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THE ENGINE OR THE CABOOSE: HEALTH POLICY IN DEVELOPING COUNTRIES*

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ABSTRACT: A discussion of health policy in developing countries is presented. It argues that developing countries must adopt a progressive approach to health policy which rejects the two-tiered system of public and private health care. However, it also points out that ideology is not sufficient to maintain support. A progressive health system must utilize administrative and social and behavioral sciences to achieve effectiveness and efficiency in health care delivery. It cannot ignore these goals any more than a private health care system can.

KEYWORDS: Health policy. Developing countries. Health system.

INTRODUCTION

Too often we ask how we can improve health policy without examining the underlying assumptions of our existing system and questioning whether it can take us where we want to go. We may ask, for example, how to implement a nutritional program in a shanty-town or what services to offer in a rural health facility. Or we may concern ourselves with improving the quality of health data and the statistical techniques used to analyze them. Or we may argue that quantitative analysis is politically tainted and advocate qualitative techniques instead. However, the first question which should be asked is: How should health services be delivered? In this paper, the authors discuss their view about how to answer this question and then suggest answers to the subsidiary question of how to improve health policies.

The question of how to deliver health services must be asked in both developed and less developed countries, and its answer will be based on an ideological judgement about whether health care is a "public good" or a commodity which should be governed by market forces. Often the commodity position is said to be non-ideological. It is asserted that treating health care delivery as a transaction no different from the manufacture and sale of automobiles is recognizing a fact, not espousing a philosophy. Yet there is a strong ideological basis for this view with important implications for the delivery of health services.

First, private property, by its very nature, means exclusiveness; the denial of access is what makes property so treasured. Thus, ignoring the needs of those who cannot afford health care becomes acceptable. Second, private property means minimal interference with and scrutiny of the production process. Thus, government involvement in the regulation and delivery of health services is deliberately limited. Populations can be segmented on the basis of profitability, not community need. Services or product lines, as they are called, can be located where they will bear financial fruit rather than on the basis of regional priorities; "crown jewels" are the indicators of success. Health care is a caboose trailing after the general economy.

Few proponents of the commodity viewpoint are so committed to it that they completely ignore public good. Therefore, public good is paid lip service, and a public health system is tolerated. Two separate fields are developed - public health and health. The latter focuses on macro-analysis and the role of the public sector within the overall system. Not surprisingly, public health has not been a serious force; it is seen as a secondary level of services and policies. In many countries, the political right has even reduced its role during the past decade. The only area where public health has been visible recently is that of AIDS.

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Often, public health is not involved in any agenda setting. Rather it has developed a passive, defensive stance within the total health system. As a result, public health officials attempt to control the environment within public administration by expanding their turf and competing with other departments such as transportation and social services. They exchange patronage and make compromises without any significant health gain. They often lack public confidence because of their inability to serve the basic health needs of those who are unable to obtain care in the private sector. Retrenchment succeeds not only because of strong political opposition but because of the very actions of public health officials.

At the same time, the private sector maintains a favored position that it has not necessarily earned. Its special interest groups are effective in playing hierarchial, pluralistic politics at the expense of the public good. Even in the United Kingdom (UK), where the populace essentially supports a dominant public sector, the polity increasingly tries to promote the development of the private health sector to justify privatization of lucrative public services and to support private enterprise.

The authors of this paper hold the position that health care is a public good. They believe that the application of the concept of private property to health care is a violation of basic human rights, no different in spirit than torture, just as damaging, and resulting in just as many lives lost. Health is a human right. The World Health Organization (WHO) aim of promoting health for all by the year 2000, stated at the historic meeting in Alma Ata (1978), will be jeopardized if public good health policies are not forcefully implemented in the nineties, the last decade of this century.

Lee[2] has defined two positions within the public good perspective: 1) the bureaucratic or planning position; and 2) the institutional or class position.

...the bureaucrats see a more rational planned system in which resources are effectively coordinated and more appropriately allocated. Perceiving the primary obstacle to rational planning and resource allocation as the professional monopoly of physicians over medical education and practice, bureaucratic reformers would basically adjust the existing system to achieve agreed upon goals, such as equity of access and cost containment.

...Those who hold that the defects in health care are deeply rooted in the structure of a class society would radically alter the present health care system, creating a national health service, with decentralization of administration and community control over health care institutions and health professionals.

The authors reject the bureaucratic approach. First, technocrats have the power to and usually prioritize needs without true community participation. Furthermore, there is little pressure for efficiency or effectiveness. Last, scrutiny is difficult.

Rather, the progressive approach, described by Lee[2] as radical change, is advocated. However, it is suggested that this approach will succeed only through efficient administration linked with quality research, evaluation, and allocative planning. This is the engine approach driving improved health care for less developed countries.

EXTERNAL ENVIRONMENT

Within every system of health care delivery there is planning; only the role, type, and overtness of planning differ according to the precepts of the system. The commodity or caboose approach maintains that free market forces substitute for formal planning. Thus, to many, laissez faire implies non-planning; however, the results of this approach are not accidental; resources are cleverly allocated. The populace may perceive minimal public involvement; reality is another matter.

Sometimes there is a recognition that a market failure exists and adjustments are necessary. One method of dealing with failure is for a large buyer, such as an insurance company or government, to force change in the system. The expectation is that not only the original buyer but other buyers as well will benefit. The outcomes of these methods are mixed; some efficiency is achieved but community needs are disregarded and clinical management is possibly compromised. Effectiveness and other issues related to quality of care are de-emphasized. The regulatory approach is tried when the failure of laissez faire is clearly demonstrated - private sector abuses such as the dumping of non-profitable patients, fraud, over-utilization or duplication of services, and unnecessary purchase of high technology. Then government tries to intervene by regulation, usually through administrative law. It may attempt to control purchases of expensive equipment or other capital expenditures, for instance. But when regulatory devices are implemented, they are usually met with successful ways to avoid or capture the regulation.

Incrementalism, advocating very small changes in the health system labyrinth, is another approach. New entitlements are added to old programs with no overall perspective. This approach tends to lack a long-term view and to increase fragmentation rather than providing comprehensive care. However, since incrementalism does not tend to disrupt the existing social order, policy-

makers favor it.

Significant improvement in health policies requires the engine-drive, allocative approach which accepts the necessity of overt health planning and a unified public sector.

Resource priorities are based on real need; major changes are desired, and there is a "political will" to make them in a reasonable period of time. This may be called the process of "public-ization" of policy. In developing countries, planning for health policies is indeed difficult when one is limited to the public sector. If public health is not allowed to expand its services or to unify the system, all efforts to improve health care in these countries will be fruitless.

This progressive view of planning based on health need should not be associated with economic or political collapse. Planning is not alien to modern man. In fact, multi-national firms practice the most sophisticated planning; they are more intrusive than any government. It would be prudent to apply many of their training and planning methods to our ends. In many cases, planning does not fail but is simply not given the chance to succeed because it lacks popular support. The commodity argument states that planning is more expensive or inflationary. Underlying this myth is the assumption that it increases demand which will be released dysfunctionally and unintentionally. Advocates of this position cite the U.S. experience on two accounts: 1) wage and price controls; and 2) certificate-of-need regulations (CON) but overlook the systemic problems that allowed circumventing CON regulations. These case studies only highlight the problems of a two-tiered system.

In many developed countries, with progressive health policy-making at the national level, it may be only a matter of resource allocation. In the UK, for example, the national budget for health is shared by different regions on the basis of the population size weighted by specific mortality rates, the so-called RAWP (Resource Allocation Working Party).[4] Local health policies are established by health districts and regions which depend on: 1) trained staff working at a steady pace; and 2) continual reassessment through monitoring of activities and outcomes. These along with the historical legacy of the national health service — the influence of the medical profession and the level of government funding — are the determining factors of the success of the national health system.[6]

Undoubtedly, there will be negative experiences; less developed countries will not be spared disappointments and inequalities in health care delivery any more than have developed countries such as the UK[7]. Nevertheless, these are much more due to political conditions than to administrative limitations.

It is paradoxical that less developed countries with progressive ideologies must adopt program—based planning — which is utilized by those favoring the commodity approach — when population-based planning is preferable[5]. Program-based planning is favored under the market system approach because it is less disruptive of the system. However, population-based planning is only possible when information is widely available and surveys are routinely conducted. Therefore, developing countries are restricted to program-based planning because information is poor and resources, both human and financial, are meager. As a result, programs very often fail to meet health needs either because they ignore the interdependence of different health problems or because they are conceived on the basis of imprecise need assessment. Program-based policy making is an important deterrent to a desirable, holistic approach to health care delivery. To move from this to the population approach one must necessarily begin by seeking improvement of human resources and development of local research.

In 1979, WHO co-sponsored a book concerning the relationship between epidemiology and health planning.[1] Its authors concluded that even though epidemiology contributes significantly to the understanding of the natural history and causes of disease, the findings of epidemiologists do not ordinarily inform health policy development. Apart from vital statistics data and some descriptive information on morbidity, few of epidemiology's methods and results are used by policymakers.

If population-based planning is to be introduced, the infrastructure to conduct routine epidemiological and health services research studies must be developed. Improving health policy for the next decade requires the use of the best tools available and their constant updating. These include the fields of economics, regional planning, business, statistics, management information, epidemiology, and sociology.

INTERNAL ENVIRONMENT

If a progressive, engine-driven approach to health is to succeed it must also pay attention to its internal environment. An organizational culture which fosters in its members commitment to the overall goals of the system must be developed. Restructuring the internal environment to improve public administration of health care is essential. The organizational culture must facilitate excellent and responsible client service. Not only must health policies enlarge and integrate services but also encourage organizations to be proactive in providing services at an optimum level. Corrup-

tion at all levels must be halted. Changes in industrial relations, productivity, and rewards are imperative.

To achieve quality services and superior coverage through internal and external health planning, excellent health service research and evaluation are required. This will require talented, committed scientists who have the necessary resources and support. Thus, another important need of less developed countries is training programs in management and administrative studies. Some developing countries may boast control of some endemic conditions and adequate health care for some risk groups but few are prepared to face the challenges and opportunities of planning for managing a total health system. Thus, besides a well-supported "political will", better technical expertise, continually updated, at every level of the system is needed.

However, a problem which will have to be addressed is attracting people to a progressive system. Even in the developed countries, with or without a commodity approach, this is difficult. Often the brightest, most ambitious, and talented people eschew a career in health, or at least the public health sector of it, because rewards are higher elsewhere. In developing countries, the same pattern holds; the best graduates are also enticed into the private tier or out of health altogether.

It must also be recognized that a necessary resource in a progressive health system is a relational information system. This requires the development of computing and information systems as integral parts of any attempt to improve health in developing countries. Furthermore, it must be accepted that systems will become obsolete, both theoretically and technically, but that commitment must be made to remain at the cutting edge.

Currently, in Brazil, political decisions have already been made to implement a new health model the mainstay of which is the unification of health services and the decentralization of management. At this point, the competence of personnel to carry out new functions emerges as vital to the success of such the enterprise. While legislators put forth general guidelines, it is expected that health professionals will translate these guidelines into action. It was not by chance that it was in S. Paulo, the wealthiest state and therefore the best staffed, that the new model was tried first. In this state, those responsible for the implementation of the new health system detect the limited capabilities of managers and others to recognize and cope with the administrative problems of the new integrated system. The necessity of research and training is evident and both topics have received special attention. As Lombardi[3] said"... there is a need for countries like Brazil to get involved in what can be called the knowledge administration, that is, the critical capacity to analyze knowledge and transform it in a regional context." These efforts must be ongoing and indepedent of political changes. The goal of adequate health care for all can be achieved only by well-nourished and stable health policies at the national level.

CONCLUSION

Less developed countries, apart from their health conditions, face many daunting social challenges including poor housing and high unemployment and crime rates. All of these problems are important, and therefore, health planning is always dependent on the political trends within a country. Although this reality must be recognized, the authors of this paper suggest that health policies for developing countries must be engine-driven if they are to meet the WHO goals for the next decade. "Political will," technical skill, and professional commitment are needed; together these will facilitate improved health care delivery. Better planning methods and management capabilities are the tools needed to accomplish our objectives as we move into the 21st century. However, in developing as in developed countries, the issue is not quantitative v. qualitative methods but whether the policy intent is progressive or not.

Most policy-makers are aware that no magic wand exists which can provide a nation with exemplary health indices. Just as a nation commits its resources, intellectual heritage, appropriate linkages, values, and financial capabilities to a global economy, it must do the same in the health sector. It is difficult to imagine any other type of policy for developed countries — impossible for developing countries.

GOLDSTEEN, R. L. et al. O reboque: políticas de saúde em países em desenvolvimento. **Rev. Saúde públ.**, S.Paulo, **24**: 523-7, 1990.

RESUMO: É discutida a política de saúde em países em desenvolvimento. Defende-se a proposta de que esses países devem adotar uma abordagem progressista quanto a sua política de saúde, rejeitando o sistema que se apóia em dois pilares — o da saúde pública e privada. Salienta-se que a ideologia não pode ser seu único sustentáculo. Um sistema de saúde progressista deve utilizar as ciências administrativas, sociais e comportamentais na formulação e implementação do conjunto de seus programas e propostas, para que possa servir à população de modo eficaz. O sistema de saúde pública não pode se eximir em relação a meta da eficácia.

DESCRITORES: Política de saúde. Países em desenvolvimento. Sistema de saúde.

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