



**A Travelling  
Seminar  
on the  
Attainability  
and  
Affordability  
of Equity in  
Health Care  
Provision**

**Workshop Proceedings  
The Philippines  
June 28 – July 5, 1997**



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Edited and compiled by Lucinda Franklin, David Harrison and Michael Sinclair

**Also available on the internet  
<http://www.healthlink.org.za/hst>**

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ISBN: 1-919743-25-1  
April 1998

Funded by the Henry J. Kaiser Family Foundation, USA



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## PREFACE

The South African health policy is premised on the goal of “equity” in health. The concept of equity in health is the subject of an ever-expanding body of international literature. There are almost as many definitions of equity as there are writers on the subject. This illustrates the fact that although equity is an easily articulated policy goal, giving practical reference to the concept is far more complex.

In July 1997, a group of about 25 top-level South African health policymakers and managers met for five days with a similar contingent from a number of South East Asian countries. These countries were selected because of their experience in implementing over the past decade, far reaching efforts to establish more equitable national health systems.

Organised under the auspices of the US-based Henry J. Kaiser Family Foundation, the main objectives of the Manila forum were to: critically examine the attainability and affordability of equity against the evidence of the South East Asian experience; and to give practical definition in the South African context, to the relevant measures / indicators, the appropriate management structures for the attainment of equity, and the fundamental question of financial sustainability.

Discussions were informed by an international-level faculty. This report publishes the best of their contributions in the hope that wider dissemination will stimulate even more discussion. The report was prepared for publication by Lucinda Franklin of the Health Systems Trust, Durban, and edited by David Harrison, Health Systems Trust, and Michael Sinclair, Kaiser Family Foundation.

This report is published by the Health Systems Trust with funding support from the Henry J. Kaiser Family Foundation, California, USA.



## EXECUTIVE SUMMARY

The Travelling Seminar on the Attainability and Affordability of Equity in Health Care Provision was held against the background of South African commitment to redressing past injustices, and a rekindling of international public health interest in achieving greater equity. Its intention was to reflect on international experience, in reviewing the implementation of strategies towards greater equity in health care provision in South Africa.

Through a series of presentations and plenary and small group discussions, participants sought to better understand:

- ▶ factors affecting the attainability and affordability of equity
- ▶ strategies to promote equity in health care provision
- ▶ the trade-offs which may be necessary in the implementation of strategies
- ▶ positive spin-offs and unintended consequences of different strategies
- ▶ ways of monitoring progress towards equity in health care provision.

### **Affordability and attainability of equity in health care**

Economics professor Bill Hsiao presented his view of the attainability and affordability of equity in health care provision, outlining a number of prerequisites for achieving greater equity. Noting the tendency of leaders to focus on financing strategies, he stressed that human resource development, management capacity and information systems were equally important factors in the attainment of equity. Are equal health services affordable? By definition, argues Hsiao, yes - if expenditure equals revenue. But adequate revenue generation and its allocation and use require leadership, political will and savvy. In turn, these requirements depend on public support and satisfaction with the quality of service provision.

### **Strategies toward greater equity in health care provision**

Gerald Bloom argued that the first step for governments was to recognise their inability to ensure equal access to all health services, so that they can concentrate on measures that yield the greatest benefits. Restructuring of the health sector was the first major task toward equity, which entailed: placing equity at the centre of strategic plans; setting clear objectives for improving access to basic health services; formulating strategies for best use of available resources; and monitoring progress. In addition, Bloom considered options for financing increases in the funding of basic health services once the size of the public health budget has been determined.

Continuing the theme of health sector restructuring as a critical strategy towards equity, provincial governor Rosario Diaz outlined the process of decentralisation of public health administration in the Philippines. The experience of the Cotabato province illustrated that governance, service integration and equity *can* be enhanced through devolution.



South African efforts to achieve greater equity in health care provision were reviewed and assessed. In background papers to the Seminar, Diane McIntyre spelt out the dimensions of inequity in South Africa, while David Harrison summarised health care developments since 1994. Peter Barron provided a critical appraisal of some of the main strategies towards equity adopted by the Ministry of Health.

Emmanuelle Daviaud initiated discussion on the use of a core package of services as a principal strategy towards equity in health care provision. She described the process of attempting to define a core package of PHC services, conducted by researchers and health officials in South Africa. Aspects of equity which could be enhanced through the introduction of a core package were identified, as well as some of the difficulties of implementation. Bill Hsiao and Eleuther Tarimo pursued the issue further, sharing country experiences of the implementation of affordable and sustainable core packages of services.

Former Philippines health minister, Alfredo Bengzon, emphasised the importance of intersectoral collaboration in the attainment of equity, drawing on his experiences in the government of President Cory Aquino.

### **Monitoring progress towards equity in health care provision**

David McCoy and Lucy Gilson discussed the development of systems for monitoring and evaluation which specifically identify and monitor change in key aspects of health care inequities. A number of focal points for selecting indicators were identified, including: financial allocation, accessibility, provision of services, quality of care (including assessments of individual health programmes), health care decision-making processes, and population trends. They outlined factors to be considered in the selection of indicators both to measure – and more importantly – to drive the process of change.



# INTRODUCTION

## THE EQUITY PHENOMENON – IS IT MORE THAN A FAD?

*Steve Tollman*

When one thinks of the people's revolution in the Philippines, the Reconstruction and Development Programme in South Africa, the Alma Ata Declaration on Primary Health Care, and the numerous national health plans throughout the 1980's which had equity at their heart, it is tempting to say that this phenomenon is clearly not a fad.

Justice, or fairness, is a common notion that we come across when we talk about equity. When we try to decide what is fair and just, we find firstly that most problems are complex. Choices of this nature have to be made within fixed resources. The public's view however, is important and needs to be taken into account, and of course, there's always room for differences of opinion. Interestingly, in industrialised countries there has been a considerably greater emphasis on the rights of the individual, autonomy, and freedom to make a choice than there has been on values related to solidarity, responsibility and obligation.

The tension between these values reduces to equity on the one hand, and the individual and individualism on the other. What is equity concerned with? It is concerned with the distribution of resources, and the burdens and the opportunities within society. The question is, how do we decide which principle is a just one?

Which of these principles is most just, or equitable? Should we be distributing resources by basing our principle of distributed justice according to each person receiving an equal share? Or should we distribute to each person according to his or her needs; to each person according to his or her individual efforts; or even more, to each person according to his or her societal contributions? Some might even argue, that people should only receive rewards according to merit. So the questions of firstly how to create a consensus, and secondly 'what is equity?' are extremely important. Despite its ambiguity however, equity is an enormously powerful motivation.

The operationalisation of equity critically depends on the values that society holds dear. Different people, different groups, different societies hold different ideas about equity. The question is, how can we operationalise it in a way that makes sense to everybody?

If we assume that our goal is equal access to health care, and by equal access, we ensure a core package of quality care, this seems to involve not just equal care for equal need. It implies that there may be an element of unequal care for unequal need. For example, maternal and child health problems, in certain rural areas (and in certain urban areas), may be particularly profound and so, in this case, the objective may be to give greater care, and therefore greater investment in these areas. In other words, unequal care, for unequal need. This is what we mean when we talk about the philosophical principle of equity and its embeddedness in society.



These proceedings show that there is much that is concrete about measuring equity (see McCoy and Gilson paper). The entire purpose of the equity oriented objective is to improve health status. In many countries, due to the absence of vital registration systems, we rarely have an acceptable understanding of the problems for which we are designing systems/solutions.

The response to equity cannot be mechanical - it has to be with an understanding of the environment within which we are working. If one looks at the nature of the problems, diarrhoea, kwashiorkor, violence, circulatory disease, and a reversal in female mortality related to AIDS, it is clear that while we within the health care sector have a prime and central role to play, we will need partners to deal with this. We will need partners at the local, provincial, national, and even at the international level. The concept of being able to use the information that we have, or can generate, from our own environment in order to understand the issues of equity, is absolutely fundamental.

The concept of a core package of services is itself very much focused in the first instance, on health status. The Minimum Package makes use of the DALY, and ranks this along with interventions to look at cost effectiveness of developing an intervention package. The idea was to take a rationing approach, given that resources were scarce.

The argument in the 1993 World Development Report is that in low-income countries, for only \$12 a head, and middle-income countries for just over \$20 a head, a major impact could be made with a carefully composed package of clinical and public health interventions. This was the argument that has capitalised much of the debate and led to a major study in Mexico and other countries which attempt to identify what might be the so-called minimum or core package. There have been a variety of critiques of this approach, some of them extremely important. The most important issue was that those working on developing the idea were not terribly familiar with how our health system, or our health services worked. There was an element of naiveté in thinking, “here is the package, go ahead and deliver it”. Furthermore, the derivation of the package was expert driven, it depended on a logical understanding of data and an economic approach. The components of this package were top-down, specialist in nature, and in a sense, impotent. This is only part of the concern. In fact, by avoiding or failing to engage with the public, the package undermines itself profoundly, because social gain, social preference, and culture are profound influences on priority setting and on the choices that people make. Perhaps there is a case for seeing the concept of a core package as a tool and to take it on with a degree of pragmatism and flexibility, which is part of what we will address in the course of these proceedings.

Globalisation and the effect it has on international markets is a real phenomenon. We have already seen over the past decade or more, a number of regional economic groupings emerge – the North American Free Trade Association, the association of South East Asian Nations, the Southern African Development Community, and the European Union. In addition, summits dealing with environmental issues such as the Rio summit, the Rio Plus 5 summit, other issues involving international law, these are all part of the global environment, which is becoming more and more the reality in which we operate.

Accompanying this, is the question of market operation, whether it is the internal market – in the British NHS – the issue of using and finding the forms of interface between the public and private sector, or whether it is even relying substantially on the private sector itself to deliver goods and services, including health. In other words, the role of the private sector and NGOs, have become part of our reality.

Furthermore, the role of the State is likely to change. The State is going to be confronted with having to regulate, monitor and certify more, with limited experience in any of these areas to date. Whether it is in the Philippines, or South Africa, these are things that the public sector has not yet grappled with either sufficiently or effectively, it is an area where expertise is required. I have little doubt that these



forces are going to stress the idea of solidarity, they are going to put pressure on the ideas of equity, whether it is at the local, national, or international level.

The public sector holds an absolutely fundamental role in promoting the importance of investing in health and other social areas. Which other sector can take such a long term view, an overall impression? Which other group has the right, even the obligation to look at the public and the private sector, the interface between them and attempt to architect the most equitable of health services?

In addition to being expected to deliver effectively and equitably at the public sector level, we are faced with a number of major challenges as far as the question of encountering markets, the private sector, the regulation thereof, contracting and so on. The public sector faces a critical challenge as far as the question of equity and as far as the question of health management is concerned. And there must be a strong argument for looking at how, at all levels to strengthen the managerial, the organisational, the analytic, and the monitoring capability of the public sector. Linked to that, is the need to experiment and to be able to demonstrate an ability to learn and to learn quickly. The ability to set-up ways in which the public sector can be a learning organisation. How can one turn the objectives of the public sector into a learning organisation?

We are faced with this whole question of health reform, which is a process we are going to be part of for a very long time. Health reform in middle and low income countries, is involving major moves towards decentralised and district-based health systems, we know this because we are part of it. Does this, through the envisaged closer contact between the public sector and communities, and perhaps between stronger more local information bases, offer good prospects for furthering the pursuit of equity? I do not think we should assume that, but I think that what we can say is that by deliberately restructuring towards an organisational form that is potentially more flexible and responsive and is explicitly accountable to local communities, such a change is an attempt to grapple with some of the critical issues. Equity is clearly not a fad, in my view, but advancing equity in health is going to require stamina, determination, and all our imagination.



# IS EQUITY ATTAINABLE AND AFFORDABLE?

## EXAMINING THE ISSUES AND APPROACHES

*William Hsiao*

In order to understand how to design and implement effective programmes, we must first identify the prerequisite conditions for making equitable health provision workable. To do this, three questions need to be posed:

- ▶ What is the role of government in providing equitable health services to the people?
- ▶ What works, and why?
- ▶ What does not work, and why?

### **A working definition of “Equity”**

My own narrow practical framework for translating equity into practice, or for translating equity into a term called equality is to say that what we are trying to achieve is equality in access to health care and between income classes, races, sex or regions. In other words, we are looking to achieve equality in health status between these population groups.

When I talk about equity, I will be referring to equality, rather than the broader, more vague concepts of equity, which is determined by consensus and social values shared by everyone. In aiming to achieve equitable health provision, there are three major issues I would like to share with you based on international experience. The question is: What determines health status?

A study of health status in Eastern European countries by Barr and Preger showed that health services themselves contributed to only one quarter of the population’s health status outcome. Pollution, education, environmental pollution and occupational health played a much more important role. We emphasise health care, but what is the relative priority of health care in the larger framework? What is the priority? Is health care an investment item or a consumption item?

### **Trade-offs in achieving Equity**

Furthermore, there is a trade-off between equity, efficiency, quality and sustainability. We all think the answer is obvious. The most equitable way of providing equal access to health care, is to make services free - so that the poor can feel equal to the rich in their ability to access health services. But this effects efficiency. The empirical evidence shows that when you make drugs free, they are wasted. In China, where they have done very close studies of this phenomenon, they found that when drugs were free, or nearly free, almost 40% of pharmaceuticals taken home were never used. Patients indicated that they took the drug just in case they needed it. The free distribution system is abused because the monetary cost of the drug means nothing to them.

The second issue is that equity and sustainability are often involved in a trade-off because health leaders try to improve equity very quickly. However, it may not be sustainable financially or operationally in the long term.



The third issue relates to The 1993 World Development Report, which was severely criticised for what people described as its “unitary and simplistic approach”, arguing that the core benefit package should include services that were most cost effective for improving health. Population surveys conducted in Egypt, China, Cyprus and Columbia show that, particularly in the rural areas, people want basic health services, or primary care. The study found that if the head of the household particularly, became seriously ill, the household would sell off their assets or borrow to pay for medical costs. In two countries where the study was conducted, the governments refused to pay any attention to health care issues until the results of our survey showed that in the rural areas, health care costs were the number one poverty generator.

Almost 40% of people who had fallen into poverty in the last three years had a serious episode of illness in the household. These households drained-off whatever assets they had to pay for the medical costs. They sowed their seeds for the next season, mortgaged whatever they owned, borrowed from relatives, and in some very unfortunate cases, sold their daughters to prostitution. The fact that this was the number one poverty generator caught the attention of the governments, and finally convinced them that they must invest in health and health care. So, it is not as simple as the 1993 World Development Report states - that health status is important only when trying to prioritise finance for services.

Taking the option of risk pooling, or financing some large medical expenses is a difficult trade off, requiring a delicate balance between what primary care services and acute services you will finance.

## **The Core Benefit Package**

The Core Benefit Package means targeting by service, ranking by cost effectiveness, and identifying what services the government will be responsible for financing and providing on an equitable basis. That means, providing equal access for everyone. Many countries such as Thailand have introduced health cards which target low income households. Some programmes target a whole community, because they are disadvantaged by income or race. South Africa targets by facility, where the government facilities are relatively free to all comers - there is no differentiation of people’s income. In Singapore and the Philippines, targeting is done by Wards. A Hospital ward is divided into ABC – where payment for C Ward is the least expensive. This enables patients to vote with their feet. In most countries often several of these methods are used. The reason being that none of them are perfect. Some sections of the population are always left out, so a combination of different target mechanisms is the only way to attempt to combat this.

## **Is equitable health care provision attainable and affordable?**

Arguing from a narrow economic approach, we say that economists always like to analyse a problem by looking at what constrains your actions and ability to reach the goal you are trying to achieve. Here, what is affordable, in simplistic terms, and the availability of financial resources. Attainability requires a combination of actions, which includes the institutional structure. Research has found that the ability for a country, or even for a regional government to achieve its goals is dependent on how the power and responsibility is divided, otherwise known as the institutional structure. I would put centralisation versus decentralisation into this category, along with coordination and competition between the public and private sector. Structurally, what role do different organisations at different levels and ownerships play in achieving equitable health provision? We need to look at our internal organisations (Ministries of Health) and assess what kind of organisational structures they have in place. Is a hierarchical structure, or a more horizontal approach adopted to organise hospital staff or do they give the decision-making power to the chief of each service (medical versus surgical)?



In practice, the issues of Human resources, management capacity and information systems are often ignored because they are complicated, complex issues. It takes years to build human resource capacity and develop a workable information system. Leaders usually focus on issues such as the development of a new national health insurance system, and the subsequent introduction of a new tax, or the move towards decentralisation.

Affordability can be expressed in very simple, third grade arithmetic. Expenditure for a program is equal to the unit cost for services, multiplied by the quantity of that service. If I make the expenditure and revenue into balance, or constrain by what I think I can produce on the revenue side, the programme is automatically affordable. It is only when expenditure is greater than revenue that it becomes unaffordable.

So, what is the solution? On the revenue side, there are different options: tax support; insurance payments, or pre-payment; and user fees as introduced by the World Bank 12 years ago. (Interestingly, today the World Bank is calling for user fees to be abolished, following the release of their policy document that says that they are inequitable).

As health officials, when we want to make something affordable, we generally ask for more funds, or put new financing programs into place such as social insurance or user fees. I would argue that there are at least 2 other alternatives. In most countries that I have worked in, arguments between Ministers of Finance and Health turn on this issue. The Ministers of Health argue that they are under-funded, that they need more money, that the health centres do not have drug supplies, and salaries are low. The Finance Ministers usually have evidence that says that the Ministry of Health employs 10 people in a district health centre, which sees only 15 patients a day, where occupancy of the beds is a mere 49%. They argue that the Ministry of Health can use the same amount of resources, but by improving efficiency the services will increase. I would argue that both sides are correct, but the Ministers of Finance do not understand, or care about the institutional or bureaucratic constraints. Even if the Minister of Health wanted to improve efficiency, reorganisation and allocation of new managers would take some time. One could always undertake a reallocation of resources towards more cost effective services such as prevention in primary care, but the question is, would the political forces allow you to do it? By definition when you reallocate, it means that something is taken from A and shifted to B. Would the people in A allow you to do that? In practical terms, unless there is a very strong leader, my suggestion is that you need to think of a substitution. If you are going to take something from A, then the livelihoods of the people at A are going to be affected. To state the obvious, if you are going to shift government support from tertiary centres, towards primary care and to the rural poor population, the tertiary centres are going to ask how they will survive. If you do not give them a way out, they are going to fight for their self preservation. And that creates a tremendous amount of political opposition.

You are not going to shift resources that easily, but you can provide substitutions. In urban areas, you can create a social insurance which would actually replace the government's general revenue funding for these tertiary centres. If employees and workers pay, then the government's general revenue budget can be shifted towards the more worthy programmes and to the poor people. So, there is more than one approach to increasing funding. You can improve efficiency by reallocating resources, but by reallocating them through a sensible strategy such as substitution, you avoid political tensions and opposition that potentially could delay the process.



## **Financing Equity**

When we discuss financing (besides general revenue), most people think of social insurance, private insurance and user fees and of putting these programmes in place for the whole population. And yet, the make-up of the urban population is very different to that of the rural population, with different attachments to occupations and employment bases. The rural population on average has a much lower income and usually depend on agricultural production. Financing methods such as social insurance and private insurance, cannot be used for the rural population for a very simple reason – the premium. In the urban areas, the premium can be collected through people’s workplaces, which also acts as a focal point where we can enforce the law or the regulations – and there is a capacity to keep records. There is no way to do this with farmers and other rural dwellers.

Despite this, the International Labour Organisation (ILO) always pushes for this approach. By definition, ILO’s approach favours the urban areas, helping to generate organised financing for the urban population. With the funding available, it acts like a gravity force. The doctors, and the technicians are drawn by the gravitational force of money. The doctors will leave the rural areas, and the rural population will be worse off than before.

In short, when you consider how you are going to expand the financing in your country, the recommendation is that you consider implementing a parallel strategy - one serving the rural population, and one for the urban population. In developed nations, much of the population is urbanised, so the problem is not encountered. But even for middle income countries (countries with an average per capita income above \$US 5, 000 – 7, 000), social insurance usually covers less than 50% of the population by excluding street peddlers, part-time workers, and farmers. I believe the parallel strategy is something that every nation in attendance at this seminar may want to give some serious consideration.

## **Sustainability**

Let me move onto the issue of sustainability. Financial sustainability requires public support, and that means public satisfaction. Put into simple terms, public support is a function of the quality of the service. It is inversely related to waiting time, distance to service, and choice of practitioner. Public provision often uses these devices to ration services, because demand exceeds supply. Once you are able to increase the resources for public provision for equitable reasons, if you want to sustain that public support, they will either have to pay taxes, premiums, user fees, or pay community financing (the portion that is contributed by the households). Obviously this would have to be modified to suit each country’s circumstances.

The following example illustrates the importance of this one variable. We conducted a study based in Cyprus to understand why, when the population has a free public health service available to them, they insist on going to a private practitioner (and pay out of their pockets) to obtain health services. The study asks the household to rate the technical quality of physicians and nurse practitioners. We asked them to rate the attitudes of the public sector providers versus the private sector providers. We were surprised by the rating they gave to technical quality, attitude, and whether their diseases were treated adequately or not. The 2 providers (public and private sector) came out almost identical. Both sectors rated very highly – partially because Cyprus has an oversupply of doctors and hospital beds. But then we were puzzled. If the population thinks the public sector is providing such a good service, why do they go to the private sector where they pay the full amount themselves? First we suspected it was the waiting time, so we statistically modeled and controlled for this possibility and found that this did not explain anything. The second phase of the study found that what really determines why people choose to utilise the private sector rather than the public sector is having a choice of practitioner.



These facts are known through international experience and can be shared in terms of improving public satisfaction, leading in turn to greater sustainability.

## **Structuring the Incentives System**

To this point we have concentrated on finance. However, money does not produce services. The institutional structure of the organisation, the incentives, management and so on has to go through a transformation. As economists, we often overlook this side of things. There is a tendency to concentrate on the financial side of things. This could be mistaken as being a limited viewpoint, but I would argue that you need to pay at least equal attention to this aspect.

Although we know what would improve the purchasing of drugs, there are many political and institutional considerations. A similar issue occurs with management and with obtaining information, which is more difficult to institute, simply because the information you require depends on where you sit. Most government officials think in terms of their role as planners. They think they know what people need. They do not necessarily look at what people value and why, and that is why you see the failure of government-managed hospitals and clinics in developed countries such as the UK and Sweden. They shifted the government's role to purchaser and shifted the power to the demand side. Prior to this, the government controlled the supply side, although now the government is trying to give the power back to the public. When patients say we do not want your free service, we are willing to pay money to go elsewhere, it ought to be a wake up call. When people can get the goods free, but indicate that they do not want them, it means that there is something wrong in that operation. The question is, how do we structure incentives that will influence the providers such as the doctors, nurses and technicians in an institution.

The incentives system comes from within the payments system. If you use a budget to pay a hospital or clinic, worldwide we observe a normal human behaviour. People will try to minimise their work effort. If you pay them on a fee for service basis, they are going to maximise the units of services that they provide, and that creates inflationary pressure. So neither a budget nor a fee for service system is the right way to pay either physicians or hospitals. There is a whole body of knowledge emerging around the world on how one might structure the incentives system better than what we have been doing in the past. Making use of human resources, particularly nurse practitioners, is a realistic method for a developing country that lacks physicians, or rural physicians in particular, to staff these areas. You can entice staff by offering higher pay, but that is very expensive. By 'substituting' doctors with nurse practitioners or physicians' assistants, you can render very high quality primary level services to the population in need.

## **Conclusion**

We also learned that equality of health care can be achieved, but it requires change. However, it means that there have to be winners and losers. As soon as there are winners and losers, and the decisions are made by the public officials, then politics becomes involved. And politics cannot be divorced from your decision to create more equitable services for the whole population.

In the last 25 years, we have made great strides in developing skills and tools that can be shared with other nations, and these skills and tools can help us to generate better information to inform decision making. It will not make the decision for you, but it will help you to persuade opponents to move from their existing position.

Is equitable health care provision affordable and attainable? My answer is that equal health services are affordable. As I have said, if expenditure is equal to revenue, then it is automatically affordable. So,



in other words, in decision making, you have to consider how much revenue you are going to generate, and you may try to relax this constraint through different means, but you are still going to have to make these two things equal in the end. And I would also argue that we have enough knowledge and experience to make it attainable and sustainable. However, this requires leadership, political will and political savvy to be able to persuade the established power in a society to do this. These are the basic requirements to make equity attainable, affordable and sustainable. You need laws and regulations. In any society, there has to be some legitimacy in what you do, in order to make it sustainable and acceptable by the people. A strong leader can activate a program, but without the law, there is a lack of legitimacy, and then once that leader is no longer in power, the program usually falls apart.



# **THE AFFORDABILITY CONUNDRUM: TAILORING EQUITY TO WHAT IS SUSTAINABLE**

*Gerald Bloom*

## **Introduction**

The health sector of a number of countries provides sophisticated medical care to those with economic or political power while it does not meet the basic health care needs of many others. There are high levels of avoidable sickness and premature death, as a result. This adversely affects economic development. This paper raises questions that government policy-makers must address in attempting to correct this situation. It argues that restructuring the health sector is a major task which governments have to manage. They need to set clear objectives for improving access to the most important health services; formulate strategies for making effective use of scarce public health resources and limited regulatory powers; and monitor progress towards achieving targets. If a government wishes to create a health sector which addresses health problems effectively, it has to put equity at the centre of its strategic plans.

## **Structured Inequality in the Health Sector**

The population of many low and middle income countries<sup>A</sup> is segmented into groups on the basis of how they earn a living. In some countries these groups differ greatly in levels of income and access to social benefits. These inequalities are reflected in all aspects of social organisation. The health sector is usually segmented in parallel with other structural inequalities. This is an exaggerated form of the institutionalised segmentation which characterises the health sector of the United States (Reinhardt, 1996). The dividing lines between segments are not clear cut and the following provides a simplistic picture of a complex reality.

## **Health services for the economic elite**

The high income earners have a lifestyle similar to that of the upper middle classes in advanced industrialised countries. They own their own business, have senior positions in large organisations or provide professional services to the elite. They have access to international media and their consumption patterns reflect this influence. They tend to live in well serviced urban areas. They possess many household goods and may also own other assets, including a substantial pension fund. The health of this group is similar to that of the middle classes in advanced market economies. Previously this group may have had preferential access to the more sophisticated government health facilities, but it increasingly uses local or foreign private doctors and private hospitals, financed through insurance.



## **Health services for formal sector employees**

Many people work for enterprises which are integrated into the formal economy. These enterprises function in a regulatory environment that is more or less similar to the advanced market economies. They are mostly situated in urban areas and their employees earn higher incomes and have better access to social benefits (education, pensions, urban infrastructure and so forth) than the rest of the population. There may be substantial differences in access to benefits between higher and lower paid workers. The health status of the lower paid formal sector workers tends to be worse than the economic elite but better than the rest of the population. They obtain outpatient care from both public and private providers. They tend to use government hospitals but they also use relatively low cost private hospitals, in some countries.

The mechanisms for financing this social group's health care varies. In the apartheid regimes of Southern Africa<sup>B</sup> health services were organised and financed differently for high and low income employees, reflecting a racial differentiation in job categories. The former were covered by medical aid, which paid for outpatient treatment by private doctors and hospital care in public or private facilities. Most other workers used public health facilities or fee-for-service private practitioners. Those living in remote localities often had access to services in facilities owned by their employer. More recently, medical aid societies have developed cheaper packages of coverage for the lower paid.

## **Health services for non-participants in the formal economy**

A majority of the population of many low and middle income countries work the land and/or participate in informal economic activities. They live in rural areas or poorly serviced urban settlements. Most earn little more than subsistence-level incomes. In many countries there has been relatively little investment in safe living conditions or basic social services and many people are exposed to health hazards associated with poor housing, lack of clean water, low literacy levels and periodic food shortages. They often suffer from high levels of sickness and premature death due to preventable and treatable illnesses. They depend largely on government facilities and not-for-profit providers for their health care. They may also use poorly regulated traditional healers, unlicensed health workers and drug sellers. This exposes them to the risk of ineffective or dangerous treatment.

A proportion of the non-participants in the formal sector are particularly disadvantaged because they have few opportunities to earn a living. They often cannot feed themselves adequately and they frequently have little access to public services. Households with only one productive adult, usually a woman, are often vulnerable in this way, as are residents of temporary squatter camps, and the disabled.

## **The magnitude of the inequalities in access to health resources**

These groups have very different access to health care resources. In 1993 in South Africa, for example, members of medical aid schemes used services costing 15 times more than average public health expenditure in the 20% of magisterial districts with the lowest average levels of household income (McIntyre, Bloom, Doherty, Brijlal, 1995). The difference in levels of health expenditure per capita was even greater when the highest paid members of medical schemes were compared with the 4.7 million residents of the magisterial districts with the lowest public health expenditure per capita. The former spent 40 times more on health services than the latter. This is one reason why South Africa has high levels of avoidable sickness and premature death, in spite of spending much more on health services than other countries with similar levels of national income. Governments have a difficult task in restructuring the health sector to increase its capacity to deal with the major health problems.



## **Towards Equity in Health Services in an Unequal Society**

The long-term goal of governments interested in promoting equity is a health sector which provides access to services on the basis of need to members of a more equal society. However, policy-makers have to begin the transition from the starting point of a highly segmented health sector. The major short- to medium-term aim is to begin to change the balance of benefits between population groups.

Policy-makers also have to take into account the likelihood that major socioeconomic inequalities will persist for a considerable length of time. These inequalities are reflected in many aspects of social organisation. There are substantial differences in pay between people with different skills, and a doctor may earn much more than most patients. The labour market may be segmented so that private providers of specialised services to the elite earn much more than people with similar skills in the public sector. The government system may also reflect these inequalities, with some local governments having much higher tax revenues than others.<sup>c</sup>

There are limits to the degree to which consumption of health services can be made equal in a country with substantial socioeconomic inequalities. It is too costly to provide everyone with the kind of health services to which the more affluent aspire. Furthermore, people with low incomes may not view the purchase of expensive medical treatment as the best use of the funds available to subsidise services they use. On the other hand, it is difficult to stop the better off from purchasing additional medical care, and it is not clear why it should be desirable to discourage them from spending more on health services if it does not affect access to essential services by others.

Most countries with substantial structural inequalities have not achieved fully equal access to health services. Even when China was implementing radically egalitarian social policies during the Cultural Revolution, it did not equalise health spending. Health expenditure per capita was three times higher in urban than in rural areas in 1981 (Bloom, 1997). In spite of this, almost all of China's population had access to basic preventive and curative health services and they lived longer than in other countries with similar income levels. This illustrates how a focus on reducing the most relevant health inequalities can yield benefits. This is underlined by China's subsequent experience during its transition to a market economy. The health sector expanded in rapidly growing areas. However, health facilities in the poorer parts of the country experienced serious financial problems and they lost their most skilled personnel. Health indicators ceased improving and there has been a resurgence of some preventable diseases, in spite of economic growth. The government acknowledges that this is a serious problem, however, it does not yet have a strategy to ensure that all localities provide at least the essential health services.

It is important to distinguish between different measures taken in the name of equity. During the immediate post-colonial period, many African and Asian governments promised universal access to health care on the basis of need. This meant, in practice, that public health services were provided virtually free of charge. The structure of these services reflected inherited structural inequalities, and a large proportion of public expenditure was allocated to hospitals which had previously served the colonial elites. A number of countries built new referral hospitals and medical schools. The main beneficiaries of these changes were formal sector workers, urban residents and health workers. Subsequently, many governments invested in basic health services for non-participants in the formal economy. The public health sector in many post-colonial countries represents a compromise between efforts to meet the demands of urban workers and the needs of the poor.

Zambia provides an extreme example of the problems that can occur when a government does not establish realistic priorities.<sup>d</sup> After independence in the 1960s, its government promised a full range of highly subsidised services. It built new hospitals and a network of rural health facilities. During the 1980s Zambia suffered a prolonged economic crisis which compelled it to decrease public health



budgets substantially. It did not adjust its health sector aims, and, by the beginning of the 1990s all facilities were severely under-funded and the district health services had almost no money for non-salary expenditure. Many rural people did not have access to effective health care. This contributed to a rise in under-five mortality from 152 to 202 per 1000 live births between 1980 and 1992. The government is now re-allocating its public health budget in favour of primary and secondary care facilities, and the more sophisticated hospitals will have to adjust to substantial decreases in government funding.

Once governments accept their inability to ensure equal access to all health services they can concentrate on measures that yield the greatest benefits (Normand, 1997). The most important objectives are to reduce the burden of avoidable sickness and premature death and improve the capacity of poor households to cope with serious sickness in the family. Governments are also under pressure to facilitate access to modern health care, at an affordable price, for formal sector employees. They need to balance these potentially conflicting objectives while supporting the long-term development of a health sector appropriate to a more equitable society.

## **Basic Services For All**

### **The right to essential health services**

The principal health sector objectives are to diminish the burden of ill-health and premature death; insure households against the risk of impoverishment when a family member falls seriously ill (from the loss of earning power of a sick family member and the need for someone else to spend time caring for them); and protect society against epidemics.

In order to achieve these objectives the health sector must provide the following services: public health measures, such as the provision of safe water and disposal of human wastes; preventive programmes; basic curative care; and nursing and social support, to protect households against the negative economic effects of having a seriously ill family member. The impact of additional health expenditure on well being diminishes as spending rises. A point can be reached where additional spending on medical care provides less benefit than spending on other services for the poor.

One could argue that people should have a right to access to the most cost-effective health services. Governments tend to be reluctant to define such a right, partly because it involves identifying the services to which they will not guarantee access. The definition of essential services depends on judgements about the costs and benefits of various health interventions. This must be based on information about the prevalence of different health problems and the effectiveness of the available interventions. It must also reflect the perspectives of different population groups regarding the kind of social support the seriously ill and disabled and their families need.<sup>E</sup> Other papers in this volume deal with this issue in more detail.

It is unnecessary to define precisely the services to be provided as a right. It is more important to determine minimum standards for the availability of facilities and personnel and the provision of access to preventive and curative services. It should be possible to define easy-to-measure indicators to monitor whether these standards have been met. Local health service managers can decide the best use of the available resources, subject to national guidelines.

The organisation of basic health services is relatively simple. It usually includes a network of primary care facilities and front-line hospitals and a management and supervisory system. It is possible to estimate the cost of providing these services by defining norms that relate the supply of facilities and personnel to population and by estimating the probable costs of drugs and other operating expenses. It is more difficult to estimate the cost of referral services at specialist facilities. One option is to set norms for the provision of these services in terms of the number of specialist beds relative to population,



but it is difficult to reserve access to these services for those who need them the most. The definition of essential health services has implications for the allocation of public funds. It almost certainly requires a substantial change in the pattern of public health expenditure (Baker, van der Gaag, 1993; Mooney, 1996; World Bank, 1993).

### **Investing in basic health services**

The most common strategy for improving access to essential services is through public sector investment. During the 1970s and 1980s many countries built primary health facilities and trained many health workers.<sup>F</sup> They also established national preventive programmes and strengthened district health management. It is difficult to expand access to services without this kind of investment.

Many countries have attempted to build basic health facilities while also upgrading and expanding their network of referral hospitals. In many cases this has delayed reductions in inequalities in access to health care. The larger hospital projects tend to crowd out smaller ones, as a result of bottlenecks in the construction programme. Also, the new facilities compete for skilled personnel and government budgets. This underlines the need to formulate a public sector investment programme which gives priority to improving access to essential services.

It is often relatively easy to implement a substantial investment programme, particularly after a change in government, because politicians push for new health facilities for their constituents, and donors like to support “one-off” investments with a visible outcome. It is more difficult to finance the running costs of the additional services.

### **Financing Increases in Funding of Basic Health Services**

This section explores options for increasing the impact of the available resources on basic health services, once the size of the public health budget has been established.

#### **Allocation of public health budgets between localities**

One strategy for improving provision of basic health services is to set targets for diminishing differences in public health expenditure per capita between geographical areas. A simple target is to aim for equality after a number of years.

Governments may decide to spend more on public health services per capita in localities with greater needs. The British Government allocates more to districts with a higher than average proportion of old people and/or above average age specific mortality rates. Countries with large income inequalities and high poverty levels will probably use other indicators of need. These could include: the proportion of people living in poverty; the existence of vulnerable populations; and a high prevalence of special health problems, such as AIDS. Government may also allocate less to affluent localities, where the demand for basic services is lower, because people are healthier or more likely to use private practitioners. In order to make this kind of decision, governments need to have information on health expenditure, provision of health services and relevant socio-economic indicators for districts.

The speed of equalisation between localities should depend on the ability of the health sector to manage change. A government elected on a platform which includes reductions in health inequalities must balance the need to take advantage of a window of opportunity for change, against the need to ensure that the results of change are sustainable. It has to guard against increasing grants to localities so quickly that inefficient and ineffective services are established. It also needs to help health services in well-funded localities adjust to reductions in public funding.<sup>G</sup>

Government needs to decide whether the public sector should provide the same health services



throughout the country. One option is to create a national health service which provides a uniform quality of services. The success of this strategy depends on the ability of the central government to collect taxes and of the health sector to negotiate an adequate share of public expenditure. The dangers are illustrated by the health services in much of sub-Saharan Africa which have suffered serious financial constraints due to major reductions in government budgets.

The other option is to encourage local governments to supplement central government health budgets, or even substitute for them. Local governments may be able to raise revenue from previously untapped sources. Municipal health services illustrate how this can work. Individuals and companies based in a city have an interest in creating an environment in which productive enterprises can be fostered, and they may be willing to contribute financially towards this end. This can increase overall health finance, and some of the additional funds may be used to improve subsidised care for the urban poor. However, it institutionalises regional inequalities in health finance, particularly if residential areas for the rich and poor are administered by different municipal authorities. It may also enable the better funded localities to employ an unfair share of skilled personnel.

In countries where systems of public health finance are decentralised, the higher government levels (national and provincial) need to ensure that every one has access to, at least, essential health services. They require sufficient resources to subsidise basic health services in poor localities, and/or the power to make local governments legally responsible for providing at least a minimum standard of services. If they do not exercise these powers, regional inequalities in access to health services can grow.<sup>11</sup> The national level also needs to establish a regulatory framework to prevent unacceptably large differences in service provision. For example, it can attempt to reduce problems in staffing health facilities in poor areas by limiting inter-regional pay differentials and creating incentives for people to work in underserved localities.

### **Charging for services used by public patients**

One way to increase funding for basic health services is for households and/or community organisations to contribute a share of the cost. The impact on equity may be positive if some health facilities would not be able to provide effective services without this revenue. Rural health services are funded this way in China, where government finances only 14% of total health expenditure. Many peasants would not have access to medical care if health facilities could not charge for services and sell drugs. The same is true in many areas of sub-Saharan Africa, where health facilities and health workers depend on legal or illegal payments from users.

Substantial user charges make access to basic health care unequal (Creese, Kutzin, 1997; McPake, 1993). The poor may delay consulting a health worker or they may purchase a partial course of drugs. When they are seriously ill they may have to go without treatment or borrow money and/or sell assets to pay for hospital care. The financial barriers to access may particularly affect vulnerable groups such as women or the aged. In some circumstances these problems may have to be accepted as the only alternative to health service collapse.

Some countries have attempted to supplement health finance by establishing local prepayment schemes which collect money from households. These schemes finance part or all of the cost of certain health services. They are particularly important in countries where community structures are well-established, but local government finance is weak. They function as an informal alternative to local government funding. They are more likely to be successful in communities which are experiencing economic growth and where local leaders have the authority to convince people to contribute. Government needs to ensure that poor communities and poor members of rich communities are not left behind, if prepayment schemes become an important source of health finance (Creese, Bennett, 1997).



The financial barriers to access to care can be reduced by a system of medical relief for the poor, which pays some, or all, of the costs of basic health services for people certified as destitute. It is difficult to manage such a system, particularly where a substantial proportion of the population is poor and local administrative systems are weak. The result is that people do not receive benefits to which they are entitled.

None of the measures described above should be necessary in South Africa, where government health budgets are large, and it should be possible to finance basic health services by shifting resources from less cost-effective public services. There will inevitably be a poorly defined boundary between essential and non-essential services. All advanced market economies have a network of drug stores which sell many over-the-counter preparations and a variety of providers of health-related services who work on a fee-for-service basis. This leaves difficult questions about what should or should not be subsidised. Should government supply tonics and drugs for minor symptoms free of charge? Should traditional healers be subsidised? It is better that policy-makers acknowledge government's inability to finance all health services so they can focus their efforts on ensuring that inequalities in access have the smallest possible impact on well-being. It also makes an informed public debate on health priorities possible.

### **Reduction of government subsidies to hospitals**

One manifestation of the segmented nature of health services in countries with large structural inequalities is that a substantial proportion of public expenditure is used by specialist hospitals. When public health budgets are rising rapidly, funding of basic health services can be increased by allocating most of the additional funds to priority services. Otherwise, government has to spend less on these facilities.

The need for such measures is illustrated by Zimbabwe, whose post-independence government substantially improved access to rural health services by building a network of primary care facilities, training and deploying a substantial number of health workers and strengthening preventive programmes (Bloom, 1997). The public health budget almost doubled, in real terms, between 1979/80 and 1987/88, making a substantial increase in rural health activities possible, without a reduction in other services. Under five mortality fell from 104 to 87 per 1000 live births between 1980 and 1990. This achievement has been widely praised as an example of how a country can improve its population's health by increasing access to effective basic health services.

During the 1990s, Zimbabwe's public health services have faced serious problems. They have had to cope with substantial falls in government budgets and with increases in demand, due to drought-related malnutrition and the HIV/AIDS epidemic. In spite of this, government attempted to provide a full range of services to everyone who asked for them and it continued to build new facilities. It reduced its allocations to the referral hospitals, however, it did not allow them to reduce their range of services or generate much revenue from other sources. This stimulated a shift by the better off to private hospitals and contributed to discontent about the quality of public health services. The government now recognises the need to develop a systematic approach for reducing subsidies to the specialist public hospitals so it can improve the funding of basic health services.

There are several ways to reduce government spending on hospital services. One is for hospitals to become more efficient. It is estimated that the South African Department of Health could reduce its grants to hospitals by 10% without reducing the quantity and quality of services they provide (McIntyre, Bloom, Doherty, Brijlal, 1995). It could make further savings by rationalising drug use. However, government should not assume that it can release a great deal of money rapidly through painless cost reductions. It is difficult to effect this kind of change quickly without affecting the quality of services, and it takes a considerable investment of time and resources to change staffing patterns and improve facility management. All other decisions regarding the adjustment of hospitals to reduced government grants



imply changes in the quantity and/or quality of services they provide or in the charges they require users to pay. These options affect access to health care by various social groups differently.

Public hospitals can adjust to reduced government grants by providing fewer services and reducing the sophistication of the services they provide. This frequently happens through a series of incremental responses to budgetary constraints. This may be an appropriate response to a temporary financial squeeze, when the main aim is to disrupt services as little as possible. But, it is an inefficient way to manage a long term adjustment by hospitals to reduced government grants. Governments tend to prefer this approach because they can avoid difficult political decisions. However, if they allow this to go on for too long, services deteriorate disproportionately. The alternative is for government to formulate an explicit strategy for adapting its hospitals to reduced public funding.

Hospitals may be able to discontinue some services without affecting health outcomes very much. Wards or even entire facilities can be closed where facilities are located close together and bed occupancy levels are low. It may be possible to substitute less expensive alternatives for some services provided by specialist hospitals. For example, specialist hospitals can close general outpatient departments and they can divert some inpatients to general hospitals or nursing homes. These measures should not reduce access to basic services, in theory, if good alternatives to the specialist hospitals are available.

If the measures described above do not release enough money, it may be necessary to reduce subsidised access to specialist care. One way to reduce public funding for specialist care is to change some specialist hospitals into general ones. This option is attractive in localities with a shortage of general hospital beds. It leaves the facility's role as a provider of services to the general public unchanged. However, it means that people who had previously depended on it for specialist care can no longer do so.

It is sometimes better for hospitals to continue providing specialist services but to charge for them. The government could still give them a grant to pay for public patients,<sup>1</sup> but these hospitals would fund the rest of their costs themselves. This option maintains the public sector's capacity to provide specialist care. However, it institutionalises two-tiers of access to health facilities.

The impact of the changes described above differs between social groups. The degree to which non-participants in the formal sector lose depends on how much they had previously used specialist hospitals. They will benefit from the loss of specialist care if they have much improved access to other health services. Participants in the formal sector are more likely to lose when public funding is reallocated in favour of basic services. Members of this social group commonly use specialist facilities a great deal and they often exert powerful pressures against major changes in hospital finance. They are more likely to accept changes if government can assure them that they will continue to have access to specialist services at an affordable cost. The following section explores how this can be achieved.

## **Health Services for Participants in the Formal Economy**

### **Structured inequality in health finance**

The previous sections argue that public health budgets should be allocated preferentially to the most cost-effective services. The logic of this argument could lead to the conclusion that government should focus entirely on basic health services, as defined in elsewhere in this volume, leaving other health activities to the market. This simple dichotomy between the roles of state and market does not reflect the complexity of the health sector.

Governments play an important role in the health sector of every advanced market economy. They organise mechanisms to finance health services, enforce regulations against dangerous or ineffective



practitioners and take measures to control costs and encourage the provision of cost-effective services. There is virtual unanimity amongst policy-makers and researchers that government must be an active participant in the health sector, although they differ on how it should influence the health sector to be efficient and equitable. The need for government involvement is equally strong in low and middle income countries, where an unregulated market is unlikely to provide cost-effective services or insure individuals against having to pay large medical bills (Chernichovsky, 1995; Hsiao, 1994). Government has the added responsibility, in these countries, of balancing the health service needs of the different population groups.

People earning above subsistence incomes expect to have a more sophisticated kind of medical care than the basic services described in previous sections. Government can contribute to the welfare of this population group by ensuring that health facilities provide cost-effective services and by supporting the development of risk-sharing. The aim of this involvement is to improve access by individuals to medical care and contribute to the economy's competitiveness by reducing labour costs. There is a similar argument for government involvement in other activities that provide benefits largely to the economically active, such as development of urban infrastructure, regulation of insurance and pension services, maintenance of urban transport systems, and monitoring of the quality of consumer goods.

The case for state involvement in the finance and regulation of health services for a minority is weakened if it reduces access to services by the rest of the population. This can occur for a number of reasons. There may be an adverse effect on public funding of services for the poor. A dynamic private sector may attract skilled personnel away from the public health service. There is also a danger that regulatory bodies will approve regulations that make it difficult to address the problems of the poor (for example, by preventing anyone but a doctor from providing services), if they are dominated by sectional interests. When ministries of health ignore these issues the result tends to be a fudge which works in the interests of those with influence.<sup>l</sup>

If governments want to reduce health inequalities they have to balance the needs of various stakeholders. They have to find strategies to ensure that the needs of the poor and politically weak are met. They also have to support the development of appropriate structures for financing and regulating modern health services for people with higher incomes. When there is a conflict of interest, they need to ensure that the needs of the poor are taken into account. The next section illustrates with the example of compulsory health insurance.

### **Insuring against the risk of major medical expenses**

Southern Africa has a well-developed health insurance industry which has covered the better paid workers for years. This has led to pressures by the less well paid for more equal treatment. South African and Zimbabwean medical aid societies have developed cheaper schemes, in response. Both countries may introduce compulsory health insurance to increase the number of people who are insured. This section discusses how this use of government powers could affect equity.

The main purpose of health insurance is to protect members against large medical bills. Governments often make contributions compulsory to avoid risk-rating.<sup>k</sup> Young and old make similar contributions and the scheme redistributes funds between generations. Such a scheme enables people to have access to the services they need by spreading the cost over their working life.<sup>l</sup> It also redistributes funds in favour of people who require more medical care during their life.

A compulsory scheme can redistribute resources between high and low income earners, if contributions rise with income, and everyone has the same benefits. The impact on equity is clear when everyone is insured. However, in countries with major structural inequalities, it is important to consider equity both within and between population groups (for example, the insured and uninsured or urban and rural



residents).<sup>M</sup> If insurance schemes do not cover members' families, it is also important to consider the impact on equity of access between salaried workers and other household members (often women and children).

The impact of compulsory insurance on access to services by the uninsured depends largely on how public health budgets are affected. Governments often subsidise health services for contributors to health insurance schemes by charging less than the full cost for using public health facilities, exempting contributions to schemes from taxation, and paying for training, monitoring and regulation of private sector health workers. This reduces the resources available for basic health services for the uninsured.

People may resist tax increases because they view compulsory contributions to a health insurance scheme as the equivalent of a tax. This applies particularly to the better paid, who contribute more than they receive in benefits. Their higher contributions are, in effect, a tax from which only members of insurance schemes can benefit. This highlights a dilemma governments face in designing compulsory health insurance. They have to weigh the wish to lower the cost of insurance to the less well paid against the need to fund services for the uninsured adequately.

Compulsory health insurance affects the capacity of the public health service to meet priority needs in other ways. For example, by increasing the demand for private health care, it can encourage trained personnel to leave public sector employment. Government can deal with this problem by charging substantial licensing fees to repay the costs of training and regulation. This can release public funds for high priority services and reduce the incentives for public sector personnel to move to the private sector. Another option would be to exempt private practitioners from licensing fees if they work on a sessional basis in public facilities.

The cost of compulsory health insurance commonly increases over time. This is because health facilities tend to offer more services, and organisations representing workers put pressure on schemes to finance them.<sup>N</sup> The cost of health care can become an increasing burden on scheme members and their employers, and it can even reduce the competitiveness of companies. This puts pressure on governments to subsidise the services. A rise in the cost of health insurance can reduce the well-being of the uninsured by increasing the prices of goods and services and reducing the resources available for public health services. It also makes it harder to extend coverage. This highlights the need to ensure that bodies responsible for regulating the performance of insurance schemes include advocates for the interests of non-members. One of their major tasks should be to prevent unnecessary cost increases.

One of government's objectives in supporting the establishment of health insurance is to gain the consent of formal sector workers (including government employees) for reductions of subsidies to specialist hospitals. This has to be achieved through measures to ensure that they have access to services at an affordable cost. That is why government has a strong interest in fostering the development of cost-effective models of health care delivery in the public and private sectors. It can do this by encouraging experimentation with new models of service delivery, providing seed money, giving tax advantages to providers of cost-effective services and funding research. If government provides health insurance for its employees, it can begin by rationalising the benefits it provides. If nothing is done to make services affordable, introduction of compulsory insurance can lead to cost increases, which benefit health providers much more than users. This would jeopardise the sustainability of measures to make access to health services more equitable.



## **Towards Sustainable Reductions in Health Inequalities**

It is easy to obtain almost unanimous support for a long-term goal of providing equal access to health services in a future egalitarian society. It is much more difficult to formulate and implement the first steps towards this goal from the starting point of a segmented health sector in a society with substantial structural inequalities. Governments need to define clear targets for improving access to health services and focus their efforts on attaining them.

Ministries of Health have to play a role in all segments of the health sector. They need to address the health care needs of large numbers of people outside the formal economy as well as meet workers' aspirations for efficient, modern services. If they ignore conflicts of interest between these groups, the more articulate and powerful will dominate policy-making. In order to avoid this, governments need to set clear policy objectives. These might include the attainment of minimum standards of provision of basic services and the development of a cost-effective health care service for workers. In addition, government needs to have a vision of the kind of health sector it hopes to foster. It then needs to assess the impact of alternative strategic options on the achievement of these objectives.

The key to the achievement of greater equity in the health sector is a government that is firmly committed to change. That is a necessary, but not sufficient, condition. In addition, government has to manage the transition process actively. This is a different role from the traditional one of administering public health services. It requires a capacity to use government powers strategically and participate actively in negotiations with stake holders. It involves a willingness to contemplate fundamental changes to the use of public funds and the role of some health facilities, as long as these changes contribute to the attainment of sectoral objectives.

In order to play this role effectively, governments need access to high quality analyses of the implications of different strategic options. Some questions that these analyses could address are listed in the following box. If governments do not provide informed and dynamic leadership, reform programmes may disrupt health service delivery without improving health services for low-paid workers or non-participants in the formal economy. This would jeopardise the attempt to create a more equitable and cost-effective health sector for years.

### **Questions to be answered in formulating strategies for reducing inequalities**

- How should essential health services be defined? Should government specify the precise services to be provided, or should it establish minimum standards for provision of facilities, personnel and public finance?
- Should local health services be permitted to provide more than the minimum standard of health services?
- Should government fund basic services fully, or should people pay a share?
- How can government subsidies to public hospitals be decreased? Should certain services be provided on a full cost recovery basis? Should some facilities be closed or transferred to the private sector?
- How can local health services be helped to adapt to changes in public funding?
- How can compulsory health insurance be designed and regulated to take the interests of the non-insured into account?
- How can government improve the cost-effectiveness of public and private health service providers?
- How can governments become more effective in assessing strategic options and negotiating with stakeholders on behalf of the poor and the long-term national interest?



## References

- Reinhardt U (1996) A social contract for 21st century health care: three-tier health care with bounty hunting. *Health Economics* 5(6): 479-500
- McIntyre D Bloom G Doherty J and Brijlal P (1995) *Health Expenditure and Finance in South Africa*. Health Systems Trust and World Bank, Durban
- Bloom G (1997) *Primary Health Care Meets the Market: Lessons from China and Vietnam*. IDS Working Paper No. 53, Brighton
- Normand C (1997) *Health Insurance: A Solution to the Financing Gap*. In: Colclough (ed.) *Marketizing Education and Health: Miracle or Mirage?* Oxford University Press, Oxford
- Baker JL van der Gaag J (1993) *Equity in health care and health care financing: Evidence from five developing countries*. In: Van Doorslaer E, Wagstaff A, Rutten F. (eds.) *Equity in the finance and delivery of health care: An international perspective*. Oxford University Press, New York
- Mooney G (1996) *And now for vertical equity? Some concerns arising from Aboriginal health in Australia*. *Health Economics*. 5: 99-103
- World Bank (1993) *World Development Report: Investing in Health*. Oxford University Press, Oxford
- Creese A and Kutzin J (1997) *Lessons from Cost Recovery in Health*. In: Colclough (ed.) *Marketizing Education and Health: Miracle or Mirage?* Oxford University Press, Oxford
- McPake B (1993) *User charges for health services in developing countries: a review of the economic literature*. *Social Science and Medicine* 36 (11):1397-1405
- Creese A and Bennett S (1997) *Rural Risk-Sharing Strategies in Health*. Presented to an international conference on Innovations in Health Care Financing, Washington, March 1997
- Bloom G (1997) *European Union Counterpart Funding to Zimbabwe's Health Sector*. Report prepared for an evaluation of European Union balance of payments support to Zimbabwe
- McIntyre D Bloom G Doherty J and Brijlal P (1995) *Health Expenditure and Finance in South Africa*. Health Systems Trust and World Bank, Durban
- Chernichovsky D (1995) *What Can Developing Economies Learn from Health System Reforms of Developed Economies?* In Berman, P (ed.) *Health Sector Reform in Developing Countries*. Harvard University Press, Boston
- Hsiao W (1994) 'Marketization' - the illusory magic pill. *Health Economics* 3: 351-367
- A The World Bank classifies South Africa as an upper-middle income country.
- B Namibia, South Africa and Zimbabwe prior to the coming to power of non-racialist governments.
- C One argument for preventing the better off from buying unlimited amounts of health services is that it may reduce the supply of health services for the rest of the population. This is most likely to occur where there is a shortage of health workers. If health workers earn much more in private practice than in public sector employment, they may prefer to stay in areas where potential private patients live. This can make it very difficult for the public sector to convince doctors to work outside the cities.
- D The data are derived from Bloom, G., 1996, 'The Adaptation of Zambia's Health Sector to Economic and Institutional Change', report prepared for an evaluation of European Union balance of payments support to Zambia



- E The latter is a particularly serious problem where HIV/AIDS is prevalent.
- F China and Vietnam which provided models for the development of the primary health care strategy, invested heavily in the creation of infrastructure and training and deployment of staff (Bloom 1997). In Southern Africa, Zimbabwe and Botswana implemented successful basic health investment programmes which created a network of health facilities. For example, 80% of residents of rural Zimbabwe lived within 8 km of a health facility in 1989.
- G The story of London's teaching hospitals illustrates how difficult this can be. Every government for the past quarter of a century has recognised the need to reduce the share of the national health budget allocated to these facilities. However, none have succeeded in negotiating an acceptable formula for rationalising London's hospital system. The government elected in 1997 will have to address this issue if it seriously intends to improve primary care services and community care, given the very constrained public finances.
- H China's experience with reforming its taxation system illustrates this problem. Tax raising powers have been radically decentralised. Local governments in the rapidly growing parts of the country have substantially increased their revenue and in some areas they are financing major improvements in social services, including health. However, the share of total revenue available for redistribution between localities has diminished. Some poor areas are barely able to pay their salary bills and their health services are seriously underfunded. The solution to the problem in China is likely to combine measures to increase local revenue generation and improve the cost effectiveness of services with larger fiscal transfers to poor areas.
- I These funds could be paid as an annual grant in exchange for the provision of a prearranged share of services to public patients or they could be disbursed as payments for individual patients.
- J The health sectors of the apartheid and colonial regimes of Southern Africa, for example, were structured largely to meet the needs of certain population groups.
- K Insurance companies charge individuals different prices for a year's coverage, depending on factors likely to affect the risk they will make large claims. This means that people have to pay the most when they are least able to afford it.
- L The experience of South Africa's medical aid schemes illustrates how difficult it is to manage intergenerational transfers. One reason for the rapid increase in the cost of medical aid is that the number of scheme members past retirement age is rising. These schemes did not put aside funds to finance medical care over its members' lifetime, and they find it difficult to meet their obligations. They face a choice between reducing the entitlements of pensioners, or asking new members to contribute more than previously to finance these obligations. This raises difficult questions concerning equity, particularly if new members earn much less than the pensioners previously did, or if they are from previously excluded racial groups.
- M This is illustrated by the organisation of a number of social benefits during the apartheid period. Measures were taken to reduce inequalities between members of a single racial group and safety net provisions were made to protect "poor whites". This welfare provision for the minority was financed at the expense of very poorly funded services for the rest of the population.
- N One factor which contributes to this pressure is the existence of an elite group of high income earners who can afford very sophisticated medical care. The facilities which serve them establish a gold standard, to which everyone else aspires. This demonstrates the inter-connection between the different segments of the health sector and provides an argument for government efforts to encourage even the most expensive facilities to provide cost-effective services.



# INTEGRATION OF HEALTH SERVICES FOR EQUITY: THE CASE OF THE PHILIPPINES

*Rosario P. Diaz*

This presentation outlines how decentralisation of public health administration in the Philippines has created more responsive governance, integration of health services and improved equity.

Our experiences in Cotabato stand in direct contrast to widely held notions that devolution has caused the deterioration and even break-down of health care in local governments. A quick review of the major performance indicators of the health sector in 1996 reveal steady improvements over the previous five years for almost all leading causes of mortality and morbidity. For example, we have reduced our Crude Death Rate in 1996 to 2.95 which is well below the national average of 7.

Our transition to devolution has proceeded in the context of several inhibiting factors. The most notable of these are: (a) resistance and fixed mind-sets of devolved health personnel; and (b) limited managerial skills on the part of local chief executives for health.

## **Public Health as an investment item: resource mobilization**

Increases in the health budgets since devolution have been possible through a combination of provincial strategies. These include:

1. Rapid capitalisation of health resources available from outside the province.
2. Cost recovery to enhance revenue.
3. Close co-operation with non-government and community organisations.
4. Partnerships with private medical practitioners.

The combined effect of these initiatives have made it possible for us to more than triple our health budget in five years.

## **Identifying and investing in Primary Health Care programs**

Provincial health has continued to provide the basic service programs that were previously implemented as national programs by the DOH. The whole point behind the devolution of health services, was to provide the elbow room for local governments to better respond to local health conditions and requirements. The degree to which the DOH regular programs for basic services were adjusted by local governments was a function of two factors: the clarity local chief executives had as to the types of community services needed, and the preparedness of devolved health workers to plan for the delivery of basic services under the direct supervision of the local government.



In this situation, the role that the PHO has had to take relative to primary health care programs has been more directive and proactive, rather than merely to assist and support. That is:

1. Encourage the Municipal Health Offices to begin differentiating preventive services between those that bear upon the general health situation at the community level and those that address the specific needs of the most vulnerable or high risk populations. Promote closer examination of available community data on Minimum Basic Needs, particularly in terms of how the top unmet needs bear upon the health situation in the communities.
2. Extend assistance to strengthen the capabilities at the RHU level to provide basic services needed to address the leading cause of morbidity and assist municipalities within district hospital catchment areas, especially in outlying areas, to access ambulances from various external sources to facilitate the referral system.
3. Provide assistance to make accessible at the RHU level the basic services for chronic care.

To advance all these initiatives, the following were provided:

- Technical assistance to the municipal governments and RHUs on the various aspects of health sector management.
- Capacity building in health sector management for LGU managers, specifically the non-health personnel.
- A review of Health Sector Performance of interested municipalities was provided to advance all these initiatives.

### **Identifying and investing in secondary and tertiary health services**

At the time of devolution, there was an uneven distribution of public hospitals with only one 10-bed hospital servicing the first congressional district, and four public hospitals, including the Provincial Hospital with 95 beds located in the second. Hospital facilities were inadequate; equipment incomplete. Personnel had to be motivated by fair compensation and benefits.

For all public hospital facilities of the province, we have had to invest heavily to expand the capacities of these facilities to respond to the growing demand for curative care. Resources have been, and continue to be allocated for infrastructure, facilities and equipment, and salary adjustments and increases. As a direct result of these investments, we have been able to attract greater patronage of the services and facilities now available in the public hospitals. The Provincial Hospital 1996 occupancy rate of 144% has risen from the 123% level of 1993. The same trend is reflected in the utilisation of laboratory services, which rose from 131% in 1993 to 154% in 1996.

A general profile of inpatients at the Provincial Hospital, based on a socialised pricing scheme legislated by the Provincial Board in 1994, gives some indication of the population served. For the 1994-1996 period, 11.6% was constituted by patients with no visible income or means of support who could completely avail of free medical services, 70% by partial-pay patients who were enjoined to extend donations, and 8.4% by those who had Medicare benefits or could pay.

The following points are most important to consider:

1. We have had to invest heavily in health infrastructure and equipment. In the second congressional district, one 10-bed hospital has since been added and two hospitals have been upgraded from 10- to 25-bed, making for a post-devolution 145-bed total capacity for the province. In the first congressional district, two more hospitals are at various stages of construction. These new hospitals will add another 35 hospital beds to service the district.



2. At both the district and the provincial level, we have sought to operationalise the DOH thrust for transforming hospitals into “centres of wellness” where promotive, preventive, curative and rehabilitative care is promoted and extended. All public hospitals in the province are “baby-friendly”; and this has been instrumental in the dramatic decreases noted in the cases of neonatal diarrhoea.
3. Consistent with the general thrust to bring the delivery of basic services closer to the populations they are supposed to serve, the district hospitals have the capacity to handle simple medical, surgical and paediatric cases. All cases are referred back to either the RHU or the barangay (community) health workers for follow-up care.
4. While this networking system is being implemented, the provincial government sees to it that the capacity of the district hospital is constantly upgraded. The necessary training of health personnel is given priority as part of the human resource development program, in a way that best matches the skills needed with the morbidity pattern in the catchment of each hospital. Specialists at the provincial level are sent to the district hospital to train and transfer their skills to the doctors at the district level.

We continually address the bottlenecks in our procurement systems, to better provide the supplies and drugs and medicines when these are needed. We have heightened our cost recovery and revenue enhancement efforts in our hospitals, and are currently undertaking a comprehensive operations and financial review of the Provincial Hospital. This review is expected to generate a plan for increasing the recoverable costs from all possible sources, and not just from the present base of user fees for drugs and medicines, laboratory services, and the use of the operating and delivery rooms. As with previous incomes that have already been generated, additional costs recovered from hospital operations will be plowed back to further upgrade facilities and equipment, and thus make the province better prepared to meet the epidemiological transition that is expected to be set in the coming years.

### **Popular participation in the identification of the right investments in public health programs**

The Local Government Code has mandated that local health boards are to be organised at the provincial and municipal levels. These boards represent the interests of the various stakeholders in local health development. Local health boards are tasked to review the health budgets of their local government unit.

In the province, we have again capitalised on the codal provision of the local health boards to institutionalise popular participation in direction-setting for health:

1. Local health boards in the province have expanded their membership and composition beyond what has been required by the Code. In all instances where the composition of health boards have been expanded, more representation from the private sector, non-government and community organisations has been accommodated.
2. In some municipalities, the counterparts of local health boards have been organised all the way down to the barangay (community) level.
3. The involvement of the members of these Expanded Health Boards both at the provincial and municipal levels has been exemplary. Members of the Expanded Provincial Health Board sit in meetings of their counterparts at the municipal level. This has helped to ensure that the intended health initiatives at the provincial and municipal level complement each other.
4. The Expanded Provincial Health Board has decided to embark on the organisation of Hospital Boards for all public hospitals in the province. The hospital boards are not intended to dictate the



operations of public hospitals relative to the technical standards set by the DOH. Rather, they are intended to increase public participation in improving the delivery of hospital-based health care services. The hospital boards serve as an added venue by which communities within the catchment areas of the public hospitals are able to articulate their needs and provide feedback to the hospitals. We anticipate that local health boards and hospital boards can come together to discuss the best possible ways of investing public resources for the best possible set of health services.

These local health boards and hospital boards are not viewed by the province as additional bureaucratic layers, but instruments to ensure the broadest participation in policy setting, and sectoral planning and budgeting - thus helping in a meaningful way to steer the politico-administrative structures of local government.



# HEALTH FINANCING AND EXPENDITURE IN SOUTH AFRICA

*Diane McIntyre\**

## **Distribution of resources across provinces**

Although there are alternative ways of evaluating the equity of the current geographic allocation of public health care resources in South Africa, there are three provinces which (in 1992/93) were significantly under-resourced relative to the rest of South Africa, namely Mpumalanga, the Northern Province and North West. This under-resourcing related not only to financial resources, but also to personnel and physical facilities. The major reason for this resource distribution pattern is that these provinces include the former 'homelands' areas which were significantly underfunded during the apartheid era. They are also largely rural, which means that there will be longer distances to travel to health facilities, and which makes it difficult to attract and retain health professionals. Rural dwellers also have less political 'voice' to effectively express demands for improved services. In addition, while the Eastern Cape was better resourced than these three provinces, it had the poorest health indicators of all the provinces. One of the reasons for this is that there are vast disparities in resource distribution *within* the Eastern Cape, with levels of resources being significantly higher in former Cape Provincial Administration areas than in the former Transkei and Ciskei 'homeland' areas. The Eastern Cape in fact best typifies the stark internal disparities existing in provinces containing former 'homelands'. It is thus these four provinces which should receive particular attention in attempts to redress resource imbalances.

## **Distribution of resources across socio-economic groups**

It is possible to divide South Africa's population into three broad categories on the basis of their household income. This categorisation is especially useful for considering the public/private health sector mix in South Africa, in that it provides a framework for establishing a profile of the persons who use services within each sector. The three categories are briefly described below.

1. *High income* earners, which includes the majority of Whites, enjoy a lifestyle similar to that of people in advanced industrialised countries. Most high income earners, and their dependants, live in their own home or rented accommodation in well serviced parts of the cities. This group obtains most of its medical care from the private sector and the majority are members of medical aid schemes (which provide a relatively comprehensive package of services). Approximately 6.7 million people are members of these schemes or purchase private health insurance. The number of people in the high income group is approximately 7 million (i.e. 17 percent of the population) (McIntyre *et al* 1995).
2. The *low to middle income* group includes approximately a third of the population. Large numbers of this group live in badly serviced urban localities. An important characteristic of this group has been the growth of unionisation since the legalisation of African unions in 1979. One result of this increasing organisation of the workforce has been the development of institutionalised social

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benefits such as pension and provident funds, and low-cost medical benefit schemes. Approximately 2.3 million people belong to medical benefit and ‘exempted’ schemes (which cover a relatively restricted package of services), or have access to on-site industry-specific services. In addition, there are a large number of low income earners (including groups such as informal sector workers and domestic servants) who do not belong to any medical scheme.

3. There is significant debate about the definition of a poverty line (Reconstruction and Development Programme 1995). Some define households as *poor* if their annual income is below the ‘household subsistence level’. This was approximately R9,500 (i.e. US\$3,167) per household in 1993 (Potgieter 1993). Du Toit and Falkena (1994) estimate that almost half of South Africa’s population is poor by this definition. Another study defined the poorest 40 percent of households, which account for 53 percent of the South African population, as poor (Reconstruction and Development Programme 1995). Thus, both these ‘poverty measures’ suggest that about half of South Africans can be considered to be poor. The highest concentrations of poverty are in the former ‘homelands’, small towns, commercial farming areas and peri-urban areas within the metropolises. In these areas, the population is mainly African. The conditions of life in these areas are similar to poor areas in other parts of Southern Africa, where people find it difficult to obtain clean water, there is inadequate disposal of human wastes, literacy levels are low and a large proportion of children are malnourished (McIntyre *et al* 1995).

In terms of the income related categories described above, high income earners have access to the full range of private sector health services, while the private health sector access of those in the low to middle income group is largely restricted to the primary care level (i.e. general practitioner services and medicines for minor acute ailments). Poor households have very restricted access to private sector services.

The differential access of these income groups to public and private sector resources and health services can be illustrated by calculating average expenditure per person by the broadly defined socio-economic groups. The ratio of spending on health services for members of medical aid schemes to spending on public health services in the poorest districts in South Africa was almost 15:1 (McIntyre *et al* 1995). Whereas the average expenditure for members of medical *aid* schemes was approximately R1,800 per beneficiary in 1992/93, the average expenditure on members of low cost ‘*exempted*’ medical schemes was R713 per beneficiary (these schemes offer very limited benefits packages), and the average public sector health care expenditure in the poorest districts was R122 per person. This provides a general indication of the differences in health care expenditure between the three broad socio-economic groups.

**Table 1: Health service indicators by broad socio-economic group**

Indicator	High Income	Middle-low income	Poor
Principal service provider	Private	Private - primary care Public - hospital care	Public
Per capita health expenditure	R1,800	R713	R122
Primary care utilisation (per capita, per annum)	5-6	(Not available)	1

Source: McIntyre (1997)



Similar disparities are evident in the utilisation of primary care services. Medical aid scheme members visit a general practitioner 5 to 6 times a year on average (McIntyre 1995), while residents of the poorest districts in South Africa utilised outpatient services (clinics and hospital outpatient departments) on average once a year (McIntyre et al 1995). These data reflect the average per capita number of visits. They could not be weighted for age and gender differences as the demographic profile of the socio-economic groups are not known.

In summary, there are significant disparities in the financial and human resources available in the private and public sectors, relative to the populations served by each sector.

### **Distribution of public sector resources between magisterial districts**

The poorest 150 of the 377 magisterial districts existing in 1992 (i.e. quintiles 1 and 2) contained almost half of South Africa's population, including the entire 15.2 million residents of the former 'homelands', 15 percent of the residents of small towns and commercial farming areas, and nearly 20 percent of the residents of the metropolitan areas. Almost the entire population of these districts was African and a high percentage of households had incomes below the household subsistence level. There were more females than males, reflecting the migration of men to metropolitan areas in search of work. It should also be noted that, not only were there legal restrictions on women moving to urban areas under former 'influx control' laws (priority was given to men who were the main providers of manual labour), there are social barriers to women migrating to urban areas.

While half of the population in the poorest quintile of districts were children below the age of 15 years, only a quarter of the population in the richest quintile of districts fell into this category. Conversely, while only 45 percent of the population in the poorest districts were adults between the ages of 15 and 64, 70 percent of the population in the richest districts fell into this category (McIntyre et al 1995). The demographic composition of these districts reflects the effects of apartheid policy, whereby those who were not seen as 'economically active' (i.e. the young, old and women) were restricted to the former 'homelands'. Residents of the poorest quintile also tended to have the poorest health status, and are particularly vulnerable to infectious and parasitic diseases (McIntyre et al 1995).

Data analysis indicates that residents of poorer magisterial districts had less access to public sector hospitals and clinic services, and had a lower health service utilisation rate, than residents of the richest magisterial districts. In addition, the public sector in the richest magisterial districts employed 4.6 times more general doctors, 30.8 times more specialist doctors, 2.4 times more registered nurses, 10.8 times more pharmacists, and 6.1 times more health inspectors/environmental health officers than in the poorest districts. Average public expenditure per person on health services in the richest districts was 3.6 times more than in the poorest districts. As indicated previously, the richest districts also have access to substantial private sector resources. While residents of these districts may have had access to public sector health care facilities in neighbouring districts, districts in quintiles 1 and 2 are clustered together, particularly in the Eastern Cape, KwaZulu-Natal and some parts of the Northern Province. In these areas, geographic access is likely to have been particularly poor. In addition, even if residents did have access to care in neighbouring districts, they would have had to incur the indirect transport and time costs associated with using more distant health services.

This analysis indicates that the population which has the lowest socio-economic status, a relatively greater capacity to benefit from health care, and which is the most heavily reliant on public sector health services, had the least access to public sector health care resources (facilities, personnel and financial resources). The allocation of resources to service provision for this socio-economic group would, on equity grounds, be a priority for the use of limited government resources.



One flaw in this approach is that it does not identify poor communities in districts with a high income per capita, particularly in the metropolitan areas. However, this can be overcome if the 1996 census is sufficiently robust to permit the calculation of per capita income at enumerator area level. This would allow detailed evaluation of health service inequities at the intra-district level, and would permit even more refined targeting of scarce public sector resources.

## **Demand-side factors influencing health service utilisation**

The above analysis focused on supply-side factors (i.e. the availability of health care facilities, personnel and financial resources) which may influence health service utilisation. Utilisation is essentially the interaction of supply and demand factors. It is thus important to recognise that there are demand-side factors which play an equally important role in determining the utilisation of various health services.

Demand for health services is critically dependent on people's income. While someone may 'want' a health service, they will not demand it unless they have the ability to pay for the direct costs (i.e. the price of the health service) and indirect costs (e.g. cost of transport, and lost time for work and productive, yet unpaid, activities). The price of health services will not only influence whether health services are demanded or not, but will also influence which health services are demanded (e.g. whether public or private sector services are used). This was clearly illustrated by the implementation of free care at primary level.

There are other determinants of the demand for health services, such as individuals' tastes and preferences. The perceived quality of care is a particularly important factor influencing patients' preference for particular health care providers. Recent studies have found that patients in Sub-Saharan Africa regard the availability of medicines as one of the key indicators of quality of health services (Bitrán 1995; Leighton 1995). Access to doctors is also frequently seen as an indicator of good quality services. Staff attitudes also influence patients' perceptions of service quality and rudeness and lack of caring by health personnel can be a deterrent to service utilisation (May 1996; Women's Health Project 1996). Cultural factors will also affect health service provider preferences (e.g. the use of traditional healers).

It is thus important to recognise that utilisation rates which may be considered to be 'low' may result from a 'demand-gap'. This could relate to an inability to pay for health services, or from factors such as perceived poor quality of health care.

## **Overview of the equity of health service financing**

The above evaluation of inequities in health service delivery and utilisation attempted to address the question: "who benefits from health care?" The following health care financing equity analysis attempts to address the question: "who pays for health care?"

Table 2 provides a brief overview of the relative progressivity of alternative health care financing sources in South Africa. At present, general tax revenue is the most progressive source of health care finance in South Africa. However, the degree of progressivity of general tax revenue is decreasing with the increasing reliance being placed on indirect taxes. Out-of-pocket payments tend to be the most regressive form of health care financing.



**Table 2: Relative progressivity of main South African health care financing sources**

Financing source	Degree of progressivity
General tax revenue	<ul style="list-style-type: none"> <li>• Personal income tax has a progressive structure</li> <li>• VAT is a regressive tax</li> <li>• Increasing emphasis on VAT revenue reducing overall progressivity of general tax revenue</li> </ul>
Medical schemes	<ul style="list-style-type: none"> <li>• Contributions have a regressive structure</li> <li>• But, majority of members in higher income groups</li> </ul>
Out-of-pocket payments	<ul style="list-style-type: none"> <li>• Most regressive form of financing (based on international evidence)</li> </ul>

### Inter-provincial resource allocation policy

After the elections, the national Department of Health moved away from a historical budgeting process and, as from the 1995/96 financial year, attempted to redistribute resources between provinces. The stated goal was to achieve weighted per capita equality in provincial health budgets within 5 years. A resource allocation formula was developed by the national Department of Health, in consultation with the provincial Health Departments.

Given the significant existing disparities in per capita public sector health care expenditure and the goal of achieving equity in per capita allocations within 5 years, substantial changes in provincial budgets were required on an annual basis. For example, the budgets of certain provinces were cut by 20 percent in real terms, while other provinces received real budgetary increases of as much as 30 percent, between 1994/95 and 1995/96. There were debates around components of the formula, but the major concern related to the pace of change and the ability of provinces to effectively absorb large budgetary cuts or increases (McIntyre et al 1995; Doherty and van den Heever 1997).

The pace of the inter-provincial resource reallocation process has placed enormous pressures on certain provinces, especially Gauteng and the Western Cape (Portfolio Committee on Health 1996) (see case study in Box 1). Academic hospitals in these provinces have been particularly severely affected. This has promoted a *relative* redistribution of resources between levels of care (i.e. cuts have been greatest at tertiary level and lowest at primary care level). While attempts are being made to upgrade primary care facilities, particularly in underserved poor areas, this has been constrained by the moratorium on filling vacant posts. Although primary level utilisation rates have increased substantially, staffing levels have not increased much which may adversely affect quality of care.

#### Box 1: Implications of budgetary cuts in the Western Cape

- 2,545 beds in tertiary hospitals (i.e. 69% of tertiary beds) and 166 beds in other hospitals (3% of such beds) targeted for closure in 1996/97
- 7.5% of nurses have been awarded voluntary severance packages (VSPs)
- Nearly 60% of VSPs awarded are at the tertiary level, while 12% are at the primary care level
- Moratorium on filling posts has led to high vacancy rate (23%-64% at regional offices; 21%-35% at secondary hospitals; 16%-22% at academic hospitals)
- But, have improved primary care coverage (outpatient visits increased by 20% at community health centres and 49% at community hospitals)

Source: Data provided by Dr F. Abdullah, Chief Director, Western Cape Provincial Administration



In contrast, the resource redistribution policy has significantly improved financing of health services in previously disadvantaged provinces. It has enabled 700 additional posts to be created at primary care level within these provinces (Health Systems Trust 1996). This is likely to represent a significant improvement in access to first level health services in underserved areas (see case study in Box 2). In addition to the reallocation of health budgets, RDP funds for the CUBP have also contributed to service improvements in these areas (note that RDP funds are used for infrastructural development while provincial health budget increases, have been used for upgrading facilities, hiring additional staff and improving routine medical supplies). Poor communities, largely in rural areas, are the major beneficiaries of these service delivery improvements.

While all stakeholders recognise the need for a redistribution of resources, the primary concern is the *pace* of change. The Ministry of Health ultimately recognised the inability of provinces to cope with substantial budgetary changes on an annual basis. A more gradualistic approach was adopted in 1996/97 (using a slightly modified version of the 1995/96 formula), with the Minister of Health stating that it would probably take closer to ten years than the originally anticipated five years to achieve equity (Health Systems Trust 1996).

**Box 2: Key achievements in Northern Province as a result of increased resourcing**

- 79 existing clinics in poor condition upgraded in 1996 (from provincial resources), and 21 replaced (from RDP funds).
- 25 new clinics in first round of RDP CUBP, and a further 25 in second round.
- All 43 hospitals are being upgraded.
- All new and existing clinics are being provided with essential equipment (RDP funds).
- Over 100 ambulances repaired, with 67 new ambulances on order.
- Over 300 other vehicles for improved service delivery and management ordered.
- 725 posts have been unfrozen and 800 new posts created, all for clinic based staff.

Source: Crisp (1996)

Although it will be a gradual process, substantial gains have already been achieved. In 1995/96, the per capita health budget in the Western Cape was 153 percent greater than that in Mpumalanga. By 1996/97, the gap between the per capita budget between these provinces had declined to 115 percent (Makan et al 1996).

The resource allocation process described above will change as from the 1997/98 financial year. The newly adopted Constitution gives greater decision making powers to the provinces. The provinces are thus now awarded global budgets, from which they can determine allocations to individual functions. This has curtailed the power of Function Committees to determine provincial budgets within a specific sector. The Financial and Fiscal Commission (FFC) has recommended that the global provincial budget allocations be determined on a formula basis (Financial and Fiscal Commission 1995). Provinces in fact received global budgets in 1996/97, and could determine the *final* budget allocation for each function within their province. However, the Health Function Committee still exercised some control over the 1996/97 provincial health budgets.

The FFC's proposed formula would 'ring fence' resources (through conditional grants) for the provision of district level health services, which would support the Ministry of Health's prioritisation of improved access to first level health care. It would also make provision for certain training and unique service costs at academic facilities.



There are, however, concerns that the FFC formula only specifically earmarks resources for a portion of provincial health services (Doherty and van den Heever 1997). Additional allocations to health will be entirely at the discretion of the provincial government. The concerns that this raises are twofold. Firstly, as there will be different sectoral priorities within each province, the process of reducing inter-provincial health care resource inequities is likely to take considerably longer than under the centrally driven 'Health Function Committee' process (or it may possibly stall the health care resource redistribution process completely). The ability of health departments successfully to compete for a greater share of the provincial budget will be particularly constrained in those provinces which have large bureaucracies (i.e. general provincial administration), as it will require significant time to 'right-size' these administrations. This problem will arise in the very provinces that most urgently require additional health care resources, namely Mpumalanga, the Northern Province, North-West and the Eastern Cape. These are the provinces which have had to integrate former 'homelands' administrations into the new provincial government structures. Secondly, those health services which fall outside of the conditional grants (e.g. regional hospitals) are likely to be adversely affected by health budget cuts (as the conditionalities will require that the 'ringfenced' components of budgets are used only for district level services and certain components of academic hospitals). The Primary Health Care Approach recognises the importance of not only having good access to first-contact care, but also the availability of adequate referral services. On this basis, some may argue that the entire health budget should be made a conditional grant.

However, it is essential to recognise the contribution of other sectors (e.g. housing, water and sanitation services) to improved health status. Thus, 'ring fencing' certain resources for the health sector has to be balanced with the need to ensure sufficient flexibility for adequate funding for other sectors which also contribute to improving the health of the population. There are mechanisms, other than the system of conditional grants, that could be used to address the two potential problems mentioned above. For example, minimum norms and standards or a set of guidelines for health services at all levels of care, could be developed by the national Department of Health. This would provide a basis for health departments more effectively to argue their case in the provincial budgetary debates.

The Budget Council has as yet not approved the components of the FFC's inter-provincial allocation formula. However, the global provincial budget allocations for the 1997/98 financial year (based on the proportional allocations calculated using the FFC formula) were approved (Clive Pintusewitz, FFC - Personal communication). Whatever the final decision of the Budget Council, it is clear that global provincial budgets will be allocated, and that the health allocation will be subject to inter-sectoral budgetary competition. Such competition is likely to become more fierce in view of the fiscal imperative to reduce government consumption expenditure, which is outlined in the "Growth, Employment and Redistribution" strategy. The national Department of Health should thus urgently develop service delivery guidelines, to ensure that the health sector is able to compete effectively *for* resources. This is required as health frequently receives a low political priority.



## References

- Bitrán R (1995) Efficiency and quality in the public and private sectors in Senegal. *Health Policy and Planning*. 10(3): 271-283.
- Crisp N (1996) Developing health services in remote rural areas. Mimeo by Dr Nicholas Crisp, Superintendent General, Northern Province Department of Health and Welfare. Cape Town: Oliver Tambo Fellowship Programme, University of Cape Town.
- Doherty J, van den Heever A (1997) A resource allocation formula in support of equity and primary health care. Johannesburg: Centre for Health Policy, University of the Witwatersrand.
- du Toit J, Falkena H (1994) *The Structure of the South African Economy*. Halfway House: Southern Book Publishers (for ABSA Bank).
- Financial and Fiscal Commission (1995) Framework document for intergovernmental fiscal relations in South Africa. Midrand: FFC.
- Financial and Fiscal Commission (1996) *The Financial and Fiscal Commission's Recommendations for the Allocation of Financial Resources to the National and Provincial Governments for the 1997/98 Financial Year*. Midrand: FFC.
- Health Systems Trust (1996) *South African Health Review, 1996*. Durban: Health Systems Trust and the Henry J. Kaiser Family Foundation.
- Leighton C (1995) Overview: health financing reforms in Africa. *Health Policy and Planning*. 10(3): 213-222.
- Makan B, McIntyre D, Gwala P (1996) Financing and expenditure. In: Health Systems Trust (1996) op. cit.
- Makan B, McMurchy D (1996) An economic evaluation of Community Health Worker Programmes: Western Cape Province case studies. Health Economics Unit Working Paper No. 26. Cape Town: Health Economics Unit, University of Cape Town.
- May J (1996) Experience and perceptions of poverty in South Africa. Durban: Data Research Africa.
- McIntyre D (1995) Demand side and cost factors affecting the affordability of a National Health Insurance system. Briefing document prepared for the Committee of Inquiry into and National Health Insurance system (South Africa (1995) op. cit.).
- McIntyre D, Bloom G, Doherty J, Brijlal P (1995) *Health expenditure and finance in South Africa*. Durban: Health Systems Trust and World Bank.
- Potgieter J (1993) Household Subsistence Level in the major centres of the RSA. IPR Fact Paper No. 95. Port Elizabeth: Institute for Planning Research.
- Reconstruction and Development Programme (1995) *Key indicators of Poverty in South Africa*. Pretoria: Reconstruction and Development Programme Office.



# **A BRIEF CHRONICLE OF DEVELOPMENTS IN HEALTH CARE IN SOUTH AFRICA SINCE MAY 1994**

*David Harrison*

## **Restructuring health services in the public sector**

In 1994, 14 different health departments were responsible for first tier management of health services. An amalgam of health authorities was responsible for second and third tier management. The first task of the new Ministry of Health was to integrate these departments into a single national department, and then to decentralise most competencies to the nine new provincial departments. Provincial departments were established following an interim period of planning under the leadership of Strategic Management Teams. These provincial departments are responsible for service delivery and account to provincial legislatures.

The district health system has been accepted as the vehicle for the delivery of primary health care. Progress with its establishment varies from province to province. In some, district management teams have been appointed. With the exception of KwaZulu-Natal (and Northern Cape which, given its small population and large surface area, will only decentralise to regional level), all provinces have defined district boundaries. One of the problems confounding district systems development is the fact that several authorities are responsible for aspects of primary health care delivery in most cities and towns. Although the new Constitution makes it clear that local health service delivery is a competence of local government, discrepancies in conditions of service for health workers and variable service capacity within local authorities make devolution difficult. For the foreseeable future, provincial departments will continue to render PHC services in some areas. Most urban areas are still grappling with the complexities of creating a single management structure for all primary health care services.

## **Revamping the private sector**

Although only a fifth of South Africans have access to private sector health care on a regular basis, sixty percent of health care expenditure occurred in the private sector. Nearly three-fifths (57%) of doctors, 87% of dentists and 94% of pharmacists work in the private sector. Most nurses (86%) work in the public sector.

The cost of private sector care has spiralled over the last 15 years. During the decade preceding 1992, private health expenditure grew from 6.3% to 17.4% of per capita gross domestic product. Consequently, membership of medical schemes has peaked at less than 20% of the population. Recognition of this fact has led the private sector to introduce measures at containing costs. These include the emergence of managed care and “new generation” medical schemes which incorporate savings incentives.

The Ministry of Health has proposed measures to minimise the use of public facilities by employed people who do not pay for the service, and maximise the use of the private sector to reduce dependency on public health services. One of the measures mooted, but not yet clearly defined, is the introduction



of compulsory hospital insurance for all public sector employees and their dependants. New medicines legislation currently tabled before Parliament providing for routine generic substitution, international tendering and a new pricing structure should help limit cost increases in both the public and private sector. At present, medicines account for almost one third of health expenditure in the private sector.

Although the Committee of Inquiry into a National Health Insurance System (1995) proposed greater collaboration between public and private providers, particularly at primary care level, there is little evidence of this occurring yet. The part-time district surgeon system, which proved very expensive and difficult to control, is gradually being disbanded in some provinces and restructured in others.

## **Health expenditure and finance**

Total expenditure on health care (public and private) accounts for about 8.5% of Gross Domestic Product. Significant disparities in annual expenditure on health care exist between people:

- ▶ served by the public and private sectors
- ▶ living in poorer and wealthier districts
- ▶ living in different provinces.

These disparities and government's response are outlined more fully in the accompanying paper by Di McIntyre. Just to note that the principal strategies adopted thus far to redress imbalances and remove financial barriers to health care:

- ▶ A formula to move financial resources from more- to less-resourced provinces has been adopted
- ▶ Free health care for pregnant women and children under five has been introduced at public facilities
- ▶ Free health care for everyone at public primary care facilities has been introduced.

The impact, intended and unintended, of these strategies will be critiqued in a paper to be presented at the Equity Seminar.

## **Health facilities**

### **Clinics**

A national Clinic Building Programme was adopted as one of the Presidential Lead Projects of the Reconstruction and Development Programme. Over 70 new clinics have been built and an equal number upgraded. The intention is to build a total of 300 clinics by the end of 1997. These have principally been built in rural areas. Staffing these new facilities has proved difficult in some areas, and some have yet to be opened.

A review of existing clinic infrastructure found a significant number without basic amenities. In Northern Province, for example, 30% of clinics did not have an adequate water supply, while a quarter had no telephone nor grid electricity. In some provinces, a "Quick Fix" programme of clinic upgrading has been established.

### **Hospitals**

In 1993, there was a total of 4.0 public and private hospital beds per 1 000 population. The distribution of beds varied greatly between provinces, ranging from 2.1 beds per 1 000 in Mpumalanga to 6.0 beds in Gauteng.



A national facilities audit conducted in 1995/6 found that many of the existing hospitals were in a dilapidated state, with serious shortcomings in their electrical, water and steam systems. The costs of restoration and/or replacement run into billions of rands.

The two principal challenges facing the public hospital sector are the need to:

- ▶ shift more resources to a lower level of care
- ▶ improve the efficiency of hospitals

A national health expenditure review, based on 1992/3 data, found that 44% of public sector health expenditure was on tertiary and academic hospitals. Government's twin strategies of clinic building (using additional funds from the Reconstruction and Development Programme) and reallocation of funding between provinces have sought to address the first need.

In an effort to promote hospital efficiency, a Hospital Strategy Project was initiated to improve management and performance. This Project was responsible for establishing hospital norms and performance indicators, as well as recommending ways of improving hospital management. The Project has now been terminated, but much of its work has yet to be implemented.

Given the budgetary cutbacks to relatively well-resourced provinces, rationalisation of hospital services has become a necessity. Gauteng is presently implementing a plan for the transformation of a number of level 1 hospitals to community health centres, and rationalising services in others. A similar planning process is underway for Pelonomi and Universitas Hospitals in the Free State. In the Western Cape, severe financial constraints have precipitated a crisis in service delivery in academic hospitals, but there is as yet no clear public plan for rationalising training and service functions in the two academic complexes. In KwaZulu-Natal, a plan for hospital rationalisation in the Durban Functional Region has been tabled, but has yet to be implemented.

These budgetary cuts, and consequent service changes, have evoked significant media attention. Academics and provincial administrations adversely affected by the cuts argue that the move toward allocative equity has been too rapid, undermining existing services while the capacity in under-resourced provinces to use the additional funding optimally has been limited.

## **Human resources**

### **Distribution**

There are three main facets to the maldistribution of human resources in South Africa.

First, the majority of doctors, dentists, pharmacists and supplementary health personnel work in the private sector, serving the health care needs of a minority.

Second, health personnel tend to be concentrated in predominantly urban provinces, and in urban areas within provinces.

Third, the distribution of most health professionals across levels of care is top heavy, with an undersupply of key categories of staff such as doctors, pharmacists, physiotherapists and occupational therapists to district level health services.

An observation rarely made is that, relative to other health workers, nurses are fairly well distributed between rural and urban areas and across levels of care. Over 85% of nurses work in the public sector.

Following countrywide strikes by nurses in late 1995, significant increases in nurses' and doctors' salaries were announced, helping to temper dissatisfaction with conditions of service. But the most publicised and controversial strategies for addressing maldistribution of personnel have been the importation of



200 Cuban doctors for rural areas and announcement of an additional 2 years vocational training for medical graduates prior to full registration with the South African Medical and Dental Council. The latter has still to be approved by Parliament.

A strategy for pruning staff establishments in relatively over-resourced provinces has been the freezing and abolition of posts. Concern has been voiced that across-the-board, rather than carefully selected post restructuring, has damaged health services through attrition.

The decision to introduce an examination for all foreign doctors wishing to work in South Africa, outside of bilateral exchange agreements, has met with alarm from superintendents in many rural hospitals almost completely dependent on non-South African doctors. They fear that the examination will act as a disincentive for doctors wanting to spend a year or two in rural South Africa - many of whom end up spending much longer.

### **Use of personnel**

The generalist professional nurse (“PHC nurse” or “nursing clinical practitioner”) has been accepted as the backbone of the South African health service, the intention being to establish an adequate system of support to and referral from clinics. Past fragmentation of services and restrictions on nursing practice have inhibited effective use of nursing personnel. Many nurses who were previously responsible for limited functions - either largely preventive in local authorities or largely curative in provincial administrations - feel inadequate in their new task of providing comprehensive care. No real sustainable process of support and in-service training has been established to meet this felt need.

An issue of continuing debate is the value of community health workers. CHWs are unlikely to be formally accepted as a cadre of public health worker, although district management teams will retain the option of engaging the services of CHW programmes administered by non-government organisations.

### **Training of personnel**

There has been considerable discussion, but little finalisation, about training of health professionals. The number of nursing colleges is likely to be reduced, while the number of medical schools will probably remain at eight. Curricula review is underway at most training institutions.

### **Caring ethos**

The death of a woman in a wheelbarrow, after having been turned away from a clinic, has once again highlighted the degree of apathy and disinterest amongst many health workers. The Minister of Health has called for an “ethos of caring” amongst health workers. While there is clear recognition of the multi-faceted nature of strategies to change attitudes and foster caring, little has been done in a systematic manner to engender this ethos.

### **Drug policy and pharmaceuticals**

Introduction of the Essential Drugs Programme in May 1996 signified an important step in containing health costs and promoting rational drug use in the public sector. The Essential Drugs List for primary care contains roughly one tenth the previous number of drugs available to primary practitioners in different parts of the country. The challenge now facing the South African Drugs Action Programme (SADAP) is to ensure the implementation of the formulated standard treatment guidelines and adequate support for new clinical nursing practitioners.

Legislation currently tabled before Parliament aims to contain the excessive cost of medicines and promote rational drug use by, amongst others:



- ▮ requiring routine substitution of generics, wherever possible
- ▮ permitting international tendering (and parallel importation)
- ▮ introducing a new pricing structure for medicines.

These proposals have met with fierce resistance from pharmaceutical manufacturers in particular.

## **Information systems**

The present information system essentially consists of financial and administrative information (within provinces) and notifications data (collated and analysed by the national health department).

Efforts to establish a national health information system (NHIS/SA) have, in most respects, failed. Greater emphasis is now being placed on the development of province-specific information systems with some degree of uniformity in data elements and technical specifications. The Free State has established a province-wide system of “patient data tick-cards”, which will begin to provide health information about people presenting to primary care facilities. A similar process is now underway in the Northern Province.

There is growing recognition of the need to focus on district-based information, and to pay greater attention to the collection, interpretation and use of information at primary care level. A series of reports have been published, presenting health information which is available in each province. This process, which seeks to involve health managers in interpretation of data, is being repeated in a number of regions and districts. A simultaneous process to encourage use of information for local planning has been initiated in a number of provinces.

## **Public participation**

Given the prominent role of civil society in opposing apartheid, and political mobilisation around health issues, public participation in health is quite substantial in South Africa. This participation takes different forms, from NGOs involved in health care delivery to community “care groups” to more structured clinic committees. Efforts are now being made to formalise public participation in health care. Some of these efforts are briefly described:

### **National**

The National Parliamentary Portfolio Committee on Health has emerged as one of the most active Parliamentary Committees. It received prominence as it considered the Choice on Termination of Pregnancy Bill and is presently hearing evidence related to amendments to the Acts controlling pharmaceuticals.

The national Department has initiated a bi-annual policy forum, at which policy proposals are mooted and discussed, and a White Paper on Health has recently been released for comment and discussion.

### **Provincial**

Three provinces have taken the lead in promoting public participation in health, namely the North West, Free State and Mpumalanga. The North West has legislated for governance of health, developmental social welfare and hospitals. The Free State has adopted a bill establishing hospital governance bodies, while Mpumalanga has outlined the functions and powers of community and clinic committees.

### **Districts**

Governance structures for districts are not yet in place, given the tussle between provincial and local authorities. It appears that a fairly pragmatic stance will be adopted, with some districts being governed by local authority structures and others firmly under provincial structures.



## Promotion of quality in service delivery

Recognition of the fact that additional resources for service delivery will be limited has led to greater focus on improving all aspects of the quality of service provision. The national department has commissioned studies attempting to develop norms and standards for health care, but appears to be accepting that the *process* of achieving improvements in quality (“total quality management”) is as important as the *definition* of norms and standards (quality assurance).

A process towards accreditation of public sector hospitals has been adopted in the Free State (COHSASA), while efforts to improve quality of primary health care include the Patients’ Rights Campaign and the Initiative for Sub-District Support. The former promotes awareness amongst the public of their rights to quality health care, while the latter attempts to address those factors impacting negatively on service delivery in selected districts across the country.

## Priority health programmes

### HIV/AIDS

The national HIV/AIDS programme (and indeed much of the national health department) was severely distracted by a political storm which blew up around the allocation of substantial funding to perform a play promoting messages related to the prevention of HIV infection.

Since the matter has been reasonably resolved, there is evidence of more systematic implementation of a 5 pronged medium term strategy, namely:

- ▶ life skills and programmes advocating responsible sexual practices
- ▶ mass communication strategies
- ▶ increased access to barrier methods
- ▶ stepping up STD management
- ▶ providing guidelines for the care of AIDS patients.

Non-government organisations are being brought in as partners in this strategy. Latest HIV prevalence studies suggests that the growth rate of the epidemic could be slowing down in some provinces, but is still rising exponentially in others. The impact of AIDS on health services is now being felt in provinces like KwaZulu-Natal.

### Nutrition

A National Primary School Nutrition Programme was established in 1994 to help alleviate hunger in children at school. The success of the programme probably peaked in 1995, when over 5 million children were being fed on a regular basis. However, the Programme has experienced significant problems related to management and corruption, and has virtually ground to a halt in at least three provinces. Efforts are underway to implement simple, effective management systems and to foster the use of the programme as an instrument for broader community development (eg. Nutrition education, school gardens, employment generation etc.)

Although the intention is to integrate the three existing food supplementation programmes (Primary School Nutrition Programme, National Nutrition and Social Development Programme, and the clinic-based PEM Scheme) into the Integrated Nutrition Programme, it is not yet clear what this means in practice.

Two nutrition strategies which have been strongly advocated as cost-effective and rapidly beneficial are routine mass-deworming in endemic areas of parasite infestation, and compulsory fortification of



foodstuffs. Apart from the nutrition benefits of the former, routine administration of anti-helminthics to children in the former Transkei and southern KwaZulu-Natal will significantly reduce the financial and social costs associated with the high prevalence of epilepsy related to neurocysticercosis. Recent studies have shown widespread deficiencies in Vitamin A, and food fortification is regarded as an important strategy in addressing this, in the light of high child mortality from acute respiratory and diarrhoeal infections (and measles in some areas).

## **Maternal, child and women's health**

In June 1994, free health care was introduced for pregnant women and children under five. This policy resulted in a dramatic increase in utilisation of services by these population groups, and studies demonstrated that women "booked" earlier for antenatal care as a result. Concern has, however been expressed about the impact on the quality of care, staff morale, and other services - but this is discussed further in a paper to be presented at the Equity Seminar.

For women, the most significant development to date has been the passing of the Choice on Termination of Pregnancy Act, permitting foetal abortion on demand up to 14 weeks, and under certain broadly specified conditions up to 24 weeks. This controversial legislation has the potential to reduce mortality rates amongst young adult women significantly, but has met with resistance from health workers in many facilities.

A National Plan of Action for children has been accepted, and is the responsibility of the provincial MCWH directorates to implement. The WHO manual for the management of the sick child has been adapted for South Africa and should soon be implemented. Delays in appointment of district level personnel have constrained the systematic implementation of the Plan of Action, and in reality, there has to date been little impact on service delivery.

## **Legislation**

### **Constitution**

The Bill of Rights, contained in the new Constitution, guarantees every person the right to an environment which is not detrimental to his or her health or well-being. Children have the right to security, basic nutrition and basic health and social services. Although no positive duty is placed on the State to provide essential services to other groups in society (women, disabled, elderly), the right to human dignity arguably protects a person from human suffering resulting from denial of health care.

Health services are listed as a concurrent functional area, whereby legislation can be passed at national and provincial level. In effect, service delivery is the responsibility of provincial government, although primary level care ("municipal health services") is delegated to local government provided that conditions of delegation are mutually agreed to by province and local government ("co-operative governance"). The present state and capacity of local government in South Africa, outside of the cities and large towns, means that the provinces will continue to administer the bulk of primary health services for some time to come.

### **Overarching health act**

No comprehensive health legislation has been passed since 1994.

A White Paper on Health has recently been released for discussion, and will serve as the basis for drafting the Health Act. No provincial health acts have thus been able to be passed.



## Other legislation

A number of other health-related acts have been amended or adopted, relating to the:

- ▶ functions of statutory professional councils
- ▶ medicines regulation
- ▶ termination of pregnancy
- ▶ tobacco control

## Synopsis

In summary, health care developments since May 1994 have been characterised by:

- ▶ restructuring of national, provincial and local management structures
- ▶ decentralisation of most legislative and executive competencies to provincial level
- ▶ systematic moves towards district-based care (although governance of districts still largely unresolved)
- ▶ reallocation of resources towards less resourced provinces
- ▶ introduction of free health care for pregnant women and children
- ▶ introduction of free primary health care to everyone
- ▶ significant clinic building and upgrading programmes
- ▶ a degree of rationalisation of hospitals
- ▶ implementation of an Essential Drugs Programme
- ▶ introduction of legislation to curb spiralling medicines costs
- ▶ implementation of a Primary School Nutrition Programme (with varying success)
- ▶ release of a White Paper on Health

Less successful have been efforts to:

- ▶ establish a national health information system
- ▶ implement a systematic, comprehensive strategy for redistributing personnel (public/private, geographical and among levels of care)
- ▶ implement a highly visible strategy to prevent HIV infection
- ▶ provide a legislative framework for policy changes over the past three years.

As district structures are put in place, emphasis will clearly shift from national policy formulation to:

- ▶ the implementation of key service delivery activities
- ▶ efforts to improve the quality of service provision
- ▶ efforts to rationalise and sustain hospitals within a comprehensive health system.



# A CRITIQUE OF SOME POLICIES AIMED AT INCREASING EQUITY IN HEALTH SERVICE DELIVERY IN SOUTH AFRICA

*Peter Barron*

Current health policies in South Africa aim to improve the health of the population as a whole, and to address inherited inequalities in health service delivery. This paper will tabulate some of the main strategies adopted by the Ministry of Health since 1994.

Strategies for Equity	Impact	
	Positive	Negative
Resource Allocation Formula	<ol style="list-style-type: none"> <li>1. This formula aimed at getting an equal allocation per capita based on the population of the provinces weighted by a poverty factor, after taking off a proportion for supraregional services (top slicing).</li> <li>2. The goal is to arrive at an equitable distribution of resources between provinces over a five-year period.</li> </ol>	<ol style="list-style-type: none"> <li>1. The speed at which parity in funding was envisaged to take place; viz over five years was thought to be too hasty. This resulted in down-scaling under severe pressure in some provinces especially in those with academic institutions. The consequence of this has been continuous crisis management focusing on financial issues at the expense of service provision and a deterioration in staff morale.</li> <li>2. Personnel costs have not been under the control of health services management. The only way of reducing staff in the short term has been through the mechanism of voluntary severance packages. This has led to unplanned reduction of services which has had negative consequences.</li> </ol>



Strategies for Equity	Impact	
	Positive	Negative
Free Health Care (FHC)	<ol style="list-style-type: none"> <li>1. The FHC policy led to a rise in the attendance of patients at most public sector health facilities which suggests that the previous system of user fees was a deterrent to people using public health services.</li> <li>2. At clinic level the number and proportion of referred cases increased, which suggests that the policy may have improved access to clinics for patients who require referral.</li> <li>3. There was increased attendance at antenatal clinics, and an increase in the number of women booking for antenatal care. In most facilities, there was a decline in the proportion of unbooked deliveries. These trends are likely to be associated with improved health outcomes.</li> <li>4. There was general support for the FHC policy by health service users who felt that access to health care has improved, especially for people living in rural areas, informal settlements and on white-owned farms.</li> <li>5. Most (70%) of health care workers felt that the free health care policy helped prevent serious illness or death amongst pregnant women and children under six.</li> </ol>	<ol style="list-style-type: none"> <li>1. Studies from two tertiary hospitals indicate that the number and proportion of visits for health problems which could have been treated at a lower level of care, has also increased. However, where a well-functioning system of primary care facilities existed, the impact on the tertiary hospital was less significant.</li> <li>2. There was some evidence that the policy may have encouraged patients with minor complaints to bypass primary level services and to use tertiary care "inappropriately".</li> <li>3. Health workers (and consumers) agreed that one of the main reasons for the "inappropriate" use of referral hospitals was the inadequacy of primary care facilities.</li> <li>4. Health workers felt very strongly that the FHC policy had aggravated a number of existing problems within the health services, such as poor working conditions and low pay, a shortage of medicines, overcrowding and poor staff morale.</li> <li>5. There was a general sentiment that the implementation of such extensive policy changes should be preceded by greater consultation and planning with health personnel.</li> </ol>
Free Health Care For All	<ol style="list-style-type: none"> <li>1. Policy has removed one of the barriers to access for all users of primary level services.</li> </ol>	<ol style="list-style-type: none"> <li>1. Priority target groups (viz pregnant women and young children) are now in competition with adult curative patients.</li> <li>2. Curative care is tending to squeeze out promotive and preventive care</li> <li>3. Health workers are overwhelmed with demand and quality of care is deteriorating.</li> <li>4. Because of the demand for services, unguided rationing is taking place based on who arrives first at the health facility.</li> <li>5. Health workers are becoming increasingly demotivated.</li> </ol>



Strategies for Equity	Impact	
	Positive	Negative
Primary School Nutrition Programme	<ol style="list-style-type: none"> <li>1. The policy was aimed at the poorest school children in the country.</li> <li>2. Developmental in nature in that it aimed at improving malnutrition and by so doing health status, and also the quality of education.</li> </ol>	<ol style="list-style-type: none"> <li>1. The programme costs nearly half a billion rands per year (about three percent of total government spending on health). Although it is generally reaching hungry primary school children it is not well targeted to decrease malnutrition.</li> <li>2. PSNP has drawn heavily on the time of overloaded health and education department professionals, taking them away from their line functions.</li> <li>3. PSNP is a vertical programme which has not contributed positively to the development of comprehensive primary care and the development of a district system.</li> <li>4. Logistical costs of the PSNP in rural areas are higher than in urban areas because of economies of scale and transportation. Yet the allowance per child per meal is the same in all areas.</li> </ol>
Primary Care Facilities	<ol style="list-style-type: none"> <li>1. The funds for this programme came from the Reconstruction and Development Programme budget. The rationale behind this programme was that many communities did not have access to care facilities. In addition the existing clinics had not been adequately maintained or supplied with appropriate infrastructure.</li> <li>2. Through the initiatives of this clinic building programme a projected total of 301 new clinics will have been built and 1 000 upgraded by the end of 1997. By the end of March 1997 approximately R350 million rands had been spent on new clinics. Considerable resources have also been spent on the upgrading of existing clinics.</li> </ol>	<ol style="list-style-type: none"> <li>1. Lack of integration between physical and human resource planning.</li> </ol>



Strategies for Equity	Impact	
	Positive	Negative
Human Resources Distribution	<ol style="list-style-type: none"> <li>1. One of the relatively short term policies to reduce the inequitable distribution of doctors was the government-to-government contract between South Africa and Cuba. This saw 275 Cuban doctors sign three year contracts to work at assigned public sector facilities. In some provinces the addition of the Cuban doctors has made a significant difference to the overall rates.</li> <li>2. A more fundamental solution to the maldistribution of doctors is being sought in the form of a vocational training policy.</li> </ol>	<ol style="list-style-type: none"> <li>1. There is gross maldistribution of human resources for health services in South Africa.</li> <li>2. More than half of all categories of health professionals, with the exception of nurses, work in the private sector.</li> <li>3. Vocational Training has been called community service under another name.</li> <li>4. Because new doctors require supervision they will have to work in institutions which can provide them with training. These are likely to be in urban areas. Thus even those few graduates who would have gone to rural areas will now not go. Thus, in the short term, there is the possibility that there will be an increase in the maldistribution of doctors.</li> </ol>
Decentralisation and District Development	<ol style="list-style-type: none"> <li>1. Bringing decisions closer to where the services are delivered is likely to result in more appropriate implementation of national policies.</li> <li>2. Management will be more accountable to the needs of the community/district, which in turn will translate into greater equity in improved service delivery.</li> </ol>	<ol style="list-style-type: none"> <li>1. Governance issues. The long term goal is local government, but in the absence of viable local government with the required capacity to run districts what should the provinces do?</li> <li>2. Differences in salaries and conditions of service between health workers in local and provincial governments continue to hamper efforts to integrate these organisations.</li> <li>3 There is a lack of skilled managerial capacity to manage these districts.</li> <li>4. The core package of services to be offered at primary level has not been agreed upon. This is fundamental to many of the issues relating to equitable health service delivery.</li> </ol>



Strategies for Equity	Impact	
	Positive	Negative
Drug Policy (SADAP)	<ol style="list-style-type: none"> <li>1. Major step towards the attainment of equity and the improvement of the quality of primary level health care.</li> <li>2. <i>Standard Treatment Guidelines</i> and <i>Essential Drugs List for Primary Care</i> were published in March 1996 and form a major component of the National Drugs Policy.</li> </ol>	<ol style="list-style-type: none"> <li>1. No coherent strategy for implementing the EDL.</li> <li>2. No visible monitoring and evaluation of the implementation of the policy.</li> <li>3. Considerable training effort is required to enable primary care nurses and doctors to utilise the list.</li> <li>4. Drug supply systems need improvement, including all aspects from procurement, storage, and distribution to record keeping.</li> </ol>

## Conclusion

Overall, there is a sense that there is a very strong political will to achieve equity coming from the Ministry of Health. Many of the policies introduced are directly aimed at achieving equity. The resource allocation formula at a macro level and the introduction of free care at the micro level illustrate the commitment of the Ministry of Health towards equity.

Similarly, policies have been initiated to put into place some of the key elements which affect health service delivery. These include the distribution of doctors, providing facilities from which these professionals can work and ensuring that appropriate drugs are available.

In concept, these policies have been generally sound. However, in implementing them there has not been sufficiently thorough analysis of the potential problems and obstacles. The result of not integrating sufficient flexibility into the policies, and the haste to implement them on a grand scale without sufficient pilot testing has led to many unforeseen and negative consequences.

Most people would agree that things are now better in terms of resource availability in the Northern, North West and Mpumalanga Provinces, whilst health workers in the Western Cape and Gauteng would agree that these provinces are worse off in terms of resources. There has been a definite narrowing between what is available to the best off and the worst off and in that sense there has been a strong push towards a more equitable health system.

What counts at the end of the day is not so much whether there are increased resources for the health system, but whether the average residents in, for example, rural Northern and North West Provinces have better access to health services and whether they are receiving better quality health care. At present it is not clear whether health services on the ground have improved or not. It therefore becomes important to develop standardised indicators which can be used to monitor improvements in health service delivery and so measure the movement towards equity over time.



# TO WHAT EXTENT AND IN WHAT CONDITIONS DOES A CORE PACKAGE OF PHC SERVICES CONTRIBUTE TO THE PURSUIT OF EQUITY?

*Emmanuelle Daviaud*

## **Introduction**

The South African Department of Health is starting to develop a Core Package of PHC services in order to define common norms and standards for the development of a comprehensive service, and through this assist in the reallocation of resources. The process is one of inclusion rather than of exclusion. However this has to take place within limited budgets and competing demands.

This paper describes the process of the definition of a Core Package, highlighting the implications for equity in the assumptions used and choices proposed. It then concentrates on those aspects of equity which will be enhanced and those which will not be touched by such a package, both as a process and as a product. In a third section it looks at the difficulties in implementation, and the inevitable impact on equity. It ends by raising some issues on the potential strength and limitations of such a package in the South African context.

A team of researchers from the Centre for Health Policy from Wits University and the Centre for Health Systems Research and Development in the Free State was charged with developing the first draft of such a package and to pilot it amongst experts, health service planners, managers and front-line providers in those two provinces.

## **The Approach to Defining the Core Package**

The first step was to define the basic principles regarding the purpose of the package. Is it :

- ▶ To increase equity, including between urban and rural areas?
- ▶ To increase efficiency?
- ▶ To define minimum process standards and improve quality?
- ▶ To help the process of prioritization through transparent criteria?
- ▶ To help the process of allocation of funds, between hospitals and PHC, between province and local authorities?

Whilst some of these principles are contradictory, the ambitious task of addressing all these issues was agreed upon, reflecting closely the view expressed by New (1997): "...A health care package is not (necessarily) about saving money ... the desire is to promote equity, collective understanding and reassurance ... It should not vary from one area to another and it should be derived as the result of an explicit, democratic process."



The aim of a core package of services is thus very different from that described in the international experience with, as a consequence, a different impact on the equity issue. The purpose is not to exclude services along the lines of selective primary health care, but rather to identify ways to include services towards comprehensive services in a way which will enable the restructuring of service delivery. By increasing the scope of services rendered at primary level, demand on hospital services would decrease, thus helping the re-allocation of resources towards primary level services. By setting minimum standards, it also aims at improving comprehensiveness and quality in the poorer services. The concept of prioritization thus does not refer to inclusion / exclusion, but rather to the different time periods at which new services can be phased in.

The task was then to set relevant guidelines for services to be delivered at each level of facilities: community, clinics, community health centres. The requirement was to balance the need to set common standards across facilities, whilst at the same time taking into account the feasibility of implementation at the different phases given the disparities in levels of training, infrastructure and management, both between areas and between provincial and local authority services. The feasibility issue had then to become a serious imperative and a number of services are aimed at a two to three year period: whilst they are already delivered in some places, the goal is for them to be delivered everywhere within 3 years, thus allowing time for the upgrading of staff and facilities or support services.

Another principle was that a core package is not merely the sum of services for various conditions, but rather had to reflect the organisational base which would enable an incremental approach to a service delivery which is patient-based rather than condition-based. "An important way in which the Package of Essential Health Services differs from priority lists designed by experts is the clustering of interventions that can be delivered together and the effort to make the package congruent with the infrastructure and model of care functioning at the district level. The packages designed so far have been adapted to the existing health system and cannot be delivered through separate, vertical programmes" (Bobadilla, Cowley, 1995). The model of PHC delivery was based on a very vertical approach: one day immunization, another Family Planning, another day STDs ... The package had to propose an organisation of services which allows, for instance, a mother and child to receive all these services in one go, in what is termed a one-stop approach. This requirement - of a more holistic approach - is also seen as a way to influence demand, and increase utilisation in particular for preventative services. This exercise took place at a time when discussions were held in the Gauteng Province on the re-organisation of levels of services and service points, with the aim of preparing infrastructure for the shift from hospital out-patients to PHC level.

## **The process**

Following initial consultation with experts and service managers, a list of services were spelt out for delivery at specified levels: district, mobiles, clinics and Community Health Centres (CHC). In parallel with this service-based type of approach, an in-depth analysis by main conditions was developed to ensure that all levels of interventions for each condition were covered, from promotive to treatment, to rehabilitative or palliative (example, scoring). This enabled a reassessment of what was done and highlighted requested modifications to the current practice for instance regarding frequency of visits. Combining these two approaches, it was then possible to develop a list of services with detailed activities for each level of service. This breakdown by level of service, and by detailed components was an essential step to assess the implications in terms of service inputs and organisation, hence the feasibility across the package.

The next step was to prioritise for inclusion at different time periods.



This exercise developed with several pillars:

- ▶ the integration of basic equity principles : needs of the most vulnerable groups have to be protected, in particular those of mothers and children and the poorest. Research has shown that it is for maternal and child morbidity indicators that the disparity between rich and poor is the widest. Fortunately, some simple medical interventions on mothers and children have had a big impact on health status, hence on equity.
- ▶ the analysis of international experience and consultation of experts regarding the effectiveness of various intervention service statistics regarding current profile of demand.
- ▶ the integration of projected emerging needs (AIDs, Chronic diseases ... ).

The latter point reflected the acknowledgment that a potential limitation of a Core Package of Services is to be based on existing needs, thereby ignoring new emerging needs. This is of particular relevance to the situation of South Africa given the changing epidemiological profile of the population with health needs increasingly representing that of an urbanized and aging population with its accompanying load of chronic diseases, as well as the new AIDS epidemic, still in its relative infancy in that country.

Our approach benefited from the experience of other countries, in particular regarding the limitations of cost-effectiveness analysis taken on its own:

“Cost-effectiveness analysis of interventions, which are more often than not, disease-specific, tend to neglect the role of the health system in delivering these interventions. There are no specific analysis of the cost-effectiveness of improving physical or human infrastructure of the health system” (Murray, 1994)

Whilst part of our objective was to develop the exercise along transparent criteria which would help a democratic process of consultation, we were forced to accept a ‘common sense’ approach with its inherent subjectivity.

Suggestions around phasing in were however the object of difficult discussions in particular regarding the issues of cervical cancer screening, and mental health services.

This is a good example of a political and public health priority. Cervical cancer is the first cancer amongst black women, it is highly preventable through screening and early intervention. However, screening is not a simple intervention like immunization. It requires proper lighting in clinics and trained staff to perform the test, the slides must be sent to a laboratory, women must come and collect their results, and the positive smears must be followed up by a colposcopy. Along this chain a number of difficulties arise: how many clinics in rural areas do have proper lighting, have nurses trained for smears, how many have regular access to laboratories, what happens with the results? Typically only between 25 and 30% of women come to collect their results, how many referral hospitals or CHCs have the capacity to do the number of colposcopies required if a systematic screening was undertaken ? None of these problems are insurmountable: after a single day of training, nurses in the Eastern MSS in Gauteng were taking smears with an inadequacy rate of under 1%. Experience in the Western Cape has shown that if women have the purpose of the test properly explained to them, the large majority return for their results. Public service gynaecologists acknowledge that if the demand was there they could re-organise to perform many more colposcopies. Whilst the equity issue would then dictate a call for an immediate introduction of cervical cancer screening for all women between 30 and 60 , a phased approach was suggested : that this screening service be offered to women attending Family Planning only (a more limited group of women who tend to come back for results). However this limited inclusion will put pressure on the development of support services, with the goal in 3 years time to extend it to all women between the age of 30 and 60.



The principles for phased implementation were then adopted:

- ▶ Priority health areas reflecting significant public health issues, should be protected, and interventions in these areas be given immediate priority:
  - Child health, in particular infectious diseases
  - Reproductive Health: Ante-Natal, Family Planning, Maternity
  - STDs and AIDS
  - TB
  - Mental health
  - Chronic Diseases (HP, diabetes)
  - Trauma and injuries
  - Disability

There was very wide agreement regarding child health and the aspects of Reproductive Health indicated. So too for STDs, AIDS and TB which were seen by all as increasing epidemics. Mental Health problems, whilst serious, are less visible. Public health personnel considered them a priority, whilst front-line workers were very reluctant to include them in the scope of clinic services, partly because they did not feel adequately qualified. A phased integration, with training, has been suggested. This is a good example of the role of the core package to protect the interests of a category of patients least able to voice their needs.

- ▶ Effectiveness should be used in the selection or in the frequency of interventions, giving added weight to some preventative interventions, and modifying some of the existing practices.

For example:

- preventative services for children should be better targeted: for instance developmental assessment should be focused on at risk children, rather than on all children
- the number of ante-natal visits could be reduced to 4 for low-risk pregnancies
- the frequency of visits for stabilized chronic patients could be reduced from monthly to three-monthly, with a more thorough consultation at the quarterly visit

Although these modifications may have some negative impact on equity in terms of needs, the package had to work within the double constraints of including more services within resources which would only increase in a limited way.

- ▶ Feasibility

A stepwise approach should be adopted where possible to take into account infrastructure, training, and financial resources. Slow phasing in was suggested for interventions requiring important logistical support. This however carried an important equity price, as shown by the case of cervical cancer screening.

## **Consultation**

The initial draft package was then taken through a consultation process with service planners, service managers and front-line providers. Various levels of facilities were consulted, from mobiles, to clinics to Community Health centres. This took place in Gauteng province (very urbanized area) and in the Free State with its mixtures of peri-urban, semi-rural and rural areas.



Whilst this consultation highlighted the potential benefit of the Package as a product, as a process, it also showed the limitations of what can be expected from such an exercise.

The positive comments focused on the process triggered by the Core package:

“it will be a useful step towards participative management. If reassessed regularly at local level, it will be a tool to assess what has not been implemented and why”

“it will help management and politicians to be aware of what nurses are doing. The managers don’t know what’s happening downstairs”

“it will be a useful tool to transfer information to nurses”

“The process of consultation is the main strength of a package”

The consultation exercise provoked discussions on aims and priority of work of front-line staff which had not happened before. By taking a step back from the next type of approach, these discussions have the potential to lead to the more sensitive and efficient operation of a facility. This aspect of the package as a process should not be under-estimated.

The rapid process of definition of the package focused on the development of a comprehensive service, with less in-depth attention given to the process of prioritization, seen not as ‘what should be excluded’, but rather as ‘what should be implemented now, within 2-3 years and within 5 years’. The expectation in our project was that timing prioritization would be developed further through the consultation process. This failed on two counts: health workers in particular were little able and willing to suggest a phased approach to implementation, and piloting with politicians and communities has still not taken place.

Given the limitations of the scope of services covered by the current PHC system, a huge component would have to be added to make those services comprehensive. Asked how they would prioritize these basic services, health workers refused to take part in the exercise saying all these services are needed. Nurses were often torn between seeing themselves as patients and their position as nurses. So, whilst saying “if there is a need we must provide for it”, and placing 95% of services in the category ‘for immediate implementation’, at the same time they were saying that there was not enough staff, not enough time, not enough drugs, not enough space, not enough equipment or not enough training. For instance, all nurses consulted put cervical cancer screening for immediate implementation and were reluctant to discuss the resulting logistics issues. Service managers often suggested additions to the initial list presented to them, whilst acknowledging, when asked, that they did not know what would be the financial implications, and glossing over some of the logistical implications. Generally this type of consultation on a list of services produces a wish list and does not elicit conflict of resources. In addition due to the separation between hospitals and PHC services, it proved very difficult to discuss with PHC personnel (both managers and nurses) implications regarding up-wards referrals.

## **Contribution of the package towards equity**

The potential role of such a package in the achievement of a higher level of equity will be outlined. It may be useful at this point to recall Mooney’s (1983) multiple definitions of equity.

- ▶ equality of expenditure per capita
- ▶ equality of inputs (resources) per capita:
- ▶ equality of input for equal need
- ▶ equality (opportunity) of access for equal need : equal costs to patients
- ▶ equality of utilisation for equal need



## **Equality of expenditure per capita**

Costing of this package, taking into account the demographic profile of the population, will help to define the level of resources to be allocated. By quantifying the number and level of staff, the type of facilities and equipment required to provide a basket of services, it will help the planning process. It will also highlight the conflict of resources between PHC and hospitals or between geographical areas. If these conflicts are addressed, then a significant move towards equality of expenditure per capita will take place. However, another condition for meeting this criteria is an equal level of utilisation of health services. This is notoriously lower amongst the most disadvantaged groups. Whilst a more comprehensive package will help in that direction, factors other than supply affect the level of demand for health care services.

## **Equality of inputs (resources) per capita**

By setting a common list of inputs and services, the Package is clearly a step towards this goal of equity. It will define what services **MUST** be included, in particular those not currently rendered everywhere (e.g. Mental Health, Rehabilitation etc). It will also be a way to control clinicians heterogeneity, and ensure comparable treatment of patients: "Clinician heterogeneity is as much a problem as patient heterogeneity." (Klein, 1997). Through these two points it may help move away from the tendency for the most articulate patients to get the best services.

This criteria relates again to horizontal equity : equal treatment of equals. However, such equality of inputs can only take place if health workers in all areas are adequately trained to provide the full basket of services. This may require unequal training subsidies to ensure equal level of competence. As such, the implementation of this objective requires a level of vertical equity: the unequal treatment of unequals.

## **Equality of input for equal need**

The first issue relates to the definition of needs. Who decides and how, who has what needs. The package responds partly to some of the physical needs of specific groups, e.g. mothers, children.

However, at this stage it has not tackled in a minor way the issue of need. As was clearly stated by Mooney (1996), this step goes through consulting the community; "The question of equality of what remains to be answered especially when we consider vertical equity. It is a question that can be addressed only through establishing community preferences". However, whilst the goal is clear, the practice is more difficult for two main reasons: the difficulty of defining who should speak for the community, and the issue of methods. What bodies exist, what organisations should be consulted, what interests do members of organisations represent and do not represent? It also became apparent that a high proportion of workers, and thus somewhat unrepresentative of the general public whose views were being sought. As a consequence, the intention to provide an objectively derived set of priorities based on the views of the public were not realized (McKee, p71).

What methods to use? "The conclusions to emerge from the research in this field (involvement of public in priority setting) is the difficulty of involving the public effectively in priority setting. The research also indicates that the results of public consultation are sensitive to the methodologies used." (Ham, p36). Notwithstanding these difficulties, the project will embark in the coming few months on a process of community consultation which process has still to be defined.



## **Equality (opportunity) of access for equal need: equal costs to patients**

Clearly the fact that services are free is an important contributor towards equity of access. However, such goals imply also that the format of service delivery must be adapted to patients who cannot go to a health service due to distance (in particular in rural areas) and due to disability or sickness. This has cost implications. Such situations highlight the conflict between cost-effectiveness and equity and the difficulty of striking a balance between these two objectives in a situation of scarce resources. Whilst there is a program of building clinics including in the rural areas, the contribution of the Core Package to this issue of accessibility, in particular with the development of home visits, will not take place significantly in the short term.

## **Equality of utilisation for equal need**

This goal refers very specifically to vertical equity, as Mooney (1983) describes: “There may be a desire to discriminate positively in favor of those who are less willing to utilize health care ... There should be additional resources made available to multiply-deprived areas, more than in proportion to any extra needs that exist”. This objective emphasizes that the pursuit of equity must also attempt to impact on demand. A large body of research has focused on the factors affecting the utilisation of health services, from issues of information and access, to issues of cultural barriers, of perceived relevance, quality and benefit of services offered. By stating clearly what the community and politicians can expect and demand, the package has the potential of increasing the overall utilisation of services. In addition, a number of interventions to be performed by the district have been included in the Core Package which should help lowering some barriers to utilisation: local media campaigns in relevant languages to inform about services with opening times and location of services, and regular community surveys (not just patient exit interviews) on perceptions of services. Such initiatives will however, have to be matched by monitoring of quality of service and efficient management systems to ensure appropriate drug supplies and referral systems. However it is unlikely that the introduction of the Core Package will be accompanied from the beginning by such initiatives with the likely consequence that this objective will be unsatisfactorily addressed.

Whilst this package clearly has the potential, both as a product and as a process, to make some positive contribution on the road towards equity, one must also ensure that it does not carry with it the potential to either increase inequity or to block further development towards equity.

## **Problems of Implementation**

When the principle of the Core Package of services is accepted, a long series of questions will no doubt be raised around the conditions of its implementation.

The first issue concerns whose responsibility it is to ensure its implementation at a local level: the province or the local authority. Local authorities have very varied levels of capacity, different levels of infrastructures and support systems. As a consequence the type of package municipal services will be able to deliver will vary. Local authorities will receive subsidies from their province to deliver PHC services. The Core Package may ensure that this level will be defined at a level which will allow the poorest local authorities to deliver the minimum package. For the local authorities that are already in a position to deliver more than the minimum, will the level of subsidies be increased accordingly? Such a move carries the risk of increasing inequity. Where then will the funds come from? With an, at best, stagnating health budget, such a package will be implementable only by diverting funds away from hospitals. This shift towards PHC will also require a re-deployment of hospital staff towards primary care levels. The mechanisms for both financial and staff moves do not exist yet. They may also contribute to



weaken further community and regional hospitals with a negative impact on the chain of referral upwards from primary level services.

It is specifically due to the seriousness of these issues that the Department of Health sees the Core Package as a way to speed up the shift of resources. Inputs for the package (infrastructure, equipment, staff, drug supplies) will have been quantified. Each province will then be able to assess the gaps it has to cover. Since provinces have the discretion to allocate between hospital and PHC services, this will put pressure on them to shift within their budget or to lobby with the national level for a different slice of the national budget. Whatever responsibilities are finally being allocated to local authorities it is the province's ultimate responsibility to ensure that the Core Package of services is being implemented. It is envisaged that this should be phased in over a five year period, with different speed of implementation to take into account the various starting points and at local level.

Given the legacy of focus of PHC services on promotive and preventative, the majority of PHC staff are not trained to run a curative service. A cross-section of regions in the Gauteng Province indicates that in 3 years time only 50% of clinics will be able to render comprehensive services if new fully-trained staff are not appointed, or hospital staff not redeployed. As a consequence, staffing requirements will have to be increased by 20% for the next 3 years, to cover the need to send staff for additional training.

Another important aspect of the reality check about the Package is to assess the resource implications, and the feasibility of this level of resources. A costing exercise was carried out which looked at the financial implications of increased coverage and wider supply. The initial package would cost about R60/year/capita, with the full package representing a 28% increase on that figure at about R200. Currently (95-96 figures) the average PHC cost per capita per year is R125 for public services and for people without medical aid, but covering huge variations, from R77 in the Eastern Cape to R232 in Mpumalanga. With the proposed package costing 28% more than what is currently being spent, it is clear that implementation even of the minimum package will have to be phased in. In addition, the discrepancy, up to three fold, in the level of PHC spending between the provinces points to the need for re-allocation of resources highlighting once again the role of the Core Package in the move towards equity. Such reallocation cannot be done at once. Besides the political cost of drastically cutting budgets of the more resourced areas, this would destroy both services and jobs at a time where the poorer areas may not have the capacity to absorb significantly higher level of resources. An estimate carried out by the Centre for Health Policy shows that services should not be cut in real terms by more than 3% a year and expand by more than 6% a year.

Whilst some consultation on services and priorities has taken place, only piloting or phased implementation, with in-built evaluation, will enable us to identify in a realistic way, conflict between demands and resource inadequacies. Ways to curb escalating demands for curative services in order for priority services to be protected will have to be addressed. This may take the form of reinforcing some services with better levels of staffing. Alternatively a portion of curative contacts could be referred to hospitals where they would pay or the demand could be regulated through queues. Each of these options have clear equity implications. Relevant systems will probably have to evolve following piloting on the ground.

## **Next steps**

An initial step will be a process of consultation with every province. Feasibility was one of the criteria to determine timing of inclusion in the package. It was tested in Gauteng and the Free State. Testing in the other provinces may modify what is considered feasible.

The other important step is the development of the process of community consultation.



Finally, proper implementation will have to be tested, whether through a piloting process or through more general implementation with in-built evaluation. Tools for such an evaluation will have to be developed.

## Discussion

Whilst this paper focused on the role of a Core Package of Services in the pursuit of equity, it is important to re-establish that equity in health will essentially not be established through health services.

“The right to equal opportunity (or even equal health?) given to all members of society as part of the collective responsibility can only be secured through co-ordinated policy action across many sectors, and not through piecemeal and unconnected palliative actions in different sectors” (Gilson, 1989)

Health services have however a role to play. This paper has attempted to show that a service-based comprehensive package of services could be a step towards development of equity, unlike a selective primary health care approach. It also emphasizes that changes cannot happen only at clinic level, that it is a system approach which involves proper rebalancing between tertiary/secondary and primary levels with reallocation both in terms of financing and staff, which involves proper development of districts and clarity regarding issues of governance. Those are complex issues involving complex processes and a combination of partners, national, provincial, local, hospitals lobby, unions. The government has the legal power to set national norms and standards, but it needs to use its political leverage to develop the required processes and modify existing systems. It is worrying to note that in the National Department of Health, both the Health Systems Directorate which also covers Policy and Legislation, and the Hospital Directorate have a fraction of the full-time professional staff that vertical program directorates like the AIDS or TB directorates command. What will happen to implementation if the relevant processes do not take place?

With the concern to develop what Klein calls “a national template” is there not a danger that its level be set at that of the lowest common denominator? This ambitious package, which will have to be curtailed through piloting and costing, aims at setting a minimum standard at a level significantly higher than the current base level of services. The required transfer of resources would then help counterbalancing some inequalities between health services and limit the leaking of public funding towards the rich. It is however essential to build in, from the beginning mechanisms, to ensure that the Core Package is a dynamic process and does not remain at the current minimum level. The proposal around cervical cancer screening with limited inclusion now to prepare support services for wider inclusion later is aiming precisely at that objective.

How also to ensure that the focus does not remain at the level of a list of services at the expense of the way services are being delivered? Klein argues that “Rather than worrying about drawing up an NHS menu, we should concentrate on what’s going on in the kitchen”. Consulting communities might bring in much relevant information and could help ensure that an improvement on the supply side meets increased utilisation, especially on the part of those who have traditionally under-utilised health services whilst needing them most.

If the package sets higher standards, if there is a deliberate process of participation for the implementers and the users, if there is a proper strategy of implementation and support, then a Core Package has the potential to make a positive contribution to the objective of equity, even if in a step-wise way.

But will the conditions exist in South Africa to make it more than just another interesting policy document?



## References

- Bobadilla JL et al (1994) Essential national package of health services. *Global comparative assessments in the health sector*. WHO, Geneva.
- Bobadilla JL Cowley P (1995) Designing and Implementing packages of essential health services. *Journal of International Development*, Vol 7, No 3, p.543-554.
- Gilson L (1989) What is the future for equity within health policy? *Health Policy and Planning*, 4(4).
- Gilson L (1997) In defence and pursuit of equity, Unpublished paper.
- Ham C (1996) Priority Setting in Health. *Health Policy and Systems Development - An Agenda for Research*, Janowsky K (ed), WHO, Geneva.
- Klein R (1997) Defining a package of healthcare services the NHS is responsible for: The case against. *British Medical Journal*, Vol 314, 15 Feb.
- New (1997) Defining a package of healthcare services the NHS is responsible for: The case for. *British Medical Journal*, Vol 314, 15 Feb.
- Makan B et al (1996) Financing and Expenditure. *South African Health Review 1996*. Health Systems Trust, Durban.
- McKee M. Health Needs Assessment. *Health Policy and Systems Development - An Agenda for Research*. Janowsky K (ed), World Health Organisation.
- Mooney GH (1983) Equity in health care: confronting the confusion. *Effective Health Care*, Vol 1, No 4.
- Mooney GH (1996) And now for vertical equity? Some concerns arising from Aboriginal Health in Australia. *Health Economics*, Vol 5.
- Murray et al. (1994) Cost Effectiveness Analysis and Policy Choices: Investing in Health Systems. *WHO Bulletin*, 72(4).



# WHAT PACKAGE IS AFFORDABLE AND SUSTAINABLE?

## Examples From Columbia

*William Hsiao*

### Three steps to developing a “core package”

In order to develop this package, you need 3 basic starting steps. The first step is to measure the burden of disease by using the DALY. To do this, you need the country data by region for mortality, morbidity and disability. Most countries do not have this accurate data, so you must first go through some complicated calculations.

You then deal with the affordability / benefit package. Look at the current public spending on preventive/ curative services by the government in a base year. In Columbia the process (on fast track) took roughly 2 years. The advantage of doing this is that you can integrate the preventive programmes/measures along with curative measures. So you can prioritise for the low-income groups (the programmes lie in order of their cost effectiveness). It maximises the improvement in the health status of the people. It integrates the preventive and curative, as well as telling you which intervention is most cost effective in improving health status. Thirdly, this combines mortality data and morbidity data. The outcome in Columbia was that when the planners looked at what was affordable, those people who were already covered under the civil service and labour insurance rejected the package because it would have been a cutback to the services they already receive. In both countries, within a week, the chief planners for this reform had to cave in and say that they would not touch the people who were already covered under another insurance program. So the first thing is political. Then they had their programme split into 2 sections – into the contributory (workers in the formal sector or the civil service) and the other 40% of the people are low-income earners and their benefits were prioritised. They have less now, but they have Primary Care services available to them.

The implementation in Columbia was problematic. Immediately, questions of priorities arose – in that the organisation of services was not considered. The district hospitals questioned the prioritisation on the grounds that it would only pay for certain types of surgical procedures. Who will pay for the rest? Staff were concerned that although the package would only pay for abdominal surgery, they were expected to perform other types of surgery as well, and that the fixed costs of the surgery were too high for it to be sustainable.

Furthermore, this approach to prevention and promotion breaks down cost effectiveness by age and sex. In other words, people over the age of 19 have to pay for the services that people under this age receive for free. Health workers say that this creates a public relations problem within the community. Similarly, when someone comes into an emergency ward, the staff must evaluate whether the wound is major or minor, and if it's major, the patient must pay. Staff find this very difficult to deal with. These kinds of policies, funded by the World Bank, were put forward in Columbia. They did not work. WHO also promotes programmes such as those put forward by the World Development Report, and there is money to support them from the World Bank and other organisations. I ask that before you take these programmes on that you consider the mistakes made in Columbia and tread carefully. Learn from what other countries have encountered.

So the question is, how do you do it? My suggestion is that you promote equity by building up the



basic services at the lowest level first, similar to what Thailand did. In South Africa, you need to invest in capital and human resources and build up your clinics first. Then you must decide if they are to be staffed by one doctor plus nurses, or all nurses. By using the cost benefit approach, you can then decide whether you want to add mental health services or dental health services, for example first, you must start with the organisation and see how you expand it using cost effectiveness principles. Once that's available and equitably distributed, you can move up to your health centres and from there, your district hospitals. To me, that's a much more sensible way of going about operationalisation – make the services functional and available to all people. That is how I would define an affordable package.



# WHAT PACKAGE IS AFFORDABLE AND SUSTAINABLE?

*Eleuther Tarimo*

How do you decide whether a package is both affordable and sustainable?

I would first ask myself 7 questions:

1. How does this package relate to the overall system? If this is a package that requires separate action from the rest of the health system, then it is unsustainable.
2. Is the package dealing with the efficient use of workers' time? For many countries, particularly in Africa, 70 to 80% of their current budget goes on salaries. In the long term, I'm sure it will be possible to change the proportions to ensure that one has adequate supplies, but in the short term these are resources that are already tied up. Every study on the utilisation of workers' time shows that only 60 to 70% of their time is truly utilised. Therefore, a package that does not take that potential into consideration is not sustainable.
3. Is this package encouraging the use of the holistic approach? It's often found that the gain of one programme is the loss of another, such as the outbreaks of cholera – they have been directly due to the success of the immunisation programme. How? Simply because the immunisation programme, with lots of resources from outside has attracted workers from the environmental sanitation programme and their own programmes have collapsed. So one needs to ask oneself if this is a package that looks at things horizontally, or are you only picking up particular elements?
4. Is this package enhancing equity? Is there some form of targeting? This is a fairly obvious objective.
5. Are donor agencies willing to be involved in providing long term resources/funds for implementation?
6. Does the package enhance linkages with communities?
7. Does the package allow for implementation, monitoring and evaluation in a way that's realistic and sensitive to political considerations

In essence, we can only make a judgement once we have seen the product. And once you have done that you are in a position to make conclusions. First of all, the establishment of packages has been mostly concerned with financing issues – institutional development and organisational factors that are essential for sustainability. These have been more or less sidestepped. Secondly, packages to a large extent, are dependent on the approaches taken to set them, and the values used. And in this case, the approach was to reduce the burden of diseases rather than the organisational or management issues.

Thirdly, despite its' attraction, can we be sure what we mean by 'the package'? Is 'the package' for the people who are making decisions or is it a package at the clinical or the operational level? That is, to whom is the package addressed? Fourthly, the planning of the systems of the packages, if they are to promote PHC and sustainability, have to emphasise more than linkages with communities. My final point relates to the term 'package'. It is very important, yet carries some sort of mystification. Would it not be more useful (and honest) to call it by what is actually inside the package?



# INTO EACH OTHER'S WORLD

*Alfredo RA Bengzon*

All of our differences of experience and opinion notwithstanding, we all belong to one sector, bound together by the accumulated and transmitted bodies of knowledge, activities, values and traditions that give substance to the banner of *health*. Efforts to attain equity within this sector are complex and multifaceted. Such inherent complexity is magnified and multiplied as reform initiatives tend to be highly controversial and divisive, seeking to balance societal scales and indeed tip these in favour of those who are most marginalised and least empowered.

Effecting lasting reform under such conditions cannot be realized by using traditional adversarial approaches that are advanced on the basis of the superiority of some and the subjugation of others. Neither can this be founded on perspectives that are based solely on technical proficiency, political expediency or economic necessity. Instead, the nature of reform prescribes that we be expansive rather than restrictive, and inclusive rather than exclusive.

As reform is complex, it becomes necessary for us to draw from a wide range of disciplines, expertise and experience. As reform is controversial, it becomes imperative for us to develop a strong and solid base of support to implement and sustain reform, particularly in the face of formidable opposition. Indeed, it is apparent that the larger and more ambitious the purpose of reform, the broader the base of collaboration that is required. Let me put it more emphatically: for different sectors to collaborate effectively they must *enter into each other's world*.

Now the question may be asked: What stands in the way of entering into each other's world? Or, 'other' having come in to our world, what prevents us from working together more effectively? Put more conventionally, what are the obstacles to productive collaboration across the various sectors of society?

Intersectoral collaboration presupposes commonality or alignment on three levels: concept, method, and motive. Incongruities among the collaborative parties at one or more of these levels will necessarily cause a breakdown in the collaborative effort.

## **On the level of Concept – Hospitals and the Health Care System**

With the reconstitution of the Philippine Congress in 1987, newly-elected legislators, eager to make contributions to their communities in the area of health, focused their efforts on the most tangible component of the health system - the hospital. From 1988 to 1990, 148 bills were filed by members of the legislature for the establishment and expansion of local hospitals and health facilities. This barrage of bills was a clear manifestation of the common fallacy that equates health care with hospital care.

Given limited resources, the Department of Health (DOH) was not inclined to establish or expand hospitals. But the political reality was that these legislative initiatives could not be stymied. Rather than attempting to obstruct these directly, the DOH defined a set of criteria for hospital site selection based on local needs and presented the legislators with a smorgasbord of options – including medicines, midwives, and ambulances – in lieu of hospitals. By enlightening the members of Congress, we managed to strike a balance between political motivation and more rational use of health resources.



## **On the level of method – The Devolution of Health Services**

In 1987, representatives from both the Lower House and the Senate proposed bills designed to devolve substantial powers including health services from national to local government. The DOH recognised that if implemented properly, devolution could result in improved access to and enhanced responsiveness of health services. However, the DOH was concerned that local executives were ill equipped to manage the technical and administrative demands of health service delivery. In addition we feared that field infrastructure would be dismantled, resulting in fragmented service delivery and compromised service quality.

Political pressure to pass a law providing local autonomy *before* the scheduled 1992 elections proved greater than the influence the DOH could exercise. Because of a failure to come to agreement regarding the various operational requirements of health care in a devolved environment, implementation of devolution has proven problematic.

## **On the level of Motive – The Philippine National Drug Policy**

The Philippine National Drug Policy (PNDP) evolved with a desire to eliminate corruption and improve efficiency and responsiveness of DOH drug procurement. In its final form the PNDP was composed of four interrelated pillars that sought to address the wide range of issues that emerged in the area of pharmaceuticals: Quality Assurance of Drugs; Rational Drug Use; Self-sufficiency in Drug Production; and tailored Government Procurement.

When the Philippine Congress was reinstated in July 1987, a number of legislators eagerly took up the nationalistic cause espoused by the PNDP. Within the same month a Generics Bill was proposed by members of both the Senate and the House of Representatives. As such, the DOH helped shape and enact the Generics Law – a bill that provided for mandatory generic labeling, prescribing, dispensing and advertising of all pharmaceutical products, as well as the development of an Essential Drugs List. Implementation was then undertaken using a systematic and phased approach. At the same time, deliberate efforts were directed at cultivating stakeholders who would facilitate and champion policy change. However, the radical nature of the PNDP and the Generics Law did elicit negative responses from foreign players within the pharmaceutical industry, who were alarmed by the possible consequences of the PNDP on their bottom lines. Pressure was thus brought to bear by their home governments and the Drug Association of the Philippines (DAP) filed a legal petition requesting the nullification of generic labeling.

In the end, the DOH prevailed in the courts. However, this victory was achieved at substantial human and financial cost, and to this day we continue to face opposition. It is all very clear: incongruencies between different sectors prevent the emergence and sustenance of potential allies.

What stands in the way of intersectoral collaboration? For those of us in the health sector, the obstacle is probably hardness of the heart. How can this be overcome? By looking for opportunities to be engaged by them in their own territories, so that we ourselves may be convinced that unfamiliar territories are not necessarily hostile. For our South African colleagues, that could be now and for some time. For us in the Philippines, that could be the next 12 months as we prepare for elections and become engulfed in a campaign where all candidates promise to bring to the doorsteps of every Filipino, particularly the deprived, the fruits of a resurgent economy. If we are alert enough, imaginative enough and driven enough, we can all find, and perhaps even facilitate, the emergence of a *defining period* that would allow us to enter into each other's world.



# IMPROVING AND MONITORING THE EQUITY OF HEALTH CARE PROVISION: A DISCUSSION OF THE SELECTION OF INDICATORS

*David McCoy and Lucy Gilson*

## Introduction

The promotion of social justice lies at the core of the new South African state. The constitution states, “*We, therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to heal the division of the past and establish a society based on democratic values, social justice and fundamental human rights*” (Constitutional Assembly, 1996).

What remains unclear is how best to provide health care in ways that promote equity. Despite the implementation of wide-ranging health care reforms in many countries, there has been little attempt to monitor their impact on equity either in Western Europe (Politt, 1995), or in Africa (Gilson and Mills, 1995). Even in societies with well-established health systems that espouse equity as a core goal, such as the United Kingdom, there has been little evidence of progress towards equitable health care (Benzeval et al, 1995).

At present, those sections of the South African population who are most vulnerable to ill health are “those who also have the greatest difficulty accessing health services and are those who are treated the most shabbily when they do” (CASE, 1995). As policy-makers design and implement responses to this situation, it is critical to develop monitoring and evaluation systems that specifically identify and monitor change in key aspects of health care inequity.

The determinants of inequity in health, however, are located within a complex web of political, economic, social and historical factors that leave individuals and population groups more or less (unfairly) vulnerable to ill health. The focus of this paper is to identify indicators of health care provision, and does not focus on the provision of services by other sectors.

In addition, the bulk of this paper is focused on health care provision in the public sector.

### Equity

In this paper, equity is concerned with ‘fair shares’ and not ‘equal shares’. This interpretation should imply that the more needy groups in society benefit more from improvements in health care provision than other groups. As recent conceptual debates emphasise<sup>6</sup>, one equity goal for the health sector is that health care provision should be distributed in ways that preferentially favour the most needy groups. This is reflected in South African policy where the 1995 national District Health Systems policy document interprets equity as requiring “*improved service delivery to under-served communities and the development*



of a system that will ensure equity of service provision in the long run" (Mooney, 1996).

This approach has important implications for the selection of equity-related indicators. They must not only monitor the provision of health care to the most needy groups of the population, but also determine whether the relative gap in provision between them and the less needy declines over time.

## Factors considered in the selection of indicators

### Different types and uses of indicators

Different types and uses of indicators have been considered. These include:

- ▶ Indicators for the purpose of monitoring;
- ▶ Indicators to identify and target disadvantaged population groups and areas of the country for preferential attention;
- ▶ Indicators to help identify appropriate strategies and interventions for *preferentially* improving health care provision to disadvantaged population groups and areas;
- ▶ Non-quantitative indicators that are used to guide and promote certain policy-making and health management processes.

Fundamental to this paper is the belief that indicators need to be selected and used in a way that helps to drive the process of change, rather than to simply monitor change.

### Highlighting decision-making processes

Progress towards greater fairness and justice in health care provision requires that decision-making processes in health policy are monitored. Equity is as much, if not more, to do with fairness in decision-making as with fairness in the distribution of resources.

Two further arguments support a focus on procedures. The participation of vulnerable groups in decision-making is important both because it empowers them (Benzeval et al, 1995), and because it generates the social capital that is an important component of health egalitarian societies (Wilkinson, 1996). By enabling vulnerable groups to address their own problems, the social cohesion and public action required to redress inequity more generally is generated (Dreze and Sen, 1989). Moreover, participatory decision-making processes which ensure that the voice of critical stakeholders, such as front-line health care providers, are increasingly recognised as important requirements of effective health policy-making (Walt and Gilson, 1994).

For example, the isolation and distance of rural areas from centres of decision-making (usually located in capital cities) often means that the rural perspective is lost when it comes to influencing policy. Rural health workers are much less likely to receive white papers or draft policy frameworks on which they can comment. As a result, the development of policies, clinical protocols and post-graduate training courses reflect an urban bias, and take little account of the typical constraints and realities of rural health care. This reinforces the inequity between urban and rural areas which has already been caused by inferior staffing levels and facilities.

Developing indicators for monitoring fair decision-making and for helping to ensure that the voice of the most needy groups is heard, listened to and actively considered within decision-making structures and processes, is difficult. It requires not only monitoring the existence of structures and mechanisms for fair decision-making, but also monitoring whether these structures and mechanisms actually work



in ways that reduce levels of inequity. Because fairness is a complex social value that is not quantifiably and objectively measurable, indicators that are used to monitor fairness need to be seen as tools that point towards the development and implementation of processes, rather than as tools of measurement.

### Using a mix of population disaggregations for the development of indicators

The picture of South Africa's inequity in health can be reflected across a number of social divides, or disaggregations of the population (see Box 1). The "haves" and the "have-nots" of South Africa can be identified in a number of different ways, and offers various options for the selection of indicators.

International experience points to the importance of using more than one population category in assessing inequity. The range of relevant disaggregations includes disaggregation by race, by area, by socioeconomic status, by education, by age and by sex. The use of racial categorisations to monitor progress towards equity is controversial. Whilst it does well in capturing the current picture of inequity (as a proxy indicator of socio-economic status), it has been questioned on the grounds that will continue to promote discriminatory views and sustain a perception that inequalities in health care provision are biologically determined (Ellison et al, 1996).

#### Box 1: Examples of health inequalities in South Africa

##### Differences between racial groups

The Infant Mortality Rate varies from 54 for Africans to 7 for Whites

Per capita expenditure on health (1987)

- Whites R 591
- Coloureds R 340
- Blacks (RSA) R 138

##### Differences between socio-economic groups

Per capita health expenditures vary from R1,800 for high income groups to R713 for middle income groups to R122 for low income groups (McIntyre, 1997).

##### Differences between geographic areas

6.0 public and private beds per 1 000 population in Gauteng as opposed to 2.1 in Mpumalanga (Rispel and Behr, 1992).

Doctors per 100,000 population:1992/93

- Western Cape 144
- Northern Province 16

Per capita expenditure on health (1987)

- Blacks (RSA) R 138
- Blacks (Homelands) R 55

##### Differences between the private and public sector

Total Health Expenditure (1992/93):

- 58% on private health sector, serving approximately 23% of population
- 39% on public health sector, serving approximately 77% of population

62% of doctors, 93% of dentists, and 89% of pharmacists work in the private health sector.<sup>17</sup>

##### Differences between urban and rural populations

Doctor:population ratios:

- Urban 1: 875
- Rural 1:12,700



## Identifying indicators to monitor health priorities and relevant types of health care provision

Apart from monitoring differences in the standard of health care provision across different disaggregations of the population, progress towards equity can also be measured by monitoring how well the health system is orientated and aligned towards providing the types of health services that address the particular health needs of those who live in poverty.

The health problems of TB, STDs/HIV, malnutrition, and preventable causes of infant and perinatal mortality are problems that typically and predominantly afflict the disadvantaged and vulnerable groups of society. Preferentially addressing these health needs as priorities of the health system would therefore have the effect of improving levels of equity in health care provision.

This would help reverse one legacy of the apartheid government - a health system that neglected the priority health needs of the disadvantaged, in favour of the affluent. Thus, while Cape Town became an international centre of excellence for human organ transplant, it had one of the highest TB rates in the world co-existing with a hopelessly ineffective system for TB control.

Monitoring the appropriateness of the content, mix and priorities of the health service is therefore one way of assessing the degree to which inequity in health is being addressed, and can help shift attention and focus away from the delivery of health services that are not as effective in meeting the needs of the disadvantaged.

Although indicators to monitor progress towards the provision of an appropriate mix of health services will help to ensure that the priority health needs of the disadvantaged groups of society are quickly met, it will not necessarily improve equity in health. However, it is argued that the process of providing this minimum package can help to ensure that more attention and resources are allocated to the currently neglected population groups and areas of the country.

## Focusing on indicators to monitor the quality of care

In addition to developing a more appropriate health service, indicators must be developed to monitor the quality of health care. Quality monitoring has been described as making comparable quality assessments in order to identify deficiencies in health care provision and to correct them (McGlynn, 1995). Without an adequate focus on quality assurance, indicators to monitor equity in health care provision may end up just comparing differences in health system inputs and outputs without an adequate comparison of differences on outcome or impact.

If the deficiencies in the quality of health care provision to the most vulnerable populations are corrected in preference to those of the less deprived groups, then some progress towards equity will be made.

**Illustration:** The evaluation of South Africa's policy to provide free health care to pregnant women and children under six years, concluded that while the policy had increased health service utilisation for the poorest sections of society (ie. better equity measured in the form of health system outputs), problems with the capacity of primary level personnel to cope with the increased workload, and a failure to ensure adequate supplies and stocks, meant that the actual quality of care may have been compromised. (McCoy et al, 1996)

**Illustration:** Whilst a clinic-building programme in the former homeland areas of South Africa may help to improve levels of equity in terms of the clinic:population ratio (ie. better equity in the form of health system inputs), insufficient staff and inadequate supplies to these new clinics may mean that improved equity in terms of access to quality health care has not been achieved.



Finally, the quality of health care provision from the patient's perspective is emphasised. One needs to monitor aspects of health care provision that influence satisfaction and other social and cultural interpretations of accessibility and acceptability. For many South Africans, not having access to a doctor who speaks their own language is a significant barrier to quality health care that predominantly affects the disadvantaged members of society.

### **Focusing on health districts**

This paper stresses the development of indicators that can drive change as much as monitor change. For this reason, this paper emphasises the advantage of disaggregating the population according to health districts. While variation in the quality of health care provision can be compared across various population groups and at different levels (eg. at individual, facility, and area level), it makes sense to use the health district as the unit of cross-comparison because it is the basic management unit of the South African health system. Measuring disparities in the quality of health care between different districts will facilitate strategies for improving equity that can be implemented through the normal administrative and management structures of the health system.

At the same time, it is important to recognise the limitations of using administrative boundaries to categorise population groups. Some health districts may consist of a mix of rural, urban and informal settlement areas, each with a different picture of health and a different set of health needs. The CASE Household Survey of Health Inequalities in South Africa indicated that it is people living in rural areas and informal settlements who have to travel furthest to a health facility, who must wait longest to see a health care provider and for whom a medical consultation is most likely to last less than five minutes (CASE, 1995). Indicators must therefore be developed to highlight the poor standard of health care for people living in such areas.

### **Linking indicators to resource redistribution**

One way of improving levels of equity is to redistribute resources in favour of the disadvantaged areas and populations. The obvious starting point is to redistribute financial resources more equitably. However, this does not always translate into shifts of real resources, especially with personnel, because it is much more difficult to shift people than it is to shift funds. Furthermore, attempts to create greater equity by simply shifting resources to disadvantaged areas can be counter-productive to the equity goal if these resources are inappropriate, and/or if they cannot be used.

Some of the important resources that need to be redistributed, but which are rarely monitored are the time, energy and attention of personnel who are located in well-resourced and well-served areas, but who can play a role in supporting and improving the standard of health care provision in the under-resourced areas. These would include senior provincial-level staff, and people with appropriate expertise from academic institutions and from the NGO sector. Using their help in developing human capacity, appropriate policies, management systems, and in fast-tracking bureaucratic procedures, could be important strategies for preferentially improving the quality of health care provision in the under-resourced areas of the country. Indicators that can assess how such people and institutions impact unequally on different areas and population groups could help to ensure that they distribute greater amounts of their time and attention to the underserved areas.

## **Selection of indicators**

### **Indicators of financial resource allocation**

Some progress towards equity in health care provision could be achieved through appropriate budget allocations. At present, because of the skewed and grossly inequitable funding patterns of the apartheid



era, providing “equal per capita shares” of funding would, by itself, improve levels of equity. However, as equity is about providing “fair shares”, a resource allocation formula that is based on apportioning finances according to “health need” must also be developed.

There also needs to be monitoring of the type and content of health services, to ensure that they are appropriate for the alleviation of the health problems of the poor and disadvantaged. Monitoring the relative financial allocation between academic/tertiary health services and primary health care services would be one way of doing this.

Issue	Indicator	Use
Equitable geographic distribution of financial resources	Per capita expenditure on health by province	Equity calculation: % difference compared to national average
Equitable geographic distribution of financial resources	Per capita expenditure on health by district	Equity calculation: % difference compared to national and provincial average
Allocation of financial resources according to “need”	Difference in per capita expenditure on health between socio-economic groups	Equity calculation: % difference between quintiles of districts in highest and lowest expenditure groups
Distribution of financial resources according to “need”	Difference between actual provincial and district budgets compared to a “shadow budget” determined according to a resource allocation formula	Indicator used to monitor finance allocation
Distribution of financial resources in favour of primary health care services	Expenditure on secondary, tertiary and academic health institutions as a proportion of total expenditure nationally, and by province	Indicator used to monitor finance allocation
Allocation of health research funds	Proportion of total research expenditure on health systems research and PHC research	Indicator used to monitor the appropriateness of health research to reducing inequity in health care provision

### Indicators related to personnel

The biggest line item in the health budget is for staff salaries. Another way of monitoring the fair allocation of resources would be through indicators on the distribution of health workers. This is especially important because the lack of human resources is one of the most critical deficiencies of under-resourced areas and population groups in terms of health care provision.

In the same way that one needs to monitor the type and content of health services to ensure that they are relevant to the needs of the disadvantaged, there needs to be a critical appraisal of the staff mix of district health services. Different health problems and different environments need different kinds of health workers to provide different kinds of health services.

For example, the HIV crisis and the high incidence of childhood deaths from preventable causes indicate a need to focus less on the supply of curative health workers, and more on the provision of health personnel who are able to change social practices and behaviors. This together with the geographical constraints of delivering health care in rural areas, may make Community Health Workers (CHWs) particularly more appropriate and important to addressing the health needs of the rural poor. A lack of



CHWs in some areas may therefore represent as big a deficiency in the health system as a lack of doctors.

Indicators on the relative distribution of health service personnel between academic/tertiary services and primary health care services would be another way of monitoring that the health system is being realigned in a way that will reduce the level of inequity in health care provision.

Issue	Indicator	Use
<b>Equitable geographic distribution of health workers</b>	<ul style="list-style-type: none"> <li>• Number of categories of health personnel per 1 000 population:</li> <li>• professional nurses, staff nurses, midwives and advance diploma midwives;</li> <li>• doctors;</li> <li>• dentists and dental assistants;</li> <li>• physiotherapists, occupational therapists, occupational therapy assistants and rehabilitation assistants;</li> <li>• pharmacists and dispensary assistants;</li> <li>• community-based nutrition officers;</li> <li>• school health nurses; and</li> <li>• community health workers.</li> </ul>	Equity calculation: % difference between specific provinces and districts with national and provincial averages, or, % difference in terms of a set of norms and standards for staffing levels - this would allow the identification of districts that are “over-staffed”
<b>Appropriate staff establishment and mix</b>	Non-numerical indicator to help ensure that an assessment of the staffing needs for the disadvantaged health districts is carried out.	Indicator used to ensure that a certain management process takes place, preferentially in favour of the disadvantaged districts.
<b>Distribution of health personnel in favour of primary health care services</b>	Number of doctors, professional nurses and staff nurses in secondary, tertiary and academic health institutions as a proportion of total number nationally, and by province.	Indicators used to monitor transformation and reorientation of the health system.
<b>Focus of resource people and resource institutions on the disadvantaged areas of the country</b>	<p>Degree to which the provincial health department is focused preferentially on meeting the health needs of the most disadvantaged population groups and areas of the country.</p> <p>Degree to which the academic and NGO sector is focused preferentially on meeting the health needs of the most disadvantaged population groups and areas of the country.</p>	Non-quantifiable indicators used to ensure that a critical appraisal of the existence of equity-improving processes are taking place.



## Indicators relating to access

Indicators of the availability of health services and of physical barriers to health care are important for monitoring the equity of health care provision. Two aspects of access that must be monitored are the adequacy of transport and telecommunication services. Difficulties in physically getting to clinics and hospitals, and difficulties in calling for emergency help have been identified as major on-going barriers to health care access (McIntyre, 1997). Efforts to provide reliable and affordable public transport and telecommunications services would go a long way towards improving emergency health care provision for many of the disadvantaged population groups and areas of the country.

Issue	Indicator	Equity calculation
<b>Availability and physical accessibility of primary level facilities</b>	% population > 5 km away from nearest permanent clinic	% difference <i>pf</i> provinces and districts with the national and provincial average
	24 hour clinic/OPD service point: population	
	% population with access to emergency health care within 1 hour	
<b>Availability and physical accessibility of Level 1 Hospital services</b>	In-patient beds : population	% difference <i>pf</i> provinces and districts with the national and provincial average
	% population > 30 km away from nearest Level 1 hospital	
<b>Adequacy of telecommunications</b>	Percentage of clinics with direct telephone lines	% difference <i>pf</i> provinces and districts with the national and provincial average
	Percentage of clinics with reliable communication	
	Direct telephone lines : population	
<b>Adequacy of transport</b>	Percentage of patients who have travelled for more than 1 hour to reach their nearest health care facility	% difference <i>pf</i> provinces and districts with the national and provincial average
	Percentage of patients who have travelled for more than 4 hours to reach their nearest Level 1 hospital	
	Average cost of travelling to hospital	

## The quality of health care provision by health districts

The overall quality of health care is determined by how well various health system inputs, processes and outputs are put together to ensure appropriate, effective, efficient and acceptable health care delivery. All components of the system are important, and hence there is a need to adopt an integrated and multi-faceted approach to monitoring the quality of care.

This paper suggests the development of a tool that can be used to assess the overall quality and standard of health care provision provided by a health district (Table A). Such a tool would collect indicators on various aspects of health care provision and produce a composite score for the district. Districts with low scores provide poor health care (and therefore require preferential attention from the Department of Health), and districts with high scores provide good quality health care. In addition, the standard deviation of the distribution of scores would provide an equity calculation that could be monitored.



What would be tricky to develop is the actual scoring system and deciding on whether the scores attributed to the indicators should be weighted in relation to their relative importance to the overall provision of health care. Table A provides an example of what a scoring system might look like for assessing the adequacy of primary level health clinics.

The reason for using what may appear to be a complicated system of composite scores is to avoid the use of selective indicators that may not adequately identify important deficiencies in health care provision. For example, while indicators on the distribution of health care personnel would be important indicators of equity in health care provision, by themselves, they do not monitor the equitable delivery of good quality health care.

The development of such a tool can also be used to identify the specific kinds of deficiencies within a health district so that appropriate strategies and interventions can be developed. By disaggregating the overall composite score, one could also provide ‘quality of care’ scores for specific health programmes. Thus, districts with poor nutrition services could be identified, and this information used by the Department of Health to organise targeted support for the nutrition services of these districts.

**Table A: Overall Provision of District Health Service**

Area of health care provision	Indicator	Score
<b>Primary level facilities</b>	<p><b>Percentage of clinics which are adequate:</b> Numerical score (based on facility-based assessment tool)</p> <p><b>Accessibility:</b> % population &gt; 5 km away from nearest permanent clinic</p> <p><b>Accessibility:</b> 24 hour clinic/OPD service point : population</p>	
<b>Level 1 Hospital Facility</b>	<p><b>Overall adequacy:</b> Numerical score (based on facility based assessment tool)</p> <p><b>Accessibility:</b> In-patient beds:population</p> <p><b>Accessibility:</b> Percentage of patients who have travelled for more than 1 hour to reach their nearest health care facility</p>	
<b>Quality of care for specific priority health programmes</b>	<p><b>Overall adequacy:</b> Numerical score (based on separate assessment tool)</p>	
<b>Adequacy of staffing</b>	<ul style="list-style-type: none"> <li>• Number of categories of health personnel per 1 000 population:</li> <li>• professional nurses, staff nurses and midwives</li> <li>• medical officers</li> <li>• dentists and dental assistants</li> <li>• physiotherapists and rehab assistants</li> <li>• occupational therapists and OT assistants</li> </ul>	
<b>Adequacy of supplies</b>	<p><b>Overall adequacy:</b> Numerical score (based on information from facility-based assessment tool)</p>	
<b>Adequacy of telecommunications and transport</b>	<p><b>Overall adequacy:</b> Numerical score (based on information from facility based assessment tool)</p>	
<b>Utilisation</b>	Average number of primary level visits per person per year	
<b>TOTAL / COMPOSITE SCORE</b>		



Table B provides an example of a list of indicators that could be put together and used to provide an overall estimate of the quality of maternal health care provided in a district. These indicators have been put together for illustrative purposes, and are not actually a proposed or suggested set of quality indicators.

**Table B: Assessment of the Quality of Maternal Health Care**

Aspect of programme	Indicator	Score
<b>Staffing</b>	MWs : population ADMs : population Medical Officers : population	
<b>Accessibility</b>	Clinic with ANC services at least five days a week : population 24 hour delivery points : population	
<b>Transport and communication</b>	An indicator of adequacy	
<b>Working equipment and supplies</b>	Reliable availability of BP machine and urine dipsticks	
<b>Quality of care</b>	Perinatal Care Index* An indicator of the quality of syphilis screening An indicator of the use of clinical protocols An indicator of patient satisfaction (eg. That deliveries are conducted with adequate privacy, support and analgesia)	
<b>Health care seeking behaviour</b>	% first trimester bookings % unbooked deliveries average number of ANC visits per delivery	
<b>Audit</b>	An indication that regular perinatal and maternal mortality audit meetings are taking place	
<b>TOTAL / COMPOSITE SCORE</b>		

\*The Perinatal Care Index (PCI) is an interesting indicator that modifies a health status indicator to give a rough estimate of the quality of care. The PCI is the ratio of the low birthweight (LBW) rate compared to the perinatal mortality rate. The indicator uses the LBW rate to control for the underlying health and socioeconomic health status of the community. A PCI of < 0.35 is an indication of poor health care.



Using a composite set of indicators to assess the quality of a programme is not new. Table C shows the set of 10 core indicators developed by the World Health Organisation (WHO) to monitor how well national HIV programmes were doing. This would allow countries to monitor the success of some of their HIV prevention strategies, as well as allow the WHO to identify those countries that were failing to make progress, thus indicating the need for support and help. What we are advocating is a similar approach, but for the district level.

**Table C: Core Indicators for National HIV Programmes Suggested by WHO**

<b>Issue</b>	<b>Indicator</b>	<b>Method</b>
<b>Knowledge of prevention practices</b>	Proportion of people citing at least two acceptable ways of protection from HIV infection	Questionnaire survey
<b>Condom availability and use</b>	Average number of condoms provided per person aged 15-49 years in the past 12 months	Enumeration of all condoms supplied over a 12 month period divided by denominator.
	The proportion of "major condom outlets" that have had an uninterrupted supply of condoms in the last 12 months	Sample survey of each type of "major condom outlet" - three sampled outlets are visited per "cluster" area per year.
<b>Sexual behaviour change</b>	Reported number of casual sexual partners Reported condom use during most recent act of intercourse with a "casual sexual partner" Knowledge levels of preventive practices	Biannual interview surveys of the population sampled from households in urban and rural areas.
<b>Quality of STD case management</b>	Proportion of patients receiving adequate and appropriate STD treatment Proportion of patients receiving basic advice on condom promotion and partner notification	Descriptive survey of health care facilities: appropriate and adequate STD management is defined in terms of history taking, examination, diagnosis, treatment, partner notification and condom promotion. Methods used include observation, interviews with health care providers, and patient simulation.
<b>STD prevalence</b>	Reported incidence of urethral discharge in men	Interview surveys of population sampled from households in urban and rural areas.
<b>HIV prevalence</b>	Sero-prevalence of HIV and syphilis in antenatal patients	Anonymous HIV testing on sample blood specimens.



An accurate composite score of the overall quality of care provided by health districts would be difficult to measure because of the subjectivity involved in assessing some aspects of quality. In addition, it would be difficult to devise a scoring system that appropriately contrasts the adequacy of health care provision with the actual health needs and problems of specific districts. For example, in rural areas, the issue of transport is more important to health and health care than for urban areas. The equal distribution of vehicles between districts would therefore not necessarily reflect equitable distribution because different districts will have different needs.

However, although it is difficult to objectively measure the quality of some aspects of health care, it should not be discarded as an activity. One reason is that if we do not try to measure the quality of some aspects of health care because it is difficult to do (eg. health education given to STD patients), one can inadvertently give the message that this is an unimportant aspect of health care provision. Thus, the use of some indicators are more important for encouraging certain types of actions and processes within health districts than they are for measuring differences between districts.

Another argument against the use of quality of care indicators is that they are too complex for the health system. Whilst this may be true given the fact that many provinces are struggling with the utilisation and analysis of basic health service data, these indicators should be seen for their importance in encouraging evaluation of and support to health districts by provincial health departments.

If we are to really provide equitable health care delivery, then at some stage, sooner rather than later, provincial-level managers must be able to clearly identify which of their districts are failing to provide an adequate standard of health provision to their community, and why. They can then take the necessary steps to uplift the quality of care of the poorly performing districts. For example, we need to get to the stage where provincial TB programme managers are able to identify which districts in their province have poor TB case holding rates, and why.

### **Health care provision within districts**

Because many health districts will consist of a mix of population groups and settlement types (eg. informal settlement, rural and urban), indicators that can help to monitor and ensure preferential health care delivery to disadvantaged population groups within a district need to be developed.

Measuring quantitative indicators of health care provision for different population groups within a district could be done through various types of studies and surveys. However, this may be difficult to do in all districts. Non-quantitative indicators should also be developed for the purpose of monitoring and ensuring that steps are taken by districts to identify pockets of poverty within their district and to target the provision of health care to these areas.

### **Health care decision-making procedures**

As mentioned earlier, indicators should also be developed to help ensure that certain equity-promoting processes are conducted. The table below lists some suggestions of relevant non-quantitative indicators built around various management and policy processes that would promote fair decision-making and greater equity in health care provision.



Issue	Indicator	Use
Policy frameworks	Existence of national and provincial legislative and policy guidance supporting fair decision-making	Indicator used to ensure that a certain management process takes place
Existence of appropriate structure	Establishment of provincial and district 'consultative forums'; Establishment of hospital boards and community/clinic committees; Establishment of communication channels to front-line providers (eg newsletter); Establishment of complaints procedures for front-line health workers; and Establishment of complaints procedures for patients	Indicators used to ensure that a certain management process takes place
Practices that support fair decision making	Establishment of terms of reference for structures	Indicators used to ensure that a certain management process takes place.
Practices that support fair decision-making	Establishment of terms of reference for structures	Indicators used to ensure that a certain management process takes place
Functioning of structures: representivity	Degree of representivity of concerned stakeholders on structures gender balance within structures	Indicators used to ensure that a certain management process takes place
Functioning of structures: decision-making practice	% structures using 'fair' procedures	Indicators used to ensure that a certain management process takes place

### Indicators for monitoring trends within other disaggregated groupings of the population

Sections 3.4 and 3.5 have emphasised the selection of sets of indicators that are related to the way the health system is organised, and which can be used to drive change and to direct appropriate interventions and strategies for the improvement of equity.

The use and selection of indicators specifically to monitor the success of the underlying policy of equity in health need not be so complex. Because these indicators are being used to monitor trends rather than to identify areas or population groups for targeted and preferential attention, a smaller set of indicators is required. These indicators should be disaggregated by race, gender and socio-economic status. These may include:

- ▶ Health service utilisation rates
- ▶ Mortality Rates (Perinatal, Infant and Maternal)
- ▶ Immunisation Coverage Rate



- ▶ TB Case Holding Rate
- ▶ % First Trimester Ante-natal Booking Rate
- ▶ % Unbooked Deliveries
- ▶ Number of women with continuous couple-year family planning protection.

In addition, periodic household surveys such as the CASE Household Survey of Health Inequalities conducted in 1993 can provide a comprehensive and useful set of baseline information on various aspects of health inequality, including the perceived quality of health care provision.

## References

- Benzeval M, Judge K and Whitehead M (1995) The role of the NHS, in Benzeval M, Judge K and Whitehead M (eds). *Tackling Inequalities in Health: An Agenda for Action*. London: King's Fund.
- Constitutional Assembly (1996) *Constitution of the Republic of South Africa*. As adopted and amended by the Constitutional Assembly, Act 108 of 1996.
- Dreze J and Sen A. (1989) *Hunger and Public Action*. Oxford: Clarendon Press.
- Ellison GP, Dewitt P, Ijsselmuiden CB, Richter LM (1996) Desegregating health statistics and health research in South Africa. *South African Medical Journal*, 86(10): 1257-1262.
- Gilson L and Mills A (1995) Health sector reform in sub-Saharan Africa: Lessons of the last ten years' *Health Policy*. 32: 215-243.
- Hirschowitz R, Orkin M, et al (1995) *Household Survey of Health Inequalities in South Africa*. Prepared by the Community Agency for Social Enquiry (CASE) for The Henry J. Kaiser Family Foundation, USA.
- McCoy D et al. (1996) *Free Health Care for pregnant women and children under six in South Africa: An Impact Assessment*. Health Systems Trust, April, Durban.
- McGlynn EA, Halfon N, Leibowitz A. (1977) Assessing the quality of care for children. *Arch. Paediatr. Adolesc. Med.* 149: 359-68.
- McIntyre D. (1997) *Input Paper on Health for the South African Poverty and Inequality Report*. Unpublished paper, Health Economics Unit, University of Cape Town, May 1997.
- McIntyre D, Bloom G, Doherty J, Brijlal P. (1995) *Health expenditure and finance in South Africa*. Health Systems Trust and the World Bank.
- Mooney G (1996) *And now for vertical equity? Some concerns arising from Aboriginal health in Australia*. *Health Economics* 5: 99-103.
- Politt C. (1995) *Justification by works or by faith?: Evaluating the new public management*. *Evaluation* 1(2): 133-154.
- Rispel L and Behr G (1992) *Health indicators: policy implications*. Centre for Health Policy, Paper 27, June 1992.
- Walt G and Gilson L. (1994) *Reforming the health sector in developing countries: the central role of policy analysis*. *Health Policy and Planning* 9: 353-370.
- Wilkinson R. (1996) *Unhealthy societies*. Routledge: London.



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