of staff awareness of efficiency and cost control in health care. Training in subjects like these would be easier if teaching methods were modernized by the use of new approaches such as case studies in problem-solving within the community.

Participants showed concern over the growing levels of expenditure on private health care, which they felt ought to be balanced by an increase in the public sector.

Governments should use practical short-term health systems research to generate information about health care resources, costs, service output, and quality of care. *Information* of this kind is of immediate use in planning and *problem-solving* and should lead to *the development of generally acceptable indices of efficiency, quality, and levels of performance*. Health service staff at all levels should be involved in such research, which would increase their awareness of efficiency and performance issues. Success stories as well as difficulties should be analysed.

Many problems are encountered in the procurement, use, and maintenance of health supplies and medical equipment. Lack of standardization leads to difficulties in distribution, maintenance, and the supply of spare parts. In developing countries these problems are often aggravated by the variety of types of equipment and vehicles provided by different collaborating agencies. Considerable waste also results from the inefficient use of drugs. In all these areas governments have a major part to play in establishing procurement procedures, guidelines, and equipment standards, in strengthening maintenance systems, instituting training courses, and facilitating the local production of spare parts.

The public is not generally well informed about the need for cost-control measures and the cost-effectiveness of prevention. Advan-

tages could stem from *better public information* about the personal savings that can be achieved through disease prevention, health promoting behaviour, and the policy of using the least costly medicines and interventions. Health education should also try to increase public appreciation of and trust in primary health care services, including those available in the community such as home care and day care. When health education is being organized, special attention should be given to the important role of women as providers of health care in the family.

## A call for action

Health is a shared responsibility that rests on the individual, the community, and the government.

As *partners* in the health-for-all strategy, ordinary people should have an opportunity to contribute actively at the individual, family, and community levels. They should have access to knowledge that allows them to share responsibility and make choices in health care.

Mobilizing economic support for health has many implications for health policy-makers and administrators. They need to be firm advocates of social priorities based on concern for the poor, and they must generate commitment and support from other sectors.

*Health administrators* must increase their ability to define equitable schemes for obtaining funds and allocating resources. They must be able to provide the policy-makers with different options for mobilizing additional resources, and they must manage scarce resources in the best possible manner.

*Governments* can pursue a number of measures that are financially feasible and economically viable and can protect and even improve the health of vulnerable groups during periods of financial restriction. Concerted action by governments on the recommendations that emerged from the technical discussions is urgently required to protect the health and wellbeing of the poor and vulnerable and to safeguard the health of future generations.

# **The Fortieth World Health Assembly Technical Discussions**

General Chairman and Keynote Speaker: Dr Aldo Neri

Opening Plenary Panel Members:

Dr Suwardjono Suryaningrat, Minister of Health of Indonesia  
Dr Taieb Bencheikh, Minister of Public Health of Morocco  
Dr A. D. Chiduo, Minister for Health and Social Welfare of  
Tanzania  
Professor Brian Abel-Smith, London School of Economics and  
Political Science, United Kingdom

Secretary: Dr S. Khanna

Co-Secretary: Dr M. Jancloes

There were four working groups, namely:

## **Group 1 Economic policies for equity in health**

Moderator : Dr Jon Norbom  
Co-moderator : Dr Harcharan Singh  
Experts : Dr Amorn Nondasuta  
Mr T. Bencheikh  
Secretary : Dr A. el Bindari-Hammad  
Co-secretaries : Mr C. Krishnamurthi  
Dr Cesar Vieira  
Dr H. Hellberg

## **Group 2 Financial Planning**

Moderator : Mr Mohamed el Imady  
Co-moderator : Professor Brian Abel-Smith  
Experts : Professor Dominique Jolly  
Mr Upendra Man Malla  
Secretary : Mr A. Creese  
Co-secretaries : Dr C. Vukmanovic  
Mrs S. Ray-Tabona

### **Group 3 Resources mobilization**

Moderator : Professor O. Ransome Kuti  
Co-moderator : Dr G. Miranda Gutierrez  
Experts : Professor M. Conception Alfiler  
Mr S. Kananiyne  
Secretary : Dr S. Kingma  
Co-secretaries : Dr H. Zöllner  
Mr L. Laugeri  
Mr F. Golladay

### **Group 4 Making better use of resources**

Moderator : Dr M. Kökeny  
Co-moderator : Dr Khalid bin Sahan  
Experts : Professor Ralph Andreano  
Dr G. Mwabu  
Secretary : Dr S. Sapirie  
Co-secretaries : Dr Omer Imam Omer  
Dr J. Martin  
Dr N. Drager

The general administrative and support secretariat included:

Ms P. Brice	Mrs S. Lambert
Mrs M. Cabral de Mello	Miss S. Lloyd
Miss J. Fisher	Miss B. Pumfrey
Mrs B. Goelzer	Miss S. Sehovic
Miss J. Habgood	Mrs J. Sikkens
Miss J. Harwood	Mrs C. Willumsen
Mrs L. Kreutzer	

Volunteers:

Miss A. Gonzalez	Ms V. Pirlipko
Miss R. Hammad	Ms T. Savinykh
Mrs A. Issakov	Mr S. Serdahely
Mrs M. Mani	Mrs A. Tesfaye
Mrs K. Martin	Ms A. Wheeler
Miss O. Meshkovskaya	Mrs M. Wieboldt
Mrs L. Pigott	