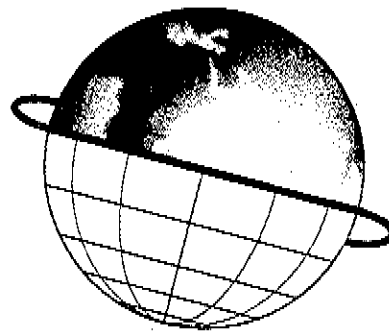


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International Conference

on

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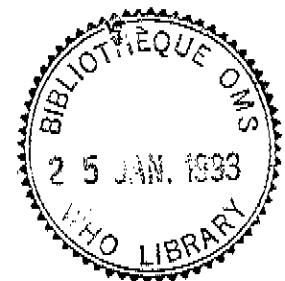
and

HEALTH

In Countries in Greatest Need

Report of the Rapporteur

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INTRODUCTION

Several papers were presented and discussed at the International Conference on Macroeconomics and Health in Countries in Greatest Need, the first of its kind organized by the World Health Organization. As resources have become scarcer in many developing countries in recent times, it is now necessary and pertinent to recognize the macroeconomic environment existing in these countries in order to design and implement appropriate health policy programmes. It is hoped that, as a result of this Conference, the interconnection between macroeconomic development and health in countries in greatest need would be analyzed; and the tools for making policy decisions and establishing relevant health systems would be developed.

The two main themes of the Conference addressed: Macroeconomic Environment and Health; and Health Care Finance. In addition, country case studies that analyzed how the macroeconomic environment affects health conditions, and how macroeconomic decisions influence the establishment or adjustment of health policies and health financing schemes in countries, were presented.

1. Macroeconomic Environment and Health

The nature of the papers presented in this section was twofold. On the one hand, they provided a theoretical framework on the linkages between macroeconomic development and health; and on the other, concrete illustrations of the influence of structural adjustment policies on health were identified through country case studies.

1.1 Impact of Health on Economic Growth

Health and economic growth are inherently interlinked. On theoretical grounds, they interact in important ways both with health affecting economic growth and economic growth affecting health. Health is an important component of human capital in the sense that investments in health have important direct effects on productivity and thus on economic growth. Given other complementary inputs, healthier individuals may be more productive per unit of time. Economic growth, including the nature of that growth and its distribution, is most likely to have an impact on the expected returns to investments in health.

While economic theory provides the framework for the analysis of the relationship between health and economic growth, it does not, however, provide the order of magnitude of the relationship. Not much can be gained by looking, in isolation, at either the theory or the empirical work.

There are both direct and indirect productivity impacts on health. Drawing extensively from studies based on socioeconomic surveys and experimental studies, there is growing evidence of direct positive effects of health on labor productivity of poorer individuals in developing countries. These effects appear to be immediately due to current intakes of calories or micronutrients, medium-term—as reflected in weight, and long-term as reflected in height. Thus, given the existence of such effects, an argument for being concerned with the health of the poorer members of society is provided, not only because health is of some value in itself but also because productivity gains can be made.

The indirect effects of health on productivity are seen through achievements or inputs to producing such capabilities. Schooling appears to have a substantial impact on labour productivity in developing countries. Studies based on socioeconomic surveys from Brazil, China, Ghana, Nepal, the Philippines and Thailand, suggest that poor long-term health, rather than transitory fluctuations, adversely affect schooling performance.

1.2 Impact of Macroeconomic Growth on Health

The state of the macroeconomy impinges upon health by affecting the actual and the expected values of the variables that determine health. The nature of the impact of macroeconomic variables on health or proximate determinants of health is complex because they operate through the whole economy with delayed action and retroactive effects. Economic theory does not predict precise quantification effects but instead provides a range of possibilities, the relevance of which depends on the magnitude of a large number of behavioural responses. The dominant tendencies can, however, be listed as follows:

The *first* major effect of economic growth on health is likely to be through affecting the expected returns to investment on health. These investments cover a whole range of preventive and curative care. In addition, any other expenditure on determinants of health, such as water and sanitation, can be seen as an investment.

The *second* major effect of economic growth on health is through increasing current income. In turn the latter enhances the financial capacity of people to invest in health.

Thirdly, economic growth results in the concomitant development of markets of various types. The development of the product market, for example, tends to increase the expected productivity returns from health investments. With growth, the economy is better integrated and leads to the development of rural infrastructures such as transport and communications. The overall impact of growth on society's socioeconomic development, and health status in particular, depends on the way additional resources from growth are distributed. Substantive health gains can only be realized when the benefits from economic growth are disseminated throughout the population.

Fourthly, economic growth results in the expansion of government command over resources. The effect on health depends on the extent to which the increased resources are devoted to the health sector *per se* or to health-related sectors. The greater the amount devoted to health, or health-related sectors, the greater is likely to be the impact on health.

Ample attention will need to be paid to the cost-effective use of these additional resources. In addition, increased resources lead to the improvement of the degree of equity in health sector expenditures. By a more equitable allocation of resources, the overall health status of a society is enhanced.

In short, economic growth matters - especially for health.

1.3 Macroeconomic Adjustment and Health

In the process of clarifying linkages between macroeconomic changes, conventional adjustment policies and health outcomes, three broad intermediary groups are identified: (i) household characteristics (e.g. education, family income, fertility etc.); (ii) supply and cost of health services (e.g. government expenditures on the health sector and the cost of the imports of medical equipment); and (iii) crucial environmental variables (e.g. sanitary conditions, clean water accessibility, overcrowding etc). As determined by the analyses, macroeconomic developments have significant impact on these variables. The precise nature and the magnitudes of the effects of macroeconomic changes on these variables depend on the structure of the economy being considered (whether mainly agricultural or semi-industrialized); the exact nature of the disturbance(s); and the location (in terms of economic activity and physically) of the vulnerable groups in society, especially children and the elderly.

On theoretical grounds, one should not expect the relationship between macroeconomic changes and imbalances, adjustment policies and health outcomes to be the same in all developing countries, nor should one expect it to be felt at the economy-wide level.

The empirical studies on linkages between macroeconomic factors and indicators of health outcomes show that intermediate variables do have the suggested impact. For example, both the sustained increases in income and the level of education have been shown to decrease infant and child mortality rates. Similarly, increased government expenditures on the health sector, in the absence of deterioration in efficiency, has provided positive effects on health outcomes. These, however, are long-term effects that do not necessarily apply in the short term. It is possibly because of this caveat that recent studies have been unable to identify significant economy-wide deterioration in health outcomes in a broad range of African and Latin American countries during the recent economic crises of the 1980s, and in particular since the adoption of a structural adjustment programme (SAP) in some countries. Indeed, because of the existence of delayed action, it has not always been possible to find a clear

negative effect of economic decline on the health status. It must be recognized, however, that one of the present weaknesses in the analyses is the absence of a comprehensive and practical model of linkages between health and the economy.

The conclusions are as follows:

- (i) Macroeconomic adjustments do not necessarily have adverse consequences for health outcomes as a whole. To understand the impacts of macroeconomic adjustments on the health sector, one must take into account the structure of the economy and of the health sector, the extent/magnitude of the adjustment programme and impacts of the adjustment programme on the structure of spending on health and health-related sectors, by governments and households.
- (ii) In terms of health outcomes, there is a long-term relationship between the level of income and infant mortality rates. It is not, however, easy to establish the short- and medium-term relationships.

2. Country Case Studies

A number of individual country case studies, as well as country studies of Sub-Saharan Africa, Asia and Latin America, were presented. The focus of these studies was on least-developed countries (LDCs). The objective is to assist these countries in the analysis of their economic aspects of health and the formulation of appropriate health policies. Specific country studies include those on Bolivia, Chad, Guinea, Guinea Bissau, Malawi, Mali, and Nepal. The coverage of these countries centres on the relationship between the macroeconomic environment and the health sector and/or macroeconomic environment and the financing of the health sector, as well as the adoption of structural adjustment programmes and the health sector.

The experiences of the countries discussed varied over the period covered. Not only have the economic prospects of the countries been dissimilar, but the responses to external shocks experienced have also varied. In spite of the differences in the impacts of macroeconomic changes on the economy and the difference in the financing mechanism, a number of common themes concern these countries. The individual country case studies show how changes in both the macroeconomic environment and government health policy are interwoven. Long-term, the health status tends to improve as income increases: infant mortality declines, mortality from certain diseases almost disappears; and life expectancy greatly increases. In almost all cases, government activities have been constrained by available resources. Hence, it proves to be difficult, in view of governmental budgetary problems, to increase real health expenditures in the short term.

Additional resources for health care are needed, and how much finance will be required from the government sector is determined by the cost-sharing arrangement introduced. The macroeconomic environment will, however, condition the possibilities for government financing. The prospects for growth of the health sector depend not only on the growth of the public sector resources, but more importantly on private sector resources, since a large proportion of total health expenditures is (or can be) financed through the private sector by direct payments by households. There is need for improvements in the efficient use of resources in the health sector. Finally, planning in health involving a new and durable partnership between government, donors and households, becomes essential.

The following is a summary of findings from these country case studies:

2.1 The Need for Short-term Indicators

The health sector has been influenced by developments within the macroeconomy. The crises and reforms which occurred in the 1980s in Sub-Saharan African and Latin American countries had detrimental effects on economic growth. Negative trends were experienced by all income groups with a large share of the burden falling on the poor. Shortfalls among the poor resulted in a serious deterioration in their already low standard of living. Although overall decreasing long-term trends in child mortality continued in LDCs in the 1980s, infant mortality showed sensitivity to economic stress in several countries. During such periods of economic stress, a number of countries suffered deterioration in their nutritional status.

In order to create awareness of the problems and adopt corrective policies, great emphasis should be placed on developing short-term indicators of the well-being of vulnerable groups, especially their health conditions. A model is needed where such indicators could be related to macroeconomic variables.

2.2 The Impact of Structural Adjustment Programmes

The impact of structural adjustment programmes (macroeconomic changes) are often felt through their effects on government expenditures and shortfalls in government expenditures in general. In some cases, the shortage of government finances available for health has led to the development of cost-sharing arrangements (e.g. the Bamako Initiative and the ABOTA system in Guinea-Bissau). Another way to finance health care is via increases in the tax effort. The tax rate in Bolivia, for example, is said to be low and a lot of revenue can, therefore, be gathered through this channel. Other sources of funding include the proceeds from privatization, and debt-for-health swaps. The health sector in the poorest countries is mostly funded from external sources. In Guinea-Bissau, for example, four-fifths of the health care is funded externally.

In addition to poor financing, and/or arising from it, major constraints to the health sector include inadequate health infrastructure, lack of qualified personnel, and problems of management and planning.

The stabilization and adjustment programmes have also resulted in cuts in employment. Thus unemployment in the formal sector rose and absorption was sought from the informal sectors. However, in spite of the structural adjustment programme, no crisis actually occurred in the health sector in some countries.

Finally, the structural adjustment policy emphasized "getting the price right". That focus is appropriate in countries where institutions and infrastructures exist in the right form. That is, those which would be utilized to respond to price incentives. For example, an increase in the price of maize due to price liberalization is meaningless in a country where there are no roads to transport the maize to where it could be sold.

2.3 The Linkages between Health and Development in other Sectors

The health sector in some countries is closely linked to developments in the agricultural sector. The linkages between agricultural outcomes and health outcomes are usually explained in terms of the contribution of agriculture to productivity and income generation; and, hence, poverty alleviation. Increases in food output impact both on general food availability and food prices and generally contribute to the nutritional status of the population. It is also true that changes in technology can influence the health of the workers.

While analysis in terms of the described linkages have not been brought out in the papers, the impact of population health on the agricultural sector in Malawi was described. Several developments in that sector showed impacts on health. First, the policy of price liberalization had implications on health. The price liberalization initially implied high prices which led to high food prices and therefore to declines in the real income of workers, especially in urban areas. The loss in household purchasing power had impacts on the nutritional status, in particular of children and the elderly. Secondly, price liberalization caused a transfer from food crops to cash crops. In the process, food crops suffered and the nutritional status was affected.

Two other changes also affected the health sector in Malawi. The first was the removal of the Agricultural Development and Marketing Corporation (ADMARC) as the distributor of fertilizer. This led to the lower application of fertilizer and consequently to a drop in the production of food. The second was the fertilizer subsidy removal programme (FSRP). This led to the lower application of fertilizer with the consequent effect on nutritional status of the population.

2.4 The Problem of Increasing Poverty

Increasing poverty in urban areas is reflected in larger budget shares going to food, lower food consumption, higher prevalence of food deficiency among the urban poor and in some cases increasing prevalence of malnutrition among pregnant women and preschool children. The decrease in government expenditures (as a result of economic decline) contributed to deteriorations in nutrition and health. Such decreases were particularly severe in Latin America.

The 1980s were not kind to the poor. What contributed to the misery in Sub-Saharan African countries included inappropriate policies, and institutions, and unfavourable international economic conditions. Most of the rural poor that survived the decade are today still poor. The prospects of improving the conditions of the poor depend not only on policy changes but on the crucial development path chosen including institutional changes and reforms that will ensure access to markets and resources by the poor.

3. Health Care Finance

Given the worsened economic conditions in many African countries, health-care financing is one of the most important issues to be addressed.

3.1 Characteristics of Health Care

There are many facets of health finance and health care. The starting point would be to give due consideration to the characteristics or the uniqueness of health care. These facets indicate that:

- health is a basic necessity;
 - serious illnesses are unpredictable in the sense that illnesses can occur at any time and sometimes when least expected;
 - health care expenditures are part of investment in human capital;
 - the health sector is influenced by many external factors;
 - there is professional authority over health which can affect the rate of utilization, affect prices and induce demand.
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3.2 Goals of Health

The second important issue for developing countries and especially those in greatest need setting out the goals of health itself. These, for all countries, include:

- the mobilization of adequate funds for health care;
- the appropriate and efficient utilization of resources; provision of equal access to basic care to all citizens;
- ensuring the quality of care.

3.3 Financing Issues

The third set of problems deal with those faced by developing countries in health-care financing. Within the present context, these include the following:

- shortage of government funds to finance existing programmes and health services, support to effective new programmes, and the provision of health services to meet rising expectations and demand;
- inability to reallocate resources;
- rapid expenditure inflation in urban areas;
- shortage of foreign exchange for imported drugs and supplies;
- inefficiency.

As a result of the structural adjustment programmes which many countries are undertaking, or any other demands on resources, the governments of many African countries have found it increasingly difficult to finance health care today. The three common types of changes that would have to take place are in the sources of finance; the payment mechanism; and the different roles of actors in the health sector. There is a need, therefore, to consider various forms of health financing that can be efficiently and equitably utilized.

3.4 Methods of Financing Health

Health is funded from different sources, such as:

- government finance
- national insurance
- user fees
- social emergency funds
- community financing
- private and household financing
- external financing.

The relative importance of these funding sources has changed over the last years. The poorest countries are dependent on external financing for their health systems. This reliance raises the issue of dependency and sustainability. What happens when the external funding is no longer available?

As a means of increasing resources for health, suggestions have been made to increase the tax effort in some countries where the tax rate is presently low.

3.5 Merits and Demerits of Financing Mechanisms

All the various sources of finance mentioned in 3.4 above, have their merits and demerits. For example, one of the characteristics of a national insurance scheme is that it modifies relationships between the health care providers, the patient, and the payers. This relationship, which is normally bilateral, becomes trilateral with insurance. In addition, insurance does not necessarily guarantee better quality of health care and health outcomes. Indeed, insurance is known to change the awareness of consumers and generate wastes and unnecessary demands for services. Additionally, insurance alters the locus of financial power. In most cases, the power-base shifts from the Ministry of Health to the national insurance scheme or company(ies). In many developing countries it is difficult to establish an insurance scheme because of the sophisticated organizational arrangements which are necessary for its operation.

A community health care financing system has been strongly proposed because of its merits. In particular, it is a system of shared responsibility and partnership. It also integrates prevention, primary and secondary care. Governments provide the operational roles while the community is saddled with the responsibility of management, organization and control. Community financing can take many forms: payment for drugs by patients at the community pharmacy, a simple insurance or repayment scheme, and user charges.

In many developing countries, user charges have been introduced which have had varied impacts on different members of the society. In some cases, the imposition of user charges have had negative effects on the utilization of health services. It has also been claimed that the imposition of user charges affect the poor more than the rich. The correct impact of user charges on the poor or any other income class can, however, only be assessed within the framework of income and substitution effects before the final impact can be unambiguously determined. In such analysis, the use to which the revenues derived from user charges is put, is crucial.

3.6 Health Finance Simulation Models

Limited budgets and increasing demand for health care compel decision-makers and administrators of health-care systems in developing countries to search for new alternative ways of solving their health-care problems.

Health finance simulation models can be useful in the allocation of resources to health and/or in tracing the impact of some macroeconomic changes within the economy on various sectors and in particular the health sector.

The health finance simulation model (Healthfismo) presented at the Conference is used with a personal computer and Lotus 1-2-3 software. It has three interlocking parts: a budget submodel; a patient care delivery system submodel; and a nurses submodel. These three parts interact to provide a series of outputs. A separate nurses' training model is also included.

Healthfismo has the capability to calculate and print:

- total budget of MoH;
 - budget for patient care;
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- proportion of the MoH budget assigned to patient care;
 - distribution of the budgets for patient care among three types of health-care delivery systems;
 - ratio of three types of health-care services, or interventions, to population;
 - total investment.

The health finance simulation model deals with three types of health-care delivery systems. These are: primary care: health posts and similar facilities; secondary care: health centres or clinics and similar facilities; tertiary care: hospitals and hospital-like facilities.

3.7 What Determines Aid for Health: An Empirical Analysis of Bilateral Aid Flows

In discussing foreign aid for the health sector, the most relevant questions are the following:

- what are the patterns of aid distribution across countries?
- what are the economic and political variables that can explain the distribution of aid?
- do aid flows follow donor interests or recipient needs?

The stylized facts and the empirical analyses of the determinants of bilateral aid for health across countries in the period 1981-1989 show that:

- From individual countries' analyses, there is no clear trend or discernible pattern on the relationship between the amount of Official Development Assistance (ODA) for health and country indicators such as population size, GNP per capita, infant mortality, etc.
- Empirical analyses suggest that, on balance, bilateral aid for health is more donor-oriented than health-development-oriented, although the mix of donor interest and recipient needs criteria may vary among donors and recipient countries.

One of the implications of the findings for aid effectiveness is that aid is not given on the basis of a set of economic criteria. It is, therefore, possible that aid may not be going to countries in greatest need.

Given the scarcity of aid in recent times and the increasing competition for it; and the need to have it where it is most desired and presumably where it would be optimally utilized, there is a need to develop appropriate criteria for aid allocation to developing countries. Such criteria should be agreed upon by donors and recipient countries in order to maximize aid effectiveness.

CONCLUSION

To conclude, I state the main reasons why this Conference has been so important to WHO and its Member Countries, in particular the least developed. First, there is an urgent need to reverse the growing inequities in health status and access to health care which are evident both between countries as well as within countries. The poorest countries are the most needy. Technically we know what to do and we know how to do it. What we do not yet know is how to reorder financial and human resources for health, directing them to those activities which will make most impact on the health of the entire populations but especially the most needy. Secondly, economic analysis is the tool we need to develop and apply. It must become a part of the analytical tool box used in every country, as important as epidemiology. As a result of this Conference, WHO is better informed on how this can be brought about. In so doing, one perceives a great opportunity to assist the health sector to extricate itself from a situation of perpetual isolation and thereby put health in its rightful place as part of the motor of economic and social development.

For future action, one of the basic questions we must ask is how can we best speed up improvements in health which are under an overall setting of poor economic performance, and public health systems, which are under stress. In most needy countries a process of health reform is underway, where all the actors, namely households, communities, local and central governments and development agencies, are interreacting. The financing of planned activities in these health reforms is very much dependent upon external resources.

As part of the WHO initiative to intensify its technical and financial support to countries in greatest need, economic analyses will be further used not only to assist in the decision-making and implementation process but also in the mobilization of adequate international cooperation. Training programmes will place special emphasis on the use of economic analysis in the health policy making process.

Operational objectives will be pursued. *First*, is the need to help the health sector make better use of the resources already available. In many countries this will require our close involvement in guiding the process of fundamental health sector reforms. In addition to achieving greater cost-effectiveness, this will make the sector more attractive for additional funding, whether from local communities or foreign donors.

Second, is the need to promote investment in health as an essential component of economic investment. This means protecting the health of industrial and agricultural workers and their families from debilitating diseases. The economic pros and cons are measurable, and the pros should win.

Third, is the need to help the health sector to measure the economic burden of coping with the unacceptable health consequences of environmental risk factors. Economic analysis can make a forceful case for measures to eliminate such health risks or for compensation to meet the costs of treatment and preventive measures by the health sector.

WHO will also support the health sector in the involvement of all major partners in the financing of health, in national health operations planning and implementation. That is why it is WHO's strategy to contribute very concretely to the process of mobilizing and utilizing resources, including aid, in several countries in greatest need, by providing support to the preparation and the management of sectoral consultations.

This process involves the assessment of needs of the health sector, priority setting and subsequent economic and financial analysis of feasibility of alternative health plans. In turn, the proposed interministry policy dialogue, as well as the organization of donor meetings, are important inputs into this feasibility analysis. It also needs to be emphasized that WHO

does not see this process as a means to merely achieve cost-recovery objectives, but as a major opportunity to enhance sustainable health development at all levels of their health system, especially at the community level.

The connections between health and the economy constitute a fresh challenge for decision-makers. Health professionals and decision-makers need to be informed of and become knowledgeable about these linkages. They have to promote this knowledge by closely working with other Ministries, such as those of Finance and Economic Planning, in order to promote those development policy options that are favourable to health. It is part of WHO's commitment to assist Ministries of Health in this added responsibility.
