

The need for equity-oriented health sector reforms

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To many, the expression 'health system reform' brings to mind a particular set of measures widely adopted during the 1990s in order to deal with a particular problem: increased reliance on private sector institutions and operating procedures in order to improve efficiency. But in principle, the expression 'health system reform' is a general one, applied to a broad range of policy measures designed to deal with an equally broad range of problems. According to one standard definition, for example, health sector reform can be defined as 'sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector.'¹

Adoption of a broader definition provides an opportunity to move beyond the current narrow debate over whether the particular reform measures of the past have helped or harmed the poor, to a broader look at the reform measures required to benefit the poor in the future. Such a look is badly needed. For a rapidly-growing body of evidence points to large differences between the poor and better-off not only with respect to health status and the use of private health services, but also with respect to the use of government services, including services widely promoted because of their anticipated relevance for the poor.

This evidence points to a clear need for a new wave of major equity-oriented health sector reforms, conceived and executed with even more passion and determination than the efficiency-directed reforms of the 1990s. The objective: to increase the efficiency and effectiveness with which health systems reach the poor and disadvantaged, thereby alleviating current inequities in health service use and contributing to lessened differences in health status.

The passages that follow will seek to stimulate further thought about how to achieve such reforms by presenting three arguments. The first is that significant reforms will require changes that are far deeper than commonly recognized in policy circles. The second is that current movement toward debt relief in poor countries is creating a climate potentially more favourable to such deeper changes than the climate of the recent past. The third is that epidemiological and health systems researchers can best help equity-oriented health policy makers take advantage of the present climate by developing an evidence base concerning intervention options for reaching the poor effectively.

The need for deeper reforms

The depth of the reforms needed in order to improve health equity can be seen by considering the record of earlier equity-oriented health initiatives started during the late 1970s and early 1980s. This was a period dominated by a concern for the global poor, as manifested in such highly-publicized events as the 'health for all' movement growing out of the

WHO-UNICEF 1978 Alma-Ata Conference,² and the UNICEF 'Child Survival Revolution' begun in 1982.³ Among other things, such events gave rise to determined efforts by WHO to extend the use of primary health care; and by UNICEF to promote growth monitoring, oral rehydration, breastfeeding, and immunization —a package of procedures that became known under the acronym 'GOBI'.

How well did these vigorously-promoted initiatives succeed in reaching the poor? It is not possible arrive at any fully satisfying conclusion. However, recent research on poor-rich disparities in health service use provides strong hints about the situation that currently prevails with respect to three of the five measures just mentioned: primary health care, oral rehydration, and immunizations.

The information about primary care comes from a recent series of studies in the 'benefit-incidence' tradition, which assesses the distribution across social class of the financial benefits from different types of government expenditures. Approximately two dozen known benefit-incidence studies of government health spending have been carried out, the majority under the auspices of the World Bank, where the tradition originated. The most informative is a set of studies covering seven African countries.⁴ Table 1 presents summary figures.

In those countries on the table for which recent data are available, income or consumption in the top 20% of the population is from five to twenty times as high as in the poorest 20%.⁵ Yet notwithstanding the frequent invocation of equity as a justification for government involvement in health service delivery, the government health service expenditures covered in the table generally reinforce rather than counterbalance those income/consumption inequalities.

That is, the government expenditures tend to benefit Africa's richest people more than its poorest in absolute terms. On average, the highest 20% of the population receives well over twice as much financial benefit as the lowest 20% from overall government health service spending (30% versus 12% of total benefit). For primary care, the poor-rich benefit ratio is notably lower (23% versus 15%), suggesting that, from an equity perspective, the move toward primary care represents a clear step in the right direction. But since the highest group receives half again as large a financial benefit as the lowest even from primary care, it would be difficult to judge the size of the step as more than modest. Elsewhere in the developing world, the situation is not quite so stark; but in no known country study produced to date does the poorest 20% of the population receive as much as 25% of the financial benefit from government expenditures.

There are, to be sure, numerous methodological limitations to be considered before arriving at any definitive assessment of such

Table 1 Percentage of total financial benefits from government health

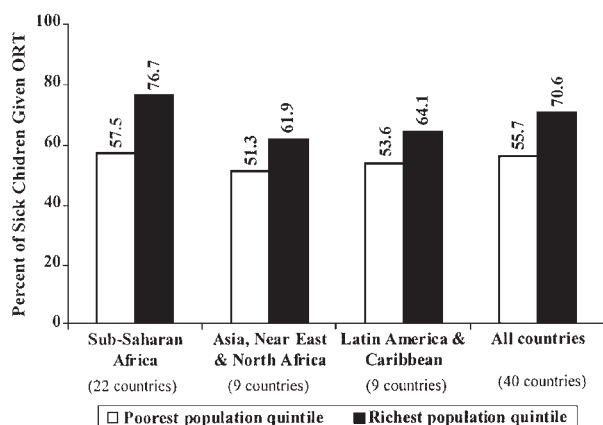
Country	Care expenditures accruing to the poorest and richest population quintiles			
	Primary Care		Total Care	
	Percentage of Benefit of Gained by:		Percentage of Benefit of Gained by:	
	Poorest Population Quintile	Richest Population Quintile	Poorest Population Quintile	Richest Population Quintile
Côte d'Ivoire (1995)	14	22	11	32
Ghana (1992)	10	31	12	33
Guinea (1994)	10	36	4	48
Kenya (Rural – 1992)	22	14	14	24
Madagascar (1993)	10	29	12	30
Tanzania (1992–93)	18	21	17	29
South Africa (1994)	18	10	16	17
Unweighted Average	15	23	12	30

Source: Castro-Leal F, Dayton J, Demery L and Mehra K. Public spending on healthcare in Africa: Do the poor benefit? *Bull WHO* 2000;**78**(January):70.

benefit-incidence figures.⁶ Yet, even after these have been taken fully into account, it is difficult to reconcile a finding that primary care confers greater benefit on the richest 20% than on the poorest 20% of many countries' populations with the vision that motivated the authors of the Alma Ata Declaration.

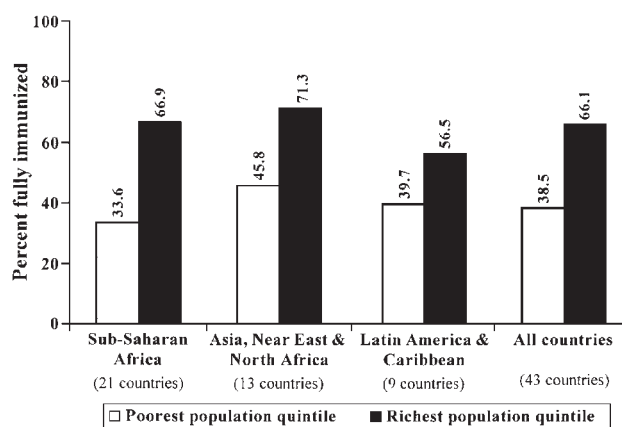
Similar data about oral rehydration and immunization have recently become available through a series of studies based on comparable household data from 44 countries of Africa, Asia, and Latin America.⁷ These studies, commissioned by the World Bank, provide the values of approximately 30 health, nutrition, and population indicators for each socio-economic quintile of the population. The oral rehydration and immunization findings are summarized in Figures 1 and 2.

Of the two, the record of oral rehydration therapy is the more impressive from a poverty perspective. In all major parts of the world, around one-half all cases of diarrhoea among children in the poorest 20% of families had been treated with some kind of oral liquid regime. Given the difficulty of reaching such poor families, this is a noteworthy achievement for a technology that

**Figure 1** Use of oral rehydration therapy by poor and rich in developing countries

Percentage of children under three, four, or five years (depending upon the country) reported ill with diarrhoea who were given oral rehydration salts, recommended fluids, or increased liquids.

Source: Demographic and Health Surveys.

**Figure 2** Full immunization rates among poor and rich in developing countries

Full immunization refers to the percent of living children 12–23 months who had received BCG, 3 doses each of DPT & OPV and measles vaccination by the time of the survey.

Source: Demographic and Health Surveys.

had existed for only around 20 years at the time the data were collected. Yet even in this case of a technology developed with the needs of the poor particularly in mind, the uptake has been greater among the upper classes, with rates of use typically running 10–20 percentage points higher in the highest quintile than in the lowest. And while half of the poor have been served, half have not; and there is no clear indication that they will be in the foreseeable future.

A look at the immunization data is less encouraging. Although the available data are far from ideal, they leave little basis for doubt that immunizeable diseases are clustered primarily among the poor. Yet immunization programmes are not reaching the poor nearly so well as they are the better-off. On average, immunization coverage in a developing country's poorest 20% is around 35–40%, only a bit more than half of what it is among the average country's richest 20%, meaning that the poor benefit far less even after taking into account the indirect benefits that can accrue to the poor from immunizations in other groups.

Whether the glass portrayed in the preceding paragraphs is half full or half empty unavoidably depends on one's perspective. From the perspective of this observer, it seems undeniable that the poor have benefited significantly from the innovations described and the many others like them that were also introduced during the late 1970s and early 1980s. Yet it would be equally difficult to deny that the benefit has been modest relative to the total burden of ill health among the neediest; and, as suggested by the data presented, also smaller than the benefit that the innovations have brought to the not-so-needy.

This is not to say that the innovations were misguided. While they may have not reached the poor nearly so well as their proponents appear to have anticipated, they also seem to have proven notably more 'pro-poor' than the earlier types of health services from which they parted company. If so, the innovations can be defended as representing a start in the right direction. But with the benefit of hindsight, it is clear that they were no more than a start. In themselves, they have not been nearly enough to overcome the challenges of reaching the poor effectively, challenges that the experience described above has shown to be far greater than previously expected.

Bringing about deeper reforms

If one accepts the proposition just put forward, it follows that any truly effective effort to reach the poor effectively with the services that they need will require a much sharper break from the past than is generally appreciated. The need is not simply for the vigorous promotion of a package of attractive services laid alongside a health system as it is currently structured, but rather for a much more basic change in the orientation of the system as a whole: in other words, a major health sector reform.

This is admittedly much easier to advocate in the abstract than to bring about in practice. But recent months have seen a development that, if effectively exploited, might represent a beginning in this direction: the drive to reduce the external debt in many poor countries.

A central component of this drive has been the production of poverty alleviation strategies by increasing numbers of developing country governments. These strategies, incorporated in formal documents known as 'poverty reduction strategy papers' (PRSP), have as their long-term broad objective the provision of guidance for overall government development initiatives. The immediate, short-term goal on the part of the first governments engaged in the PRSP exercise is to obtain debt relief.

These governments are of the 41 countries that are poor and indebted enough to be eligible for partial debt relief under the IMF-World Bank HIPC (Highly Indebted Poor Country) initiative.⁸ Under this initiative, actively promoted by a consortium of non-governmental agencies, an eligible country qualifies for debt relief upon the provision of assurance that the resulting increase in uncommitted government funds will go for activities to benefit the poor. The preparation of a PRSP is the way in which a government provides such assurance. The PRSP preparation process got under way in late 1999 and increased in momentum as 2000 progressed. As of March 2001 four countries had completed full PRSP; an additional 31 had finished interim PRSP;⁹ and plans were under development to extend the PRSP process to all 78 countries qualifying for

subsidized lending through the World Bank's International Development Association (IDA).

As of that same date (March 2001), the World Bank and IMF had agreed to an estimated \$20 billion (in net present value terms) of debt forgiveness to 21 of the first 35 countries completing full or interim PRSP. Health ministries have frequently been active participants in the PRSP process, and approximately a quarter of the funds released through the HIPC/PRSP process—around \$5 billion—are believed to have gone for health programmes.¹⁰ The majority of these health funds had been allocated for augmented programmes of the sort that first came to prominence during the late 1970s and early 1980s, and that were described in the preceding section: primary care, immunizations, maternal and child health, and the like.

In the light of the foregoing discussion of the limitations of such programmes in reaching the poor, it is clear that they represent measures that, while useful, are far from enough to constitute the major reform required. Thus, the principal reason for interest in the measures lies less in the benefits that they themselves will bring, than in the indication they provide of a welcome break from the past decade of inattention to the needs of disadvantaged groups. The measures thus indicate the existence of a potential opening, an opportunity to work for more fundamental reforms by strengthening, deepening, and extending the process that debt relief movement and preparation of PRSP has set in motion. The question is whether the measures will be taken as such and thus serve as the beginning for a series of major changes, or whether the process will stop at efforts to implement the measures as currently put forth and thus end up producing progress that is modest at best.

The role of evidence

Given the central role of domestic political considerations in any major health sector reform, the political and policy leaders of the countries concerned will necessarily play the principal roles in answering the question just posed. But there are also important supporting roles for many others. One such role, for which the epidemiological and health systems research communities are especially well qualified, is the development of a reliable evidence base concerning available intervention options.

This is a notable missing element in the work recently undertaken by epidemiologists and other researchers increasingly concerned with health equity and the health of the poor. The work to date has produced significant increases in knowledge about the magnitude and nature of health inequalities, and has resulted in valuable conceptual frameworks for approaching these issues. But it has not yet reached the heart of the matter: the identification of measures that can effectively deal with the inequalities that have been uncovered.

The identification of such measures constitutes the next frontier for epidemiological and health systems research related to health equity and the health of the poor. In the words of the participants in a recent consultation organized by the Rockefeller Foundation in collaboration with the World Bank, the principal health equity research need is 'to shift the present static emphasis on measurement and analysis of health inequities toward dynamic **identification and evaluation of**

policy measures that can effectively bring about greater equity.' (emphasis from the original).¹¹

Particularly pressing are solid empirical assessments of how well existing health and development initiatives reach the poor and further knowledge about what needs to be done for them to work better; and field experimentation with promising new approaches. And these are needed quickly, to take advantage of the current momentum for poverty alleviation represented by the debt relief movement. Unless and until such approaches are available, developing country governments wishing to orient their health programmes more toward the poor have no choice but to continue looking to the imperfect record of the past for programme ideas. And the poor will continue to be poorly served as a result.

Disclaimer. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author. They do not necessarily represent the view of the World Bank, its Executive Directors, or the countries they represent.

References

¹ Berman PA (ed.). *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Boston: Harvard School of Public Health, 1995, p.15.

² World Health Organization. *Primary Health Care: Report of the International Conference on Primary Health Care*. Alma-Ata, USSR, 6–12 September 1978. Geneva: World Health Organization, 1978.

³ Grant JP, Executive Director of the United Nations Children's Fund (UNICEF). *The State of the World's Children*. 1982–1983 New York: Oxford University Press, 1982.

⁴ Castro-Leal F, Dayton J, Demery L and Mehra K. Public Spending on Health Care in Africa: Do the Poor Benefit? *Bull WHO* 2000;**78 (January):**66–74.

⁵ World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington: The World Bank, 2000, pp.282–83.

⁶ *Ibid.*

⁷ Gwatkin DR, Rutstein S, Johnson K, Pande R and Wagstaff A. *Socio-economic differences in health, nutrition, and population*. Washington: Health, Nutrition, and Population Department of the World Bank, 2000 (also available at: www.worldbank.org/poverty/health/data/index.htm.)

⁸ www.worldbank.org/hipc/about/hipcbr/hipcbr.htm

⁹ www.worldbank.org/prsp/

¹⁰ HIPC Unit, The World Bank. *Financial Impact of the HIPC Initiative: First 22 Country Cases*. March 1, 2001 (www.worldbank.org/hipc/hipc-review/hipc-review.html).

¹¹ *Current Activities and Future Directions in Health Equity: A Consultation with NGOs, Researchers, Foundations, and Bilaterals*, 23–24 June 1999 (mimeographed, the Rockefeller Foundation, 1999).