SUMMARY RECORD OF THE SEVENTH MEETING

WHO Conference Hall, Manila
Friday, 22 September 1989 at 2.30 p.m.

CHAIRMAN: Mr N. Supa (Solomon Islands)

CONTENTS

1. PLANNING AND MANAGING FINANCES FOR HEALTH: Item 16 of the Agenda (Document WPR/RC40/12) (continued from the sixth meeting, section 3)

The Chairman said that the morning session had underlined the significance of the Committee's task, namely to improve the health policy formulation process. A number of interesting and potentially valuable measures for improving the performance of health services through financial policies had been described. Quite a wide range of measures were being taken, reflecting the great diversity of the countries of the Region, but a number of common factors were emerging. He therefore suggested that, in the remainder of the discussion, the Committee should concentrate on: (1) cost containment; (2) expanding the sources of financing; and (3) health policy development. It would be useful to know how experience with regard to those issues was evaluated. Why did certain problems in these three areas seem so easy to settle in some countries, and so difficult in others? The Committee should also explore what WHO could do to further national efforts in planning and managing finances for health.

Dr SHIN (Republic of Korea), referring to the first issue said that "costs" could be understood in many ways. One could talk about national health expenditure as a cost, institutional expenses, or unit costs for the services. All three aspects were important. Since the insurance system had been adopted in the Republic of Korea twelve years previously, the utilization rate (in terms of inpatients and outpatients) had increased 2.5 times. The Government had subsequently established a co-payment system. It had also set up a referral system to limit the number of people seeking care in the university hospital setting (which was highly technological and therefore very expensive); those who went to the university hospital without referral had to pay the total costs themselves.

The Republic of Korea was deeply concerned about the situation regarding pharmaceuticals. The Philippines had already adopted generic names, thus to a certain extent avoiding overuse and overexpense. The pharmaceutical companies were highly commercialized and countless new chemicals and antibiotics were produced every year.

His Government was encouraging government-owned hospitals to form a special foundation, giving them full autonomy for decisions and management. There were problems with the payment system which itself generated a tendency to inflation, since doctors tended to promote more services under a fee-for-service system.

Dr ABDULLAH (Malaysia) said that there was an escalation of health service costs in Malaysia, which was trying to introduce an insurance system with a view to relieving the problem. He would welcome the views of other representatives based on their own experiences as to the appropriateness of that measure. He suggested that an insurance system might result in some health services being over-utilized and others underutilized. Also, he asked whether the introduction of an insurance system normally resulted in the privatization of hospitals. Perhaps there were alternatives to insurance to prevent further escalation of costs.

Professor RAJPHO (Lao People's Democratic Republic), noting the references made to equity and efficiency, outlined the situation in the Lao People's Democratic Republic - one of the poorest countries, with a population of 3.8 million, a population increase rate of 2.9 per thousand per year, and life expectancy of about fifty years. For 1989 the health budget had been increased by about 14% over that for 1988; however, expenditure on health remained low - representing only 3% of the GNP.

Mountains and forests rendered access to many areas of the country difficult, and the limited transport and road system hindered the development of the health services. Overall, only some 60% of the population was covered by the health services, and the percentage coverage was far lower in rural areas and for ethnic minorities.

The health budget was inadequate; there were health structures in the districts and the villages, but they were often underutilized because of lack of qualified personnel. Supervision and monitoring, as well as coordination between the various programmes (such as maternal and child health, immunization, etc.) were lacking.

Most of the financing was derived from taxation, but there was also community participation, and international assistance. Those sources of funding allowed the provision of free services. A survey was being carried out to ascertain the possibility of setting up an insurance system for civil servants and others.

Since 1987, thanks to the help of WHO and other international organizations, it had been possible to strengthen the development of the health service infrastructure, science and technology.

Emphasis had been laid on the district health system, where all aspects of the work were being coordinated and managed in accordance with the principles of primary health care.

In July 1989 a WHO-supported workshop had been held in Vientiane with a view to strengthening the management of primary health care at all levels; by the end of the year three districts would be chosen in regions with different socioeconomic conditions, with a view to funding specific and appropriate solutions; that pilot project might be extended to other areas.

Dr BULE (Vanuatu) said that in Vanuatu health services were largely funded by the Government, and only to a limited extent by the private sector.

The economic situation had been declining since 1986. As a result of enforced budget reductions, the 1989 health budget showed a 10% reduction by comparison with 1988. On the other hand, there was an annual population growth rate of 3.2% and demands on the health service were increasing. With a view to reducing the anticipated over-expenditure by the end of 1989 and planning for a manageable budget for 1990, the Health Department had looked into the following cost-saving measures: (1) negotiations had been started with the churches for them to share the running costs of some of the health facilities previously in their care; (2) the public service regulations had been amended to provide for part-time employment (in view of underutilization of some health facilities); (3) local government authorities were encouraged to increase their role in the provision of basic health care and the promotion of primary health care activities; (4) the organization of health services was being restructured in order to ensure better utilization of available resources; sub-committees had been set up for health planning, senior management, staff development, infrastructure developments, disease control, primary health care, and information. Those committees played an important role in view of the lack of adequate middle and top-level managers and dependence on expatriate officers; (5) consideration was being given to reducing the workforce by retiring staff.

Mr DROLLET (France) thanked WHO for making the debate on health financing possible and hoped that the outcome would be positive and enriching. Although there was no absolute universal solution to the problem of financing, the sharing of experience would enable Member States to avoid making mistakes that had been made by others.

Two years previously, French Polynesia had reviewed its health structure and the health situation to investigate different options for financial intervention. The population of French Polynesia was 200,000, which was small in comparison with China, but the methods of intervention being tested in China could also be useful in French Polynesia. Compared with other Pacific islands, French Polynesia was large, as it was dispersed over a massive area the same size as Europe.

There were three different levels of action for financial management. First, the primary health care service, where health services had to be provided even in remote islands with problems of training and transportation, and where an essential requirement for a health worker was that he should be able to talk on radio. In order to ensure equity and efficiency in the health services, people who were far away from Tahiti must not be overlooked.

Second, in addition to primary health care services, there was a hospital in Papeete, Tahiti, which was extremely modern, equipped with sophisticated equipment and technology. That was costly but essential, and he was open to suggestions of ways to finance such expenses.

There was a health insurance system in Tahiti for people who were employed. However, the relatively high employment rate of just over 11% meant that many people were outside the health insurance, tax and social security systems, but they too needed health care. The operational cost of the hospital in Papeete was extremely high, and about 70% of it was spent on personnel. An additional problem was that it was difficult to find people to undergo medical and paramedical training.

The Government had tried to set up a system to cover the entire Polynesian population so that even if there was no tax equity, there would at least be social equity.

Third, there was Malardé Institute and its laboratory, which had been subsidized jointly by the governments of Tahiti and France. The Institute had been encouraged to diversify its financing as that would be safer. As the Institute also played the role of public health laboratory, it was financially self-sufficient.

Those were the three levels for which French Polynesia had to find financing solutions. He thanked all the participants for sharing their experience in that area.

Dr TALWAT (Papua New Guinea), referring to the Korean delegation's statement that there had been a 2.5% increase in the utilization of health services since the introduction of health insurance, asked whether there had been a proportional increase in administrative costs. Papua New Guinea was well aware of the hidden cost of introducing new systems into services, especially of staff to ensure that collection, record-keeping and so on were carried out.

Regarding management structure, in Papua New Guinea as elsewhere, 50% of the health budget was spent on personnel, so little remained for the actual services. While the introduction of new financial systems was being encouraged, the old administrative systems were being kept for health services, a matter which should be investigated. It was possible that certain staff positions could be done away with, or one staff member could do the work currently done by two. Such measures would reduce costs. Staff numbers should be reduced throughout the system, preferably starting with the top level, that is the decision-makers, as those were the people who usually received increments. The people directly involved with patients in the health care service should be the last to be affected.

Dr SHIN (Republic of Korea), before responding to the question from Papua New Guinea, mentioned that each country had a different socioeconomic and political environment and thus a health system that was suitable for one country might not be appropriate for another one. The utilization of health services after the introduction of health insurance had multiplied by 2.5 in the twelve-year period from 1978 to 1989. One explanation could be that previously unmet demands were now being met. There was a strong demand for equality of service, and the consequences of ignoring it could be disastrous. Insurance had been one way of achieving the goal of providing good health services to the people. When introducing insurance, it was necessary to consider certain factors such as the type, number, allocation and distribution of physicians, and the availability of health service facilities throughout the country. By introducing health insurance, people had the impression that they had free access to health services, whether in urban or rural areas. In the early 1980s, the insurance system had been strongly promoted in the Republic of Korea, and there had been a great shortage of doctors and hospitals. Owing to the free market system, doctors' salaries had increased two or three times. This led to a crisis, although the country recovered fairly quickly.

Replying to the question from the representative of Papua New Guinea, he said that he did not know the increase in administrative costs, as the system was managed by insurance companies, not government. There were 400 such companies which were responsible for the collection of premiums and the payment of bills. Administrative costs for the big companies were generally 2%-3% of the total revenue. However, administrative costs for the small companies had increased to between 15% and 20% of their revenue and that was creating a problem. The Ministry was thus considering having them taken over by the tax authorities. A big political issue in the country currently was whether to retain the 400 independent companies or consolidate them into one, thus sharing costs and reducing the risk of bankruptcy.

Referring to Malaysia's intention to set up an insurance system, he said that such a system increased costs rather than reducing them because of the increased access to health services. However, if one was aware of that, it was possible to set up a subsystem where patients paid for health care and were therefore aware of the cost. In the Republic of Korea, the structure of the payment system was inflationary and needed to be modified. Doctors and hospitals preferred to use the fee-for-service system continuously, which resulted in a big battle between them and the policy-makers.

Privatization was not essential with the insurance system; in the Republic of Korea 20% of the hospitals were public but they were still under the social insurance system.

Dr TAITAI (Kiribati) said that, although Kiribati was small, it suffered from the same problems as other Member States. Kiribati did not use an insurance system. Costs in Kiribati were mainly incurred in curative services owing to the technology involved. For Kiribati, the introduction of primary health care had been one way of containing costs especially for peripheral health services. The establishment of community self-help groups reduced government costs tremendously. Primary health care had also increased the accessibility of health care services to almost 100%; they were run by the people themselves, with the government providing drugs, equipment and manpower.

Recently, Kiribati had experienced difficulty in maintaining services because of rising costs. It was committed to several programmes including that of population control and family planning for which it requested WHO's continued support. Once such programmes had been established, they would also reduce costs. A further measure to reduce financial problems was to encourage self-sustaining and income-generating enterprises.

He thanked WHO and nongovernmental organizations for their support to Kiribati in the provision of health services. However, he noted that the Kiribati Government was careful not to let outside aid undermine its policy of self-reliance.

Mr MANATA (Solomon Islands) emphasized the fact that health services in Solomon Islands were basically government-financed, as required by the Constitution. However because of the Government's financial constraints in the current economic decline, the Government was looking for ways of reducing its financial burden by sharing it with others who had the means to pay for it. As part of the population was poor, a health insurance scheme might not be appropriate. The current government programme of action had stated the necessity of a feasibility study for a national health insurance scheme as well as measures for recovering costs.

The Ministry of Health had requested a WHO fellowship for an undersecretary of health to do a master's degree in Health Administration, specializing in health financing. WHO had granted the fellowship. Solomon Islands had also mentioned the need for a long-term consultant to replace the Undersecretary during his fellowship. The consultant would be required to work in the health planning unit in Solomon Islands to review certain aspects of the budgeting and accounting system and investigate the feasibility of various means of financing health services. Such collaboration would provide invaluable background information to the Government. The Undersecretary, upon his return, could develop a system that was suitable for conditions in Solomon Islands.

Dr SCHUSTER (Samoa) said his delegation regretted that it had not had the opportunity in the time available earlier to relate its experience in planning and managing finances for health. He commended the Regional Director and his staff on the well-prepared documents and presentations.

He agreed that the central issues were clear - equity and efficiency in management, and accountability for every dollar spent on delivering health care across the entire spectrum of services. The element underlying both those requirements was the quality of health care given to the people. Quality encompassed both equity and efficiency and the three policy issues under discussion, namely cost containment, expansion of sources of financing and health policy development. Further, the final impact of health care would depend on the quality of delivery.

Samoa was trying to improve its health indicators but was still far from satisfied. Further commitment was needed to ensure more efficient use of the available resources of a fragile economy. The equity and quality of services were relatively good, thanks to the country's unique culture, but there was considerable room for improvement. Samoa expected to encounter many difficulties along the road to health for all by the year 2000 and beyond, and would therefore be compelled to explore all possible avenues of improving the structure, content and functioning of the health care system and the planning and management of health financing. Samoa was grateful to WHO, nongovernmental organizations, bilateral donors and others for both technical and financial assistance in those efforts.

Dr ADAMS (Australia) said that Australia had a long history of experience of private health insurance and, since 1975, experience of a government-supported insurance scheme, insuring all citizens for basic medical costs, which was funded by a 1.5% tax on income. The representative of Singapore had indicated at the previous meeting that introduction of fees for services had curbed demand. His own experience was, however, that fees for services supported by health insurance had increased the

frequency of servicing by professional groups. Unless a monitoring system was established, there was a danger of over-provision of services by a small sector of the medical profession, which could give rise to financial problems.

He had noted the developments in the Philippines with regard to drugs. Australia had many years of experience in subsidizing a large range of pharmaceutical products, including essential drugs, under a benefit scheme. In the past few years, it had proved such a drain on government resources that drastic steps had to be taken, including the encouragement of increased generic prescribing, and the issue was still in dispute.

The emergence of new technologies was a further cause for worry. Although they produced good results, they were always extremely expensive and their introduction was always strongly supported by the specialist group concerned. There were always the dilemmas of whether to restrict their use to the public sector or to make them more widely available under health insurance, and of when they ceased to be experimental and were recognized as widely needed. He had no answers to the continuing argument as regards the rationing of health services, such as the restriction of some services to limited groups.

Australia's federal system permitted each state to experiment with different management structures. Some had systems similar to those described by the representative of New Zealand, with area health services and bulk grants for hospital services, primary health care, etc., for a defined population.

There were increasing moves to involve the private sector with the public sector to a greater extent, with the sub-contracting of certain services. Although there was some doubt whether it was appropriate for the private sector to handle accident and emergency services, it could certainly help with waiting lists for elective and day surgery services.

In a fee-for-service system funded by insurance there was a problem as to how preventive services such as immunization and cancer screening should be funded. There was a need to experiment with different ways of paying hospitals and health-care personnel to provide such services, and he had heard with interest the representative of New Zealand's remarks in that regard.

Policy issues were not easily solved and would continue to give rise to interesting discussions.

Mrs SMAIL (New Zealand) said that, at the previous meeting, the Chairman had warned of the danger of increasing health service supply without disciplining the demand. Disciplining of service providers was also needed. Private management consultants claimed that they could improve the efficiency and costs of any organization or business by about 20%. Experience in New Zealand had shown that similar results could be achieved in the health services. If changes in management structure were not addressed, however, many of the other efforts would be less effective. New Zealand had established a health services development management unit to strengthen management training skills, both nationally and in the area health boards. Greater attention was being paid to priority setting for the allocated funds. It was inevitable that health would always have an unquenchable demand for funding, but New Zealand, like other countries, had finite resources.

New Zealand was beginning to develop management information systems, and a resource utilization system was being introduced into hospitals and area health boards, with initial focusing on hospitals which received the bulk of funding. The system followed

the individual patient and determined costs for all items during treatment, highlighting the percentage of costs incurred for indirect services and administrative overheads. As the representative of Papua New Guinea had said at the previous meeting, it was surprising how high a proportion of costs resulted from services other than direct patient care. It was hoped that the system would lead to more appropriate targeting of cost containment measures. It should also permit the comparison of different medical staff and of the performance of different units, hospitals and area health boards.

Since 1985, New Zealand had placed more emphasis on community participation in health services, with more education as to the finite nature of health resources and the establishment of community committees within health boards to give communities a more formal say in developing policies and setting priorities in their area.

General business management practice has much to offer health policy development. In New Zealand it had been recognized that, in the past, too much time, energy and money had gone into maintaining the status quo, with insufficient examination of whether the right things were being done, with the right priorities and goals, and how new areas could be incorporated.

After much discussion, New Zealand was developing clear national policies and expectations as to what could be achieved with the public funds going into the health services. It had been decided that it was not appropriate to use an autocratic approach and that it was necessary to reach agreement between government, the health services and the people through consultative processes in order to develop relevant health policies which would encourage greater commitment.

Dr TAPA (Tonga) commended the Regional Director and his staff on the informative documents provided which should prove most useful.

The Constitution of Tonga required the Government to protect the life and property of the citizens, which it did through taxation, mostly indirect taxation. Per capita health expenditure had risen over the past ten years from Tongan $17.67 in 1981-1982 to $26.06 in 1985-1986 and was budgeted at just under $40.00 for 1989-1990, the Tongan dollar being approximately equivalent to the Australian dollar. The health budget had represented 11.3% of the total budget in 1981-1982 and in 1985-1986 and 10% in 1989-1990. From a high of 13% some years earlier, there had been a continuous trend downwards. However, it was the responsibility of the Government to provide health care for the total population, irrespective of ability or willingness to pay.

Health care economics was concerned with the optimum allocation of scarce resources and cost-benefit analysis of resource utilization. His Government and Ministry of Health were giving increased emphasis to that area and, with the support of WHO, the health planning officer had recently attended a health care economics course in the United Kingdom.

There was no health insurance scheme in Tonga. In addition to tax revenues, a small proportion of health funding derived from user charges for certain specialized services, such as X-ray and immunization services for those wishing to emigrate. Some years earlier, the Government had introduced laundry and catering charges for hospital patients but in June 1988 they had been dropped. He was pleased at the decision, since most patients were from low-income groups and deserved compassionate consideration.

The authorities had decided that all new technologies should be assessed by the division of health planning and information before a decision was taken to proceed with procurement.

Changes in management structures would help in the containment of costs. In Tonga a small programme of cost containment had been introduced, with efficiency measures in respect of the use of electricity and water at the hospital level. Tonga had also adopted the WHO recommended list of essential drugs, which had cut drug procurement costs.

Centralization of management of resources should be dealt with in a tactful manner. The over-centralization of some decisions on financial management often resulted in slowing down the rate of programme implementation, but there were some financial savings, and centralized decision-making could contribute to the optimum use of health care resources.

On the question of expanding the sources of financing, user fees for all Tongan patients had been done away with but there was a growing attitude among the public in favour of taxing commodities that were detrimental to health, such as tobacco and alcohol, and using the proceeds to increase the amount provided to the health services.

Community financing had been taking place and the communities were contributing in self-help projects. When his Government's water supply and sanitation project had begun some twenty years earlier, there had been a tripartite arrangement in which the Government, UNICEF and the people had participated, the latter providing their contribution in the form of labour in kind. That arrangement was continuing.

The role of nongovernmental organizations was still significant. There was a family planning association, and hospital boards of visitors had been established to raise money from the public, provide amenities for patients and help with the procurement of some domestic equipment which the Government was unable to provide from its budget.

On the question of health policy development and how to improve the process of policy analysis, formulation and implementation within each country in relation to financial issues, the answer was by financial planning and management. The preparation of a financial plan was an essential step towards ensuring the successful implementation of health policies included in the national health plan. Financial planning and management skills had to be widely dispersed among policy and decision makers throughout the health care sector. That was important for budget preparation, resource allocation and the efficient management of scarce resources at all levels. Health systems research on health care financing was also important for providing new information on decision-making and optimum resource allocation, on the current cost of health care services, on the effectiveness of health care delivery services and on the identification of various unit costs. That was essential in order to contain costs. Other essential issues were the equitable geographical distribution of resources, identification of underserved areas and provision for those living in them, budget allocation to the primary health care programme, reallocation of health care resources, allocation of resources to the public health care programme and consideration of alternative ways and means of financing the health care system.

WHO had provided his country with fellowships to enable two members of its Health Planning and Information Division to learn the methodology of health systems research and apply it on their return.

Tonga was eager to carry out comprehensive financial planning and cost studies and hoped that WHO would respond favourably.

He fully supported the comments of the Chairman at the previous meeting concerning the great need for Ministers of Health not to be mere onlookers but to play an active role in the question of financing health services. There was a need to influence multilateral and bilateral aid programmes. The support of multilateral and nongovernmental organizations should be advocated. In developing countries such as Tonga, with scarce resources, almost all development projects were funded from bilateral aid programmes, and planners and management must learn more about projects so that they could have a better understanding of them when they applied to the bankers. He expressed his Government's appreciation for the bilateral aid it had received from the Governments of Australia, New Zealand and Japan.

Dr REODICA (Philippines), referring to the question of how to contain costs, and the effect of insurance on utilization, said that her country's Medicare programme benefited some 21 million public and private sector employees and their dependants. In endeavouring to increase the support value of Medicare without increasing the premium, the Department of Health had experimented with an alternative financial and service delivery scheme, which involved linking Medicare with the Health Maintenance Organization, consisting of a group of accredited hospitals and other health care providers. Medicare members who chose to join the scheme received any necessary treatment from that organization, which was financed by Medicare on a capitation basis to an amount equivalent to the premiums. The health maintenance organization thus shared the financial risks with Medicare and therefore had an incentive for efficiency in providing health care. In addition to inpatient care, that organization provided outpatient care including consultations and preventive care such as immunization, thus avoiding hospitalization wherever possible. The experiment had been in operation for about nine months. As of May 1989, the number of enrolled members was 12 567 from 32 Government agencies and 125 private companies, representing only 0.6% of the total number of Medicare members, and the scheme was so far limited to the Manila urban area. Available data indicated that for the same amount of resources, the Health Maintenance Organization had been able to provide a support value of 44% - an improvement of 14% on the standard Medicare plan, which had had a support value of about 30% in 1987. It thus appeared that that financial scheme was capable of providing more health care service benefits to members for the same level of financial resources.

With respect to the effect of applying the latest technology, emphasis in primary health care had been placed on technology transfer at the household level in such areas as oral rehydration therapy in the control of diarrhoeal diseases, growth monitoring for nutrition, family planning supply points and tuberculosis case-finding.

On changes in management structures, she referred to the restructured health care delivery system, in which a midwife had been employed to respond to the health needs of about 5 000 people. The role of the midwife had been expanded from that of a traditional birth attendant to that of a person able to offer consultation and treatment at the village level. Preventive and curative health care had also been integrated at the provincial level. Decision-making, including funding, had been decentralized at the provincial and district levels.

Dr TEARIKI (Cook Islands), referring to the means of containing costs, said that his country intended to consider the question of insurance.

On the effect of applying the latest technology, it was realized that technology was constantly changing, but the question to be considered was the appropriateness of such technology. It was often pointed out that life or health could not be valued in monetary

terms, but the provision of high technology demanded by consumers depended on whether the Government could afford it. Cook Islands was in fact applying technology appropriate to its needs.

On the question of changes in management structures, his country was planning to continue the periodic evaluation of its management system and was considering how to expand its services and sources of funding. It was currently difficult to expand services apart from the possible application of a user's fee. Consideration was also being given to developing the private sector so that it might share the costs currently borne by the public sector or the Government.

Health policy development was an important issue. His delegation realized that policies changed with time depending on community demand, which was sometimes realistic and sometimes not. There were always some financial implications to be considered and much depended on the ability to afford the policy being designed for the community.

The health policy in Cook Islands, designed some ten years earlier, was an issue that had been considered basically by professionals but during the past four years there had been a shift from health professionals to consumers. To bring health providers and consumers together was currently seen as the most appropriate means of designing a policy whereby providers could recommend the kind of policies they considered relevant to the community. At the same time, health consumers would have an opportunity to say what they felt they needed. It was intended to introduce that policy during 1989 and it was thus hoped to develop a better system, to minimize costs and consider possible sources of funding.

The REGIONAL DIRECTOR said that the one day allotted for the discussion of so important an issue appeared to be too short. He had learnt a great deal from the comments of representatives. A large step had been taken towards finding ways to make better use of resources and understanding and managing finances for health. The Committee had heard how each country was concerned to use and allocate resources more efficiently, develop mechanisms for better health, remove inequities in the health sector and particularly control the ever-rising cost of health services.

In the light of the Committee's discussion, he believed it was now possible to indicate a few specific measures that could be taken to increase the financial viability and effectiveness of the health sector.

In the small island countries, for example, there was ample room to develop more efficient schemes for user charges, however small, particularly for the hospital services. Those countries might also find it beneficial to study carefully the feasibility of introducing health insurance programmes. There would also be many opportunities in those small island countries of conducting cost studies comparing the benefits derived from various services and facilities.

For countries of the Region with severely limited economic resources it would also be quite beneficial to examine alternative health financing mechanisms including health insurance programmes tailored to the specific needs of individual countries. In many such countries it would also be useful to explore ways and means of using cooperative societies for community financing of primary health services or, in others - as in the case of China - a collective medical service.

Over the longer term, the role of the private sector in providing health care should probably be expanded in such countries in order to ensure efficiency through competition. It would also be important for those countries to give high priority to exploring ways of controlling the costs of expensive health technology. Above all, for low-income countries, the improvement of financial and physical access to adequate health care for all citizens was an urgent task.

Larger developing countries would no doubt continue to explore efficient ways of expanding health insurance coverage for the self-employed or those not employed by firms or enterprises. Insurance would be an important aspect of the financial plans in those countries for some time.

Methods of financing preventive care and particularly immunizations, and of using health insurance to improve the quality of care, would be of particular interest. It was extremely important that quality of care should not be neglected by introducing new mechanisms. The emphasis in many cases would need to be on the poorer population groups.

A further issue would be that of efficiency in intersectoral allocation of resources (the health and non-health-related sectors) and intrasectoral allocation (among the various health services within the health sector).

There would also be great interest in developing cost containment mechanisms. The service sector in middle-income or high-income countries had been expanding rapidly and the trend would no doubt continue. Concurrently, increasingly sophisticated management techniques had developed in the service sector, but the health sector had lagged behind other service sectors in that respect in most countries of the Region. As an increasing proportion of national resources had been allocated to health, that failure to keep pace with other sectors in developing management and economic capability would be of concern to all. There were therefore two interrelated needs in the area of training in the health sector. The first was the need for a comprehensive training programme for health staff in economics and financial management, and the second, the need for economists and management scientists to learn about the health field. Expertise in managing and financing the health sector must be developed either for more active involvement or for taking concrete and positive action. In that respect he agreed with the Chairman's comments on the possible convening of a meeting of Ministers of Health and Ministers of Finance in the Region in order to start a dialogue. It would not be easy, because a finance minister might sometimes be reluctant to attend a health sector meeting, but he would certainly study the feasibility of holding such a meeting at an early date if possible.

There would also be a common need for interdisciplinary approaches, as mentioned by the representative of Tonga, involving multilateral or bilateral agencies, particularly on the feasibility of various management and financial policies for improving health.

The Secretariat would be happy to respond to any request for its help in any area in which it might be needed.

The CHAIRMAN said that it was clear from the discussion that most countries in the Region had some type of financial planning or were in the planning stage. In many of the current financial activities, however, there was no clearly stated purpose or basis for assessment. Was enough known about the expected outcome of what was being done? For example, most countries in the Region were using or considering the use of health insurance as a financing mechanism. That was doubtless an extremely useful approach,

but it was clear that health insurance programmes had many policy implications. They had direct effects on such key priorities as equity for those most in need of care, efficiency in the use of scarce resources, and cost containment under conditions of constantly developing health technology. The discussion had shown how some countries were dealing with those issues. A great deal had been learnt, and the time had come to make use of that knowledge.

There was general agreement as to the need to be more rational and comprehensive in planning, and good examples had been presented of suitable methods. The next logical step would be to start to use them. A number of innovative approaches to cost recovery and cost containment had been described, but there was a need to learn more about them, and WHO should assist in the sharing of technical experience among countries. A great deal had also been said about the need of countries for additional skills, ranging from policy analysis to programme management. There was clearly a role for WHO in collaborating with countries in finding the best way to meet that need. Finally, it was clear that countries could have common goals and were already working together to attain them. The momentum gained must not be lost and countries should continue to work more closely together to meet their common needs.

He took it that the Committee agreed with the views expressed, and therefore asked the Rapporteurs to prepare an appropriate draft resolution.

The meeting rose at 5.05 p.m.