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The financing of health care in developing countries

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Introduction

Health services are one of the most important benefits of systems of social protection, and especially so in the context of low-income developing countries. To be poor and in good health is one thing. To be poor and in bad health turns hardship into misery – a situation then made even worse if health care services are unavailable, unaffordable, restricted, delayed or of low quality. Unfortunately, low incomes and poor health status frequently go hand in hand and, in the context of developing countries, are frequently associated either with a lack of access to health services or with the existence of health services which function very badly. The financing and organization of health care are thus major social issues in developing countries and the purpose of this article is to review, very briefly, some of the problems that arise and some of the strategic options available.

Health care systems in developing countries typically include three main components:[1]

- a public system, financed from general public revenues. In principle such schemes are universally available, but are often used only by those who cannot afford, or do not have access to, other means of care;
- a small, but well-equipped, private delivery system, available to clients who are able to pay directly or who can afford private, commercial health insurance;
- between these two extremes, a range of health insurance schemes available to workers in the modern, formal sector of the economy. In many countries this tier is organized as part of a formal social security scheme, covering all workers in that sector and their families; in other countries, cover is organized, and sometimes provided, by employers

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[1] This is of course a generalization. Some developing countries possess no private sector, just as others possess no basic universal service, and in many developing countries a variety of subsystems exist side by side.

and enterprises. In both cases, such schemes are usually financed on the basis of contributions by employers and/or workers.

This article is concerned with the effectiveness of such a pluralistic system, considered both as a whole and in terms of its separate components; with the constraints which developing countries face in allocating resources to health care; and with ways in which the system might be improved: by strengthening the individual components; by ensuring better planning and coordination between them; and by promoting a greater degree of solidarity between social groups of different income levels.

It is fairly obvious that in most developing countries things are not working well, and the first part of this article sets out some of the main concerns, especially those resulting from the general underfunding of health care programmes. But developing countries confront a set of constraints which differ both in kind and in magnitude from those facing developed countries. The options available to them are limited by the structure of employment, the reach, effectiveness and yield of the tax system, the efficiency of administrative and management structures, and the underlying distribution of income, as well as by the overall level of national income. This article identifies the main constraints involved, and concludes by reviewing some options for strategy.

One principal conclusion is that, in the circumstances of most developing countries, some kind of pluralistic system of delivery and financing is inevitable. It is simply not possible to provide "equal quality health care for all, irrespective of ability to pay".[2] In the foreseeable future it will not be possible to establish the uniform, universal structures characteristic of most advanced countries. But although the components of the present structure tend to detract from each other's strengths and to exaggerate the unequal distribution of care and benefits, reforms are possible which would lead to a mutual reinforcement. Such reforms would entail a strengthening of public health care schemes; the rationalization of existing ad hoc schemes into a comprehensive (and compulsory) social security scheme, if one does not already exist; the strengthening and reinforcement of existing social security programmes; provision for the establishment of regulated private services; and the development of a high degree of complementarity, cooperation and cross-subsidization between the three levels of provision. Such a structure would require oversight from an effective central supervisory body; it would be predicated on major improvements in management and administration in all branches of health care financing.

What follows is a sweeping generalization. There are wide divergences between countries and between regions in the developing world. There are some developing countries with efficient health services to which the poor

[2] The kind of criterion applied to the health care systems of developed countries. See G. Schieber: *The financing and delivery of health care in OECD countries* (Paris, OECD, 1987).

have ready access, just as there are other developing countries where the poor have no access at all. But there are few developing countries for which none of the following issues is relevant. And there are many countries where in combination they result in severely inadequate health care.

The concerns

A number of major concerns affect the performance of health care systems in developing countries and they interweave in a complex fashion.

Underfunding

An overriding issue is that the amount spent on health care by developing countries is simply too low.

Rich countries spend more on health than poor countries. On a per capita basis, for example, the United States spends on health about 15 times the amount spent by Brazil, which in turn spends much more per capita than many African countries. Among the developed, OECD countries the relationship between the growth of health expenditures and economic growth appears to be more than proportional, whether taken across countries or over time. The richer OECD countries (such as Canada, France, Germany, Switzerland) spend on health nearly three times the amount per capita spent by lower-income OECD countries (Greece, Portugal, Spain), although their GDP per head is only double.[3] And evidence over the recent decades suggests that during the period of their expansion,[4] health care expenditures in the OECD area as a whole grew at almost twice the rate of growth of GDP. Broadly, it seems that, at least during periods of rapid economic growth, the elasticity between the growth of health expenditures and the growth of incomes is of the order of 1.5 to 2.0.

This kind of arithmetic is neither much comfort nor much help to developing countries. Extrapolated backwards, it implies that poverty in income terms is associated with even greater deprivation in health care, even though health care needs are greater among low-income groups. Extrapolated forwards, it implies that economic growth is a prerequisite for the development of health care services. But in recent decades, developing countries have not enjoyed the sustained and strong economic growth which underlay the expansion of systems in developed countries. Economies have

[3] A significant reason for differences may also lie in the type of health care systems: those countries (such as the United Kingdom) possessing National Health Services tend to have lower health-to-GDP ratios than countries relying on social insurance systems (such as Germany) or the private sector (such as the United States). See ISSA: *Cost control for quality care: Meeting the challenge of health system financing*, Studies and Research No. 32 (Geneva, 1992).

[4] The 1950s, 1960s and early 1970s were such periods. Since the mid-1970s the rate of growth of health expenditure has declined and now broadly matches that of GDP.

generally been in decline, many developing countries have focused their efforts on economic restructuring as their main social priority, budget deficits have been reduced, monetary expansion has been tightly limited, and public expenditure (particularly on parastatal organizations) has been reduced. The tax system – which in many developing countries itself requires reform – has not been able to provide the support required by the public schemes. Nor has there existed a strong framework for the collection of social security contributions. As a result there has been a marked decline, in many countries, in the quantity and quality of publicly provided health care, often accompanied by a deterioration in the services provided by the social security institutions.

However, from a policy point of view, what is more worrying is the strong suspicion that the existing systems of health care financing restrict the overall real resources available to health care. That is: if schemes were better, more comprehensive, and more coordinated, more would be spent on health care. The present components interact in a competitive rather than a complementary manner: there is no solidarity between them. There is a (sometimes costly) duplication of facilities and administrative costs; they compete on unequal terms for the same kinds of professional personnel, often to the benefit of providers' incomes (many of whom operate across all sectors of the pluralistic system) rather than resulting in an expansion of the resources and services provided; and they all employ the same (imported) technology which may be inappropriate (except for emergency services) and too expensive for the basic services provided by the universal public scheme. For want of both appropriate and/or efficiently managed financing mechanisms covering the whole of the population, demand which is incipient, even if at a low level, cannot be made effective.

Health expenditures are also lower than would be warranted by their value as an investment in human resources and hence in economic and social development. The existing mechanisms take little account of the externalities and general benefits which would accrue to the community as a whole from a higher level of expenditure on health. Developing countries are not merely disadvantaged by their low incomes: they allocate fewer resources to health than even their low incomes might lead one to expect and much less than they need to invest in a developing labour force. Nor do they appear to be catching up. There is little comprehensive statistical information on overall public and private national expenditure on health, but the limited data available show declining expenditures on health during the 1980s across a wide range of countries such as Bangladesh, Fiji, Indonesia, Mexico, Nigeria, Sri Lanka, Trinidad and Tobago and Zambia. Recent data show that out of a sample of 46 countries in all regions of the developing world, one-half reported declining government expenditure on health during the first half of the 1980s.[5]

[5] See for example ILO: *Health care under social security in Africa: Taking stock of experience* (Working document of the Social Security Department, Geneva, 1992).

In total, over the past decade or so, the ratio of health care expenditures to GDP declined, or at best stagnated, in many developing countries, during a period when economic growth was itself slow or negative.

There are other significant problems, most of them associated with the failure to generate the necessary resources.

Misallocation of resources

In addition to underfunding at an aggregate level, resources are often badly allocated. In the public system, fixed total budgets are met by reduced access, by reduced quality and availability of providers, by queuing, by rationing of various sorts, by patient copayments and sometimes by bribes. The level of service, when it is obtained, is often extremely poor, and the level of services in the regions outside the main centres are frequently minimal. Allocating health care in this way raises the question of whether the package of benefits provided is the one most appropriate to the constrained budget imposed on the public service or the one which yields the lowest cost/benefit ratio.

Similarly, the social security system faces many of the difficulties that have arisen in developed countries: benefit packages are frequently generous or open-ended, and provider reimbursement systems offer few incentives for the containment of costs, which are rising very rapidly. In a period of low economic growth and declining employment in the formal sector, recovery of contributions from employers and employees is difficult, and many social security institutions are unable to provide full coverage even to all the formal sector employees who came within their domain. These pressures within both the public health system and the social security system have to some extent been deflected towards the small, rapidly growing, but expensive private sectors of health care, with a resultant shift of qualified personnel and facilities towards the private sector and the service of wealthier clients who can pay. But within both the public system and the social security system, there are allocative inefficiencies which mean that providers are neither doing the right thing nor doing things right. There is an increasing concentration of resources on curative care, and within curative care on expensive hospital-based care. It is not uncommon for empty health centres to exist side-by-side with overcrowded hospital outpatient departments. The outpatient and inpatient delivery systems often select wrong priorities in opting for expensive high-technology treatments, and impose an inappropriate balance on staff and non-staff inputs. Substantial urban/rural differentials in access are often coupled with duplication of services which are owned by different financing systems.

Planning, management and administration

Issues of management and administration, and of the overall planning and supervision of the systems add to the difficulties.

Even the benefits that developing countries can finance are often not delivered at the time and place where they are needed; to a large extent, this is because the administrative and managerial skills needed to organize complex health care systems are lacking, or are subordinated to the technological effectiveness of specific medical objectives rather than for overall productive and allocative efficiencies. Medical services are sometimes provided without an adequate assessment of their value to the health of the patient. Operational units receive ill-defined mandates and the operational and financial efficiency of individual delivery units is neither monitored nor controlled. In many systems, operational failures mean that planned services do not become available. In others, these deficiencies are reflected in the high, often excessive, administrative costs of ministries of health or social security institutions, occasionally reaching levels which can only be explained as a misuse of contributors' funds.[6]

The distribution of benefits

As a consequence both of the inherent structure of the health care system and the pressure to which it has been subjected over the past several years, the distribution of health benefits across the population is extremely skewed: although some elements of solidarity and equity between insured persons do exist within the different health care sectors, the disparities between sectors are wide and reflect large differences in the income levels of their clientèle. The poor, who are numerous, are excluded from the social insurance schemes available to workers in the formal, modern sector. The subsidies which the public schemes obtain from public revenues are low in absolute terms and must be spread very thinly over the non-taxpaying, uninsured population. At the same time, the population which is confined to the informal sector, and which contains the poorest sections of the community, does not possess the institutional structures which would enable it to provide mutual support of its own, if only at a basic level.[7] In addition, the poor frequently lack the political weight or organization with which to press for a better financial endowment of the public system on which they rely. As they are constructed at present, the different components of the health financing structure reinforce rather than alleviate this disparity of treatment.

[6] See ILO (1992), op. cit. and W. McGreevey: *Social security in Latin America: Issues and options for the World Bank*, World Bank Discussion Paper No. 110 (Washington, DC, 1990).

[7] Although, of course, there is a great deal of informal support from the local community and from family members.

The supply side

Quite apart from the shortage of financial means, real human and physical resources for health care in developing countries are constrained, or a mismatch occurs between different types of resources. In many countries this applies to the overall availability of professionals – paramedicals, nurses, general practitioners, specialists – as well as to the supply of pharmaceuticals, ancillary technical and diagnostic services, and to infrastructure. In other countries the constraint is reflected in an imbalance between the various elements of health care provision: an excess supply of doctors and nurses in a context of scarce infrastructure or medicines. Moreover, these resources tend to be expensive and cannot rapidly be increased: training is frequently a lengthy process, often requiring overseas education; equipment, technology and the more advanced pharmaceuticals need to be imported and absorb scarce foreign exchange. On the other hand, budget cuts often lead to a disproportionate reduction in non-staff inputs, leaving medical professionals without sufficient materials and equipment. The shortages and high costs give rise to a number of problems.

Given these shortages and the excess demand pervading the system as a whole, the result tends to be cost increases substantially greater than the inflation affecting other goods and services. This tendency is aggravated not only by a dependence on imports (whose domestic cost may be increased by structural devaluations) but also by the ability of medical care providers to generate an increasing number of medical interventions, particularly in the situation where the social security (or other ad hoc) schemes restrict themselves to providing third-party finance.

In the private sector, increased costs can be passed on, and the social security component has the option, within limits, of increasing contribution rates. But limited by fixed budgets, the public sector is unable to respond to these pressures and, as a result, resources are drawn away from the public service (either directly or in the form of price or wage increases which cannot be accommodated). Quality then deteriorates, queues develop, and infrastructure is not renewed or expanded.

Emerging from these overall pressures is the question (one not fully tackled in most developing countries) of whether technologies and/or benefit packages should be adapted to correspond to the different sectors of the health care system. For it is an open question whether a lower level of technology but one providing immediate access is preferable to a more advanced technology with often only marginally better benefits for which rationing and queuing are required and which leaves the way open to demands for patient copayments, sometimes of an irregular nature. But this possibility would require a restructuring not only of financing mechanisms but also of provider arrangements and a more careful definition of the benefit packages which could be provided under the different schemes.

The constraints

Developing countries face a set of constraints very different from those confronting developed countries. These occur mostly because of the dual nature of their economies, of weaknesses in public administration and management, of a lack of overall planning mechanisms and, against a background of a wide range of incomes, of the difficulties of obtaining from middle- and upper-income earners the subsidies needed for the health care services of lower-income earners and the poor.

A prominent feature of the labour force in developing countries is its division into workers employed in the formal and the informal sectors of the economy. Workers in the formal, modern sector earn regular wages or salaries, possess greater stability of employment and income, and have earnings which can be monitored and assessed for the purposes both of paying taxes and of contributing to (usually mandatory) social security schemes. The remainder of the workers in the active workforce are typically engaged on their own account in small urban activities or services or in small-scale farming or rural activities, and are typically underemployed and much poorer. Where wages are earned, employment tends to be precarious, intermittent or seasonal. The proportion of the active labour force in the informal sector varies substantially between countries and between regions. In Latin America, it generally comprises between 40 and 60 per cent of the active labour force. In Asia, the proportion is much more variable, but may be very high. For Africa as a whole, the informal sector (both urban and rural) comprises around 90 per cent of the active population. The size of the informal sector is an important parameter in establishing the scope of the tax system, the size of the tax base, and the number of workers (and their employers) who can be brought within the scope of formal social security schemes.

As far as the tax structure is concerned, precisely because of limitations concerning the size of the modern, formal sector, personal income tax plays a smaller part in total public revenues than is the case in those developed countries where the very great majority of the active labour force has a regular job and where the distribution of earnings is less widespread. In developing countries greater reliance is placed on indirect taxes (especially import duties) and on company taxes although, again, the latter are limited by the size of the modern sector.[8] The revenues available for social expenditures in general, and for health care in particular, are also constrained by the need to provide for other functions of government (including, in some cases, relatively large military expenditures), and by the need in many developing countries to undertake measures of economic stabilization and structural adjustment. The latter usually imply a reduction in fiscal deficits, an

[8] Although in many developing countries, the ratio of total public expenditures to GDP is high, and includes substantial outlays and subsidies on state-run industries which in other countries would be privately owned.

opening of the economy (often accompanied by structural devaluations) and a winding-down of government involvement in and subsidization of parastatal organizations. Such measures are frequently accompanied by reduced employment in the formal sector, both public and private, which further narrows taxable capacity, whilst simultaneously increasing pressures for social expenditure on other priorities, notably the establishment of social safety nets and anti-poverty measures. There are many cases where the absolute size of the formal sector has shrunk. As a result of these various developments, in a number of developing countries the public resources available for social expenditures have declined over the past decade or so.

Similar problems affect the basis for social security contributions and the potential coverage of social security schemes. Although in theory it is possible to envisage an extension of social security schemes to organizations outside the formal sector – to cooperatives, local communities, trade, cultural or religious organizations which are sufficiently tightly knit to provide the necessary framework – in practice, it is the size of the formal sector which places limits on the coverage of the social security schemes and hence on the basis of record-keeping, compliance, earnings and entitlements necessary for the schemes to function efficiently.

Even within the framework of the formal sector, however, health care coverage is by no means complete. The administration of social security schemes is a complex business and relies on accurate reporting on the part of employers concerning the number of workers engaged, their earnings, their age and family status and other data affecting their entitlements. It is necessary to enforce the collection of contributions from all employers and workers who are liable to pay them and, at the same time, to ensure prompt and efficient disbursement of benefits to those entitled. The social security institutions need to minimize their own transactions and administrative costs, and to make sure that the schemes' funds are so managed that the maximum revenue is raised to support the payment of benefits.

The administration of social security schemes in many developing countries is greatly deficient in many of these respects, to the extent that their scope and effectiveness fall far short of full coverage of the formal sector. Revenues are lower than they should be: not all benefits due are in fact paid; and both collection of revenue and payment of benefits are frequently subject to long delays. Administrative charges are a high proportion of contributions. The management of financial reserves is frequently impeded by the absence of developed financial markets and investment opportunities. And reserves are eroded by high rates of inflation, by prevailing real interest rates which (in some countries) are negative, and sometimes by direct government appropriation of the reserves. The personnel of social security institutions frequently lack both the necessary training and incentives and/or the support of essential computer technology.

In addition to these operational problems, there is often an absence of the overall planning which might provide effective supervision of the

relationship between financing agencies and health care providers (whether these are in fact operated by the social security institution itself or as part of a more arms-length arrangement with private doctors and hospitals). As previously indicated, the planning function needs not only to span the social security component of health care financing, but also to supervise and coordinate health care (and health care professionals) deriving from both the private and the public sector.

Finally, there is the question of cross-subsidization between the various components of the pluralistic system and, by implication, between the different social and income groups associated with each of the three layers. Few developing countries possess the social consensus necessary to impose upon formal sector workers and employers, and upon taxpayers generally, the levies which would be necessary to provide a more or less uniform quality of health care service to all members of the population, whether or not they contribute to social security or pay taxes. The formal sector is simply too small. The rate of tax or contribution which would be necessary to achieve such universal provision would be too high: the more so the larger the informal, non-contributing sector; and the more so the distribution of income is skewed towards upper incomes. Some degree of solidarity can be relied upon. But too great a reliance places strains on the implied solidarity and provokes pressures from the higher-income groups for fragmented systems which enable them to opt out of the general scheme in favour of schemes which relate the level and quality of delivery more closely to incomes and contributions. Members of the formal labour force and other well-off groups will always find ways of buying better care than that available to low-income groups, and they cannot be denied the right to do so; even if (as is sometimes the case) this means that they pay contributions but also choose to use private insurance and private facilities.

The willingness to redistribute benefits from the rich to the poor depends upon cultural, social and, especially, political factors as well as on economic ones. This is not necessarily a binding constraint on policy, but the small numbers of rich people and the very large numbers of poor people imply that there is a limit to how far health care policies can achieve a more uniform distribution of benefits. Some disparity of treatment between the health care sectors has to be accepted as part of reality.

The cornerstones of strategy

The juxtaposition of the concerns outlined at the beginning of this article and of the constraints identified in the previous section raises the question of which strategies may be pursued in order to improve both the overall allocation of resources to health care in developing countries and their distribution to all sections of the population. The policies to be adopted will obviously depend upon the particular circumstances of the country

concerned, its background, possibilities, and its aspirations for the future. But in general there seem to be four main approaches to these problems and constraints. They arise from the need to increase the aggregate resources directed towards the health care sector as a whole; the need to develop strong vehicles of solidarity, cooperation and mutual support between the three main components of the present pluralistic structure; the need to develop a strong supervisory body which not only would coordinate and regulate the main financing mechanisms, but would also provide and control acceptable (i.e. effective but not excessive) incentive structures to health care providers; and last, but by no means least, the need to improve the management and administrative efficiency of the three financing components and their relationship with suppliers.

Increasing resources

More money for the health care system can come from three main sources only: greater allocations from central budgets; higher social security contributions; greater co-payments from clients. Each offers some possibilities and each is associated with certain difficulties.

In the first place, the possibility of increasing budgetary resources should not be rejected as a matter of course. In a number of developing countries a return to better rates of economic growth, even if still modest, should permit some increase. Where public revenues can be increased, their dedication to higher levels of health expenditure is likely to gain greater support than some other public outlays. Expenditure on health care should be given the higher priority it deserves, not only in receiving a larger share of any increased budget, but also by being better protected against cuts.

But the limits are well recognized. Even with the best of intentions, many governments are not in a position to allocate more resources to health care and many governments are also anxious to shift some social expenditure obligations off budget.

In effect, this means the social security component must be strengthened in terms of its capacity to collect contributions, of widening its field of action to include as much as possible of the formal sector and beyond, and of how effectively it can deliver enhanced benefits to insured participants. Where comprehensive social security schemes do not already exist for the formal sector, a rationalization of existing ad hoc schemes into a single unified structure may be required.

It may also mean regulating, and allowing room for, the development of private health care services for those who can afford them. Further, it may mean taking another look at the (usually fairly modest) co-payments which might be required from patients, their incidence (particularly on lower income groups), how far they can be regarded as a revenue-raising mechanism, and how far they may act to restrain excessive utilization and cost increases, notably in situations of third-party financing. But in the

context of low-income developing countries, co-payments are a weak financial and allocative mechanism.

Solidarity and cooperation within the pluralistic structure

It is not likely that success along such lines in improving the overall level of health care resources will be compatible with their efficient or equitable distribution unless express measures to ensure greater cooperation and solidarity between the various tiers of health care financing and delivery are also introduced.

In such a scenario, the most important feature would be the assistance which the social security and private sector can offer to the public schemes, both in kind and as direct cooperation. This could include sharing facilities, partial secondment of personnel, cooperation in negotiating the purchase of imported equipment and pharmaceuticals, coordination on the remuneration of professionals, avoiding the duplication of facilities, sharing certain infrastructure elements and, perhaps, some sharing of administrative costs.

The aim of such cross-sector assistance would be to provide the public sector with at least partial access, and cheaply, to the more expensive facilities and skills available in the social security and private sectors, and then to allow it to concentrate on what it does best: the provision of fundamental, not necessarily high-technology, primary care to the large, low-income section of the population in the informal sector. In part, such reinforcement could be provided without additional aggregate resources, through a more economical use of those which already exist. But in part it would also reflect direct support in kind from the upper two tiers to the lower one – an increase in solidarity which would need to be presented as such. Hopefully, it would also pave the way for the convergence of the three sectors at some point in the future.

More resources for everyone and a greater willingness to cooperate between the three tiers would result in an overall situation in which all health care beneficiaries could be better off and in which no one would be worse off, at least as far as the health care sector is concerned. But realistically this does not mean equality of treatment irrespective of ability to pay. The benefit packages corresponding to each of the three tiers would have to be defined: the benefit structure associated with the public system would still be less than that associated with the social security component, which in turn would be less open-ended than that available in the private sector. Defining the limitations would be an important exercise, during which differences in the quality, quantity and nature of treatment between the three tiers would need to be recognized. But disparities would be reduced.

Planning, supervision and coordination

Both the push for more resources and the development of a cooperative pluralistic system would require a strong planning and supervisory body, independent of all the three main tiers, with responsibility for directing the health care system as a whole, including health care providers and the financing agencies. Supervision would require the appropriate powers to achieve a better allocation of resources between the sectors and, if necessary, to enforce cooperation and greater solidarity. But without such an overarching body at a central level, the separate components of the system are likely to pursue separate and isolated paths which risk a mutual crowding-out in the competition for resources. The mandate for such a supervisory body might include, inter alia:

- pressing for health care resources at a national level;
- ensuring the coordination and cooperation of the separate components of the three-tier system, and where applicable, their mutual financial support;
- auditing – in the widest sense – the efficient operation of the various components;
- creating a regulatory framework to supervise and manage the supply of professionals, equipment and pharmaceuticals across all three components, and to monitor their costs;
- planning in a coherent way for the future evolution of the health care system as a whole, in particular to improve the distribution of health care benefits so that they are more responsive to needs.

Since ministries of finance, of health and often of labour are interested parties (through their involvement in the public health system), such a body would need to be quasi-independent of government and to reflect the broad spectrum of all interest groups within the community. Complete independence is, of course, a logical impossibility. But partial independence, coupled with a tripartite governing structure, would distance the overall management of the health care system from some of the day-to-day political pressures and at the same time give such a body planning capacity for the health care system as a whole.

Management and administration

Finally, whatever structures are to be developed in the future, the reform of management and administration, both of the social security institutions and of the public health service, is a prerequisite. Neither the existing structure nor any improved version are viable without a competent, corruption-free, level of governance.

Conclusion

In this brief article, we have sought to make three major points.

Firstly, most developing countries currently possess a mixed structure of health care financing which:

- is not working properly;
- is substantially underfunded;
- is inefficient, partly because of a lack of coordination between the three tiers.

Secondly, a number of inherent constraints preclude any movement towards a generalized, and uniform health care structure for the community as a whole. It is necessary to accept that, for the foreseeable future, a second-best situation will comprise three separate tiers providing different levels of quality and service.

Thirdly, many of the deficiencies of the present structure could be overcome:

- by improvements in the management and administration of social security and health care systems;
- by the allocation of greater resources to health care;
- by strengthening *both* the public *and* the social security systems of health care, and by leaving space for the development of a regulated private health care sector;
- by insisting on greater solidarity and cooperation between the three components;
- by establishing an independent planning and supervisory body at a national level, charged with ensuring the coordination, regulation and supervision of the different actors, both financing agencies and health care providers.

The ILO, in both its technical and normative activities, can do much to promote developments along these lines. None of these measures appears entirely beyond the reach of most developing countries and their combined implementation, even if politically difficult and protracted, offers the potential for substantial improvements in the level, coverage and quality of health care available to all sections of the population.