

## Health sector reform and equity – learning from evidence?

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### Background

Two landmark events in 1993 provided guidance to many of the health sector reforms staged during the 1990s. The first was the publication of the *World Development Report 1993* in June and the second was the *International Conference on Health Sector Reform: Issues for the 1990s* in September. The World Development Report proposed a three-pronged approach to government policies for improving health in developing countries: (1) *foster an environment that enables households to improve health*, this was to include growth policies that would benefit the poor and, where necessary, adjustment policies to preserve cost-effective health expenditures; (2) *improve government spending on health*, targeting allocative and technical efficiency; and (3) *promote diversity and competition*, suggesting a reduced role of the state in health service financing and provision, and greater reliance on market mechanisms to increase efficiency of the sector (World Bank 1993). The Conference questioned some of the assumptions of the World Development Report, in particular with respect to implementation. It came up with a policy analysis framework, consisting of four levels: (1) *Systemic*, with the main objective being equity; (2) *Programmatic*, with the main objective being allocational efficiency; (3) *Organizational*, with the main objective being technical efficiency; and (4) *Instrumental*, with the main objective being institutional intelligence for performance enhancement (Berman 1995). While there was no direct conflict between these two sets of objectives, the Conference emphasized the moral concept 'equity' at the systemic level, while, in the World Development Report, equity was not an explicit concern. According to the report, government health services should concentrate their resources on public goods and services with large externalities, providing cost-effective health services to the poor, and on compensating for uncertainty and insurance market failures.

During the following years, there was growing concern that the efficiency-driven health reforms being implemented in many poor countries, reducing the direct role of the state and increasing the use of market-like mechanisms in health care provision, would lead to decreased social justice and fairness. A number of activities were started to address these concerns, including the WHO-SIDA equity initiative (WHO 1996, 1998), and funding from the Government of Norway for the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) to manage a research portfolio on health sector reform including equity, of which this issue of *Health Policy*

and *Planning* is a component. A World Bank guide from 1999, further, mentions 12 other ongoing international programmes addressing equity and health sector reform (Carr et al. 1999).

Inequities are inequalities that are judged to be unfair, i.e. both unacceptable and avoidable (Whitehead 1992). Equity in health care means that health care resources are allocated according to need, health services are received according to need and payment for health services is made according to ability to pay. It implies a commitment to ensuring high standards of real (not only theoretical) access, quality and acceptability in health services for all (Braveman 1998).

### Current status of equity and equity research

So, did the reforms enacted in the 1990s improve access to services for the poor and vulnerable and increase equity? Looking at the findings from the research reported on in this supplement, the answer appears to be no. The choices and access to services for those who can pay increased, while for the poor, choices and access decreased. The mechanisms that were supposed to protect the poor and vulnerable did not work as intended, at least in the instances examined here.

In a recent article, Davidson R Gwatkin of the World Bank calls for a new wave of health sector reforms that are equity-oriented, and conceived and executed with even more passion and determination than the efficiency-directed reforms of the 1990s (Gwatkin 2001). He presents three arguments to support his call:

- Significant reforms will require changes that are far deeper than commonly recognized in policy circles.
- Current movement toward debt relief in poor countries is creating a climate that is potentially more favourable to deeper change than was the climate of the recent past.
- Epidemiologists 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.

Gwatkin further states that, although researchers have contributed valuable conceptual frameworks for approaching these issues, they have not yet reached the heart of the matter, namely the identification of measures that can deal effectively with the inequalities that have been uncovered.

**Table 1.** Hits in PubMed, searching on 'health care reform' and key words 'equity', 'equality', or 'fairness'

Year	Health care reform [MeSH] (1)	Equity AND (1) (2)	Equality AND (1) (3)	Fairness AND (1) (4)	(1) AND {(2) OR (3) OR (4)} (5)	(5) in % of (1) (6)
1990	19	0	0	0	0	–
1991	74	0	0	0	0	–
1992	260	3	0	2	4	1.5%
1993	1 531	7	3	0	10	0.7%
1994	3 641	20	4	6	30	0.8%
1995	2 016	21	1	2	24	1.2%
1996	1 470	20	1	3	24	1.6%
1997	1 167	18	3	1	21	1.8%
1998	1 063	19	0	1	20	1.9%
1999	809	12	0	2	13	1.6%
2000	727	26	0	6	29	4.0%
2001	554	19	3	1	23	4.2%
2002*	166	6	1	1	7	4.2%
Total	13 497	171	16	25	205	1.5%

\* up to 19 July 2002.

Using the PubMed database to search for 'health care reform' yields an impressive number of hits. From 1990 to mid-July 2002, almost 13 500 articles are identified (Table 1). However, looking into the details reveals a far less impressive pattern. Almost two-thirds of this research was published during the 4 years from 1993 to 1996. Assuming that it takes at least 1 year to publish results, this means that most findings date from before 1993/94. Given that the health sector reform process was only getting started by then, it is hard to believe such numbers of significant lessons on large-scale reforms could possibly have been drawn from experience. Furthermore, if the current trend continues, it is likely that in 2002 the number of such articles will have fallen to a level comparable with that of 1992. It seems as if the academic community lost interest in writing about health sector reform at about the same time that it became possible to study its results.

Equally disturbing is the fact that only 1.5% of all the research indexed by PubMed under the 'health care reform' heading is also addressing equity, equality or fairness. The number of such articles has remained fairly stable at about 25 per year since 1994. This is a disappointing number, given the emphasis on equity expressed at the health sector conference in 1993 and the concerns raised during the second half of the 1990s. In fact, Dr Gwatkin could, if he so wished, gather all the authors, whose publications are captured in PubMed under this topic during a whole year in one small classroom.

Several reasons might be proposed to explain these patterns and the low number of indexed articles related to health reform and equity. One explanation would relate to methodological difficulties. Research on equity often requires involvement of researchers from multiple disciplines. Assembling such teams can in itself be difficult. Because of the mix of methodologies, results might be difficult to publish in established peer-reviewed journals.

Another explanation could be that funding for such research is not available. This, in turn, could relate to the fact that the drive for health reforms is largely political and ideological and that research on equity might challenge the very base of many reforms. A simpler explanation could be fashion. The peak of indexed articles coincided with the heyday of health sector reforms, which built on the assumption that increasing the efficiency of a country's health system would automatically improve the health of its population. Since then, the pendulum has swung again. The world has since witnessed a mushrooming of dedicated initiatives designed to reduce mortality and morbidity disease by disease, thus possibly reducing funding for and removing the limelight from health sector reform research.

### About this supplement

Although TDR is defined by its name on a disease basis, it is committed through its Strategy 2000–2005, on a much broader basis, to developing solutions to public health problems, with the end-users being poor and marginalized populations in disease endemic countries who do not have access to appropriate and cost-effective means to prevent and treat their neglected infectious diseases. The articles in this supplemental issue of *Health Policy and Planning* all result from research guided by the TDR Steering Committee on Social, Economic and Behavioural Research (SEB). The articles span a broad range of geography and methodology. The different approaches taken by these studies illustrate the complexity of the concept of equity and the many aspects that it encompasses.

One way to conceptualize health equity is the burden of paying for health care as measured through summary economic statistics, such as the Kakwani index. Castano et al. used a series of national household surveys spanning a 13-year period to examine whether major reforms in health

care financing in Columbia have improved equity in out-of-pocket expenditures for health care. They found relatively little change in the Kakwani index over this period, despite a new system that supposedly provides free health insurance for the poor. Valdivia also applied econometric analytic techniques to national survey data but examined a different issue: equity in outpatient care utilization. Not surprisingly, he found a substantial gap in service utilization between the richest and poorest quintiles of the population. While he did find statistically significant evidence that Peru's substantial recent investment in expanding and improving the public clinic system has had a positive impact on equity, the magnitude of that impact was disappointingly small. Building more clinics seems to be helpful but by no means sufficient to improve equity in health care utilization.

Gao et al. also used national household survey data in China and combined this with mortality data to examine trends in health equity in China. They focused on two aspects of equity: the differences between urban and rural populations in China's rapidly changing economic environment, and within these populations the difference between income levels. They found that mortality rates have been falling in both urban and rural areas. But the fall has been faster in urban areas, with the gap between the two consequently rising. The volume of health care utilization, on the other hand, has fallen in both urban and rural areas, due largely to increasing costs and the breakdown of insurance systems. For utilization, the drop has been greater in the cities, thus tending to narrow the gap with rural areas.

The other study in this issue that used large data sets examined a different sort of question. How should we define and identify geographic areas of need and deprivation? Using data for magisterial districts in South Africa, McIntyre et al. argue that definitions of health need based solely on income are inadequate. They propose broader indices that include rurality, adequate water supply and sanitation, educational level, and age distribution of the population. They point out that incorporating these elements would result in a substantial change in the distribution of government health care resources.

The use of surveys in equity research is not limited to secondary analysis of large existing data bases. Two of the studies in this issue report on surveys that the authors themselves conducted of different types of health care providers. Chabikuli et al. surveyed general practitioners in South Africa to examine how they treat sexually transmitted disease (STD) patients, with an emphasis on differences in how the physicians report that they would treat rich and poor patients presenting with the same symptoms. Their study revealed a disappointing lack of knowledge of proper STD treatment that affected treatment of rich and poor patients alike. Regarding equity, they found that doctors tended to prescribe less expensive and less convenient (though not necessarily less effective) treatment regimens to poor patients.

Zhan et al. combined quantitative structured interviews with medical record review and in-depth individual and small group interviews to examine prenatal care and outcome for

the growing population of internal migrants in Shanghai, China. They identify a combination of economic and social barriers that result in inadequate prenatal care and poorer pregnancy outcome for these women than for permanent residents of Shanghai. We see in this article, as well as the others that follow, how a combination of research methods can paint a fuller picture of the phenomenon of interest than any one method alone. This is especially true when the goal is not only to examine quantitative measures of 'How much?' but to also gain insight into 'Why?'.

The combination of qualitative and quantitative methods lends itself well to the case study approach, in which a few institutions or areas are studied in detail to gain a clearer picture of how a particular policy is working at ground level. Though results may not necessarily be generalizable in the statistical sense, they can often produce insights that tell more about how national policies are working than examining reams of official national statistics. The final three articles in this issue apply case study methodology to examine a similar question in widely different settings, and, unfortunately, all three give similarly discouraging answers. A common element of health sector reform has been the implementation of user fees to increase efficiency and improve the financial viability of public health care institutions. To blunt the obvious negative impact of user fees on equity of access, they are often accompanied by exemption or discount mechanisms to protect those who are unable to pay, at least on paper.

An extreme example of this situation has taken place in China. Public hospitals now function essentially as private enterprises, receiving little government subsidy and free to set their own charges. While this has resulted in improved quality, it has also produced rapid price inflation. Combined with the collapse of the previous health insurance system, this has left many people unable to afford medical care. To counter this, hospitals have been urged to provide free care or discounts for the poor. Meng et al. combined detailed review of financial records with interviews and focus groups to examine how the system of discounts for the poor operates in practice in nine public hospitals in Shandong province. They found that few services were discounted and few patients received the discounts, which totalled 1% or less of the budget in each hospital. The authors conclude that such a system is unlikely ever to be effective unless government is willing to replace revenues lost through discounts and to help hospitals with the onerous task of identifying the poor.

Kivumbi and Kintu examined a similar issue in the different world of rural health centres in Uganda. Years of inconsistent and sometimes contradictory central government policy have resulted in rural health centres being allowed to charge user fees and effectively required to do so to generate needed operating revenues. Like in China, the central government has urged fee exemptions to protect the poor but has not provided funding to pay for such exemptions. Perhaps not surprisingly, the authors found that fee exemptions are not being implemented on the local level.

Paphassarang et al. examined the issue of user fees from a somewhat different perspective. Public health care facilities

in Laos have implemented user fees, and the government has legalized a rapidly growing private health care sector. The investigators studied two neighbourhoods (one rich and one poor) in each of three provinces and conducted household interviews to determine where people go and why for medical care in the new system. They found that both the rich and the poor get most of their care from the private sector; the rich mainly from private clinics in Laos or in neighbouring Thailand and the poor from private pharmacies that sell drugs, usually with little or no examination or health education. Even though a system of user fee exemptions supposedly exists in public clinics, the poor perceive them to be expensive and inaccessible due to a variety of non-price barriers, including complicated bureaucratic systems and unfriendly staff. These perceptions were endorsed in focus groups with health professionals.

### Conclusion

Each of the articles includes specific policy recommendations, based on the findings. Implementing most of these recommendations would require modifications to the design of the national health systems as well as additional resources targeted towards reducing inequities. The Commission on Macroeconomics and Health suggested in 2001 that a relatively limited set of interventions could, if adequately resourced and implemented, deal with the majority of excess disease burden faced by low income countries, but that there are problems both with the level of resources and in the health systems reaching the poor (Commission on Macroeconomics and Health 2001). The articles in this supplement suggest that although the direct cost is an important barrier in access to health care services for the poor, it is far from the only one. The economic and other mechanisms enacted in the health sector drag along with them a whole set of effects that, despite attempts to compensate, can have significant implications for the real access to health care services for the poor.

Our understanding of how these mechanisms affect the poor is still limited. More research is needed to design interventions that can more effectively reach the poor. Increasing resources for services targeting the poor is a necessity, but without a fuller understanding and better interventions, additional resources may not have the desired effects. Funders, disease control and health systems experts, as well as researchers, need to work together, each having a key role to play.

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