HEALTH AND EQUITY - EFFECTING CHANGE

A Workshop by FRCH-IIMB-HIVOS

2nd & 3rd August 2000

Indian Institute of Management, Bangalore

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HEALTH AND EQUITY-EFFECTING CHANGE
A FRCH-IIM(B)-HIVOS WORKSHOP
2ND - 3RD AUGUST, 2000
IIM (BANGALORE)

The workshop on **"Health and Equity- Effecting Change"** is being jointly organised by Hivos, FRCH and IIMB to be held on 2-3rd August 2000 at the Indian Institute of Management, Bangalore. This meeting is being called at a time when several changes are occurring globally- the rapid changes that globalisation has brought on to national economies, the growing destitution of vulnerable populations in many countries and the multiple burdens of ill health and poverty for the poor. For the many who have been engaged in development work and who have indeed spent considerable time on health issues of the poor, constructing on the field viable alternatives for the poor in accessing health care, who have sensitised governments to respond more effectively to the health needs of the marginalised or have acted as allies in the struggle for equal care it has become a time for stock taking of matters as they stand and for assessing the nature of the concerns, the contours of the crises and the responses that are required.

This meeting will provide a platform for committed development practitioners with common concerns but not necessarily with similar approaches to come together and spend two days during which time ideas may be shared, presentations with unique perceptions provided for mutual discussion and case studies across locations and constituencies mutually understood. A tentative agenda is enclosed.

Agenda for Workshop on
Health and Equity-Effecting Change
A FRCH-IIM(B)-Hivos Workshop
2nd and 3rd August, 2000
IIM (Bangalore)

2nd August 2000

08.45 a.m.	**Registration**
09.30 a.m.	**Welcome** – N.H. Antia, Hannah Piek and Gita Sen – **Introduction of Participants** - **Introduction Thematic Issues** **The State and Civil Society: Meeting Health Needs, Reaching Equity** – Shobha Raghuram **Chair: N.H. Antia**
10.30 a.m.	**Coffee Break**
11.00 a.m. – 01.00 p.m.	**Public Health in India: Its Development and Challenges** **Equity and Health** – N.H. Antia **Health Sector Changes and Health Equity in the 1990s** – Aditi Iyer and Gita Sen **The Karnataka Health and Equity: Report of the Karnataka Task Force** – H. Sudarshan **Chair: Debabar Banerjee** **Discussion**
01.00 - 02.00 p.m.	**Lunch**
02.00 – 04.00 p.m.	**Group Discussions "Challenges on Effecting Change"** **Group Discussions on** - **Medical Poverty Trap (The Problem and the Recommendations)** - Ritu Priya - **World Bank and Impact of Bank's Policies on Health (The Problem and the Recommendations)**– Ravi Narayan - **Privatisation of Health Care (The Problem and the Recommendations)** - People's Health Assembly - **Rapporteurs** – Jamuna Ramakrishna, Thelma Narayan, and Minda Groenwald
04.30 – 05.30 p.m.	**Panel Presentation by Rapporteurs** **Chair: Vimala Ramachandran**
07.30 p.m.	**Reception**

3rd August 2000

09.00 a.m.	**Civil Society Partnerships: Examples from the Field** **Protecting Consumer's Health in Developing Countries** – Debabar Banerjee **Health Financing: The State and Health Services** - Indira and Vinod Vyasulu **Discussion** **Chair: Veena Shatrugna**
10.45 - 11.00 a.m.	**Coffee Break**
11.00 – 01.00 p.m.	**Field Achievements in Health Care** **FRCH** – N.H. Antia **Women and Health** – Elizabeth Vallikad **VGKK** – H. Sudarshan **CINI** **People's Health Assembly** **Chair: Amar Jesani**
01.00 – 02.00 p.m.	**Lunch**
02.00 – 05.00p.m.	**Health Care and Ethics – A Panel Discussion** **- Medical Ethics and Human Rights** - Amar Jesani **Between the Clinic and the Community** – Vijay Thakur **People's Health Assembly** - Ravi Narayan **Chair: H. Sudarshan and Thelma Narayan**
	Vote of Thanks FRCH, IIM (B) and Hivos

Tentative List of Invitees for the Workshop on
Health and Equity-Effecting Change
2nd - 3rd August, 2000
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EQUITY AND HEALTH

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EQUITY AND HEALTH

Human history is replete with examples of the struggle between the two contradictory traits of human nature which differentiate us from all other species. At one extreme is greed which demands instant gratification regardless of the long-term consequence to self or others. And yet all prophets and wise men have preached the suppression of this unfortunate trait which leads to unhappiness and which now poses a threat even to the long term survival of our own and other species.

Health in its wider concept covers a gamut of social and economic aspects of human activities such as nutrition, education and environment. Hence attempts at improving health by focussing on an individual component such as curative medicine can only serve as a temporary patchwork arrangement without appreciation of the many other factors and above all of the socio-political forces which underlie both health as well as illness care. The following examples will help to illustrate this.

In 1846 Rudolf Virchow, [1] a German physician, questioned as to why the health of those who worked in the mines of Silesia was worse than that of the citizens of Berlin. He also stated that "medicine is a social science and that politics is the practice of medicine on a larger scale".

The study of health in the UK from the feudal to the industrial, imperial and socialist stage to the present neoliberal capitalist phase provides an interesting insight into the role of changing socio-political influences on the health of the people. The onset of the industrial revolution resulted in large-scale migration of the rural population to urban industries in search of employment. This not only disrupted the human relationship, however tenuous, between the feudal landlord and his tenants but also moved the workers from a relatively healthier rural environment to the sordid unhealthy slums provided by single-minded profit oriented industrialists. The workers had little choice. The appalling conditions in the early phases of unregulated industrialization have been vividly described by Dickens. The response was not improvement of the workplace as described by Owens and the home environment by implementing the sanitary reforms of Chadwick, a city engineer, but its rejection by the city fathers as a waste of public funds. The medical profession preferred that the money be used to support larger public medical institutions called Infirmaries where they could learn and practice curative medicine as a form of charity, while enjoying the rich pickings from the care of the affluent members of their society. It was the fire of London that burnt the unhealthy rat infested slums which resulted in the control of plague; not the medical profession. The military aspect of the same industrial revolution also led to sudden increase in the country's wealth as a result of colonization of countries like ours. Even a minor trickle-down effect of this wealth resulted in improvement in the conditions of the working class despite increased polarization of their society. Marx predicted the conflict inherent in such a situation, where the working class which had risen above grinding poverty would now organize to fight for social justice. While the predicted revolution did not occur in the UK, the impact of even a modest alleviation of poverty and consequent improvement of working and living conditions was evident in its dramatic effect on

tuberculosis. Macewan utilizing data provided by the registry of deaths per disease maintained in Britain since 1860, showed the dramatic regression of this disease even before identification of its causative organism by Koch in 1882 and tuberculosis virtually disappeared in the UK before the discovery of vaccines or drugs; a clear demonstration of the dramatic effect of even minor improvement in socio-economic changes on this as also on other communicable diseases resulting from poverty.

The two internecine wars fought in the first half of this century by the European powers for each other's colonies also demonstrated two entirely different effects on health of these countries. The economic depression of the 30s and the effect of devastation of the countries of Western Europe like Holland in the early 40s resulted in a massive resurgence of tuberculosis And yet no sooner than the economic conditions improved as a result of political programmes like the Marshal Plan, tuberculosis vanished within a few years and the hospitals and sanatoria had to be closed. This also demonstrates that the control of the diseases of poverty also lies primarily in the field of political and social action and not that of hospitals, doctors or of medical science, which are only supportive services.

And yet it was the result of these two wars that brought about a radical change in the health of the people of Europe, as seen today. The use of the workers as cannon fodder by the ruling classes of all warring nations also helped to raise their consciousness and demand for their rights as equal citizens in so called democracies. This egalitarian upsurge is reflected not only in the postwar unification of Europe but also in the dramatic overall improvement of their economy which is also reflected in the health of its citizens. To them health is no more an act of charity but a basic right of all citizen as for education, employment, food security and welfare regardless of class, gender or economic status. The immediate post war installation of the Labour Government in the UK resulted in the implementation of the Beveridge report in both its letter and spirit even though this was one of the darkest economic period of that country's history. The dramatic change that ensued in health which resulted despite shortages of food, clothing, housing and basic necessities, once again demonstrates how good health as well as good medical care can be achieved at remarkably low cost when the necessary political will is manifest for an egalitarian society based on sharing and caring.

And yet the Thatcher government, under the tutelage of the US, succeeded in backtracking in many areas of the country's post-war socialist egalitarian form of development including an attempt to privatize health. Yet it was the conservative British Medical Association which had opposed the National Health Service (NHS) in 1947 who now stoutly supports the people in refusing to dismantle the NHS. The Black Report of 1980 also revealed how the health inequalities had widened during this period. This was also an important reason for the reinstatement of the Labour Party. The renewed attempt of the present Labour government under the tutelage of the US policy of globalization, liberalization and privatization has also been strongly opposed by the people in the field of health, education and welfare. A recent report shows how the infant mortality in the industrial cities like Glasgow and Liverpool is twice as great as in the home counties. This also reveals the high priority that the people at large assign to health and medical care as a social right which once enjoyed they refuse to part with.

In contrast the US as the citadel of private enterprise has given almost unrestricted liberty to the private sector operating for profit even in the field of health which is an area where consumer resistance is at its lowest. Spending 14.5% of its GDP amounting to well over one trillion dollars or $ 4409 per capita per annum, it provides a service which is far inferior to that of the UK and other capitalist countries of Europe spending 9% of their GDP. Far worse is that 45 million (15%) of its citizens have no insurance coverage for health and medical care and have to depend on a service that resembles the Infirmaries of the UK which existed two centuries ago.

The USSR, Cuba and China starting with a virtual non-existent health and medical care service demonstrated how rapid strides could be made in both fields within a decade of achieving independence. Like Nicaragua, they were able to achieve remarkable improvement in education, health and welfare even while fighting on several fronts for their country's very survival. Sri Lanka and Costa Rica as non-socialist states have also demonstrated how similar results can be achieved when the national social conscience and political will is high. Kerala a communist state of 30 million despite being a part of a larger non-egalitarian democracy has shown remarkable results in education, population control and health despite a low level of economic development. Spending about $ 25 per capita per annum on health it has an IMR of 13 and a general health status which is not far behind that of the US with an IMR of seven. These examples clearly demonstrate that the health of the people of a country depends far more on its political organization rather than on the expenditure on health and medical services that it incurs. Health is above all a function of the social commitment and political will which also affects the efficient functioning of the medical services. It also demonstrates that good basic health and medical care can be provided to all citizens at remarkably low cost while there is no limit to expenditure on curative medical care when it is converted into a commodity for sale in the private market place.

We shall now try to examine the effect of changing socio-economic and political forces on the health of the people of our own country from the Pre-British, British to the Post Independence period in the last five decades.

Although no detailed information is available on health of our people in the pre-British era we have documentation of the existence of an advanced civilization about 5000 years ago in the Indus valley which had extended to what is presently northern Gujarat. The excavations at Harappa and Mohenjodaro reveal remarkably well-organized habitations including existence of baths and management of water and sanitation. In the following period of Indian Renaissance which was about 2500 years ago, there emerged philosophers like Mahavir and Buddha and rulers like Ashoka. This period was also associated with advances in the science of health as well as of medicine and surgery. These have been recorded in the samhitas of Sushrut and Charak. Though chiefly patronized by the elite in the subsequent millennia this knowledge of health has become an integral part of the life and practices of Indian society at large even to this day, often expressed in the form of religious practices and rituals concerning food, hygiene, exercise and social behaviour. Together with extensive knowledge of home and herbal remedies this has played an

important role in sustaining the mental as well as physical health and well-being of the vast majority of our people even during the subsequent difficult periods and even to this day. Not being dramatized and commercialized or enjoying political patronage like Allopathy, we have failed to appreciate the role of these advanced indigenous systems in sustaining the life and health of our people despite severe deprivation.

The writings of Bernier, Dubois and Adams reveal that the provinces of Bengal, Bihar and Orissa were the richest in India and had the largest hoard of gold and silver in return for the sale of produces like jute, muslin, indigo and opium. Bishop Reginald Heber also records that at that time `local women were as tall as European women'. Jaffar in 1765 records how the economy of these provinces was ruined by a firemen of the Mogul Emperor which permitted the East India Company the duty free import and export of goods. The Company freely issued permits known as `dastaks' which ruined the age old business industries which resulted within 15 years in the `dastak famine' of 1769-70 which according to Hunter resulted in the death of 1/3 of the population of this region.

This systematic loot of the wealth of our country has been well documented by Dadabhoy Naoroji and others. Except for a few favoured elite and the sepoys of their army, the impact on health of two centuries of foreign domination has been demonstrated by the life expectancy of 20 years as recorded in the 1911 census. As a result of the pressure of the Congress movement and health being transferred to local state ministries there was certain improvement as reflected in the census of 1941 when life expectancy had risen to 32 years. A further marked improvement in life expectancy to 46 years was achieved by 1961 as a result of Independence. This has now reached 60 in the 1991 census.

The dramatic improvement in the first two decades following Independence was demonstrated by the eradication of smallpox, almost elimination of malaria from 100 million to less than 100,000 cases and control of cholera and plague; the four major scourges of the pre-independence period. What is even more remarkable was that this was achieved with the then available simple medical knowledge and technology, very limited financial resources, and only a handful of dedicated public health officers. This was possible only because of sustained support by a strong political will to ensure that the benefits of Independence should reach all those who had struggled for achieving Independence. There was also an equally enthusiastic response by the people themselves who had participated in the struggle.

And yet the improvement in the following two decades is nowhere commensurate with what was achieved by China during the same period using the decentralized `barefoot' approach. China's life expectancy in 1991 had reached 70 years as compared to 60 of our own. The deterioration during this period was despite the availability of vastly improved medical knowledge and technology as also of medical manpower and infrastructure. Unfortunately unlike China after the first flush of independence the Indian scene was increasingly monopolized by an increasingly self centered political leadership supported by an equally over-centralized, over bureaucratized, over-westernized and over-urbanized public sector which alienated rather than encouraged the involvement of the people in their own health and medical care. These decades also resulted in massive proliferation of the

profit-oriented private health sector interested in lucrative curative medicine but not in preventive or promotive aspects of health. This was in conformity with an increasingly polarized society controlled by those whose single-minded interest was on creating a lucrative milieu for a small elite segment of our society living in urban enclaves and whose desire in `health' was for the `latest' expensive curative medicine as practiced by their US mentors rather than even the more socialist UK model. This has been reflected in all aspects of our country's development during this period. This was despite India adopting the democratic mode of development but where the majority of the people were marginalized and deprived of education and information with the consequence that they had little say, leave aside influence, in decisions affecting their own welfare.

The statistics that have been provided by the government are almost invariably of an aggregate nature. In a highly polarized society this conceals more than what it reveals. In 1997, Kerala [2] had an IMR of 13 while in the UP it was 85 while the All India figure was 71. Such figures generated in backward states under political and bureaucratic pressures are even more suspect. Aggregate urban statistics inform us that urban health is twice as good as that of the rural areas. And yet it fails to reveal that the statistics of half of the urban population comprising of the upper classes has a health status equivalent to that of the affluent West, while that of the slum dwellers who comprise the other half of the urban population is as bad or even worse than that of their rural counterparts. The remarkable achievements in education and health in Kerala is more the result of female education than of medical services; also that these statistics are reflected uniformly in all districts of this state. In contrast the infant mortality of the poorest families of the poorest villages of the poorest district in the backward BIMARU states is probably in the region of 500 where every second child that is born dies before reaching the age of one year. No wonder the Family Planning programme in Kerala has to emphasize that non-terminal methods of contraception should be practiced till their two children reach the age of 5 years. On the other hand the poor in the BIMARU states know that a hostile political and bureaucratic system considers them only as a population threat which dilutes the gains of development, without providing even basic subsistence and care of health during illness and old age. It is conveniently forgotten that under such conditions these families need eight children for mere survival leave aside deserving of some love and affection in an increasing hostile world.

This marked change in the approach and direction to health and medical care following the first two decades following Independence has been in keeping with the overall change in the political will among the subsequent generations of our leadership often based on dynastic considerations. The change was from an egalitarian to a more selfish approach designed by and for the benefit of a small `creamy' layer which has ceased the reins of power. This has been at the expense of the masses who had fought for the country's Independence under the dedicated leadership of those like Gandhi, Nehru and Patel. The shift in health was from an egalitarian Health for All to Wealth for a Few. This change in national development to a capitalist form of governance under the guise of representative democracy, has also adversely influenced its health policy, which in turn has been influenced in no small measure by the western powers led by the US.

This was responsible in transforming the integrated health and basic medical care approach of the Bhore Committee designed [3] for a predominantly rural nation with limited capital but unlimited human resources, to one based on the latest expensive high technology for the urban rich. This was the result of willing cultural and economic cooption of the dominant elite by the West which had increasingly become their role model of success.

Following the collapse of the USSR in the early 90s, including that of its remarkable health and medical facilities, the same strategy has been utilized in an even more aggressive form for neocolonization of the newly independent `need based' countries by utilizing the same economic and cultural weapon devised as early as 1948 at Bretton Woods for redomination of the world. Under the guise of globalization, liberalization and privatization these agrarian Asian economies were artificially overheated into a state of Western style industrialization by provision of extensive loans. Using the rich local natural resources and cheap labour by corrupting the local leadership this not only polarized their societies and created social disruption but reduced them to a state where their trade and even the mode of governance could then be dictated by the US and other Western multinationals in search of quick profit, regardless of the pauperization of the majority of their population. A replay of the previous five centuries of global exploitation through a form of `trade' dictated by the European powers but now using a subtler technique than the crude gunboat diplomacy of the past.

Beginning with industry this has now extended to the service sector. In a globalized market place there is no better field for exploitation than health, since it is an area where consumer resistance is at its lowest. The socially, culturally and economically overawed and corrupted elite leadership, who control the levers of power, have proved easy prey to the systematic assault mounted by the pharmaceutical and medical instrumentation industry which has distorted the values and ethics and even corrupted the age old medical profession. This is a part of the undermining of the values, morals, ethics and practices of older civilizations by aggressive promotion of the baubles of mindless materialism generated by Western science and technology with Mamon as the reigning deity. Advanced systems of health and medical care like Ayurveda and Yoga which have sustained the health of our people over the ages have been systematically denigrated as being `unscientific' unless validated by Western scientific paradigms or converted into marketable commodities. While ISM and Homeopathy are provided lip-sympathy by our own government, they receive less than 4% of the national health budget. [4] The production marketing and consumption of drugs [5] and pharmaceutical starting at Rs.10 crores at Independence has now reached a mind boggling Rs.25,000 crores which now comprises over 50% of the overall expenditure of our country on `health' which at 3.5% of the GDP is equivalent to Rs.54,374 crores. More than three quarters of this excessive production is consumed by the private health sector which ranges from 5-star hospitals and nursing homes to doctors roving the villages on motorcycles, providing unnecessary expensive and even dangerous injections and medicine to those who pay under duress of pain, suffering and death. This is the result of undermining of the public health sector by political and bureaucratic interference and a further `cut' of 20% of its budget imposed by the IMF, the sister concern of the World Bank, under the guise of the Structural Adjustment Programme. Combined with the implementation of Fifth Pay Commission's recommendation, over 90% of the public health sector budget is utilized in

paying the salaries of staff. After[6] imposing such sanctions further loans are freely offered by international usurers, and equally willingly accepted by our government, for facetious programmes like DOTS for tuberculosis, Impregnated bed-nets for control of malaria and for building and equipping PHC when the failure of the existing ones is the result of bureaucratic interference, inefficiency and lack of motivation and accountability to the people. The importing of highly expensive diagnostic, medical and surgical equipment, most of which is inappropriate for our country and its economy is in a stage of obsolescence. Such `health' care promoted and welcomed by our elite now presents another lucrative avenue for multinational business and industry. Even the poorest are not spared since increasing poverty and its associated illnesses are now diverting almost 20% of their meager household expenditure from food to such inappropriate form of medical care. We are now told that the answer lies in handing over the ailing public assets like hospitals and PHC to the `more efficient' private sector, together with the recurring expenditure. This privatization and appropriation of public assets by a sector well-known for its predatory instincts and practices is another bonanza for those who seek to enjoy the benefits offered by the globalized market. The privatization of health insurance now offers another avenue for such trade in human suffering. Surely, those who dictate such policies from Washington know the evils of converting people's health into a business and industry from the experience in their own country.

The effect of this latest assault by a combine of international and national governments, organizations and agencies is demonstrated by the rapid deterioration of the health of our people during the present decade and the dramatic resurgence of diseases which had been controlled such as water-borne diseases like cholera and typhoid, vector borne diseases like malaria, filariasis, kalaazar, dengue, encephalitis and plaque and diseases of malnutrition such as tuberculosis and ARI. This has occurred despite vastly increased financial inputs which evidently are of the wrong type and resulting in demand for further loans which increase international indebtedness and imposing of further `conditionalities' by IMF; an unending vicious cycle. In such a form of health and medical care the rich are dangerously over-investigated and over-medicated, the middle class pauperized when they fall ill, and `health' services are diverting scarce resources of the poor from nutrition to medicines, doctors and drugs. Malpractice has assumed proportions unbelievable only a few decades ago. The urban poor living in slums suffer from a double burden not only of such diseases but in addition those of pollution of air, water and food. Even the rural population suffers from poisoning as a result of excessive promotion of pesticides and fertilizers.
Instead of addressing the specific health problems of our country and its people at large following Independence we are being dictated by international organizations and their itinerant experts from Geneva and Washington; some with good intentions though distanced from the reality of `need-based' countries, while others have different motives and agendas of their own. AIDS provides a good example of the endless stream of vertical programmes imposed on our Ministry of Health and Family Welfare without consideration of local social, economic and cultural realities, which are far better understood by our own experts who are sidelined if their opinion does not support the advises of the `aid' providing donors. Their advice based on limited Western experiences is in start contrast to the integrated approach necessary to solve such problems. Over 400,000 deaths have occurred annually in India for the past 50 years. Yet it has remained to AIDS with a few thousand

annual deaths, a disease coming from the West, to draw attention to the far greater national problems of tuberculosis which is also essentially a disease of poverty. Even concerning AIDS the creation of mass hysteria by the use of modern mass media can only create more fear than awareness. Like leprosy another stigmatizing disease of which India has ample experience, it has been shown how such propaganda can drive such diseases underground in their early stages. The almost hysterical propaganda of AIDS promoted by the West with generous loans has resulted in increasing the stigma to tuberculosis with which this disease is now associated in the public mind. This can hence even hamper the control of tuberculosis. Substantial loans are now provided for such ill-conceived programmes which can only sink the country into further international debt without any significant impact on our people's health and can only result in further increase the diseases of malnutrition and poverty.

The control of the diseases of poverty does not lie in the present spate of vaccines that are being devised in Western laboratories which when available for diseases like hepatitis, fail to reach those most in need because of cost combined with a grossly ineffective mode of its delivery. The most desirable vaccine for controlling the diseases of poverty is a vaccine against poverty itself which can be achieved only by a concerted international political will for an egalitarian form of world order of which health would be a major beneficiary. Though poverty has been created by the global policies of the West, we are informed by them that there is no means for curtailing this. What is worse is that the diseases created by such poverty are also converted into another lucrative business and industry by their multinationals.

The role of politics in our country's development and its effect on health was clearly visualized by Gandhiji both before and after Independence. While the illiterate masses stood by him in the struggle against British rule, he foresaw that despite the Trusteeship concept, those educated elite who had sat on the fence during the struggle and who would gain the reins of leadership and power in the next generation could not be implicating trusted to look after the interest of the masses in Independent India. His remarkable vision based on an uncanny understanding of human nature made him ensure that the ultimate power be vested in the hands of the people themselves in the form of the vote by incorporating Universal Adult Franchise in the constitution; this despite the apprehension and strong objection of the educated elite. After 50 years of a tortuous course of events during operation of the Representative form of democracy, the people of this country (as opposed to most other countries who gained Independence during the same period and opted for democracy) have been able to exert the power of their vote which has enabled them to achieve Panchayati Raj as perceived by Gandhiji. This is now a constitutional right, through the enactment of the 73rd and 74th Constitutional Amendments in 1993. The health of our people will ultimately depend on the outcome of the ongoing struggle which may be justifiably called the `Third Struggle for Independence' whereby the people will regain their power and rights which have been appropriated by their elected representative under the guise of Representative Democracy. This can be achieved only through Panchayati Raj which is the only true form of democracy viz. Participatory Democracy. The Right to Information and even Right to Recall deviant elected leaders is being sought by the people who are now increasingly aware of the importance of the power of their vote for regaining

their economic and social independence. They are no longer willing to accept development in the existing form of urban industrialization imitating the Western model which produces consumer goods and services for the elite when there is ample evidence that rural small scale agro-industrialization is far more humane as well as cost-effective and whose benefits accrue to the people at large and not to a select few. A form of development which is also compatible with Education and Health for All.

Despite adopting a Westernized model, the Bhore Committee's report was the original concept of equity in health and medical care for all citizens and was adopted by the founder fathers as the model for our country's health policy following independence. Though India was a signatory to the WHO Alma-Ata Declaration of Health for All in 1978, the mere signing of the declaration had little if any impact on our health policy or its implementation. This was because by then the political will of our leadership had already changed to a more selfish objective of the succeeding generations of elected politicians. This noble declaration of Health for All was used by India, like most other signatories, as a convenient rhetoric to dupe their people while health was converted into a marketable commodity to serve a select few of their citizens. Even WHO itself soon converted this holistic and integrated concept of Health for All into a narrow Specific Primary Care approach which has further destroyed the integrated model of the Bhore Committee.

It was the independent ICSSR/ICMR report Health for All: An Alternative Strategy in 1981[7] which after reviewing health in its larger socio-political-economic dimension provided an alternative highly cost-effective model for health in which the people have to play the dominant role. This independent report clearly stated that this could not be achieved unless the people, and not mere elected representatives and bureaucracy controlled this model. All the non medical components of health and even 80% of all medical components viz. preventive, promotive as well as curative medical care can be best undertaken by the people themselves at the village level with their own local women provided with highly specific and practical training in the problems affecting the health of their community using all methods and systems of health and medical care. Also that over 95% of all problems including specialized medical and surgical care could be tackled within the 100,000 population block/taluka level. This report also clearly stated that this could be achieved only under Panchayati Raj where the people would have both financial and administrative control over all functionaries and activities at their level. Only this could provide the dominant social and human component of health and medical care which is so lacking in the existing public and private sectors. Above all this would ensure accountability to the people without need for `targets' and transfers. This would also overcome the problems of unionization which plague the existing bureaucratic system and ensure that salaries would be in keeping with local rates. A many faceted improvement on the existing system. Such a decentralized people controlled system would ensure adequate manpower, infrastructural and medicinal requirements as would be determined by the needs of the local people than by a distant national and international bureaucracy with their own perceptions and interests. Like in the UK, such an effective People's Health System would also be the most appropriate means for controlling the otherwise unaccountable private sector.

The 73rd and 74th Constitutional Amendments empower people to undertake the 29

subjects affecting almost all aspects of their life, including health, at each level of the Panchayat system. The struggle for transfer of power and with it the resources is now an ongoing process which can be delayed but not reversed in what is now the true form of democracy of a face to face Participatory nature and not of a distant Representative type which has failed to deliver the goods. This is the democracy conceived by the founder fathers of our nation, an age-old practice suited to the 700,000 villages of our country.

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PROTECTING CONSUMER'S HEALTH IN DEVELOPING COUNTRIES

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The terms, `developing' and `developed' countries will be used in a broad, generic sense. It is not necessary here to enter into a semantic debate concerning definitions. It is also recognized that there are considerable diversities among the countries put under these two groups. The emphasis here will be that, taken as groups, these are `poles apart' in more sense than one. Their relationships are based on unequal terms.

For reasons that need not be gone into here, developed countries generated conditions which created the phenomenon of European Renaissance. Development of science, technology, industry and commerce gave them a head start over the developing countries. This enabled them to acquire strong political and economic control over the other group. This gap has been widening all through the centuries. Developing countries are made to lose their autonomy in decision making on issues that vitally concern them. They are left behind to follow the mirage of `catching up' with the developed ones.

Western medicine has developed under such a setting. It registered spectacular breakthroughs, particularly during the past century and a quarter. From a scientific angle, it has reached dizzy heights, as manifested, for example, by advances in diagnostics, special surgical procedures and a wide spectrum of therapeutic practices. Over and above, new areas such as genetic engineering, biotechnology and in vitro culture of tissues of organisms, which includes humans.

As observed by the great German medical thinker in the mid-nineteenth century, Rudolf Virchow, `medicine is a social science'; it is greatly influenced by social forces. Three major social forces which has influenced medicine will be very briefly referred to in the following paragraphs.

The issue of access of medical and public health services to the people had come up since the time of Bismark, when he developed `socialized medicine' in Germany. People in the present developed countries had to struggle hard to obtain universal access at least to fundamental health services/insurance. Today, in most of the developed countries the state accounts for above eighty per cent of the total cost of health/insurance services. Even in the US, it is over fifty per cent. In a startling contrast, in a massive developing country like India, the percentage is less than twenty-five. To further compound the situation, now, under the Structural Adjustment Programme (SAP) pressure is being exerted on the country to further `downsize' state intervention in the field of health.

There has been considerable unease over the way Western medicine is being practiced even in the developed countries. Ivan Illich is among those who made a comprehensive, well-documented critique this vital area. He starts his famous book, MEDICAL NEMESIS, by asserting that `medicine has become a threat to the health of the people'. He substantiates his arguments by drawing attention to various kinds of iatrogenic diseases - diseases caused by practitioners of medicine. Medicalisation of lives of people, mystification of medicine, professionalisation and centralization, dependence creation and actively promoting addiction to medicine, are some of the

terms he has employed for making a devastating denunciation of practice of Western medicine.
So powerful have been the economic interests behind the `sale' of Western medicine to the consumers that the overwhelming evidence adduced against these aspects of the practice were simply ignored or `forgotten' and they have succeeded in generating an exponential growth of the highly faulted medical system all through the years. This has substantially added to the GDPs of the developed countries. Medicine has now become a commodity. Big corporate organisations have come into being to sell medical services to customers are `suitably motivated' by subjecting them to relentless bombardment with well-designed media onslaughts. For instance, an entirely new and booming `fitness' industry has now come into being to sell `fitness' to such intellectually sanitized people, who are conditioned to rush to buy designer made paraphernalia of various kinds.

After ensuring that markets are thrown open to `free trade' by imposing the SAP on developing countries, the developed countries have expanded their market by including the much vaunted burgeoning middle class in the developing countries in its brainwashing agenda. To the `forgotten' people of the developing countries, those `who live on the other side of the moon', these business ventures in medicine conform to what Illich had observed long ago - a menace to their health. Perhaps unwittingly, physicians have often become sales agents of this massive `medical industrial complex'. That President Clinton could not push through even the very highly diluted health care programme for the people of the US, despite most solemn promises made in his campaign to get the second term, attests to awesome power of the business interests. Those who live on the other side of the moon in the US were bluntly told that there is `no free lunch'. This conforms to famous saying of the US president just before the Great Depression: `The business of the US government is business'.

This was the structure and content of Western medicine which the developing countries encountered when it was inducted into these countries by some of the developed countries in the wake of colonial/imperialist conquest. This encounter has to be considered here both in terms of time and space, against the overall social, economic and political dynamics. When Western medicine was imposed on the different developing countries, the people there had their own, indigenously developed mechanisms for coping with their health problems. The motive force behind the induction of Western medicine in these countries was to provide protection to the ruling class.

In the countries which were colonized by the developed countries, it was made accessible to the military, the colonial administrators and the traders; it was also made accessible to the wafer-thin uppermost level of the native gentry, which collaborated with the exploiters. Thus, right from the initial phase, Western medicine was used to strengthen the exploiting classes. The increasing impoverishment of the exploited as a consequence of colonialists joining the local gentry to extract some extra revenue created conditions for increasing the already heavy load of diseases and deaths among them. At the same time, with the native elites developing a fascination for Western medicine, the quality of the indigenous practices that were developed to cope with

their health problems over centuries suffered because of lack of nurturing of these practices. The vast masses of the people, the `forgotten' people, thus suffered additional disadvantages when Western medicine was introduced in these countries.

However, here too there was a dialectical response from the people. Conditions generated by the anti-colonial and anti-imperialist struggles impelled the `leaders' of the movements to think of ways to meet the health services needs of the vast masses. Significantly, because of fundamentally different socio-cultural, economic, political, epidemiological and technological conditions, the response too had to be fundamentally different, thus laying the foundations of what is now being termed as New Public Health. It had been a long, grinding struggle for the masses. The idea of a `Barefoot Doctor' took the final form in the post-revolutionary China, while the leaders were groping for alternatives. During the anti-colonial struggle in India evolved the idea of the Primary Health Centre to provide low cost, efficacious comprehensive health services to the unserved and the undeserved populations and that of `entrusting people's health in people's hands' through Community Health Workers elected by the communities. Scholars from other countries also contributed to the growth and development of this new, people-oriented health services which are tuned to the specific conditions prevailing there; `health by the people'.

Under the leadership of Halfdan Mahler, WHO not only encouraged this trend, but it actively acted as a catalyst to give the movement considerable momentum, which culminated in the World Health Assembly (WHA) adopting the famous resolution on Heath For All by adopting the approach of Primary Health Care by the year 2000 AD (HFA2000/PHC) and getting all countries of the world specifically endorse the new philosophy in the Conference on PHC at Alma-Ata in 1978.

The Alma-Ata Declaration marked a watershed in the history of public health practice in the world. Health was declared as a fundamental human right for all the people of the world. People, rather than technology and industry were considered to be prime movers; community self-reliance or community involvement in every phase of health service development was the keyword. Social control over the health services; intersectoral action in health; coverage of the entire population with integrated health services; use of technology that is appropriate for the people, including use of traditional systems of medicine; use of only a very limited number of essential drugs in generic names, were some of the highlights of the Declaration. Halfdan Mahler also took the initiative in getting the approval of the WHA to have a WHO Programme on Essential Drugs; the WHA also approved for enforcement a Code for marketing of baby foods in the poor countries of the world.

The response from the rich countries to the poor countries daring to declare self-reliance in health was swift and sharp, as it affected their economic and political interests. They `invented' the very untenable concept of Selective Primary Health Care. They used their financial clout to mobilise international organisations like the Word Bank, WHO and UNICEF to let loose a virtual barrage of `international initiatives' on the poorer countries, which almost swept away the tentative steps that were taken by some of the poorer countries in implementing HFA 2000/PHC. These

extreme poverty; malaria still strikes up to 500 million people a year, killing at least two million; acute respiratory infections kill almost four million people every year; tuberculosis kills three million annually; Diarrhoeal disease still kill nearly three million people every year; AIDS has infected up to 24 million people, out of whom four million have already died.

An account of the hundreds of millions of premature deaths and easily preventable diseases faced by the `consumers' of health of those who accounted for almost the entire populations of many of the developing countries is a part of the account of long running confrontation between the `haves' and the `have nots' on grossly unequal terms. Political leaderships of the developed countries provided the major striking force for the oppression of the have-nots; the haves among the natives actively collaborated with them in carrying out this oppression. Inevitably, despite their tremendous disadvantage, as they have little to lose, the `haves' have mounted a sustained struggle against injustice and exploitation. The consumer movement for health in the developing countries will take the side of the wronged people. Their demands are enshrined in the Alma-Ata Declaration - this includes struggle for a rational drug policy, access to people oriented health services and a more humane and broad based, empowering population policy. This part of the struggle for human rights of the have-nots. History ordains that this struggle will continue.

POVERTY, HEALTH SERVICES AND DEVELOPMENT

An overwhelming proportion of the poor people of the world live in developing countries. About a third of them are abjectly poor, in the sense that they are unable to get even two square meals all round the year. Another third or more, though somehow manage to have the two square meals, nevertheless, live most degrading lives. These people have thatched huts, shanties or overcrowded dilapidated buildings for their living. Very few of them have sanitary latrines or easy access to protected water. The overall environmental sanitation is exceedingly poor, with virtually no arrangements for disposal of human, animal and kitchen waste, and drainage of wastewater. Various kinds of insects and pests thrive in the ecological conditions created by these deplorable levels of human existence. Earning of the meager resources for keeping alive entail hard, backbreaking work, often under hazardous conditions. Amelioration of these conditions need social and political action to usher in a more just social and economic order.

The very well-off section of the populations in these countries, constituting the upper 5 percent or less of the populations, have acquired the power to dominate the social, political and economic lives of the rest of the population. From time immemorial, the poor have undertaken struggle to wrest their rights from the dominant rich.

These also create conditions for high levels of incidence and prevalence of various kinds of acute and diseases which sap the lives of the people; the suffering caused by the diseases further disempower them, thus leading to the perpetuation of the unjust social and economic relations. It is in this context that provision of easy access to health services acquire a political significance: (a) it empowers people by

substantially alleviating the huge load of the suffering caused by diseases; (b) an additional source of empowerment is the consciousness that is generated among the hitherto neglected people about their right to have services from public institutions; and, (c) perhaps more importantly, availability of access to health services can act as an entry point for the people to demand equity in such other fields as education, employment, land rights, access to protected water, housing, environmental sanitation, social and economic justice, and so on; health services have thus the potential of serving as a major lever for all-round development of the hitherto neglected and exploited segments of people of the developing countries.

The adoption of the Alma Ata Declaration by all the countries of the in 1978 world was a landmark in the oppressed people's struggle to wrest their rights from their oppressors. Subsequent events have shown that the oppressors have managed to thwart this important movement for self-reliance in health.

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The State and Civil Society: Meeting health needs, reaching equity

SHOBHA RAGHURAM AND MANASHI RAY[1]

ABSTRACT *Shobha Raghuram and Manashi Ray examine the health standards for the poor in India within the broader context of human development concerns during the last decade, with special emphasis on the role of the state and its commitment towards achieving 'health for all'. They discuss the response of civil society in issues of public health and in monitoring the accountability of the state, underscoring the need for reforms in the state services.*

Globalization and health

While globalization has been thought of as positively contributing to setting standards globally, the divides in quality of life have become even more stark and worrisome. Health has been a sector of silent neglect in many countries receiving scant attention when it comes to financing all related public health needs. The severe local and global imbalances in the enjoyment of health call for radical measures that will bring greater equilibrium in people's access to health. The minimizing of the role of state and the increasing reliance on market mechanisms to address welfare needs during the reform period has not solved the issue of millions of people globally living with unmet needs. The discussion on globalization, equity and health should not be laboured under the same rubric of growth and liberalization. The state may indeed have performed too little in the areas of basic needs. What is required is the maximization of the state in providing sufficient conditions for basic needs provisions. Sen and Dreze (1996), when writing about intrinsic value and human capabilities, drew the attention of policy makers to the excessive concentration on issues of liberalization and market-led changes which have detracted from the fact that the social sector areas have suffered from too little role of government and not the other way around. It is clear that the grueling data of existing poverty in the country has completely influenced the profile of ill health. The political economy of health will in the coming years be a critical area of work as poverty, health and development closely interconnect, thus influencing the overall arena of social equality.

Role of state and equity: the India case

The last 51 years of development history for India have shown the limits to policy, and the greatest need for consolidated social and political action taking place at the most micro-levels and at the same time the need to evaluate national governments which, in the larger sphere of state role, advocate policies which undermine human development. Historically, after independence, the government, in response to the large numbers of poor in unequal health circumstances, made many committed pronouncements pertaining to improving the lot of the vulnerable in the official planning processes. The 1978 'Health for All' Declaration received a full-fledged commitment from the Indian government and this was important in order to propose a broad and consistent philosophy towards a strategy secured in the primary health care PHC approach.

Today, an examination of the status of health indicates that there is surprising unevenness across borders. In addition to the rural/urban divide, the caste, class and gender disparities in health persist, giving rise to a situation in which different pockets of population within the same country portray differing health status. The availability of access to social infrastructure is uneven between social groups, economic classes and geographical regions. The scheduled classes and tribes, in particular, and the poor, in general, are being adversely affected. Health problems associated with underdevelopment (among the poor and the disadvantaged) and the extent of transitions which are creating a 'polarization' of health between different groups have been the grounds for public action. For policymakers designing appropriate policy but also measuring the benefits of competing health investments on different groups of population is critical.

Social development and health during the reform years

There has been a great deal of discussion regarding the negative effects of the reform measures on the social sectors, especially in countries like India with high figures of poverty and its attendant forms of destitution.

The SAP initiative adjustment programmes in mid-1991 led to expenditure compression in Union Government finances in the first 2 years. The situation improved in subsequent years with an increase in the allocation to rural development, education and health. The cuts were severe in the first two years of the reforms, followed by some restoration in the next four years. The greatest casualty was health care. As opposed to this, the almost exclusively centrally funded family planning programme fared much better even in the worst resource crunch years.

The ideological underpinnings associated with the reforms package legitimizes the state's withdrawal from infrastructural areas, including infrastructure in social sector. The projected inability of the state to finance health care has been further used as a lever for the privatization of health care.

During the decade of the 1990s, with the international and bilateral funding of some health programmes there was a gross distortion of priorities in disease control and health development. The 1992 budget had seen one quarter of the planned Central Health Budget being allocated for HIV/AIDS, while the budget for malaria control had been decreased by 43 percent. Major diseases like tuberculosis and diarrhoea which cause high morbidity and mortality were neglected. It is important to note that the greatest killers in the post-reform period continue to be cholera, TB, malaria, and kala azar (Voluntary Health Association in India, 1997). In the case of malaria, the incidence figures have been at roughly 2 million cases every year, affecting mostly tribal populations. On the whole, after the initiation of economic reforms in the 1990s, the sustainability, health priorities and the future of public health programmes have been greatly influenced by external assistance and have not been pro-poor or pro-people. It is difficult to assess the extent to which the reforms have had an adverse affect on health in the 1990s. However, it can be postulated that because of considerable decline in the public expenditure in the first few years of the reforms, there might have been adverse impact on the overall human development indicators.

Health security and the poor: a matter of responsibility?

The state as the primary and critical actor in ensuring equity urgently requires the consideration of an overall plan which can strategically strengthen the sector of health in the overall plans of development and poverty eradication. The financing of poverty alleviation programmes as well as social sector services requires a comprehensive effort both on the field and in the budget exercises. Health policy will increasingly need to be designed keeping in mind both national and local agendas.

Market considerations have often flawed an overall social justice agenda and the wider canvas of human security is the basis for the serious management of public health. The primary objective of the National Health Policy (NHP) which was adopted in 1983 was to attain the creation of an infrastructure for primary health care. Other major priority areas were: close coordination of health related services and activities like drinking water supply, sanitation and nutrition: the active involvement and participation of voluntary organizations and the provision of essential drugs and vaccines.

The 1980s witnessed a massive infrastructure expansion and the creation of programmes for providing family health care facilities. However, in spite of the vast expansion in infrastructure it failed to work due to poor facilities, inadequate supplies, insufficient effective person hours, and the lack of proper monitoring and evaluating mechanisms. A bureaucratic approach, insensitive to recognizing and involving people's organization in the implementation of the family welfare programmes in the country forced the continuation of the use of private health services.

The other issue has been the effectiveness of expenditure incurred in terms of human development outcomes, and the relative importance of economic growth and public provisioning in capability enhancement of states (Chelliah and Surdarshan, 1999). Thus, there are severe imbalances in India between public and private health care, within public health care between preventive and curative services, between primary, secondary and tertiary health care services, and between salary expenses and other recurrent expenditures, as well as between more vulnerable, poor areas and the privileged urban centres.

Regional diversities and contrasts in health status

Progress over the decades has been uneven and remains confined to more advanced states and, even within them, to selected regions only. The health status of a large part of the Hindi speaking areas of north India, as well as the states of Orissa and Assam, remains adamantly vulnerable.

Further, the more remote, sparsely populated and resource-poor an area is, the greater are the chances of its neglect, in terms of the availability and effectiveness of health services. The flood-prone areas of Assam and Bihar and states lying along the Bay of Bengal suffer from the endemic presence of vector-borne diseases and frequent damage to infrastructure. The people in these areas – be they tribals, scheduled castes, displaced or migrant populations in search of work – remain ignored and are compelled to accept a lower quality of life. Preventive and public health care measures and primary health care services do not reach them adequately. Therefore, the political economy impinging on health policy development and its implementation has given rise to the conspicuous disparity in the health outcomes. As a result, there have been neglected areas, forgotten populations and overlooked issues. Each of these distortions is damaging enough, but when all three exist the situation is fairly acute.

Reform of the State and the role of civil society: a case for cooperative public action

Issues taken up by grassroots voluntary organizations include food security, political participation, health, urban poverty, migration, and land alienation. Governments have many mechanisms at their disposal for replicating good models that might emerge from the extensive micro-level experience that non-governmental organizations have of given communities, which help them to perceive genuine interests and to build organic links on the field. In the area of health, which

involves a spectrum of collaborative efforts. politically voluntary organizations need their autonomy from governments. as they instrumentalize different social and political interests. The mutual accountability that is being demanded of government-voluntary organizations relations requires institutional integrity (e.g. transparency). particularly to the communities involved. How they may be asked to integrate their efforts with those of the state. which is itself in the process of integration with global interests on terms clearly not set by the people themselves. is a thorny and painful issue. Social justice. accountability. high standards of morality and equality are issues that cannot be realized historically without majority consensus. For voluntary organizations or social movements the challenge lies in enabling basic needs and democracy mainstream concerns. cutting across social strata and class interests. Local bodies offer today the only hope in benevolent. decentralized state presence. where the centre may hold and the peripheries may continue to define the political spaces.

Co-operation in health strategies

The sharp gender. poverty. caste lines and the scarcity of resources make the need for extensive field co-operation an urgent matter. Communication is quite central to the effective success of programmes in public health. Health workers are the central agencies of the policy framework being materialized on the field and often this is a neglected fact. Barefoot health workers. centrally involved in communication. are often shoddily treated in their working conditions. creating a tremendous demoralization in programmes. Particularly in preventive work. information dissemination and communication. and in pressurizing the inflexible medical bureaucracies to extend support in implementation. NGOs today are making their presence felt. The work of NGOs is preventive. proactive. promotive and emancipatory. They have shown the strength of being embedded in community survival issues. Their ideas on information. education and communication (IEC) cover a large number of problems faced by the poor and by women.

Conclusion

We live in times where the poverty of others is tolerated and where women's lives. especially when they are poor. are a devalued social goal. Clean water and sanitation. universal primary education. especially for girls. more effective distribution of food and nutrition. the alleviation of poverty and greater public awareness and participation in health preservation and care are all critical components of genuine health and development strategies. Many challenges face public health policy makers. Can universal care be afforded and managed by the public sector alone? How can appropriate fiscal. human resources. and social systems be developed to achieve this goal? Could decentralization of health policy help in this process? How best can the public and private sectors be made to interact to achieve better health outcomes?

The time has come for governments to pay attention to all models of health care and campaigns which worked. This needs at regional levels both a convergence of social principles and a divergence. which may be necessary for ensuring local acceptability and success – an approach which is united on being empowering to all users. sustainable and sensitive to unequal relations of power such as class. gender and race. An action plan needs to be common to both government and private health care financing matching programmes. strategies. financial outlays and exercises for dovetailing. All frameworks need to be moving in the same direction with predetermination of strategic entry points. In tribal areas the most successful health strategies included livelihood issues. food security. literacy to enable the tribals to access their rights. e.g. food provisioning etc. Approximately they fall in the rubric of gender. class and may be judged on the basis of effectivity and accountability. Strategic interests and an overall framework cannot be oppositional in character. as is often the case. The state services with their vertical structure need to be interfaced with building horizontal linkages and working with disprivileged groups. Participation is a much used word but it is not something that can be engineered by funding and policy determinations alone. Few donors even seriously consider

financing people-linking efforts, jointly evolving approaches which involve all stakeholders.

Effecting changes which are visible is a challenge. If we wish to take this challenge there is little time left. The field conditions must recall to us the unfinished agendas of existence, well-being, and the central ethical tenets of caring for others. Health must not be perceived as an economic good and a private privilege alone. All social forces involved in health in the next millennium may wish to pledge and act on a principle which functions by inclusion and not by exclusion. Health is a social claim, and unless we pinpoint the gaps and find solutions for the structural imbalances we cannot create those dimensions which will carry forward the necessary transformatory processes.

Note

1 We thank Hemalatha D. at Hivos for all the valuable assistance in the preparation of the longer version of this article. For a more detailed version of this article see 'Globalisation and Equity in Health'. *Technical Report Series* 1.8. Bangalore: Hivos. Forthcoming.

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Community Based Approaches to Health Care of Tribal and Rural People

Dr. H. Sudarshan

Introduction

Vivekananda Girijana Kalyana Kendra (VGKK) is a voluntary organisation, started in 1981 for the integrated development of Soliga tribal people in B.R.Hills. At present VGKK provides health care to 20,000 tribal population in Yelandur, Chamarajanaga and Kollegal talukas of Chamarajanagar District and Nanjungud Taluks of Mysore District. The tribal people in the area were traditionally dependent on shifting cultivation, hunting and food gathering for their livelihood.

Karuna Trust (KT) another Voluntary organisation affiliated to VGKK is covering the entire population of Yelandur taluka (74,000) and Six-Gram Panchayats (50,000) of T.Narasipura taluka.

In contrast to Institution based health programmes, the Community Based Health Programmes are rooted in the community and ensure community participation. These are people oriented, need based, decentralised, culturally acceptable and cost-effective health programmes.

Health Infrastructure and Human Resources

VGKK has a well-equipped base hospital at B.R.Hills with an outpatient clinic, laboratory, x-ray, operation theatre and indoor hospital. Karuna Trust has a Primary Health Care at Gumballi, Yelandur Taluka. The health services are delivered through 3-tier structure: Village health workers, Multipurpose health workers and Medical professionals. The strength of VGKK and Karuna Trust are its committed cadre of Health professionals and Health workers.

Health Profile of Soliga Tribal People

Soliga tribal people seems to have lead a healthy life till they were displaced and their traditional sources of livelihood were not taken away by the forest regulation which came into force from 1978. Their major health problems are Sickle Cell Anaemia, Tuberculosis, Pneumonia, Chronic Bronchitis, Snake bites and mauling by bears, Hypertension, STD and HIV are very uncommon. We are yet to find a case of Appendicitis, Colonic cancer or a tribal student with refractive error. The health status of tribal people living within the forests is better than those who have been displaced from the forests.

I. Innovative Health Programmes of VGKK

1. Sickle Cell Amnesia Screening Programme

The Soliga tribal people suffer from Sickle Cell Anaemia. The Soliga population has been systematically screened for Sickle Cell Disease (SCD) & Sickle Cell Trait (SCT). Initially Dr. R.L. Kirk of National University Canberra, Australia, helped us to set up the screening programme. At present 28% of the Soliga tribal people have SCT and 2-3% have SCD.

The SCD patients are treated at our hospital. The clinical manifestations of the SCD in Soliga community are less severe when compared to the SCD patients in Africa. This could be attributed to the high levels of Faetal Haemoglobin in Soliga patients. A Longitudinal study to understand the behaviour of the Sickle Cell gene in the absence of Malaria has been undertaken.

2. Integration of Traditional Medicine

The Soliga tribal people had their own traditional health care system. VGKK has made an in-depth study of their system, documented it and integrated it with Modern System of Medicine. Their knowledge of Herbal Medicines and health practices like conducting deliveries in squatting posture are being promoted.

3. Training Tribal ANMs

As the non-tribal ANMs were not staying and working in tribal areas. Tribal girls were selected and trained at Mysore and Madikeri Government ANM Training Centres and then posted to remote tribal areas by creating new sub-centres. These ANMs are more acceptable to the tribal community and they stay in the remote tribal hamlets. This programme is being done in collaboration with the Department of Health and Family Welfare, Government of Karnataka.

4. Training of House Surgeons from MMC and JSS Medical Colleges

House surgeons from Mysore Medical College are being posted as part of their Rural Health Training since 1990. Later JSS Medical College also started posting their House Surgeons. During their postings, they are oriented to Tribal and Rural Health programmes.

II. Innovative Health Programmes of Karuna Trust

The major health problem in the rural population of Yelandur taluka are Tuberculosis, Epilepsy, Leprosy, Mental Health and Nutritional anaemias.

1. Community Based Leprosy Control Programmes

As Yelandur taluka was hyperendemic for Leprosy, Karuna Trust took up the Leprosy Control Programme in 1987. More than 1200 Leprosy patients have been cured of Leprosy (both PB and MB cases) and we are in the Elimination Phase of Leprosy Control Programme. The prevalence of Leprosy has been brought down from 16 per thousand to 0.2 per thousand. Karuna Trust has also taken the responsibility of Rehabilitating all the Leprosy patient with disability.

2. Community Based Epilepsy Control Programme

This was started in 1990 in collaboration with Indian Epilepsy Association, Bangalore chapter. Hot Water Epilepsy, which is very common in the Mysore plateau region, is being studied, and patients treated free of cost. Dr. K.S.Mani, a well-known epileptologist has trained Medical Officers and health workers in decentralised cost effective and community-based approach to management of Epilepsy. The prevalence and incidence and the natural course of Epilepsy are being studied. Drug trials with two herbs have also been undertaken.

3. *Community Based Tuberculosis Control Programme*

Tuberculosis control programme was taken up in January 1992. Community based health workers, laboratory technicians and medical officers were trained by National Tuberculosis Institute, Bangalore. Approach of supervised chemotherapy with emphasis on sputum smear positive cases was started in our project even before the DOTS concept. At present more than 95% of the TB patients are taking full course of treatment and getting completely cured.

4. *Community Based Mental Health Programme*

Community based approach to Mental Health Programme and integration of Mental Health into Primary Health Care was undertaken since 1994. The Medical Officers and Health Workers were trained by psychiatrists from NIMHANS. Emphasis is on early diagnosis and treatment of all psychotics in the talukas.

5. *Community Based Eye Care*

Emphasis is on early diagnosis of cataract cases by health workers and motivating them for cataract surgery. Extra-capsular extraction and IOL surgery is being done at the Operation theatre in B.R. Hills. Two ophthalmologists, Dr. Padma Prabhu and Dr. Vijaya Rao are helping us in this programme. Prevention of blindness by Vit "A" profilaxis and early treatment of eye infection and injuries is also part of the programme.

6. *Community Dental Health Programme*

We are running a Dental Clinic at Yelandur with the help of JSS Dental College. Dental Health Education and treatment of simple dental problems is done by health workers.

7. *Primary Health Centres (PHCs)*

PHC (Gumballi) with three sub-centres covering a population of 12,000 in 14 villages was handed over to Karuna Trust by the Government of Karnataka in July 1996. All the staff for the PHC and sub-centres have been appointed by Karuna Trust. All the aspects of Primary Health Care –preventive, promotive, curative and rehabilitative services are being implemented. All the National Health programmes and Reproductive and Child Health programmes are being implemented effectively. Integration of undertaken. All the health indicators show that the health status of the people in the PHC area has improved substantially.

8. *Community Based Rehabilitation (CBR) Programme*

This Programme was started in 1996. This programme for disabled includes Health and medical rehabilitation, Education, Economic rehabilitation, Awareness Building and community organisation, prevention of disability and nutrition programmes. The special features of the programme are: a) Involvement of Panchayat Raj Institutions b) Empowering persons with disability to organise themselves c) Integration of CBR into Primary Health Care d) To do Action Research in CBR.

9. Diabetes Control Programme

This programme was started with the help of Dr. Munichoodappa and Dr. Prasanna Kumar. We are collaborating in a research programme to study the prevalence and incidence of Diabetes in rural and tribal areas. We are also starting the Diabetes Control Programme for the entire population of Yelandur Taluka.

10. WHO & GOI Sponsored Pilot Project at T. Narasipur

A pilot project on "Empowerment of Rural Poor in Health" has been undertaken in collaboration WHO and Ministry of Health, Government of India. Through Participatory Rural Appraisal (PRA) technique, the rural poor are empowered to manage their health by doing Microplanning and formation of Village Health Committees. Both Karuna Trust workers and Government Health Workers are jointly conducting the programme.

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH - A CASE HISTORY

By

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FRCH was established as a no-profit voluntary organization in 1975. Its aim was to study why neither the public nor the private health sector could provide appropriate health and medical care to the vast majority of our people whether the poor, middle class or rich. This despite vast increase in manpower, infrastructure and financial inputs. From its inception, FRCH held certain basic premises viz. 1) that health was a fundamental right of the Indian people and 2) health and medical function should be undertaken by people themselves with appropriate support from professionals. It additionally possessed the vision to distinguish illness care from health, which is determined by non-medical factors such as education, sanitation, environment, culture and economics.

The experience in a medical college and its hospital in the city of Mumbai revealed that almost half the patients who sought help were residents of a nearby locality. This unnecessarily swamped the expensive services of this specialized institution for minor day to day problems. It was also noted that even many of the patients who came from distant parts of the state and country for specialized medical care could have been treated adequately in their own taluka or district hospital. Many of the specialized medical or surgical problems like leprosy and burns could also be treated in a far simpler, humane and cost-effective manner if the available knowledge and technology were modified to suit our people's and country's requirements rather than merely following the `latest' trends of the West.

If this was the state of affairs in a premier medical institution of our country, the question arose as to what prevailed at the grassroot level where the majority of these problems actually originated. The Preventive and Social Medicine Departments failed to provide any viable answers. Hence, a couple of years were initially spent in observing the health problems of a typical rural area of the Konkan in the North Alibag taluka across the harbour of this premier city. Observations during weekend rambles in the villages and of the local public and private medical services revealed that the major problem was poverty and its associated diseases. The public sector primary health centre hardly provided any of the preventive, promotive and curative functions, while the private practitioners provided unnecessary and even dangerous medication and injections even for simple ailments like flu and diarrhoea, based on the profit motive. Despite being overloaded with work, a couple of motivated MBBS doctors at the District hospital provided a remarkably efficient medical as well as surgical care with the limited facilities at their disposal.

Not knowing the underlying cause nor having the ability to alleviate the poverty, the initial effort was to see if the simple, cheap, safe yet highly effective available remedies for some if not most of these common diseases could be utilized by the people themselves. Since 70% of the population consisted of women and children and the majority of health problems affected them, thirty women, one from each village of about a 1000 population, were provided this knowledge and technology by a small team of social and medical workers supported by a very modest referral service. To our surprise within 5 years these women were able to achieve many of the `targets' set by the Government for 2000 AD in the late 70's. Besides minor ailments, this included major problems like diarrhoea, dysentery, malaria, tuberculosis, leprosy and even family planning. This helped us to overcome our confusion between education and intelligence of semiliterate and even illiterate women. This opened a new avenue for providing medical services at remarkably low cost. If simple, safe and effective knowledge and technology was provided in a simple manner, village women with their inherent social skills, intimate contact and high credibility within their own community could be the best agents for catering to the medical problems affecting their community

leaving relatively few problems for professionally trained doctors of the private and public sectors. The women were also informed as to when and how to use the available referral services.

As a result of this dramatic experience, FRCH was invited by the late J.P.Naik in 1978 to provide the research component and secretariat for the ICSSR/ICMR report `Health for All: An Alternative Strategy'. This provided FRCH a unique opportunity to interact with some of the most eminent doctors and social scientists of our country and discuss the possibility of utilizing such a decentralized people based alternative model of health and medical care which differed radically from the existing public as well as private sectors. This also introduced FRCH to a new dimension for the study of health rather than mere medical technology namely the social, cultural, political and economic factors, which underlie both health as well as medical care. This unique Report also stated that over 95% of all health as well as medical care can be best undertaken at the 100,000 population (taluka/block) level, of which 80% could be within the villages themselves. Nevertheless, this people based health care system would have to wait till the right political climate (such as Panchayati Raj) would provide them the necessary power to implement what was within their capability and self-interest.

The 80's were hence spent by FRCH in arriving at a better understanding of the difficulties and problems of the then existing health and medical systems. A series of conceptual as well as field research studies were undertaken to understand the social, cultural, political, economic as well as medical aspects that affected both health and medical care. This included interaction with the ICMR, ICSSR, and Ministry of Health and Family Welfare as well as with other NGOs, national and international agencies including those nearer home like Ralegan Siddhi. Within this period the key contributions of FRCH included a) influencing the adoption of the Community Health Worker's scheme b) compiling a profile of health care in India inclusive of health structure, infrastructure, medical education, expenditure and outlay on health and family welfare in various states c) preparation of health education materials for grass-root level workers and non formal health education schemes d) analysis of medical and public health in several countries e) utilization of tuberculosis as a disease model for advocating a new people oriented approach to control of major infections. Many of these findings earned an international reputation and formed a basis for what was to follow.

It must be mentioned that a unique advantage enjoyed by FRCH in such socio-medical studies was the availability and close interaction with its sister institution, the Foundation for Medical Research (FMR) a well-equipped research laboratory. Both these institutions working as an almost single unit provided a unique opportunity to bridge the traditional distance between the laboratory and the field for problems like leprosy, tuberculosis, diarrhoeal diseases and reproductive health problems which can be best tackled only through a combined medical and social science research oriented approach. The publications and joint activities that ensued during the 80s and 90s bear testimony to an otherwise much neglected approach to health and medical care, currently followed more systematically and with vigour.

With the advent of Panchayati Raj as a result of the enactment of the 73rd Constitutional Amendment, the major attention of FRCH in the 90s has moved to the understanding of the implications of a decentralized form of governance in the implementation of various alternative strategies for the development of the People's Sector especially in health which is one of the

subjects covered under Panchayati Raj. This has enabled FRCH to formulate a more detailed theoretical model based with the help of practical experience gained in a five-year field operational research study in a valley in Purandhar taluka of Pune district. In a carefully documented study covering a population of 17,000 amongst 13-Gram Panchayats, seventy village women have been trained in a wider concept of health than at Mandwa covering several aspects of rural development. Several of these women have in turn demonstrated their ability to train women from different parts of the country sent by organizations who also desire to undertake similar work at the grassroot level. FRCH and its village functionaries have also helped in spreading this model in two districts of Maharashtra as part of a WHO supported project.

FRCH is now imparting upgraded training for some of these village health functionaries to help bridge the gap between the village and the available professional services at the tertiary level such as the taluka hospital and health center. Termed as `Sahyoginis' they are being trained to provide in turn training, support and referrals to about 25 village functionaries who will work with each of them as a team at about the 5000-population level. This field study has demonstrated the feasibility of an alternative people's sector in both health and medical care which has several advantages over the existing public and private sectors. Such a decentralised people's sector can provide a more accessible, personalized and cost-effective service, which is accountable directly to the community of which it is a part.

Such a Community Health Care System also has several other advantages. These include involving the community in its own health rather than depending on an external service to be `delivered' by an impersonal public and profit-oriented private sectors. Since the majority of the staff consist of local village women functionaries, it offers the potential for large-scale useful employment of village women within their own villages, being a field which is highly labour intensive.

* All this at a salary far lower than the excessively paid staff of a unionized bureaucratic top-down public health service subject to targets and transfers.

* Another major gain lies in the demystification of medicine enabling more effective control and use of both the public and private sectors.

* Prevention resulting from intensive non-formal health education, together with early detection, can reduce both suffering as well as the cost of health and medical care.

* Above all, this provides a remarkably effective means for empowering women within their own communities.

* This would enable the people to justifiably demand the diversion of public resources from the urban to the rural sector.

* It would also enable them to divert some if not most of their unnecessarily expensive expenditure incurred on the private sector to their own people's sector which operates without the profit-motive.

It is estimated that such a people's health sector can provide an effective health and medical service at about Rs.175 per capita per annum as opposed to Rs.575 presently incurred in the public and

private sectors. This could also enable them to provide free health and medical care to the 33% of the population that live below the poverty line and who now have to divert 20% of their meagre household expenditure on inadequate and expensive medical care.

The Community Health Care system hence has the potential of providing a remarkably effective medical care from the village to the people's own Hospital, with specialist services. FRCH now seeks to demonstrate this on a larger countrywide scale.

Being a people's programme it is closely related to Panchayati Raj. For Panchayati Raj itself to take hold, awareness of citizens and the community at large need to be established for inculcation of accountability as well as bringing health into the mainstream of public focus. Hence, production and dissemination of information at grass-root level is a key activity for FRCH for generating a people's health movement as well as a nationwide network for health and health care. Interestingly almost all the 29 subjects covered under the Panchayati Raj enactment impinge on health. One of the activities of FRCH is hence the production and dissemination of information on Panchayati Raj and the 29 subjects covered under it.

In all these efforts, FRCH enjoys the support of a well-established library and documentation center and administration at its office in Pune. There is ongoing collaboration with state and national institutions such at the Indira Gandhi National Open University, National Open School, BAIF, ICMR, ICSSR, the Ministry of Health and Family Welfare, the Planning Commission, and the WHO.

Comments on "Case Study of World Bank activities in the Health Sector in India"

Presented at the Consultative Meeting on "World Bank Activities in the Health Sector in India" at World Bank Office, New Delhi, on 9th August 1999

The Sector and Thematic Evaluations Group and the Operations Evaluation Department of the World Bank (India) prepared a case study on the World Bank's Health - Nutrition - Population program in India based on review of literature, sector and project documents and the proceedings of the workshop on "The World Bank's Role in the Health System in India" which included 9 papers commissioned by OED.

This note by some of us from the Society for Community Health Awareness, Research and Action, Bangalore, a multi-disciplinary professional resource group working for the last 15 years supporting community level health action and community oriented health policies by the voluntary sector and government, brings to bear comments on this case study from a Public Health, socio-epidemiological; management; ethical; and public policy perspective - which are the disciplines represented among the four member group of the society, who studied the document.

We had a little over a week to study this document and in spite of a request were able to get copy of only one of the nine commissioned papers! So our comments are based on a rather rushed analysis of the document handicapped by the absence of access to the background papers from which much of the perspectives and conclusions included in the case study, are drawn. Notwithstanding this constraint we hope the concerns we raise will be taken seriously by the Ministry of Health and Family Welfare and the World Bank India operations team. We believe these are concerns that we along with so many other public health / community health / health policy resource groups have been raising for over two decades now, but we are emboldened once again to do so -because for once the findings of this case study so strongly endorse and support them. These comments are also based on insights that we have with involvement with World Bank projects at Karnataka State levels in various ways.

We believe it is time that the Ministry of Health and Family Welfare at the Centre and State and the International funding partners, particularly the World Bank ('who is now the largest lender in health, nutrition and population with the largest programme in India') - who jointly conceive, conceptualize, operationalise and monitor such large collaborative projects on behalf of the people of this country - (emphasizing "poor and undeserved and concentrating on children and mothers") took these concerns seriously.

This significant, rather short, but important Consultative Meeting could be a serious step in that direction. However, a more detailed dialogue is required if these concerns must get translated into constructive policy change.

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Comments

The Case Study of World Bank Activities in the Health Sector in India brings together findings from a variety of sources (mostly World Bank commissioned) and attempts a comprehensive, critical, historical view of 23 projects undertaken by the Bank in partnership with the Ministry of Health and Family Welfare at Central and State levels and to which the Bank "contributed over $2.6 billion plus studies and policy dialogue"

The case study is frank, introspective and 'as objective as possible under the circumstances'. Though inadequately referenced even from the commissioned studies, and perhaps representing sets of opinions rather than 'evidence based analysis' it is still a sobering indictment of what the Bank claims to be the "largest Health Nutrition and Population programme" funded by it.

Appendix 1 of this note lists out in the report's words key findings and conclusions producing a rather disturbing, disconcerting scenario and a rather frank admission of failure, and distortion. If a SWOT analysis were to be done on the case study -then weaknesses would far outweigh the strengths; and threats / distortions far outweigh the opportunities!

In the absence of access to all the commissioned studies and reports / documents quoted in the report, it would be unfair to attempt a comprehensive review of the document, but we raise the following comments, reflections and questions from a Public Health; Epidemiological; Management; Political Economy; Public Policy and Ethical perspective, keeping an overview of the overall partnership between MOHFW and the World Bank in mind and not addressing just the nitty gritty. Some of these are endorsed in the case study. Others are derived from the findings presented.

1. Public Health devalued

The whole partnership suffers from a disturbingly lack of 'public health' competence and perspective and this chronic lacunae does not seem to have been overcome even when the claim "the Bank is now on the right track" is made.

Throughout problem analysis, project planning and formulation, there is a confusion between

- public health system and public health care system
- between socio-epidemiological context of a problem and its economic or techno-managerial context, the latter taking precedence over the former every time
- the wider determinants of health status that need to be addressed by good public health is totally ignored (devaluation of nutrition is admitted but other aspects like water supply and sanitation, transport and communication, environment pollution have not been addressed and even health education in this report is put outside the confines of the health sector.
- The focus on the poor, the indigent and the marginalised which should be the central focus of an equitous public health system is ignored or if present in programme focus is ignored in programme implementation
- In fact both 'epidemiology' which is the sheet anchor of public health and 'political economy' which should be a important part of problem analysis is totally ignored.
- The regional diversities and differentials -now known for a long term are ignored.

Between the generalist administrators who now manage India's Health System and the 'economists and programme managers' that advise them from among the Bank's staff and Consultants Public Health has been totally devalued and distorted both due to a lack of public health orientation and public health competence among the policy makers concerned.

2. Primary Health Care sidelined

The World Bank projects evolved and developed when the country began to take the Srivastava (1974) and Kartar Singh report (1973) seriously; commissioned the ICSSR/ICMR Health for All : An alternative strategy document (1981) after becoming an enthusiastic signatory of the Alma Ata declaration; enunciated the National Health Policy guidelines of 1982; the National Education Policy of 1986 and the National Education Policy for Health Sciences in 1989. In addition, the ICMR initiated its review of Alternative Approaches in Health Care (1976) and the Evaluation of Alternative Primary Health Care (1980). Preceding these documents but supplementing / complementing them, there was a spate of micro-level and collective initiatives in Alternative Health Care in the 1970s and 1980s which are now well documented and a host of very incisive, evidence based, thought provoking analysis of India's health care systems from social, economic, cultural, political, epidemiological and public policy perspectives from the mid 1980s to date. The World Bank project partnerships seem to be totally 'uninformed' about all this and has not only ignored the Primary Health Care mandate but has actively distorted the Primary Health Care agenda by focussing on

- *'selective, cost effective treatment schedules' rather than enabling / empowering health care processes*
- *relying only on the now well debated and well established inadequacies of the GBD study based on DALYS (WDR - 93 and the documents that followed)*
- *focussing now on secondary hospitals rather than primary health care*
- *on first referral units rather than the Primary Health Centres*
- *totally neglecting the people and community, whose involvement at all levels was envisaged by the Alma Ata commitment and 'whose needs / capacities / aspirations were to be emphasised' and not made subservient to needs of technology or the exigencies of top down management systems.*
- *Finally, it ignores Panchayatraj, which has to be the focus of Public Health and Primary Health Care in the 1990s (even cautions against it) and then creates Registered Societies as a decentralization initiative without clarifying how they will be made accountable, transparent, responsive to public need or the country's democratic political system.*

3. Unconstitutional partnership

The World Bank seeks to influence / health policy in India by (a) virtue of being the largest lender to the sector, even though there is enough evidence that this forms a small part of the entire country's budget; (b) by various conditionalities that overrule local expertise and project formulations, (c) by thrusting on the country ideas from rather different countries with different social, economic, cultural, political, ecological and epidemiological context. (An example from Malaria Control will be given to substantiate this)

What is the 'Constitutional validity' of this leverage which is greatly enhanced by use of 'funding muscle'? and which was established during a period of economic vulnerability of the country (The big break' mentioned in page 18).

Considering that many of these are loans and not grants, is the World Bank willing to bear the costs of failure and distortions due to poor programme planning that ultimately affect the poor the most?

What is the long-term sustainability of such a leveraged process - often arrogant, top down and externally inspired. What is the effect on local health system capacity development?

Is it not leading to coercion? Distortion? Competition? Who will bear the responsibility? What is the accountability and transparency especially to civic society?

The MOHFW must seriously dialogue on these issues before the PAC, the legal system, the political system and civic society begin to question and initiate informed citizens' action against it. In Karnataka this process is already starting up.

4. Ethical issues

The case study raises some major ethical issues

(a) What are the ethics of promoting so enthusiastically the 'private sector' when there is no evidence even from Bank sources that the private sector either has the capacity to provide 'low cost effective quality care' or has any commitment to 'public health' or to the goal of equity (giving only the example of Apollo, Chennai, which is not even among the best examples of corporate social responsibility is a case in point).

(b) What is the 'ethics' of undertaking a partnership taking the credit when there is success and then pointing a finger at the MOHFW when problems are identified and not solved (the report calls the World Bank position 'cautious' but 'incompetence' is what the report establishes). Does this make World Bank an unreliable partner?

(c) What is the ethics of continuing to fund even after 1990 - a programme, when the Bank is well aware of the flaws and distortions?

(d) What is the 'ethics' of expanding 'quantity' at the cost of 'quality' or 'infrastructure' at the cost of 'services focussing on the poor'.

Is it at all surprising that ever since the World Bank has become a lender of large amounts of money -that the medical scams in the country have also gone up? There may be no cause-effect relations but why does the report ignore corruption which is endemic in the country; is now well documented by civic society; and is well accepted in problem analysis, by serious policy researchers.

Has the World Bank ignored it by oversight? Is it aware that it may be inadvertently supporting it or even facilitating it - international tenders and guidelines not withstanding?

5. Management issues

In terms of 'Management' perspectives, it is rather surprising that a partnership that claims to be able to marshall international expertise has continued to:

i. *develop infrastructure quantity rather than quality;*

ii. *expected 'training' inputs to get over needs of management reforms;*

iii. *given so little thought to accountability and transparency;*

iv. *relied on internal monitoring / evaluation by in-house staff and consultants rather than independent credible external evaluation;*

v. *ignored health human power management issues;*

vi. *focussed only on 'userfee' rather than diverse fund enhancing options including health budget increase;*

vii. *given so little thought to ownership*

Directorate of Health Service staff at all levels often feel coerced by the conditionalities /guidelines and lack of flexibility, and do not identify with it. There is also nil ownership at the community / civic society level.

(This is probably the greatest failure of the World Bank projects and both MOHFW and World Bank partnership cannot overlook this any longer).

All this may be changing now - the case study claims - but is this real change understood at core policy level?

6. Political Economy

The case study does not look adequately at the larger 'political economy' issues against which the analysis and the successes and failures should be contextualised. These include *the financial situation in the country and globally; the reduction / stagnation of public sector budgets; the impact of rise in prices on drugs / diagnostics; the contraction of public sector; the expansion of private sector under LPG (Liberalization, Privatization and Globalization) and its impact on public health and access by poor to medical care, the potential impact of WTO and changes in Patent laws; the increasing corruption and scams, etc.*, and thereby the policy researchers involved in the partnership constantly under-estimate the political, social, institutional and other dimensions of the problem analysis and hence offer recommendations that are general and not focussed on 'how and why things run' or 'do not run'. The report admits this and hope the next phase will address it. While this may be changing, of late is it still on the sidelines of the partnerships planning and problem solving efforts and depends very much on the quality and experience of consultancies and in-house expertise that is facilitated both inside the MOHFW and the WB-India office.

Unless there is a strong 'public health policy resource group within the MOHFW' in the next phase and this free-lancing, free floating, adhoc consultancies and commissioned studies are institutionalised a real change in competence may not take place. The report establishes rather well the inadequacies of the last two decades but its chapter on implication for the future or how to develop an effective programme fails to grasp the complexity of the situation. One does not know whether this naievity is intentional or inadvertent?

7. Building on strengths and new insights

While the above 6 comments may seem to focus mainly on weaknesses and distortions that have plagued the framework of the World Bank Project partnerships, we do also recognise some strengths and especially some of the new insights in the report which we hope will find increasingly higher place on the agenda of problem analysis, project formulation and project management in the future.

Some Strengths

i. By focussing on 'private sector' even though on the 'profit' rather than 'non-profit' and 'corporate' rather than 'general practice', the Bank has brought into policy focus the engagement with the private sector which has long been a 'blind spot' in Indian health planning. It is time the GOI / MOHFW studied this sector recognized, monitored, involved, regulated, evaluated and 'quality assured' in this sector.

ii. It has more recently supported the target free approach and the shift from Family Planning, especially sterilization, to Mother and Child Health (RCH) but still has a long way to go towards women's health and development.

Some New insights

iii. It has also identified the following new thrusts in its section on policy implications which are welcome

- *"need to focus on staff policies and practices regarding compensation, assignment, transfer, promotion and demotion work rules and supervision"*
- *"need to take more account of field conditions and to find solutions to implementation problems"*
- *"need to ensure that basic, simple services for the poor are not neglected in the wake of attention paid to secondary hospitals"*

All these are definitely steps in the right direction. In addition, we believe that if the points 1-7 are considered not as negative judgements but as stimulus to change track and be rooted in local social reality than these will add to important policy change as well.

8. Some of blind spots continue even after two decades of work in India. (a) One is especially striking and that is the total disregard of Indian and alternative systems of medicine and folk health traditions, in spite of the country having such a large network of institutions, health centres and human resources in these systems. (b) Is the total lack of understanding of people from a social / community point of view. Reducing everyone to a potential patient, client or stakeholder and taking about social marketing through IEC rather than community involvement in planning, organising, monitoring and evaluation continues and is another major lacunae.

9. Our comments do not attempt a response to all the nitty gritty. In Appendix 2, we list out an alternative framework of reference -a paradigm shift that is seriously required if the World Bank and MOHFW want really to be on the right track. The Bhore Committee recognised it in 1946; the WHO through Alma Ata in 1978, GOI in 1982 through the NHP; and the ICSSR / ICMR earlier in their Health for All report in 1981;

How long can the poor and marginalised in our country wait for this shift to take place in World Bank thinking. In the 1999, there is a some possibility - as seen in this report. Will 'peoples health' needs finally prevail over the 'market economy of health'? Will ethical concern for health of the poor prevail over neo-liberal economics? Will the World Bank partnership with MOHFW be willing to make this paradigm shift?

SOME FINDINGS OF THE CASE STUDY

1. Bank Project 1972 - 1988
   a. "the projects did not make significant differential improvement in project districts compared to non-project districts" (page v)
   b. "Outputs other than infrastructure were largely neglected" (page v)
   c. "No attempt was made to apply different delivery models in project districts"
   d. "project districts continued to operate under the same personnel and recurrent budget constraints.

2. TINP
   a. "less successful in reducing moderate malnutrition"
   b. "Programme experience seems to have been lost on India and with it the clear emphasis on malnutrition as a leading risk for ill health".

3. ICDS
   a. "Only modest positive effects" (page vi)
   b. "targetting essentially by self selection" rather than as originally envisaged "targetting of the poor"
   c. "no Bank support for revision or structural change". (page 11)

4. Primary services
   a. **"efforts to improve quality have not accomplished much and it has devoted inadequate attention to content, monitoring and evaluation, and feedback of results".**

5. Before 1988
   a. "Bank ill prepared to make practical, constructive suggestion for systems improvements an alternative approach"

6. Sector Studies 1988-98
   a. "Tendency to make policy recommendation that are too general" (page 8)
   b. "Tendency to draw judgements about facts without adequate comparisons to experiences elsewhere" (page 5)
   c. "Inadequate analysis of underlying political, institutional and sociological factors that explain why things work the way they do" (page 8)
   d. "Earlier studies tended to be designed and executed by Bank staff with limited consultation" (Page 8)

7. IPP - VI & IPP -VII
   a. "More success in expanding the delivery and training systems than in improving their functioning"
   b. "quality and performance of the training programme remained weak" (page 9)
   c. "Efforts to strengthen MCH & IEC not very productive" (page 9)
   d. "Little progress in shifting contraceptive mix" (page 9)
   e. "failure to involve stakeholders in significant ways in design of project"

8. IPP -VIII (1992-97)
   a. "The goals and design are appropriate and relevant but they are too new and disbursing too slowly to judge their effectiveness or impact".

9. CSSM (1992-97)
   a. "Since many of the problems could have been anticipated the **fundamental problem was a weakly designed project**, a factor that may have resulted from efforts to push this project through quickly and make it quick-disbursing"

10. Specific Disease Control programs
   a. **"Benefit-cost analysis and notions about which projects are appropriate for public funding (eg., because of externalities, poverty or failure of private providers) played hardly any role in selection".**
   b. "Considerations about the proper division of labours between public and private sectors never seriously entered the discussion"(page 12).
   c. "Risk of inadvertently introducing distortions in spending between diseases and across regions" not considered adequately.

11. State Health Systems Development Project
   a. **"The projects did little or nothing to provide the other pre-requisites for an effective referral system"** (page 15)
   b. "specific activities appear to have been selected opportunistically" (page 17)
   c. "The type of monitoring and evaluation included in these projects even if implemented well is not up to the mark for this purpose" (page 17).

12. Training
   a. "Both government and Bank documents indicate an awareness of these problems, yet the problems remain unsolved".
   ("Inadequate selection and training of trainers, course content not based on trainees needs, insufficient time devoted to field work and practicing new skills, weak management of training program, inadequate inservice training programs, lack of programmatic guidance and leadership").
   b. **"Tendency to 'throw some training' to 'correct a problem' without thinking in advance whether training alone will do the job".**

13. IEC
   a. **"Bank's resources have done little more than help the government expand weak and ineffective programs with the result that considerable resources have been** wasted".

14. Decentralization
   a. *Before April 1992*
   "No bank-financed projects included any decentralization initiatives".
   b. "Local governments do not seem to be playing any significant role in the projects investigated partly because their responsibilities are ill defined".
   c. "A more widely used mechanism for decentralization 'Registered Society' has not been evaluated".

15. Quality of Family Welfare Service
   a. **"Has been aware of the flaws in the system but has continued to find system expansion and training programs despite their flaws and has not become engaged with the personal problems".** (page 24)

16. Finally
   a. "Bank waited too long to push project and studies devoted to 'health' rather than 'population'" (page 17)
   b. "Nutrition has been undervalued".
   c. "Since 1972, the bank has provided US$2.6 billion for 23 projects in population health and nutrition - **but ..... the problems persist**, and partly for analytical reasons and partly because the more promising projects are ongoing, **there are few signs that most of these projects are having a significant impact".**

The Medical Poverty Trap
With Particular Reference to Asian Countries

Paper Prepared for the Bellago Workshop on Developing Efficient and Equitable Health Sector Strategies
July 3-7 2000

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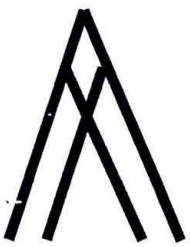

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Contents

Introduction:

Initially the paper was expected to summarise information and data from available literature that would provide insights into the nature and extent of the burden of household expenditure on health, on poor households. The study was to cover the Asian region in which countries had to address the issue of ensuring access to health care by the poor in the aftermath of economic reforms. Some of the countries had adopted mechanisms for health care financing with user participation. Others maintained traditional systems of providing free health care.

Attention has been drawn to the way in which these systems function in providing health care to the poor by some recent studies, notably in China and in Vietnam, that highlighted the substantial burden on the poor resulting from payments for health. The report on Vietnam had less empirical data than the one on China. There were, likewise, similar limitations in searching and obtaining material in time for this paper. This paper has, therefore, been restricted to an analysis basically of three situations, viz. China, Vietnam and Sri Lanka, and may be considered in the light of an exploratory study. These three countries represent two systems, China and Vietnam have introduced user charges whereas Sri Lanka has continued the provision of free health care by the State.

Section - 1

Defining the Medical Poverty Trap (MPT):

Some expenditure on health has always been a part of household expenses as shown in data from the Consumer Finance and Household Income and Expenditure surveys. The health reforms that were introduced in Asian Countries as part of the globalisation process and the market- oriented policies that went with it have changed the pattern and quantum of this block of expenditure. The escalation of household expenditure on health care was a phenomenon that took place in all the post reform situations irrespective of the system of health care that prevailed. Countries that introduced user charges for public sector health care without effective exemption schemes for the poor have found that these add to the burden of poverty on the one hand and reduce utilisation on the other. In countries in Asia such as China and Vietnam that had free or subsidised health care prior to reforms, the introduction of user fees has been described as a "sudden tax on those unfortunate enough to be sick and injured" (Prof. Pham Manh Hung –1999).

The concept of cost-sharing itself was not unacceptable. But it causes concern when it affects the poor adversely. Both Sri Lanka and Myanmar have not dismantled their free health care system in the wake of reform – Sri Lanka, because of a political commitment that politicians are wary of reneging on, and Myanmar because free health is within it's political ideology. In these two countries therefore the household expenditure on health would be that incurred either, in addition to State health care or, as a result of constrains in the State health care system. Moreover in countries in which health care is nominally free there is no provision for safety nets for the poor. The health care expenses of households would add to the utilisation costs of care such as transport, loss of work when health institutions have to be visited, and so on. Asian countries contend with high poverty, the proportion of the poor ranging from 17 percent in Indonesia to 52 percent in Bangladesh (Table 1). Hence the need to pursue

investigation into an area that has the potential to increase deprivation in already deprived communities.

A discussion on the MPT as defined above raises several issues. It needs to be viewed within the broader framework of poverty and it's linkages to health. The type of poverty trap that immediately springs to mind is the cyclical effect of ill health on poverty. The household cost of health care comes within this larger trap. An analysis of the MPT needs to get a handle on the impact of the specific variable of health care costs on the economic status of the poor. It is inevitable that when one tries to put a price on health the poor get further enmeshed in poverty. They also get entrapped in ill health.

Household costs of medical care can change the health behaviour of the poor in ways that could exacerbate the ill health trap and trigger the cyclical effects of poverty and ill health. The poor if they are unable to bear the costs of health care, will avoid accessing care until the situation reaches emergency status. If preventive services too are similarly affected then preventable diseases add to the burden of ill health and contribute to poverty as well as impose burdens on the national curative health system. The conventional arguments for cost sharing are that, if health is not costed and paid for there is a wasteful use of health care services and eventually the poor would be adversely affected. The poor in any case are unable to bear the heavy costs of health care. The way in which these forces interact to affect the poor are generally known but evidence is needed to assess the nature and intensity of the burden on the poor. This paper summarises some of the evidence available from recent studies.

The data on the MPT facilitated the separation into categories of MPTs based on the types of ill health and it's care and the differential costs incurred. The household studies carried out in the field in support of the Sri Lanka case study were able to provide a basis for categorisation. The case studies highlighted a quality peculiar to the MPT- that is, it's capacity to impoverish the non-poor as well. This is an unexpected finding that is significant for all future studies of the MPT and, in fact, for strategies for poverty alleviation.

The case studies helped also to discern two basic types of costs of medical care in two situations that prevail, in addition to existing poverty. They are:

- Cost borne by the household for a mix of common illnesses, – e.g. recurring common illnesses in children, and
- Escalated costs owing to changing disease patterns.

A sifting of evidence as is done in this paper is a prelude to further investigation and research that could guide and direct policy and strategies to deal with the phenomenon in it's varied manifestations. The discussion in the paper touches upon several aspects that impinge on the MPT and have been referred to in the issues raised in the foregoing section.

The rest of the paper is organised as follows:

Section 2 identifies the poverty causing elements of medical care. The indirect impact of external phenomena such as globalisation and structural adjustment and internal changes such as the health transition that have relevance to issues related to poverty and health care have been discussed.

Section 3 examines the health poverty nexus within which the MPT is placed.

Section 4 documents evidence of the MPT as manifest in 3 countries. In China and Vietnam the MPT is a consequence of the introduction of user charges while in Sri Lanka it is a result of constrains and weaknesses in a free health system.

Section 5 gives the conclusions and discusses the issues that would have to be faced in formulating a National Health System that has the capability of dealing with the MPT in it's varied forms.

Method:

The literature on China provided analytical reports of the impact of new health policies on health expenditure. Reports that analysed findings from a survey on medical expenditure in households in thirty poor counties in China, were used in this paper to support the case study on China. The paper on Vietnam discussed the impact of health reforms and introduction of user charges in more general terms while it's main focus was on strategies that could address the weaknesses in the system.

The case study of Sri Lanka puts together data from a series of three Consumer Finance Surveys of the Central Bank of Sri Lanka for the years 1981/82, 1986/87 and 1996/97. Only the preliminary tables were available in respect of the last survey in 96/97 since the report is not yet published. This data was supplemented with relevant data and information from other published and unpublished documents on Sri Lanka. All documents used for the paper are listed in Appendix B at the end of the paper.

Section - 2

An Overview of the Poverty Causing Elements of Medical Care: The Asian Perspective

Asian countries have a tradition of treating medical care and health services as a social responsibility of the State. The health systems that prevail in Asian countries range from totally State provided to variations of subsidised health care.

The way in which the health and social sectors evolved to achieve the varied health conditions that prevail in the region also contained features that are relevant to a discussion on the household burden of health expenditure.

Analytical writing on the health sector and health delivery systems in Asia refer to the wide variety of systems and their outcomes in terms of health indicators that span the countries in Asia.

"Health Care in Asia" - a World Bank publication- (1) contains a useful comparative analysis of country experiences in health. The study, analysing the economic links with health status, makes a significant observation based on experiences of countries such as China, Myanmar and Sri Lanka. It underscores the experiences of these countries as they demonstrate that appropriate policy decisions in social sectors coupled with judicious allocation of government

resources could overcome limitations in the quantum of national expenditure on health in achieving significant gains in health status. They have, moreover, combined those gains with relatively equitable distribution of health care.

The figures in Table 1 of key demographic and health indicators for selected Asian countries demonstrate that, although all Asian countries have made great strides in improving health status over the last three decades, some have advanced further than others and those that did so were not necessarily countries that had high per capita incomes and a steady economic growth.

The specific nature of the health problems that prevailed in these low-income countries and the manner in which these were managed could have contributed to their achievements in health.

The dominance of a set of communicable diseases that were the main causes of death and disease in nearly all Asian countries at that time, enabled State health systems to build and strengthen vigorous outcome oriented public health programmes that were also cost- effective. Countries that progressed more than others in health indicators had combined such programmes with other non-health socially progressive policies for the provision of basic needs. These successes have been achieved through recognition of the intersectoral nature of health and the need to adopt a holistic approach in dealing with health problems. These were the conditions that prevailed in Asian countries when structural adjustment programmes were initiated.

Impact of Structural Change:

The rapid changes that assailed the social and economic sectors of Asian countries, significantly affected or altered the trajectory of performance in their health sectors. Nevertheless the response of countries to the changes as they affected health care differed significantly among countries in the region. Countries such as Sri Lanka and China that had for long periods maintained very cost-effective health delivery systems on low incomes and low national spending on health were increasingly called upon to face the challenges of continuing these policies and programmes in the wake of the critical changes within the health sector itself. These challenges related to issues of both cost and accessibility to health care in the context of new health hazards and new patterns of morbidity that demanded different and, often, costly interventions. Policy decisions in this context had to face the demands of equity and efficiency as well as of affordability.

The onslaught on the health sector came both from within the countries themselves, as a result of the achievements in health status, as well as from pressures for economic reforms and market- oriented policies that flowed from globalisation and the accompanying liberal trade policies. Each of the Asian countries had its own time- table for change and the paradigms of change differed according to the different political ideologies and structures that were in place.

Discussions in the literature of the 1990s explore the links between the degree of progress in health outcomes, the success with which they overcame the health consequences of the communicable diseases and, the nature and extent of the burden of illness that arose from an imposition of the new illnesses. In view of this link the "double burden" of disease appeared to differ in its nature and composition in different country situations.

The Impact of the Health Transition:

The nature of the health transition that took place in Asian countries in the 1990s has been the subject of several discourses related to health. Countries that experienced this transition had reduced fertility levels considerably and were facing the phenomenon of a rapidly aging population with its attendant implications for dependency and old age care. Their concerns extended also to the increasing costs of medical care that were necessitated by the changes in disease patterns. These new diseases require long term and expensive care, use of new technology practised in the developed countries and which spread very rapidly to the less developed countries through the vibrant information network, and a cost burden which governments in low income countries are unable to bear. The concept of health as a social good and the State's mandate to provide health care to all was being vitiated. Countries such as Sri Lanka and China that had progressed furthest in the demographic transition but had the communicable disease burden to reckon with faced the dilemma of maintaining responsibility for health which involved provision of expensive care within the tradition of free health services.

Writings in the 1990s discuss the effect of the health transition on Asian countries and the implications of the double burden of disease and mortality. This dilemma is well documented in a paper (2) that cites ten leading causes of death in 1990 in developing countries. The study points out that seven of these diseases are communicable diseases. In contrast in developed countries the non- communicable diseases account for about 56% of all deaths and communicable diseases, for only about 4%. In the developed countries therefore the total effort of the health sector could be devoted to the health care demands of the non-communicable diseases.

These changes had implications for the use of best practices or models that other low-income countries had been able in the past to emulate. The low income countries (such as Bangladesh) that could have emulated countries such as China and Sri Lanka, in dealing with the burden of communicable diseases could do so no longer because of the distortion in the health scenario in Sri Lanka and China that had been caused by the entry of the non-communicable disease burden. They therefore had lost their role models and were left to look for their own solutions.

Section – 3

Health-Poverty Nexus: Implications of the Medical Poverty Trap:

The 1990s witnessed the emergence of analytical literature that explored health - poverty links. They established a circular link between the two. The institutional mechanisms for poverty alleviation within the Asian countries were based on the assumption that the health -poverty nexus could be best addressed within the programmes for poverty reduction. Pressure for paid health care appears therefore, to have been justified in some countries (notably Sri Lanka) on the basis that such generic measures that aimed at providing financial relief to the poor would likewise act as safety nets to ease the burden of health expenditure. Other countries, however, argued that user fees would contradict the paradigms of development they had adopted.

The manner in which health policy and macro policy interacted to deal with the totality of social problems in Asian countries could indicate the feasibility of providing a niche for MPT within programmes that are expected to enhance the capability of the poor to cope with and alleviate general deprivation. It could provide an understanding of why Asian countries can benefit by focussing specifically on MPT. The argument presented is that given the background of holistic social progress in most Asian countries, MPT, if left to grow, could creep in unnoticed and vitiate the gains of decades of progressive policies. Furthermore, the MPT could become a missed out variable of poverty in measurements of poverty. This then could be the rationale for examining its corrosive role in Asian societies and taking timely and effective measures to counter its effects.

A study (2) encompassing the SEARO countries provides an analysis of their health sectors and their progress. The MPT placed against this background is a phenomenon that should be recognised as one that can erode the gains in social indicators presented in Table 1. In that table, depending on availability, the data is given for three points of time i.e. the 1970s, 80s and 90s. The trend over this period shows that all countries have improved their health - related indicators. The key indicators of maternal and infant mortality and fertility have dropped considerably- dramatically in some- while life expectancy has risen. The point that is made in the SEARO study, however, is the persistence of poverty and deprivation in the region in the context of the rapid advances in health conditions. The general poverty conditions in the region are indicated thus.

- Nearly 45% of the adult population are illiterate,
- Nearly 80% of the population have an average life expectancy which is very much lower than the average for industrialised countries,
- 40% of the regions population are in absolute poverty,
- Between 63% and 66% of children under 5 years of age are undernourished in the countries of the region, which are the most populous.

The SEARO region does not include China and Vietnam. The data for these have been added. They highlight the negative features that Asian countries have yet to grapple with in their journey towards a healthier more progressive society.

This document and others have analysed the skewed relationship between government expenditure on health and the achievements in health indicators. The MPT could be examined in this context as well. The relationship between public expenditure and the MPT is examined in the analyses of government budgetary allocations for health. The disparities in public expenditure on health in the countries of the region show the absence of a clear nexus between state expenditure and progress in the health status. Public expenditure on health as a percentage of GDP is low in Thailand (1.1%) and Indonesia (0.7%) where it is mainly spent on public health programmes. It is high in Sri Lanka (1.8%) and highest in Nepal (2.2 %). But Sri Lanka finances a free curative and preventive health care system, while in Nepal the cost of health care delivery is relatively high. In Sri Lanka health indicators are high and are showing remarkable progress while in Nepal initial health indicators remain low.

Another study on Health Financing in Asia- World Bank (1) shows the relative per capita expenditures on health by the government among the poorer countries. It cites the experiences of China and Sri Lanka and their success in health improvements with per capita government expenditure on health (11% in China and 9.2% in Sri Lanka) similar to that of India (12.5%) and Indonesia (10.4%). But both Sri Lanka and China have attained a female life expectancy

that is many times more than India and Indonesia and an IMR that is considerably less. In the pre-transition scenario, therefore, government expenditure did not surface as a pre-condition for health achievement. What then were the pre-conditions if any? The SEARO study addresses that question.

It observes the "simultaneity of progress" where the "progress of each indicator requires simultaneous advancement on a whole range of other social and economic indicators. The deviations from the trend (e.g. high poverty and malnutrition) are equally illuminating in that they demonstrate how lack of progress in any one indicator affects the total level of well being". (2).

Be that as it may, there is evidence that illness and the inability to prevent it or to obtain appropriate and effective treatment can cripple a household despite the advances in other aspects that it has achieved. The MPT as a phenomenon is seen to have over arching consequences in eroding household capability over and above its role as a single indicator within a host of other health and economic indicators.

The two case studies that follow provide evidence of the nature and impact of the MPT on poor communities in Sri Lanka and China.

Section – 4

Country Case Studies

IMPACT OF HEALTH REFORMS ON THE POOR

Cost Sharing

The policy shifts that attempted to meet the changes that arose from health reforms generally veered towards the provision of economic solutions. The pressures for the introduction of paid health care as part of health reforms have been addressed in various forms by the different countries in Asia. Myanmar and Sri Lanka have resisted these pressures and continued with free health services by the State. Others such as Thailand China and Indonesia have introduced different formulae for cost sharing by the provider and the consumer. Two major types of cost-sharing mechanisms commonly used are the system of charging user fees in public health institutions and health insurance. The majority of the countries in Asia have adopted variations of these two.

Many of the writings that advocate user fees argue their efficacy in enhancing equity and efficiency – a ploy for which many Asian countries fell. More recently, however, a few studies carried out in China and in Vietnam and other reports have revealed the adverse effect they have on utilisation of health services by the poor and on equity. The introduction of cost sharing in other forms such as insurance has given rise to other problems such as wasteful use of drugs, inappropriate selection of treatment and medication and issues of moral hazard, thus distorting the health care scenario of the country.

Analyses of country experiences (3) point out that particularly in low-income countries where public expenditure on health has fallen "the quality of services have deteriorated, utilisation

levels in rural areas have declined and outreach services no longer function". The general tenor of the discussion in these reports is that the introduction of user fees ha in many cases been followed by sharp declines in service utilisation.

Countries in which the communicable diseases form a large part of the disease burden and where the Primary Health Care (PHC) system has been the backbone of the health sector for the poor, had perforce to impose user charges on this system as well. Literature suggests that PHC not being immediately profitable should continue to be the responsibility of the State even after health reforms.

The Chinese experience provides evidence of the break down in the low-cost community-friendly systems that had effectively provided health care to the poor when these were replaced with paid systems. The poor were therefore directly affected. There had been a premise that diseases that require costly care affect the affluent more than they affect the poor and that the poor are, therefore, largely shielded from the high cost high technology care regimes. This premise has been proved incorrect by evidence from Asian countries (4) where non-communicable diseases have featured substantially in the morbidity and mortality of the poor. Such findings have spurred on the recent concerns that are surfacing on the likely poverty causing effects of household expenditure on medical care.

Case Study of China:

Impact of Health Reforms on the Health Situation

Information was obtained primarily from two documents (5 and 6). A conscious social policy within a planned economy had resulted in great strides in improving health indicators. This was achieved with relatively low expenditure on health care. Costs of health care were contained at just over 3% of GDP in 1981. Life expectancy which was 40 years in 1950 rose to 69 years in 1982 and 70.5 in 1992. Infant mortality registered a steep decline from 85 in 1970 to 44 per 1000 in 1982.

Another noted achievement was the high insurance coverage (up to 90%) under the Rural Co-operative Medical System. The Epidemic Prevention Service that delivered public health programmes was able to reach the rural periphery with extended disease control programmes financed from the provincial budget.

The 1978 economic reforms had significant repercussions on the health sector. Two key changes that had long term effects were the break down of agricultural collectives that led to a virtual dismantling of the Rural Co-operative Medical Scheme, thereby reducing insurance coverage to only about 10% of the rural population. The second was the government encouragement of health programmes and facilities to rely on user fees.

The extent of the burden of payment to the poor is indicated by the findings of the survey of 30 counties in China. It states that those with an income of under 250 yuan per month paid 23% of that income on health services and that too with low access to and utilisation of health care. The shift of the economic burden to the poor is seen also in that only 11% of the income was spent on health care by high- income earner households i.e. with incomes between 430 and 690 yuan per month. An average hospital admission cost 60% of the annual net income of a poor household.

The primary health care system implemented under the Epidemic Prevention Service had provided the preventive safety net for the poor by reducing the incidence of a wide range of communicable diseases that could impair the economic capability of a poor household. The introduction of user fees charged by village health workers resulted in a reduction of the coverage of immunisation and in the reach of TB control services to the poor. Outbreaks of epidemics of communicable diseases have been traced to the weakening of the PHC work and the diversion of Public Health workers to activities for which they can charge fees.

The village level health facilities suffered from a dependence on revenue generation from consumers for maintenance of the physical infrastructure and for payment of health workers. The consequences of the loss of access to the rural health facilities were severe on the poor who would then have to travel further at added cost to obtain health care. Under these conditions the health seeking behaviour of the poor was affected in several ways as found in a survey in 1993.

- 60% of persons referred to a hospital were deterred from accessing one owing to high cost.
- Among the seriously ill 40% in rural China had not sought medical assistance because of excessive costs.
- The incidence of infectious diseases among the poor was three times higher than among the rich. But 33% of the poor failed to access health care as compared with only 16% of the rich.
- The poor spent only half the required time in hospital to save costs.

The implications are that the poor are likely to have carried the burden of illness not fully cured, back to their homes.

Impact on Health Indicators

The annual growth rate of GNP (9.8% in 1978-94) in China was not reflected in it's health indicators. The under five mortality that declined steadily for 40 years appears to have levelled off in the mid-1980s at about 44 per 1000 live births. A growing difference between poorer areas and major cities in China which in 1992 was more than 4 times (72% in rural areas and 16% in major cities) (6).

Some health status indicators speak for themselves. Among the rural poor;

- 90% suffered from worm infections
- 50% of children at or below the poverty line are mildly malnourished
- the poorest quintile has an infectious disease rate three times that of the richest quintile, and more than twice the IMR
- 1/3 of low income households seek no health care
- People in the lowest quintile make only 60% as many health care visits as those in the highest quintile.

The poor in China, according to World Bank criteria, amounted to 350 million in 1996. The question of who actually pays for health in China is a mounting concern with the share of government spending declining from 32% in 1986 to 14% in 1993 (excluding government insurance). The insurance from the rural co-operative medical scheme had fallen from 20% in 1978 to only 2% in 1982. As against this private health expenditure grew ten times in this

period while out-of-pocket payments are stated to have risen from 20% of health sector revenue in 1978 to 42% in 1993 (6).

Analysts of the Chinese health system cite the uncoordinated financing, pricing and organisational policies as being responsible for "a serious dissonance in the system". These are alleged to have resulted in distorted medical practices such as overuse of drugs and high technology tests creating in turn more inequities in access for the poor as compared with the rich. At a national level there did not appear to be a measurable decline in the level of health status of the people. Nevertheless, the report underscores that the changes had not produced a commensurate improvement in health status (7). The declines however, have been shown in the empirical micro level studies and have been cited in this section.

Case Study of Vietnam:

The paper (8) that was available on Vietnam dealt only in a general way with the impact of the Doi Moi reform process in Vietnam on health and costs of health care. The pre-reform health status has been described as a model – at it's level of income- of a highly cost effective system particularly for PHC services at the commune level.

One health indicator that is very significant is that it has an 11 year longer life expectancy than the average life expectancy of low-income countries. This statistic is compared with China, which has only eight years longer than this average, and Sri Lanka, which has only six. This indicator could well reflect the health status of the population at the national level, and this was a product of the pre-reform health care system.

The paper deals primarily with the distributive inequalities that affect the health status arising from the inequitable access to health care and constraints on it's utilisation by the poor because of excessive costs. Series of household surveys conducted by the Ministry of Health from 1995 to 1998 reveal an increasing trend in difference between utilisation of PHC by the rich and the poor groups. The difference is found to be around seven fold.

The poor in mountainous provinces are worse off than the poor in the Delta area, according to a study in 1997. Utilisation of public health facilities by the poor in mountainous areas was only 3.4% per year as compared with 25.9% by those in the Delta area.

Another survey in 1993 highlighted the differences in expenditure between the highest income groups and the lowest for health care. For outpatient care the difference was 2.3 times while for inpatient care it was 3.9 times.

The impact of user fees has not been fully examined in Vietnam. However the paper makes some deduction based on the way in which user fees operate in the current system. The unregulated market for drugs, it is pointed out, can lead to uninformed use by those who choose self-care because of high cost of accessing delivery points. At the delivery points although people who are unable to pay are seldom refused care, it seems likely that those who do not pay have less "comprehensive" medical treatment according to the paper.

The system as it operates affects the quality and level of services provided by health facilities. This occurs in the system in which government is expected to cover losses from non-paying patients. This is provided for only about 2-3% of population while in fact about 30% of

patients are fully or partially exempted. This affects the quality of services in poor dominant areas.

These are some of the ways in which the burden of the poor is increased and poverty exacerbated through the system of user fees as it functions in Vietnam. The paper focuses on strategies to correct the situation or as much of it as is known from the few studies done so far.

Case Study of Sri Lanka:

Concern about household expenditure on health care that can impoverish, has not emerged as a significant issue in health sector analysis in Sri Lanka even after the economic reforms which were adopted in 1978- much before other countries in South Asia, but along with East Asian countries. One reason for this is the continuing provision of free health for all in Sri Lanka, and the assumption that government health care is still capable of meeting all the health care needs. There are several features that place Sri Lanka apart within the Asian region in terms of the achievements in health so far. The differences can be attributed partly to the health policies that determined the structure and management of health services and contributed to the health outcomes, the management of the health reforms in the context of economic reforms and the nature and composition of the health transition in Sri Lanka.

The Health System

Free health care encompassed both preventive and curative care through a widespread network of multi-tiered facilities that are spatially distributed to reach the rural periphery. They provided both western and ayurvedic care. A private health system operated mainly for ambulatory fee-for- service care with a few facilities for in-patient care in the main urban capitals. The increasing demand for private facilities has resulted in an expansion of private hospitals in the last five to six years (9).

Health Outcome

The result of over half a century of investment in social capital is demonstrated in key indicators of low mortality and fertility. In the 1990s the MMR was less than 1% per 1000 live births and IMR was 17; life expectancy had risen to 74 years for females and 70 years for males; female literacy was a high 85; the net reproduction rate has now reached 1 according to the DHS 1993. These were achieved with a GNP per capita of less than US$ 600 in the 1990s (2).

The health transition that occurred as a result of these changes has been more dramatic in Sri Lanka than in other Asian countries, and the policies had to be geared to managing this change. Neither economic growth nor policy changes could keep pace with the rapidity with which the consequences of the health transition changed the need and demand for health care. The system continued to be geared to maintain its old services while it introduced few measures for emerging health problems.

As stated in the SEARO study, by the early 1990s ischaemic heart disease, cerebrovascular disease, diseases of the pulmonary circulation and malignant neoplasms had ranked first, second fourth and eighth among the ten leading causes of deaths in hospitals (fig.1 in next page). More significantly as seen in fig. 1, these diseases were within the leading causes of death in remote poor districts in the country while the facilities for their care were

concentrated in medical institutions situated in the capital Colombo or in a few major hospitals in the provinces. This positioning of facilities was governed by a concern for economies of scale. Equity of access had to be sacrificed for cost efficiency (10). Sri Lanka has been tardy in recognising and responding to the new needs in health care. There is a general recognition of the deficiencies of user charges, of insurance and of targeting. But there does not appear to be a conscious effort to look for feasible alternatives within the paradigms of development that Sri Lanka has subscribed to over the years in the context of the poverty and health conditions that prevail.

Future health policy reforms do not include the introduction of user fees. In 1971 the government introduced a token fee of twenty-five cents form outpatient first visits to public health institutions. This had immediately resulted in a 30% drop in utilisation. The assumption was that the frivolous visits would have been effectively curtailed. It was never investigated to find out the extent to which genuine users were prevented from using the facility. Be that as it may, a study (9) points out a very interesting outcome of this measure. This was the long-term effect of a decline in the rate of outpatient visits that has continued even up to the 1990s. The measure appears to have triggered an abiding change in health seeking behaviour. This would bear out the assumption that a considerable element of wasteful and frivolous use did prevail in the Sri Lankan situation.

The Task Force on Health Reform has instead of introducing mandatory user fees suggested voluntary payments by consumers. Nevertheless, the strain on public financing has raised questions of quality of care in public facilities and the increasing practice of passing on some of the services to the consumer .by indirect means such as prescribing drugs to be purchased outside and diagnostic tests to be carried out in private institutions. These are viewed as attempts to encourage the use of private sector facilities by choice. But the effect on the poor who have no choice needs to be monitored.

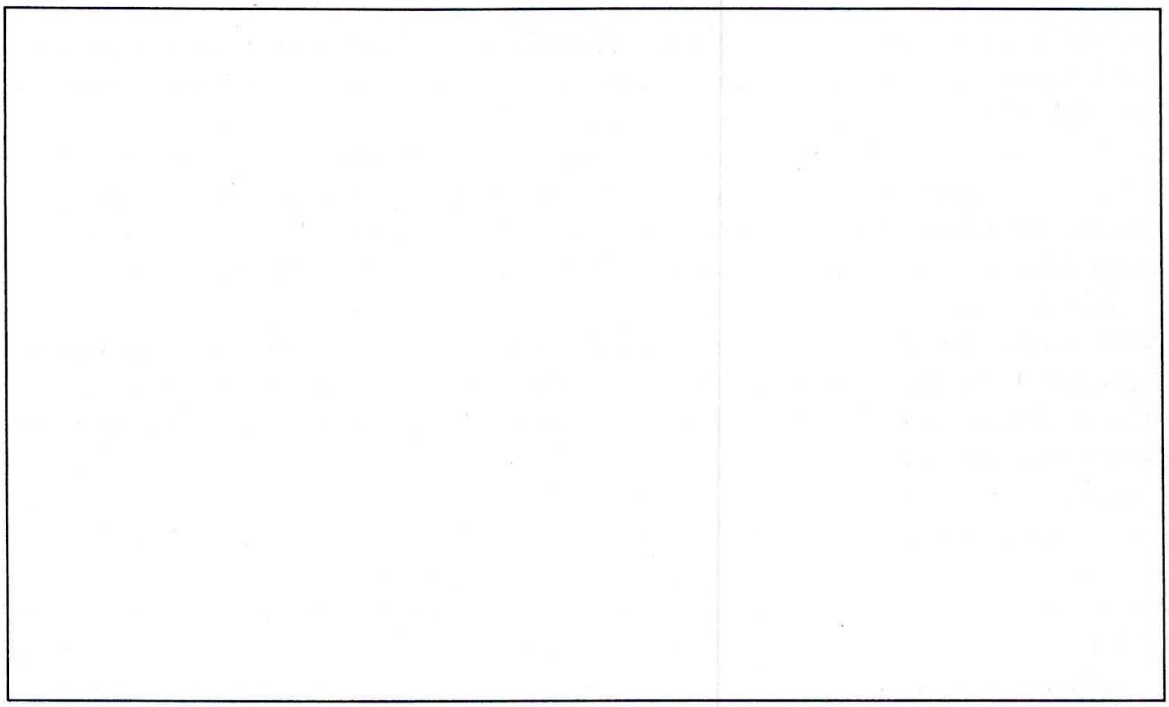
Health Care Costs

Government Spending: Looking first at government spending, evidence from budget allocations for health from 1987 to 1992 show a decline in allocations as percentage of GDP from 2.09 % in 1987 to 1.6% in 1992 (16). Figures for 1980 and 1990 show a drop in government spending from 1.7% of GDP in 1980 to 1.6% in 1990 with a commensurate increase in the share of household expenditure from 1.3% of GDP in 1980 to 1.7% in 1990. (9).

A study on Resource Mobilisation for Health (9) among others analyses the distribution of finances in the health sector. Government outlay for the health sector has been modest, between 3 and 3.4% of GDP over the past three decades. The rapid health transition has been achieved with a total public spending of less than 2% of GDP and US$ 5 per capita per year (Rannan-Eliya). Household spending on health care has shown an increasing trend and currently is thought to exceed 60% of national health expenditure (9). The absence of user fees, it is seen, does not reduce the indirect non- stipulated costs of health care to a household.

Fig: 1

Ischaemic Heart Disease - Movement Within the Ranks In Districts, of the First Ten Leading Causes of Hospital Deaths.



District

1. Colombo
2. Gampaha
3. Kalutara
4. Kandy
5. Matale
6. N. Eliya
7. Galle
8. Matara
9. Hambantota
10. Jaffna
11. Kilinochchi
12. Mannar
13. Vavuniya
14. Mullaitivu
15. Batticaloa
16. Ampara
17. Trincomalee
18. Kurunagala
19. Puttalam
20. Anuradapura
21. Polonnaruwa
22. Badulla
23. Monaragala
24. Ratnapura
25. Kegalle

Household Expenditure on Health

This brings us to the central focus of this study- the burden of health expenditure on the poor and its many faceted consequences for impoverishment. Several data sets are used in this section.

The first set of figures from the Consumer Finance Survey series has been used to derive a trend on household expenditure on medical care and this has been compared with expenditure on food (Fig 2). While comparable figures were available for the years 1981/82 and 86/87 the data for 96/97 was available only from preliminary tables. In all three the proportion of food expenditure was derived for the lowest and highest income groups and are therefore comparable. In the case of medical expenditure the 96/97 figures are based on income deciles- the lowest three and the highest three deciles have been compared (Fig. 3)

The other difference is that while the food expenditure is given per spending unit the medical expenditure is per person. These differences however made no significant difference to the conclusions that could be drawn on the relative positions and in assessing a trend. These figures are shown in table 2.

The figures show that among the low-income groups food expenditure as a proportion of all expenditure was around 70% for all three CFS periods (it had dropped to 68% in 96/97). It fluctuated more for the upper income groups being 41 % in 81/82, 57% in 86/87 and 34% in 96/97. These figures show the very limited resources that were available to the poor for all non-food items including medical items. The upper income groups were not so constrained.

When it came to per capita medical expenditure the differences between the low and high income groups were much smaller. In 81/82 it was only 0.4% and in 96/97, 1.1%. The magnitudes were higher for the upper income groups but the proportions spent would have left little for the poor groups for other essentials.

The per capita medical expenditure by type of care in 96/97 showed that a disproportionately high 78 % of was spent by the poor on western drugs and medical tests as against 54% by the rich. The trend in the proportions spent on this category was an increasing one for the lower income groups, while it was decreasing for the upper income groups. The rich spent a higher (19%) proportion on hospital charges compared to only 3.2% by the poor. Proportion wise both categories were close in their spending on western consultation fees i.e. 7.2% by the poor and 9.4% by the rich. Both the poor and the rich paid for charms higher proportions than they paid for ayurveda consultations and for ayurveda hospital charges. (Table 2).

The next set of figures from a Report on Health Strategy Financing Study of the World Bank (11) analyses health care costs from a special survey in four districts. A sample of nearly 12000 persons who reported an illness in the past month was studied.

According to the findings of this survey, in general the magnitude of out-of-pocket expenditure on illness increases with income, the average for the lowest three deciles being SLR 78.90 per illness while for the highest three deciles it was SLR 207.92

This study also looks at the burden of illness in terms of economic costs on the poor by the mean health care related expenditure for populations below and above a poverty line of SLR. 471.20 per month. The population in poverty on this basis has been estimated as 41 % of the

sample. The figures are in respect of ill persons only as a mean expenditure per episode of illness in the four weeks prior to the survey.

A summary of the findings showed;

- The mean monthly expenditure was SLR.273 for the poor and SLR 879.74 for the rich. This works out to 59% of income for those on the poverty line.
- The expenditure varied with the facility chosen. For the poor the highest cost was for ayurvedic care (Rs. 639.94) while care at the major state western (MSW) facility cost only slightly less (Rs. 610.69).
- The poor on the average spent less on private western care (Rs 439.58)

Some key issues for policy formulation have been highlighted from these findings.

- Although health care is available at no cost to all persons, considerable sums are expended for state health care as well.
- The urban ill incur higher out-of –pocket expenses than the rural ill but the latter will spend greater proportions of their income on health care.
- Outpatient consultations in public/state facilities required about 82% of total average expenditure on drugs. In the private sector it was about 50%.

A third set of data is from a document (12) that explores the measurement of a health line. One component of this is the assessment of the economic burden of the health loss to the household. It takes account not only of health expenditure but loss of healthy days due to illness. The poor are more likely to suffer frequent illness than the rich because of the general deprivations of the poor. Measurements were based on 10 case studies. Among the ten;

- the average loss of income, and expenditure on illness together amounted to 10.8% of income;
- expenditure on health alone was an average of 4.6% of income;
- The total loss ranged from 3.5% in one case to 60% of monthly income in another.

Another document – a report of a micro level study on Seasonality and Health (13) in five locations examines the seasonal variation in ill health and includes a profile of expenditure on health by households. The analysis shows that in the sample the heaviest financial burden is borne by the poorest households in the five communities. Another feature was that in farming communities ill health – and therefore expenditure for health care- escalated during cultivation because of the nature of the tasks involved and the wet weather conditions. This was also the time at which incomes were lowest since the households had long disposed of their harvests and experienced financial strain until the next harvest is due. Costs of health care would deter such households from using health care when it was most needed.

The highest expenditure of 60% was incurred on western drugs that patients were compelled to purchase from a private pharmacy owing to shortages in the State health institutions. The next highest proportion of 25% was on transport, which was considerably more costly for rural patients who accessed provincial or national health institutions. The three rural locations spent 22%, 31 % and 35% on transport to health facilities. The fees paid for private services were only 11%. The report further states that only 2% of the expenditure were on Ayurveda treatment, which was utilised more by the rural poor. (13).

The fourth and last data set has been derived from case studies of low income households that were experiencing illnesses of varying types among some of the household members (summaries in Table A in Appendix A). The interviews provided information on income and expenditure and cost of illness to the household. However, since the quantitative data could not be sufficiently checked and verified and corrected for inconsistencies relative expenditure could not be used as a useful single indicator of the burden of illness. This indicator has therefore been used sparingly. It was found that the descriptive account of the financial situation in each household provided some very useful descriptors of the poverty trap that was a consequence of illness. The ensuing section therefore captures these situations vividly providing images of the process of impoverishment in some cases and a fall into destitution in others. The process will continue in the unforeseeable future that seems very bleak indeed with little hope of recovery.

As an exploratory study the cases were purposively selected to cover both long-term chronic illness and recurrent common ailments. In the latter type colds and fevers that were earlier treated with home remedies are now increasingly complicated with viral infections. Medical advice generally is that immediate consultation with a doctor is essential to rule out serious infections. This necessitates at least one visit to a western medical doctor per child, which is becoming more and more burdensome to poor families in which children are more likely to suffer from such illness than children from non-poor families. Given the nature of the study and the time spent the information set out here is more descriptive than analytical.

The illnesses are classified under the two types of (a) recurrent ad hoc and (b) long-term chronic illnesses. The second category belongs to the newly emerging diseases, but even the earlier category of common colds and fevers is now manifesting new symptoms with viral infections that demand a different regime of treatment and care from that which prevailed earlier. The case studies present the processes of further impoverishment and the consequences for poverty within the different situations of illness in already poor households.

Consequences for Poverty

In the cases where young children had frequent viral infections, colds and fevers and respiratory infections as a consequence, the expenses were generally unforeseen, depending on the incidence of illness and the number of visits to a doctor, taxi fare, the cost of drugs from private sources and the cost of diagnostic tests. The burden was found to be heavy on already strained incomes and heavier still when a single parent (mother) was the main provider. She had to nurse as well as take the child(ren) for treatment and in addition forgo the wages she earns to maintain her household. It also strained the finances of her siblings and parents on whose support she depended for some part of her daily needs. In the case in question the old father of the widowed female had perforce to increase his workload to earn the extra support needed for the daughter's family. Nevertheless his family finances were stretched to unaffordable limits. There was therefore a spiralling of poverty that could occur in clusters of poor households that attempted to be supportive in times of illness.

When children's' illnesses were combined with a chronic ailment of an elderly parent in the same household, the burden was compounded. In this case recurrent expenditure on the parents illness was approximately 13% of the usual household income. These were for drugs, transport to the hospital and special food. In the same household, that depleted income had to meet the costs of recurrent illnesses of children that required consultations with western

doctors, drugs that had to be purchased from a private source and transport that together amounted to about 15% of their monthly income in the past three months.

Households that depended on garden produce for part of their income had invariably lost out in competing activities related to illness. One household lost 32% of income with crop not harvested in time. Indebtedness quite often exacerbated their deprivation and poverty in such households. Debts that amounted to 15% of household income were not uncommon.

Interestingly considerable sums were being spent even by poor households on charms and rituals that were believed to be beneficial to the patient. This was the practice even in the cases of children's colds and fevers and respiratory infections when the cycle of viral infections and related illnesses appeared to weaken their faith in medication alone and to demand that solace be sought through appeasing the deities. An impressionistic assessment would place the proportion of poor households affected by recurring common illnesses at around 90%.

In the category of chronic long- term illnesses, the diseases ranged from a child's chronic asthma and serious allergic condition, to paralysis, diabetes with complications, kidney ailments and cancer. These are ailments that are not uncommon currently among the poor. While the duration of the cancer was only four months the other ailments covered a period ranging from 4 years to 10 years. Throughout this period each of the households was seen to be going through a process of impoverishment and they present clear manifestations of being enmeshed in a poverty trap from which they see no means of escape. There were no safety nets or assistance for recovery. Here, Younus's grameen bank in Bangladesh comes to mind as a safety net that provided for just such contingencies.

In cases where the main provider was struck down, his loss of income was compounded by the adverse effects of the illness on the family members. It had affected the education of young children that was perceived by the poor as the only conduit for progress in life. It deprived older children of jobs/job opportunities, and in most cases where nursing care was required prevented the spouse seeking income-earning avenues that would relieve the burden of the household. Intergenerational poverty therefore prevented recovery by the next generation as well. The situation in these households diminished the opportunities for marriage of young members, while even their food consumption was reduced to a bare minimum.

Those who had some assets began gradually selling, even furniture and equipment and mortgaging land. Loss of cultivable land and loss of crops when the household was incapacitated contributed to enhancing the poverty conditions in the household.

Young families that depended on self-employment that they had carried on with reasonable success, had lost their investment in the enterprise, their savings and their enterprise at one go when the chief occupant became ill. One family so struck down at the beginning of their family life 10 years ago, had to abandon plans to build a family or a future home together.

Others who had set themselves up as independent self-reliant family units became beholden to their siblings even for their shelter and food, or else their deprivation as a result of illness shifted a part of the burden on already poor households of their parents and siblings.

The treatment for illnesses was mainly accessed through the western allopathic system. Although there is no charge for health care in State institutions all of the cases cited were

purchasing a regular monthly quota of drugs from private sources. In the case of all the chronic ailments in the case studies, missing even one dose of a drug could have serious consequences for the condition of the patient, be it diabetes, kidney ailment or hypertensive conditions. It is likely that given the privations they experienced many instances of drugs being unaffordable would have had grave consequences for the illness. State hospitals often ran short of, at times the more expensive drugs and at such times prescriptions were given for purchases outside. When free drugs were available it was through a clinic that the patient had to attend and this involved taxi hire and an accompanying person who had to spend a precious morning at the hospital with income forgone for that day. This compelled most patients to skip the clinic and buy drugs from the pharmacy.

Households spent as much as 12-15% of a meagre income to purchase drugs each month. Significantly even greater proportions were spent on charms and religious rituals on behalf of patients. This for chronic ailments such as diabetes and paralysis shows a serious gap in information regarding new and emerging diseases and the long care regimes they require. This expenditure was surprisingly incurred even for recurrent children's illnesses such as viral infections.

Resorting to charms and ritual has traditionally been a feature of the health seeking behaviour of all sections of society but the poor who can ill afford such expenses are equally ridden with a sense of guilt if the spiritual powers are not invoked on behalf of their loved one.

One exceptional case of a family that is slowly but surely progressing towards destitution in attempting to "treat" through drugs, alternative medicine charms and rituals a Mongoloid disabled child of six years is an example of the grave failure on the part of the system and the media to provide information in general and in more personalised counselling of parents of children with incurable birth defects. On the other hand would parents and family accept a doctor's verdict as final and unalterable in the environment where recourse to higher spiritual sources and faith in those has been an inherent part of the social psyche of our people. Who will dare devalue such faith and belief - if not always in its healing power, in its capacity to provide comfort and solace to a despairing household.

These vignettes provide unassailable evidence of the vicious cycle of illness and destitution that appears to leave entire households impaired for more than a generation, where the death of the patient, however loved and wanted would invariably be a relief to both the patient and the household. But that relief has been far away for most of the cases cited here.

Section - 5

Conclusion

The MPT as it unfolds in this exploratory study, spans both poverty and health concerns in countries in the Asian region. As a specific type of poverty it appears to have its roots in the consequences of economic reforms. Its links go further however, to the conditions that determined the specific nature of the economic reforms in each country which in turn was determined by the macro policies that had fashioned economic and social conditions in the country over the years.

It was shown that in the Asian region the MPT had a niche in macro policy, in health policy and the social traditions of each country. It was made clear from the three country studies that showed widely differing situations in which the MPT could occur, that interventions related to MPT will first need to identify and pin down the determining factors of MPT. The design of interventions will depend on those factors. The possibility of a MPT arising in situations where medical care is provided free of charge by the State is in itself a signal that many hidden factors combine to produce unexpected outcomes for the poor. All countries in the Asian region would benefit from examining health expenditure by households more intensively and within a poverty framework that would highlight the spiralling poverty that is a consequence of out-of –pocket medical expenditure.

It appears imperative that even for countries such as Sri Lanka and China that have a serious concern for the poverty that prevails in their societies and that have poverty alleviating programmes for the poor and the indigent, the phenomenon highlighted here of a near invisible type of poverty that traps households under unavoidable circumstances merits further study. These are circumstances that need to be foreseen and safety nets put in place for recovery or better still for prevention of the conditions of poverty arising from illness. There is a need to recognise the medical poverty trap as we see it occurring in the Sri Lanka cases, as evidence of an inherent defect in the system of social welfare which prides itself on the efficacy of the twin interventions of welfare – free health and free education for all. It is time to look closely at the way free health care works on the ground for the poor in plunging households and family into an irrecoverable state of destitution.

In the case of countries such as China that have opted for user fees for health and have attempted to alleviate its adverse consequences for the poor through several types of safety nets, the need for continuous monitoring of the working of those mechanisms is indicated. The inefficiencies of targeting are all too clearly known and documented for any kind of complacency about the poor being adequately covered by special programmes. There is undoubtedly a need for poor-oriented programmes. The fault appears to lie in the absence of a systematic surveillance system that ensures they perform for the poor. There is a need for space for further inquiry, to seek answers to questions that relate to assessment of the MPT. Is a "relative expenditure" approach adequate to cover the complexity of the manifestation of MPT? How important is it to follow a process of impoverishment to understand its ramifications? What measurements can capture the spiralling poverty that characterises MPT?

The Sri Lanka experience of 1971 demonstrates the unexpected impact of user fees on utilisation. The possible exclusion of the genuinely ill poor at the time was not investigated. Considering the escalating costs of medical care, arising also from changing disease patterns, National Health Systems will be increasingly strained for finances. Given the health poverty links how can the National Health System be organised to address the many and varied outcomes it is required to ensure.

Arriving at the correct mix of strategies is a constant challenge and requires intensive studies to understand the reality at the ground level. In the emerging health scenario the importance of a new PHC system cannot be over-emphasised. This area posed the most intractable dilemma for developing countries. The type of PHC services such, as diagnostic and monitoring tests for cancer for instance are costly and unaffordable for the poor. The consequences of not monitoring are higher costs for curative care once the disease is advanced and of course the

inevitable cycle of poverty that sets in for poor households and the impoverishment of the non-poor.

Health education has been one of the most productive interventions in improvement of health status, through prevention and management of communicable diseases. This is not as easily delivered nor are the effects as clearly demonstrable in the case of non-communicable diseases. Precautions and instructions for prevention should be do-able and affordable. If not the inequities will be heightened between the poor and the non-poor.

Further research needs to be designed carefully to capture as many of the variables that can identify typologies of poor households and the differences in their situations as they attempt to cope with high medical expenditure. Such studies would make it possible to gauge the "proneness" of types of households and prevent their fall into a medical poverty trap.

Appendix: A

Table 1: Key Economic, Demographic and Health Indicators for Selected Asian Countries

Indicator	Year	Unit	India	Indonesia	Bangladesh	Myanmar	Nepal	Sri Lanka	Thailand	China	Vietnam
Low Birth Weight Babies	1991	%	30(90)	8(90)	34	13	26	22	10	6	17
GNP Per Capita	1993	US$.	310	670	220	100(92)	190	600	2110	620(95)	240(95)
People in Absolute Poverty	1990	%	31	17	52	..	40	22	19	19(97)	29(97)
One Year-Olds Immunized	1992	%	90	92	69	74	73	88	86	98	88
	1987	"	63	71	18	24	71	79	79	..	..
Daily per Capita Calorie Supply	1992	Kcal	2395	2755	2019	2598	1957	2275	2443	2708	2438
Population With Access to Health Services	1993	%	..	64(92)	74	..	..	93	59	..	2
	1980	"	50	..	80	30	10	90	30	..	..
Central Government Expenditure on Health*	1993	% Tot. Exp.	1.9	2.7	5.9	7.4	4.7	5.2	8.2	0.4	..
	1980	"	1.6	2.5	4.3	5.3	3.9	4.9	4.1	..	..
	1975	"	2.4	2.0	5.4	6.6	5.9	6.1	3.7	..	..
Adult Literacy Rate	1992	%	50	82	36	82	26	89	93	80	88.6
	1980	"	36(77)	62(78)	26(77)	66	19	85(79)	86	..	..
	1970	"	34	57	23	60(60)	14	78	79	..	..
Infant Mortality Rate (per 1000 births)	1992		89		109	83	100	24	26	29 (91)	39 (91)
	1970		137		140	121	157	53	73	69	...
Maternal Mortality Rate (per 100,000 live births)	1988		550		650	600	850	180	180	130	400
Human Development Index (HDI Value)	1995		0.451		0.371	0.481	0.351	0.716	0.838	0.644 (92)	...(92)
Life Expectancy at Birth	1995	Years	61.6		56.9	58.9	55.9	72.5	69.5	69.2	66.4
	1992	"	59.7		52.2	56.9	52.7	71.2	68.7	70.5	63.4
Annual Population Growth Rate	1960-1992	%	2.2		2.7	2.2	2.5	1.8	2.4	1.9	2.2
	1992-2000	"	1.8		2.4	2.1	2.4	1.2	1.1	1.2	2.0
Fertility Rate	1992	%	4.0		4.8	4.3	5.6	2.5	2.3	2.3	4.0
	1970	"	5.8		7.0	5.9	6.4	4.3	5.5	5.8	...

Note: The figures given are not fully comparable as they are from different sources, and different periods of reference due to non-availability.

Source: World Dev. Report 1995 & 1996 - World Bank; Economic & Social Survey of Asia & Pacific 1996 – UN; .. Not Available
Human Dev. Report 1994 & 1995 – UN; Social Indicators of Development 1994 - World Bank
World Tables 1980 & 1994 - World Bank; Enhancement of Social Security for the poor - Marga Institute

Table 2: Data on Health Expenditure Derived from Consumer Finance Surveys:

1 Percentage of Expenditure on Food Per Spending Unit Per Month in Low & Upper Income Groups, Out of All Current Expenditure.

11 Percentage of Expenditure on Medical Care Per Person Per Month Out Of Total Per Capita Health & Non Health Expenditure for Low & Upper Income Groups.

	Items	Low Income Group			Upper Income Group		
		SL Rs.* 0<1000	SL Rs.* 0<1500	SL Rs. 0<4500	Over SL Rs.* 2000	Over SL Rs.* 3000	Over SL Rs. 12000
		1981/82	1986/87	1996/97	1981/82	1986/87	1996/97
1.	Average Expenditure on Food Per Spending Unit (%)	70	71	68	41	57	34
11.	Medical Expenditure as a % of Total Expenditure Per Capita, Per Month	1.8	2.2	1.5	2.2	3.4	2.6
111.	Per Capita Medical Expenditure by Type (%)						
a.	Ayurvedic (Fee, Test, Hospital Charges)	22	-	0.9	11	3	1.4
b.	Ayurvedic Drugs		17	6.4			3
c.	Consultation Fees (Western)		12	7.2		11	9.4
b.	Drugs and Medical Test	72	70	78	80	78	54
e.	Hospital Charges			3.2			19.2
f.	Charms etc.	4	0.7	1.2	8.5	7.4	6.2
g.	Premia Paid on Insurance on Health	-	-	0.1	-	-	0.1
h.	Spectacles, Dental Care & Other	2	0.3	0.33	0.5	0.6	6.6
i.	Homeopathy	-	-	0.3	-	-	0.1
	Total Health Expenditure Per Capita (SL Rs.)	**2.91**	**5.33**	**12.5**	**12.32**	**53.39**	**105.16**
	Total Health & Non Health Expenditure Per Capita Per Month (SL Rs.)	**165**	**247.18**	**838.62**	**572**	**1552.54**	**3990.85**

* Income Group

Sources: Consumer Finance Survey 1981/82, 1986/87, 1996/97 Central Bank - Sri Lanka

Note: The figures from CFS. 1981/82 & 1986/87 were derived for Income Group, for 1996/97 the Figures are in respect of Income Deciles.

Table 3- Summaries of Case Studies - Sri Lanka

Case no:	Type / description of illness	Description of family	House hold economy	Medical expenditure (Monthly average of past 3 months)	Losses due to sickness (Per month)	Total financial losses (Per month including medical expenditure)	Description of the poverty trap
.	**Common recurrent illness**						
.1.	Colds \ fever and a chronic bronchial condition in 3 young children.	10 members - a widow , 3 young children living with her parents & siblings.	* Mother - casual worker earned **Total : Rs 3,000 (per month)** * Food and accommodation is provided by her parents.	**(Rs)** * Transport & hospital charges - 500 *Drugs - 2000 *Ayurveda - 300 *Vitamins - 300 **Total Rs 3,100**	* For the past 3 months the mother has spent her entire earnings on the sick children.	* Total financial loss - 103% of total monthly income.	* The entire household suffered privations in food. * Her father worked extra hours each day to meet the extra expenses on her children's illness. * Childrens' school attendance has dropped. * There were earlier occasions when she pawned her jewellery to spend on childrens' illnesses.
.2.	(1) Fever \ cough , tonsils & respiratory infections in children. (2) Acute rheumatic condition in elderly patient for the past 5 years.	8 members - family with 3 children, elderly mother & siblings.	* Husband in permanent job earns Rs 4000 * wife (garment factory) earns Rs 4000 * Additional occasional from garden produce Rs 2000 **Total : Rs 8,000 (per month)**	**(Rs)** Elderly patient: Transport & drugs - 1050 (13% of their usual income). Children *Private consultation & drugs - 666 *Vitamins - 100 **766** Lump sum *Charms & religious rituals, etc. - **6000 2000** (average per month) **Total Rs 2,766** % of reduced income 46 %	* In past 3 months the mother lost approximately 1/2 months wages by staying home to look after the sick i.e. Rs. 2000 (p.m.) * Loss of produce from garden because they could not harvest on time Rs. 2000.	* Total financial loss - 68% of total monthly income.	*The family had to borrow money Rs 1500 for daily expenses. *Construction work on house was stopped . * Unable to save.

Contd.

Case no:	Type / description of illness	Description of family	House hold economy	Medical expenditure (Monthly average of past 3 months)	Losses due to sickness (Per month)	Total financial losses (Per month including medical expenditure)	Description of the poverty trap
.3.	**Chronic long term illness** Allergy / wheeze in 9 year old child for 8 years.	A family of 3 .	* Father - casual worker earns Rs 5000 (p.m.) * Mother - self employed earns Rs 8000 **Total : Rs 13,000 (per month)**	**(Rs)** * Private consultation & drugs - 2000 *Special food - 500 Lump sum (3 months) Religious rituals - 100 33 (average per month) **Total Rs 2,600** % of reduced income 24 %.	* Income forgone by parents' not being able to work was an average of Rs 2500 (p.m)	* Total financial loss - 39% of total monthly income.	*Child has virtually dropped out of education * No savings . *Mother can not improve her enterprise *Their earnings depends on continuous work . They lost wages for non - working days.
.4.	Main provider has Cancer which was detected 4 months ago.	A family of 4 with 3 earners.	* Total earned by 3 persons **Rs 15,000** (per month average income) * Had commenced cultivation on 2 acre land.	**(Rs)** *Hospital charges 200 *Tests - 2000 *Drugs - 1500 * Ayurveda - 500 *Religious rituals - 1200 **Tota l Rs 5,600** % of reduced income 70 %.	*Income forgone by main provider Rs 7000 (income reduced by 32%) * Expected income from land was lost . * Cultivation neglected.	* Total financial loss - 84% of total monthly income.	* Expenses exceeds income ,the gap being met with assistance from relatives & friends. *Loss of future earnings - from cultivation. * Fear that they may be compelled to sell their main asset- 2 acres of land .* Fallen into poverty from a non- poor status.

Contd.

Case no:	Type / description of illness	Description of family	House hold economy	Medical expenditure (Monthly average of past 3 months)	Losses due to sickness (Per month)	Total financial losses (Per month including medical expenditure)	Description of the poverty trap
.5.	Main provider paralysed after a stroke for 5 years.	A family of 3 with a school going daughter.	*Wife earns Rs 150 a day from casual work. Their usual income was around **Total : Rs 3,000 (per month)**	**(Rs)** * Hospital & tests - 275 * Religious rituals & charms - 1000 **Total Rs 1,275** % of reduced income 50 %.	* Loss of income of the main provider Rs 3500. *Intermittent loss of wife's earnings approx.: Rs.450 (p.m) Usual income was therefore Rs 2550 - 3000.	* Total financial loss - 80% of total monthly income.	* Loss of investment of total savings Rs 25,000 on catering equipment. * Family members are not in a position to assist. *Loss of income of Rs 3500 (per month) from main provider. *Family depends on casual work of wife. *they spent about Rs 300 on drugs per month because the wife can not go to the state hospital clinic. * Daughter's education is interrupted. *Debt of Rs 5000 which can not be repaid. *Wife's regular attendance affected - her wages reduced because she has to nurse the patient. * House in a state of disrepair.

Case no:	Type / description of illness	Description of family	House hold economy	Medical expenditure (Monthly average of past 3 months)	Losses due to sickness (Per month)	Total financial losses (Per month including medical expenditure)	Description of the poverty trap
.6.	Main provider suffers from a progressive kidney ailment for the past 10 years. (Progressively worsening condition).	Family of 2 , living with sister who provides food & accommodation	* Husband earned from fishing but gradually reduced income & currently can not work. * The sister provides food & accommodation for them. * Wife earns **Rs 2,000** p.m. from selling of breakfast food.	**(Rs)** * Hospital charges - 500 *Private drugs - 600 Special food - 300 **Total Rs 1,400** % of reduced income 70 %.	* Loss of earnings of husband Rs 4000 replaced by wife's new earnings of Rs2000	* Total financial loss - 170% of total monthly income.	* Shifted from rented house to sisters' residence . * Totally dependent on sisters' charity. *Wife's earnings totally spent on his medical expenses . * No savings. * In debt for about Rs 2000.
.7.	Wife has diabetes with other complications for the past 4 years.	Family of 4 with 2 school going daughters.	* Husbands income from fishing Rs. 15,000 p.m was sufficient for daily expenses * Eldest daughter earned Rs 2000 from casual work. **Total : Rs 17,000 (per month)**	**(Rs)** * Drugs - 360 Lump sum (3 months) *Religious rituals 10,000 3300 (average per month) **Total Rs 3,660** % of reduced income 27%	* Reduction of income by 10% as the husband has to care for the wife. * Eldest daughter had to give up her casual work Rs 2000 (p.m.) Total Rs 3,500	*Reduction of income approximately 20% . Total financial loss - 42% of total monthly income.	* Reduction of husband's income by intermittent loss of work to care for the sick wife . * Eldest daughter gave up her job. * Second child's education is interrupted * House hold furniture was sold from time to time. * Their only stable asset - a plot of land has been mortgaged. *Money was borrowed from money lenders . They have to continue in this manner as long as the patient lives.

Case no:	Type / description of illness	Description of family	House hold economy	Medical expenditure (Monthly average of past 3 months)	Losses due to sickness (Per month)	Total financial losses (Per month including medical expenditure)	Description of the poverty trap
.8.	Main provider has been paralysed for the past 7 years.	A family of 5 . With 3 children (2 school going.)	* Wife & daughter doing domestic work - Rs2000 *Daughter's income of (garment factory) Rs 2250 (1 1/2 m:) **Total : Rs.4,250 (p.m.)**	**(Rs)** *Hospital charges – 416 *Drugs & Transport – 500 Total - **916** Lump sum (last 3 month) * Religious rituals - 7000 2300 (Ave :per : month) **Total Rs 3,216** % of reduced income 76%.	* Patients income of Rs 5000 replaced with Wife's income as a domestic helper Rs2000. Total Rs7,000	*Total financial loss - 110% of total monthly income.	*Loss of patients' income. *Loss of wife's income. * Loss of part income of the eldest daughter due to absenteeism. * Younger daughter's education is interrupted. * Daughters marriage prospects affected. * Unable to complete construction of their house. *All past savings exhausted *No savings or security for the future. Poverty alleviation prog: of gov ernmet has given them **Rs 500** (per month) but not sufficient even for medical expenses.
.9.	**Special case** Mongoloid / disabled child.	Family with 4 . Their only son aged 6 1/2 is the patient.	* Father employed (casual job) & mother in home based - sewing. **Total : Rs 8,000 (p.m.)**	**(Rs)** *Private drugs 370 * Special food 240 * Ayurveda 600 **Total Rs 1,210** % of reduced income 22 %.	* Loss of husbands income (from loss of days of work) & wife's income . Total Rs 2,500	*Total financial loss - 46% of total monthly income.	Hospital charges , private drugs , special food, Ayurveda treatment & charms have amounted to Rs 350,00 in past 6 years. . * Wife's home - based income earned activity is often interrupted as she has to care for the child. *Daughter's education is disrupted. * Could not construct their house . * Sold the motor - bike for child's illness. * They do not accept that the child is permanently disabled.

Note : Medical expenditure was obtained in respect of past 3 months & a monthly average shown in the chart.

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(Dr. Godfrey Gunatilleke's input from several informal discussions on the subject is gratefully acknowledged)

Appendix - C

Outline For A Future Study on MPT:

The broad outline that is set out is for a set of case studies that can not only provide data on the impact of medical expenditure on poor households but also assists in conceptualising issues related to out of pocket medical expenses.

The design of the study is based on the premise that while medical expenditure would in general have an over arching effect on increasing the financial constraints in poor households, different typologies of poor households would respond differently to financial burdens. The study would make distinctions between the varied typologies of poverty and examine the impact of medical expenditures severally in these. The outcome would be a set of risk models for different household poverty models.

It will entail intensive studies of shifts in income sources, seasonality, conditionality and flow of income in addition to its quantum. Poverty will be related to other conditions of living and availability of common amenities. Other variables that would directly impinge on ill health will be considered.

Another element of poverty causing expenditure is to be the lack of knowledge and access to knowledge that leads to inappropriate and wasteful spending.

The study needs to differentiate between two categories of chronic and recurrent morbidity. Location of residence will figure significantly as a variable that determines access to services and the quality of services as well as the choices that are available.

The duration of the study should be at least one year, since the process and the cycle of change has to be studied. In designing the method of research and selection of cases micro level research that has been carried out by the Marga Institute can contribute substantially by providing data, back ground information, village, community and household profiles from a number of studies some of which have dealt specifically with issues related to health care.

A total of 20 case studies would be sufficient to construct risk models that would then determine the nature of interventions that would most effectively address the problem of compensating the poor for the financial burden of medical care.

{I acknowledge with thanks the contribution made by Dr. Nimal Gunatilleke with whom I had discussions through E-mail on the type of research that would best contribute to knowledge of the subject of medical care and its effect on poverty}

GENDER IMPACTS OF HEALTH REFORMS – THE CURRENT STATE OF POLICY AND IMPLEMENTATION

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GENDER IMPACTS OF HEALTH REFORMS – THE CURRENT STATE OF POLICY AND IMPLEMENTATION

In 1997, I wrote a paper on gender and health sector reforms (HSR). It raised a series of questions about the gender implications of health reforms mainly in low income countries. It was largely speculative as there was little hard information at that time. I revisited the policy questions in a further review in 1999 (see Standing 1997, 1999) In this paper, I will try to update the picture, taking into account particularly changes in the language and concepts of health reform and moves towards a more intersectoral view of health. I will focus on the following issues:

- The importance of contextualising health reforms and associated impacts, such as the different economic, political, demographic and epidemiological drivers in different countries
- The change in language from "first generation" supply side reforms to "second generation" emphasis on greater demand side and anti-poverty interventions
- The continuing problem of lack of data
- Marketisation in the health sector and the resulting pluralism of provision
- Decentralisation and accountability
- "Systems" versus advocacy approaches – the example of reproductive health and health sector reform
- Policy issues in relation to gender inequalities in health

1. Contextualising health reforms and gender impacts

Health reforms have been taking place globally at an accelerating pace over the last decade. This has been in response to a range of different drivers. In countries which have undergone structural adjustment, the main drivers have been constraints on government expenditure and donor conditionalities. In transition economies, health systems are being reconstructed as a response to economic liberalisation and the need to move away from command and control management models. There has been an ideological dimension to some reforms, manifest in a rethinking of the role of governments in the delivery of health care, and moves towards decentralisation/ devolution of management to lower levels. In many countries these have combined with important population based changes. These include:

- Ageing populations coupled with changing health needs and different demands for health entitlements;
- Changes in the epidemiological profile, for instance as a consequence of high rates of HIV infection;
- Greater access to specialised knowledge and a provider "market."

This has meant that health reforms have taken different paths in different contexts. We should not therefore look for one story in relation to gender impacts. Nor are the gender concerns posed by epidemiological trends going to be the same everywhere. Let us briefly contrast specific trends in two regions:

In the countries of the former Soviet Union, mortality trends show a serious decline in life expectancy. Whilst life expectancy has declined over the last 30 years, it has declined particularly dramatically for men. It is now estimated to be 71 for women and only 59 for men (UNFPA, 1998). The causes are still debated, but high levels of

alcohol related illness associated with psycho-social factors such as lack of employment have been implicated (Eberstadt 1999). The gender implications of this encompass issues such as family breakdown, loss of economic and psychological support to households and tackling prevailing cultures of masculinity.

In sub-Saharan Africa, 27.1 million of the 39.2 million people estimated to be infected with HIV/AIDS are in sub-Saharan Africa. Of these, 55% are women. Sub-Saharan Africa not only has the bulk of HIV/AIDS global burden. It is also the one area where the female infection rate is higher than that of males (UNAIDS: 1999). The consequences of this for the gender division of labour and the management of household reproductive burdens are profound and as yet inadequately documented. Social stigma and blaming of women for the crisis are noted in a number of countries, as is lack of control by women over the means to protect themselves. Health sector planning, particularly for supportive care and for empowering women and girls to gain control in sexual relationships, will have to address these issues.

2. Health reforms - from first to second generation

The language of health sector reform, as expressed by international agencies and governments, has changed over the decade from the early 1990s. The "first generation" of reforms was overwhelmingly supply side driven and focused on and within the health sector. In the "second generation," many of those basic elements remain firmly in place, but the emphasis has shifted more to the demand side and the language has broadened towards anti-poverty interventions and intersectoral approaches to health.

First generation – major elements of supply side reforms:

- Improving health sector management systems
- Public sector reform
- Cost effectiveness of interventions
- Reform of financing mechanisms, cost containment
- Decentralisation
- Working with the private sector

In many developing countries, this agenda has been heavily donor driven and linked to economic adjustment and liberalisation. But a similar menu has been pursued in most reforming countries, including some northern ones. This first generation has been distinguished by a number of serious shortcomings. The focus was purely on system level change (such as reforming the functioning of Ministries of Health) with no associated monitoring of outcomes for health and impact on service delivery. For example, donors have generally hailed the health reforms in Zambia as a success. Yet the period over which they took place saw a decline in a number of key health indicators such as IMR (Simms et.al.). Change was seen as a set of technical and managerial activities, rather than as a political process to be negotiated between stakeholders. There was no consciousness of the need to consider gender or other significant indicators of disadvantage in planning, implementing or monitoring reforms. As a result, it continues to be extremely difficult to get a comprehensive view of the gender impact of health reforms.

Second generation – towards sector wide and anti-poverty interventions?

- Partnerships with key stakeholders, e.g. SWAps, CBOs/governments
- Focus on community/user needs (e.g. through Participatory Poverty Assessments)
- Health as part of the poverty agenda (e.g. social insurance, microcredit)

More recently, international agency language and approaches have shifted quite significantly. Partly, this has been due to a tacit acknowledgement of the relative failure of reforms in a number of countries, particularly in sub-Saharan Africa, to deliver any obvious improvements on the demand side (while recognising that this cannot all be laid at the door of the health sector). However, in other countries too, widening gaps between rich and poor in health status and health care access (e.g. China and other Asian countries) have raised serious questions about the content and direction of reforms.

This is beginning to result in some broader thinking about reform. Both governments and donors are stressing the importance of partnerships between key stakeholders, although the concept of partnership remains underdeveloped. These are taking various forms: the so-called public-private partnerships between governments and different elements of the private sector, and partnerships between governments and a variety of civil society groups such as NGOs and other community based organisations which have (or are being encouraged to develop) a capability in planning, service delivery or monitoring. In countries with significant donor support to the health sector, there has been a move away from donor specific project funding to sector wide approaches (SWAps) negotiated between governments and the "pool" of aid donors (Evers 1999).

Some recognition of the limitations of supply driven reforms has resulted in greater attention to the needs and concerns of users. This has taken a number of forms. The World Bank's recent conversion to participatory methods has resulted in participatory poverty assessments (PPAs) being institutionalised in their country poverty strategy reports. Health concerns figure in a number of these. Some countries have instituted mechanisms for consulting users on issues such as priority setting (see e.g. IPPR 2000). In others, coalitions of civil society stakeholders such as consumer groups, trade unions etc. have developed advocacy strategies to enable them to voice needs and interests (Loewenson 1999, Cornwall, Lucas and Pasteur 2000)

There has been a renewed concern internationally with the intersections between poverty and health. The anti-poverty agenda has itself broadened to take in a more dynamic and social understanding of poverty and its determinants. The conceptual shift towards definitions of poverty which focus on risk, vulnerability and exclusion (see WDR 2000) has brought health risks more centrally into policy debate. That ill health can be both a cause and a consequence of poverty has been clear for a very long time. However, it has taken time to get back onto the international agenda. This concern is currently most influential in health financing strategies. Safety net mechanisms to protect the poor against catastrophic illness and to provide subsidies or basic insurance for health care are high on the agenda, as is the linking of micro-credit to health care. These strategies have many – as yet largely unexplored - gender implications.

3. Marketisation and provider pluralism

In many countries an increasingly unregulated health care market has emerged in which a wide range of providers, including public sector agencies, private sector players, NGOs and traditional healers are practising. These practitioners may or may not be qualified or competent. Health reforms have generally failed to acknowledge this diversity, proceeding instead as if a comprehensive public sector health system were in place (Bloom and Standing 1998). Yet, statistics from a number of countries show the increasing share of health expenditure which is taking place outside of the public sector, including among poor people.

This raises many important issues on the demand side. How are users (male and female) responding to the unregulated market? What kinds of services are being used and why? We know that women in particular make a number of trade offs in deciding which practitioners to consult. These include distance, the opportunity costs of their time, the perceived quality of the service (and particularly the attitude of the provider) and the costs of treatment. The transactions costs of the unregulated market are very high for the poor. Reforms have not addressed how to enable poor users, particularly the non-literate, to make more informed choices in an increasingly marketised environment.

One key to this is information. People now receive health information from a wide range of sources (eg, pharmacies, drug pedlars, the media). How can better information dissemination systems be created within the health sector, especially with regard to the information needs of poor people? As Sen (1999) points out, formal education and literacy are not the only information needs which women have. There is a need to provide information both to users and front line health staff and improve the access of poor women and men to good basic information on services and drugs. Again, health reforms have barely addressed this. Where are the examples of innovative information dissemination, such as the use of low cost software for service providers and on drug suitability and dosage for users?

On the supply side, there is an urgent need to develop ways of monitoring and regulating services in pluralistic environments. At national/subnational level, what bodies are appropriate to take on these functions? What mechanisms and procedures can be developed to do this? How can they be made more accountable and woman friendly? Global markets in health commodities also require better regulation. Many countries are struggling with the problem of how to introduce and maintain a rational drug pricing and consumption strategy in the face of powerful transnational cartels. These take advantage of WTO-GATT rules and weak or non-existent national controls to sell branded drugs at high prices, or dump unnecessary or banned drugs on the open market. Pineda-Ofreneo and Estrada-Claudio (n.d.) note that one commonly used branded contraceptive retails at $2.77 in the Philippines, $1.97 in Taiwan and 90 cents in Indonesia.

4. Decentralisation and accountability

Different forms of decentralisation are posing considerable challenges to the effectiveness of service delivery and the accountability of providers. We still know little about the gender impacts of decentralisation. However, Aitken (1998) has

explored the question from the point of view of impacts on reproductive health services. Noting that commitments by governments to the 1994 Cairo agenda already imply significant changes to the way services are delivered, Aitken looks at how this agenda fares under decentralisation. He finds that national policies often fail to get implemented locally, either because budgets are not allocated at local level, or because implementing agents disapprove of a policy and do not carry it out. This was particularly the case on "minority" services such as management of incomplete abortions, or sexual health services for adolescents. Conservatism and judgemental attitudes can be powerfully expressed and legitimated where implementation depends on local will.

Other problems include too hasty a process of change and a resultant incapacity to manage the complexities of reproductive health services, especially where the unit of implementation is too small; and mismanagement of human resources through changes in terms and conditions and lack of training.

In the context of decentralisation, the following questions need to be considered in order to create an environment more responsive to gender issues:

- Which actors can do what to create more responsive services in increasingly decentralised systems?
- What is the relationship between decentralisation and responsiveness to users' needs? What services are being provided?
- What if any examples are there of pressure for service improvement from below? What strengthens/impedes this happening?
- How is human resources management and training addressing the changing agenda in areas such as reproductive health in the context of public sector reform and decentralisation?
- Incentives for and motivation of health workers: how can the switch be made from target based approaches to quality based approaches?
- Empowering advocacy groups to hold providers and governments to account – what do they need to know, what expertise do they require, and how can they acquire it?

5. "Systems" and advocacy approaches – gender, reproductive health and health sector reforms

Reproductive health (RH) provides a good test of how a more comprehensive and gender friendly approach to service organisation and delivery fares in the context of broader health reforms. The RH approach came out of the Cairo International Conference on Population and Development (ICPD) in 1994. It inaugurated a hard fought for, comprehensive concept which went beyond family planning to encompass the lifecycle health needs of women and men in relation to all aspects of human reproduction. Two aspects of the development of the RH approach are particularly relevant to health reform.

First, the RH approach owes its existence and vitality largely to the women's movement and particularly to women's health advocacy groups in both south and north which have found ways of exploiting political spaces to get progressive policies onto the international agenda. This has entailed working through relevant international conventions (e.g. the Convention on the Elimination of all forms of

Discrimination against Women - CEDAW) and pushing through resolutions in international fora (e.g. the Beijing Women's Conference). It has enabled women's health groups and NGOs to use the language and (albeit less successfully) the legal apparatus of human rights in advocating for policies. For instance, an issue such as maternal mortality rates in poor countries has been reframed as a rights violation.

The rights discourse has both strengths and limitations. It has proved extremely powerful as an international advocacy tool. It has drawn attention to the shocking neglect of even basic health entitlements for many poor people. It opens up the possibility for greater voice among those lacking such entitlements (via demands from "below" as opposed to need identified and defined from "above"). Its limitations stem from the enormous difficulty of any kind of enforcement. Conventions and resolutions ratified by countries depend on self-regulation and on interpretation according to local circumstances. Nor have rich countries exhibited the commitment to providing resources to poor countries which would make compliance more feasible.

Second, RH remains largely an approach – a vision of what should be achieved (Myntti and Cottingham 1999). It has not proved easy to translate into practice. There is a considerable gap between on the ground service delivery issues with which RH is associated, and system level approaches to health sector reform. Thus, there is a very large number of micro level initiatives in the RH field. There is a lot of good experience, particularly among NGOs, of delivering quality services, especially to female clients. But there is very limited experience of or capacity for scaling up. Experience of RH in the comprehensive sense is very limited and for the moment mostly a feature of demonstration projects. An international seminar in Addis Ababa in 1996 noted that despite the paradigm shift since Cairo, most programmes lacked ability to deliver comprehensive services. This is changing only slowly. In particular, management and organisational capability needs to improve, and service provision needs broadening, e.g. through treatment of RTIs, programmes on men's health (International Council... 1997).

There are several reasons for the limited progress in realising the ICPD objectives.

1. RH has been framed within a different language from HSR (i.e. managerial/ technical concerns v. human rights/women's empowerment concerns). Whilst the women's health movement has made very good use of the tools of international advocacy, there has not been sufficient dialogue with the national and international agencies driving HSR.

2. Similarly, RH has been focused on service delivery issues, to the neglect of broader systems level thinking. As Fonn et.al. (1998) point out, a malfunctioning system cannot work for a woman in labour when it does not work for a man with typhoid either. RH advocates have only recently begun to tackle HSR on a systems terrain, with a number of operational research initiatives now coming on stream.

3. Systems issues are quite hard to address. One problem is where RH lies in system terms. Largely based in vertical programmes (e.g. family planning, MCH), its components are often split between different ministries/sectors, producing stakeholder conflicts between different line ministries. RH tends to be a visionary

approach, not a technical area or sector with a budget attached. Another problem is the dominant focus in health reforms on the role of the public sector and the neglect of provider pluralism. The private sector plays a very significant role in RH service delivery, often in areas where women find it most difficult to access services, such as providing abortions. A systems approach to RH needs to take a broader view of the concept of a system than much of the current HSR thinking.

4. Progress continues to be restricted by problems of data availability. According to ARROW, few data on RH are available disaggregated by age, urban-rural, class/income, religion/culture, ethnicity. Country studies of programme implementation suggest little serious attention by policy makers. There are currently no agreed core indicators for monitoring a rights based approach to women's health as advocated by the Beijing Platform for Action. ARROW suggests that wider indicators of women's health status should be developed, such as the degree of gender based violence. They also point to the need to develop a monitoring framework for financial indicators which can both differentiate spending on specific services, and monitor spending on comprehensive services.

On the positive side, some countries have incorporated RH objectives into their development plans. For instance, in Ghana, a World Bank credit for a Health Sector Support Program put family planning, obstetrics and STD services into the work programme as part of the priority service interventions. It remains to be seen whether this is enough to guarantee implementation.

Finally, participants at the Addis Ababa Seminar (ibid.) suggested the following key challenges to implementing an RH approach at a system level:

- Skills development for advocacy, leadership and planning, management and implementation
- Developing supportive management systems: planning, management information systems, human resources management, logistics
- Sorting out financing and interdepartmental issues
- Translating development plans into action

6. Policy issues in relation to gender inequalities in health

In this section, I will focus on some major policy and implementation issues at three levels: subnational, national and supranational. Cross cutting each of these is a set of common concerns which are particularly relevant to gender inequalities in health. These are concerns about participation, voice and governance/accountability (Bangser 2000).

6.1 Subnational strategies

Political and bureaucratic decentralisation has proceeded at an increasing pace in many countries. Decentralisation raises many complex issues about the relationship between gender and health (Standing 1997, and see Aitken above op.cit.). It does not lend itself to a straightforward assumption that decentralisation is good for increasing gender and health equity. However, as there has been a number of very innovative programmes on women's health focused at municipal level (e.g. PAISM), it is worth

raising the question as to what are the circumstances which favour greater attention to gender issues in health.

Bangser (op.cit.) raises some interesting questions about this stemming from her discussion of the ReproSalud project in Peru. This widely praised project, which runs in four regions of the country, had begun in the late 1970s with a group of women activists concerned primarily with promoting self-esteem and political leadership among poor women. It expanded, with donor funding, in the 1990s and is based on the premise that good reproductive health for women is linked to having control over social and economic conditions. It is thus an "integrated" development project with a strong focus on community involvement and participation by local voices.

At the same time, Bangser notes that attempts to achieve larger scale, national level multisectoral approaches to health status have not met with much success. Perhaps the often desired but rarely achieved goal of a multisectoral approach is most realistic at subnational levels? In which case, what kinds of agencies and arrangements are most likely to achieve more integrated aims? What is the optimum size/reach of some programmes?

6.2 National financing strategies

Financing systems have gender implications. Different systems can have very important consequences for women's capacity to access services. For example, cost recovery through point of service charges has been associated with a decline in the use of maternal health services, particularly hospital based ones (Kutzin 1995). User charges in this sense have been the most visible manifestation of many health reform programmes and have attracted the most political attention.

However, the link between point of service charging and utilisation remains a complex one. Schneider and Gilson (1999) note that the South African government's removal of user charges for MCH services did not result in any increase in take up of maternity services apart from a modest increase in the number of antenatal visits. They suggest that a wider set of measures is needed, including significant improvements in the quality of care provided. Similarly, it could be argued that user charges need to be seen as part of a broader question of how services are funded nationally and how financing strategies as whole affect women and men differently.

Increasingly, in poor and even middle income countries, we have seen the same segmentation of populations emerging in terms of how health care needs are met.

Main modalities for funding individual/household health care needs:

1. Insurance schemes for formal sector workers
2. Basic health insurance or community financing for the moderately poor
3. Micro-credit and funds for catastrophic illness for the very poor

This of course raises larger equity issues which are beyond the scope of this review. In the context of broader gender equity issues, it may also be noted that women will be disproportionately represented in the third category, given the prevailing distribution of poverty. For current purposes, however, I will focus on potential gender impacts within each of these categories.

There have been a number of innovative ways in which supranational advocacy and action are having an effect. For example, women's groups have been involved in the WHO led negotiations over the Framework for Tobacco Control (FCTC). This was a direct result of putting tobacco and women's health on the Beijing Plus 5 agenda.

An even more innovative supranational initiative is the "Women on Waves" project. This is a planned sea-going women's health clinic which will sail entirely in international waters and will thereby be protected by international law, but will target countries where abortion is illegal and provide termination and care services (Guardian 2000).

These new opportunities thrown up by globalisation and the internationalisation of advocacy face us with new challenges on governance and accountability. Who is entitled to speak or frame action at this level and who are they accountable to? Which voices get heard the loudest and how can the least advantaged gain some representation? The multilateral agencies are being called rightly into account for their actions. But similar issues of accountability and voice will need airing by advocacy groups as well.

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PANAMERICAN HEALTH ORGANIZATION
WOMEN, HEALTH AND DEVELOPMENT PROGRAM

GENDER EQUITY AND HEALTH SECTOR REFORM POLICIES

Analytical Guide for Presentation to Subcommittee on Women Health and Development

INTRODUCTION

In keeping with the decision of the 17th Subcommittee on Women, Health, and Development (1997), this guide provides an outline for the analysis that each Member of the Subcommittee will produce and present during the biennial session of the Subcommittee 18th meeting, 8-9 February, 1999.

At its last meeting, the Subcommittee selected "Development of Public Policies that Influence.Women, Health, and Development" as the general theme for the 18th session and agreed that members would participate in the preparation of documents. The definition of the specific topic within this theme was left to the Secretariat, which chose the topic "Gender Equity and Health Sector Reform", based on the following:

- The evidence that certain health and social security policies have an impact on gender equity.
- Ongoing health sector reform, combined with globalization and the modernization of the State in the majority of the countries of the Region.
- The absence of gender equity considerations in these reforms.

The present guide outlines the gender issues involved in the main components of health sector reform (HSR) in the Region. The first section provides a short overview of the basic concepts of gender equity in HSR, and the following four sections include gender-related considerations and questions that address each of the principal components of health sector reforms:

- Decentralization and promotion of social participation
- Reorganization of the services, including models of care, and definition of basic packages of interventions and services.
- Restructuring of human resources management systems.
- Changes in financing, including private sector participation.

Based on the HSR experience in its country, each member of the Subcommittee will analyze those components of the reform process that are relevant for the country and for which information is available. The analysis should relate to broader national policies governing health and State reform processes.

Each Subcommittee Member will share its experience during a 15-minute presentation on 9 February. The presentations will not be distributed before the meeting, but documents could be available during the meeting.

1. BASIC CONCEPTS OF GENDER EQUITY IN HEALTH

Gender Perspective in Health

Approaching health from a gender perspective means recognizing that:

- Beyond the biological or *sex* differences between men and women, there are socially constructed *gender* distinctions that affect women and men's health and their position within the health system.

Gender values and norms translate into different *roles, risks, needs, access to resources*, and *power* to make health decisions both in the private and the public spheres.

- Gender—together with class and ethnicity—is a key *determinant of health opportunities*, both at the individual and family level, and at the macro level of resource allocation within the system.

- In the gender division of roles, *women's work is consistently undervalued*: In the formal health sector, women are concentrated in occupations associated with lower pay, prestige, and decision-making power; in the informal sector women's work is free, and not factored into national accounts.

- *Women have the cultural responsibility of health care provision in the home.* As such they are the main multipliers of health and human development but also are the most affected by changes in the provision of services in the formal health sector.

- Gender inequalities are articulated and reinforced by other power inequalities. The elimination of gender inequalities thus demands the involvement of different social sectors, as well as the democratic participation of civil society, particularly organized women's groups.

Gender Equity in Health

The principle of equity in health is rooted in the recognition of health as a human right. Within this context of human rights, gender equity and women's rights in health have been highlighted and ratified at the International Conferences of Vienna, Cairo, Copenhagen, and Beijing, as well as in the Summit of the Americas.

The notion of gender equity in health applies to:

- **Health status:** The elimination of *unnecessary, unjust, and **avoidable*** differences in the opportunity to enjoy health and in the probability of becoming ill, incapacitated, or dying from preventable causes.

- **Access** to and **utilization of health services:** Men and women receiving care according to their needs.

- **Health care financing:** Women and men contributing according to their economic ability and women not having to pay more than men because of their reproductive role and their longer life expectancy.

- **Participation in the production of health care:** Balance in terms both of work (remunerated or unremunerated) and decision-making power.

Why the Emphasis on Women?

Men and women occupy different positions with respect to the use and delivery of health care. The emphasis on **women,** both as users and providers of care, is based on the following factors:

- Women have a **greater need for health services** due, particularly, to their reproductive roles and their longer life span.

- Women are **disproportionately represented among the poor.** Women tend to have less access to remunerated work and health resources, including health insurance and long-term social security.

- **Women are in a position of disadvantage within the health system**. They predominate in the levels of lowest pay, prestige, and power within the formal health sector; and they perform the informal work of health promotion and health care in their families and communities without remuneration.

1. Formal sector insurance schemes

Health insurance schemes for formal sector employees raise a number of issues from the point of view of gender impact:

- Do they cover maternity care?
- Do they impose additional payment burdens or other penalties on women?
- What happens to non/unemployed members?

For example, Chile's ISAPRES private health insurance scheme require workers to the health insurance premium, compulsory for salaried workers and voluntary for independent workers, to a private insurance entity in order to obtain the health services and benefits stipulated in its respective health plan. Competition in the sector has led some ISAPREs to launch initiatives that, in principle, facilitate coverage in areas that are especially sensitive for women, e.g. marital health plans, which are shared premiums for spouses, making it possible to distribute maternity costs more equitably.

However, ISAPRES work on standard commercial risk sharing principles. Applying the risk factor, the price of the coverage increases as a function of sex, age and the number of dependants. Women therefore have to pay an increased premium to compensate for their maternity costs, or accept less coverage. Such schemes, while providing a relatively high level of security to formal sector workers as a whole, raise important questions about the wider principle of risk sharing and who bears the costs of human reproduction.

More generally, insurance schemes of themselves are unlikely to compensate for the impact of the often different relationships which women and men have to the labour market. Women's employment patterns and histories may be more diverse and fragmented, leading to breaks in coverage. Differentiation within the labour market may lead to greater concentrations of women in low paid segments or to more casual contracts. Action is needed at a societal level to reduce the consequences of these kinds of inequities.

2. Basic health insurance or community financing schemes for the moderately poor. Experience of these is patchy. There has been some progress in community financing schemes under the Bamako Initiative in Africa, particularly through revolving drug funds. In China, attempts are underway to rehabilitate the Community Medical Schemes which provided cover for farming households. In most such schemes, coverage is necessarily selective. They might pay a proportion of costs, costs of a certain level of treatment only, or costs of certain conditions. A key gender issue is whether they cover RH conditions and of what kind.

There are very few examples of insurance schemes geared to informal sector workers, which is where the majority of employed women are located. A notable one is that of the Self-Employed Women's Association (SEWA) in Ahmedabad, western India. SEWA set up an integrated work security scheme in 1992, one element of which is medical insurance (PATH 1999). This scheme is particularly worthy of attention as it operates partly through commercial insurance companies, thus defying the view that informal sector workers cannot be reached through such means. Whilst coverage is quite limited (to hospital care only), experience indicates that it is very much valued by women members. One important side effect has been stronger demands by women

for better treatment at facilities, thus increasing women's voice and developing greater accountability on the provider side.

3. Micro-credit and funds for catastrophic illness for the very poor

Micro-credit is rapidly becoming one of the favoured instruments of poverty alleviation programmes, particularly for increasing incomes of the poor and for empowering women. More recently, there have been attempts to link it to health objectives, such as by incorporating pre-pay MCH schemes, medical treatment plans and health related micro-enterprises. Evidence so far is fairly anecdotal, and evaluations are based largely on client perceptions. A recent seminar reviewing the Indian experience of micro-credit programmes linked to health objectives highlighted the following positive gender aspects:

- Self-help groups help women to develop leadership skills which often lead to health needs becoming a priority
- Men's involvement in programmes can be a positive force for better communication on health and family planning issues
- Credit programmes are a good place to introduce programmes for preventing violence against women.

Cautions have also been expressed. Most schemes tend to be small scale and run by NGOs. They can run up against lack of co-operation from official structures and health providers. A recent report from India also notes a trend for poor women to take loans for covering the costs of hospitalisation (Ramachandran 2000). An unusually high rate of referral for hysterectomies in private sector facilities was found.

Attempts to provide catastrophic illness cover for the very poor are very limited so far. China is now experimenting with such a scheme in pilot rural counties. At issue in gender terms is less what gets covered than whether women in rural households are able to claim the same entitlements to treatment as men.

Finally, there is now increasing interest in women's budgets as a tool for monitoring public expenditure. For instance, in the Philippines, aWomen's Budget Statement has been introduced on resources for women-specific projects. This sets an allocation of at least 20% of the national budget to social programmes and services. Experience of these monitoring tools needs synthesising and evaluating. Creative thinking is also needed on how to monitor and influence non-government expenditure in areas like health.

6.3 Supranational strategies

The success of the women's health movement in working at a supranational level to get women's health onto national and international policy agendas has already been noted. Whilst processes of globalisation have arguably resulted in increasing loss of national sovereignty, they have also opened up greater opportunities for this kind of advocacy and action. The concept of health as a global public good – a shared global resource to be protected – is gaining some credence in international debate (Kaul et.al. 1999). It is important that gender becomes part of this debate. Women's health advocates have stressed women's health as a right. Arguing the case for maternal health or freedom from gender violence as a global public good allows another entry point for advocacy.

- Women are the **principal health care givers in the family** and are therefore the most affected by the ill health of others in the household. Thus, for example, a child illness tends to affect mothers more than other adult family members.

- Because they are the principal managers of family's health, women are **key to effective and sustainable health development,** and are the **link to intergenerational human development.**

Gender Equity and Health Sector Reform

From a gender perspective, the two most fundamental questions regarding HSR are the following:

> **Does HSR contribute to reduce or exacerbate the existing gender inequities in health, health care, and decision making within the health system?**
>
> **How does HSR affect women's right to health --particularly women's reproductive rights?**

In the following sections, gender equity considerations are addressed in relation to each of the above mentioned reform components[1]. The key issues are presented, followed by some questions. Please answer these questions within the context of the ongoing HSR in your country and using available information, such as sex-disaggregated statistics on mortality, morbidity, health needs, health care coverage and utilization, socio-economic vulnerability, human resources, and social participation. Incorporate also quantitative/qualitative information on decentralization, basic care packages, health care financing, priorities and targeting.

Note that the distinction between reform components is only analytical, since in reality, there are importan areas of overlapping between components. Therefore, some issues and questions will appear in more than one component.

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[1] The main elements of the guide that follows have been borrowed and adapted from the work of Hilary Standing, *Gender and Equity in Health Sector Reform Programmes: A Review*. Health Policy and Planning; 12(1):1-18, 1997.

2. DECENTRALIZATION AND PROMOTION OF SOCIAL PARTICIPATION

Examining gender equity within the context of decentralization

1. The decentralization of health resource management and the allocation of resources may result in an unequal *inter-regional* distribution that may adversely affect the most vulnerable populations. To justly target the distribution of resources, socio-economic vulnerability measures are required. These measures could incorporate specific gender indicators, such as the proportion of women heads of household.

2. Decentralization may result in the transfer of power from the central to the regional or local elites, in detriment to *intra-regional* equity. In cases where decentralization signifies competition for resources between different types of elites, it is important to support the participation of women since they have been traditionally excluded from power structures. It is important to underscore that while women provide the community support system, community leaders are predominantly men who are not necessarily commited to gender equity in the allocation of resources.

3. Decentralization may translate into a transfer of the financial burden of health care to local communities and their institutions (both public and private), adversely affecting poverty alleviation. Cost reduction strategies may have been linked to the use of decentralization as a tool for increasing community participation in health services delivery. Under this situation home care increases, with women shouldering an increased burden of providing care.

4. Recent interest in community participation within HSR has focused on efficiency and sustainability in the financing and administration of health care. Very little attention has been paid to internal community processes and to the central issue of *how and when decentralized systems improve access by vulnerable groups or marginalize them even further.*

Questions about the gender equity implications of decentralization of health care

Please answer the following questions in your presentation, using examples and data to illustrate your statements:

1. **Is decentralization of the health sector taking place in your country? If so, how are decisions made on resource distribution between regions?**

2. **At the local level, who participates in the decisions about resource allocation? How is the community or civil sector involved in making these decisions?**

3. **What efforts are made to include groups that have traditionally been underrepresented, such as indigenous groups and women?**

4. **How are women and women's interests represented in community power structures? Do women, or their organizations participate in setting priorities? In planning programs? In their implementation? In their evaluation?**

5. **How can the participation of women in decision-making be promoted without increasing their workload?**

6. **Has decentralization included a transfer for providing care from the institutional to the home setting (for sick household members, the elderly, and physically and mentally disabled people)? What effect does this additional burden have on users and caregivers? Do any measures or research exist regarding the effectiveness and sustainability of home care?**

7. **What support resources exist for providing health care in the home? What support structures are being put into place for women (or men) as health care providers in the home?**

3. REORGANIZATION OF SERVICES: DEFINING MODELS OF CARE AND BASIC CARE PACKAGES

This component generally includes organizational restructuring to improve human and financial resource management, and the definition of priorities and cost-effective interventions. Important equity concerns in defining priorities relate to the following basic issues: What criteria are used to determine health needs within the wider population? What types of needs are being addressed and which needs are considered priority? What criteria are used to assess cost-effectivenes? Human resource policies also raise issues which are discussed in section IV.

Questions on the reorganization of services from a gender perspective:

Please answer the following questions for your presentation. Illustrate your discussion with results and data available in your country.

1. **To what extent do the design of care models and integrated packages of services take into account the needs of groups with special requirements, and the specific health care needs of women throughout their life cycle (i.e., from childhood to maturity)?**
2. **How were these needs determined? By what means? By whom?**
3. **How were priorities identified? Who participated in the negotiations? Did government agencies in charge of the promotion of women participate? Organized women's groups?**
4. **Do the models and basic packages include health promotion, disease prevention, curative and rehabilitation services?**
5. **Do these models and packages include detection, care and referral services for women who experience domestic violence?**
6. **Do these models and packages consider the impact of gender power inequalities on women's (and men's) health and on women's ability to exercise their sexual and reproductive rights?**
7. **Do reproductive health components exclusively target women, or do they incorporate interventions for men?**
8. **How was cost-effectiveness of priority interventions determined? What actors intervened in the process?**
9. **Are there mechanisms in place to monitor the effects of the new models and packages on the health needs satisfaction of population and specific groups (including women)? Is civil society involved in monitoring? Does it have access to information?**
10. **What would be the response if amid a general improvement of health systems operations and health status indicators, equity deteriorated to the detriment of certain groups? Are there remedial measures in place for such a situation? Who would arbitrate/decide?**
11. **Has there been any evaluation of how cutbacks in certain services may result in increases of the time women spend caring for family members who are not healthy?**

4. RESTRUCTURING HUMAN RESOURCES MANAGEMENT

This component includes cutbacks in personnel, changes in the contracting, payment, grading and performance evaluation systems, and restructuring of post descriptions.

Reasons to examine gender equity in health sector work

1. There is a strong correlation between gender and status in the health labor force. Senior positions are predominantely held by men; women are disproportionately represented in the lower levels of remuneration and decision making. It is likely that reductions in personnel will affect more adversely the less powerful groups of employees, more of whom will be women.

2. Evidence in many developing countries suggests that women are more likely to use certain health services if the provider is female. Consequently, maintaining appropriate levels of female staffing may be important to assure equity in access to services.

3. While human resources policies tend to be gender neutral, in situations where there is a strong imbalance in the sex composition of certain occupational categories, the effects of these policies may not be neutral.

4. As a result of the interaction between the formal and informal health care sectors, policies that have an impact on staffing in the services simultaneously affect the magnitude of the informal burden of care which falls predominantly on women.

Questions concerning gender considerations in the restructuring of human resources management

Please answer the following questions for your presentation. Illustrate your discussion with results and data available in your country.

1. **What impact has health sector reform had on the gender composition of staffing at different levels?**

2. **How do specific health sector reforms affect those sectors dominated by women?**

3. **Are reforms likely to affect female employees differently from male employees of comparable status?** (e.g., regarding incentives policies)

4. **What effects have human resource policies had on relations between predominantly "male" and "female" health service professions?**

5. **Has the reduction in human resources been devolved onto unremunerated "community" workers (frequently women) and/or onto home care provided by women?**

6. BROADENING HEALTH FINANCING OPTIONS INCLUDING PRIVATE SECTOR PARTICIPATION

There is a dearth of reliable information on the impacts of the different forms of health financing on the population. The level of disaggregation of categories such as "the poor" is clearly insufficient for policy making. There is a need for conceptually comparable disaggregated data, that permits identification of the most affected groups, and measure and monitor the effects of different types of health care financing. *Sex, age, socioeconomic status, and geographical location* are important inequity markers. Additionally, there are other categories of people who are particularly vulnerable to cost recovery measures. For example, female widows, elderly men with diminished family ties, the disabled, and orphaned children and adolescents.

Gender equity issues to consider in health care financing

Cost recovery measures may affect women differently due to their greater need for services, their more restricted access to income, and their role as main health carers for their children:

1. The majority of women are either outside of the labor market, and if employed, receive lower salaries than men.
2. Women are disproportionately represented in part-time jobs and informal sector occupations that are usually not covered by social security and health insurance benefits
3. Women have a greater need for services than men, particularly because of their role in reproduction:
   a) Women of reproductive ages frequently have to pay higher health insurance premiums due to their potential for pregnancy;
   b) women in reproductive ages often have to pay a considerably higher proportion of their income in out-of-pocket expenditures for health, compared with men of the same ages;
   c) because of their greater longevity, women bear the larger share of insurance exclusions associated with chronic diseases
4. Women are culturally responsible for the health care of their children. Their responsibility is not confined to the home, but it often means out-of-pocket expenditures for their children's medical attention. Currently, more than 30% of the households in the Region are headed by women.
5. The financing (public or private) of preventive and public health services has a special relevance to women because beyond their own specific needs for preventive care, they absorb most of the additional burden of care imposed, for example, by diarrheal infections in children.

Questions regarding the gender and health implications of different models of financing of health services.

Please answer the following questions in your presentation. Illustrate your discussion with results and data available in your country.

1. **Which health care financing methods have been adopted in your country as part of health sector reforms?**

2. **How are these methods affecting or are likely to affect access to services? Which groups of people have been or could be affected the most and how? Within these groups, are women affected differently than men?**

3. **What measures have been taken to mitigate the adverse impact of cost recovery on low income groups (for example, community financing, exemptions, and subsidies)? How do these different strategies affect or are likely to affect access to services by gender?**

4. **To what extent are health insurance regimes (public or private) linked to employment status? Does service coverage depend on the level of remuneration from work? Do women dependants of**

covered persons have access to the same services?

5. **What type of coverage is provided for dependent housewives, domestic workers, part-time employees, and workers in the informal sector of the economy?** (These are all occupational categories dominated by women)

6. **What is the proportion of men/women covered by health insurance? What types of insurance?**

7. **Has the government developed regulatory regimes to lay down standards of service provision for the private sector? Are there regulations directed to improve equity or to offset existing or potential inequities in service delivery? Do these regulations explicitly address women's health needs and gender inequities in access?**

8. **Does privatization increase or decrease the probability that low income groups will be adequately served? Does it increase or decrease the probability that women's specific health needs will be adequately covered?**

9. **Do health insurance systems charge a higher premium to women due to their reproductive health needs? Do they cover chronic diseases?**

10. **How are reproductive health services** (for example, family planning, prenatal care, and maternity care/leave) **financed? Who pays for them?** (for example: government, tax mechanisms, employers, donors, other actors, or women themselves) **What services are included in different types of health insurance packages?**

11. **To what extent is the private sector providing prevention services and helping to meet public health objectives?**

Within the context of measuring impact and identifying affected groups, it is important to progress in the measurement of the following elements:

- The hidden and not-so-hidden costs of services: transportation, drugs, time spent in transportation to the consultation or to purchase the drugs, time lost in waiting, opportunity costs for the time of women, etc.

- Which family members are most likely to use health services? What types of services? (Distinguish family members by sex, levels of care used, and whether care is provided by public-private-traditional sectors.)

- Do increases in health expenditures result in reduced spending for other needs? What categories of expenditure are affected?

- What proportion of men's and women's income is spent on out-of-pocket health expenditures? Do these proportions change according to type of health care financing?

Partnership in Health and Poverty: Towards a common agenda

World Health Organization, 12- 14 June 2000
Geneva, Switzerland

Summary Report

I. Introduction

The World Health Organization (WHO) in collaboration with the World Bank, the UK Department for International Development and the European Commission, held a major meeting -- *Partnership in Health and Poverty: Towards a common agenda* (12 –14 June 2000) -- with key development partners. The 130 participants included experts from civil society organizations and academic institutions worldwide, senior government officials from developing countries, and health and development officials from UN and bilateral agencies, the World Bank and regional development banks.

The main objectives of the meeting were:

- To provide a **forum for exchanging** information on current thinking on health in development and on current practice related to health and poverty reduction
- To **identify critical gaps** and obstacles in knowledge for action
- To encourage participants (as key development actors) to discuss strategies on how to **strengthen partnerships and other efforts** to integrate health into national and international development planning
- To stimulate **joint action** on research, policies and actions
- To build **linkages** to forthcoming UN events and other international meetings.

Each of the eight sessions of the 3-day meeting was structured so as take stock of current thinking and activities; to identify obstacles, opportunities and critical gaps in knowledge for action; and to identify ideas and recommendations to be carried forward and to specify the responsible actors.

The first four sessions focused on analysis of health and poverty, covering:

1. Health as an asset: protecting and improving health as a core development strategy.
2. "Voices of the Poor" – the lessons for health.
3. Ill -health and poverty - addressing the links.
4. Globalization and health consequences for the poor.

The remaining four sessions focused on actions to protect and improve the health of the poor:

5. Implications for health systems.
6. Implications for development policies.
7. Implications for processes at country level.
8. Implications for development partners.

II. Main observations

A. Health in poverty reduction and development: a political process

Several presentations focused on the strong evidence demonstrating the centrality of health to reducing poverty and other deprivations (such as gender-related disadvantages) and to promoting overall social and economic development. But there was broad disappointment and frustration amongst the participants that this mounting evidence has still to lead to major changes in the mind-set and actions of both health and other development actors. The health community is still not doing enough to ensure that health is accorded high priority in development planning; nor do actors in other sectors give sufficiently high priority to health. The net result is that health is typically absent or of low priority on national poverty-reduction and development agendas, and not as high as it could be on the international development agenda.

To redress this, health actors need to recognise and meet their responsibility to advocate that health is a critically important means of reducing poverty and promoting human development. Similarly, the development community as a whole needs to back the case for both making greater investments in health and for protecting and promoting health in every sector, whether it be macro-planning, industry, agriculture or trade. There was strong agreement that these goals can be achieved only if health actors engage in the politics of development at the national level; simultaneously, international agencies, in particular WHO, must continue the push to place health at the forefront of the international development agenda. Health actors need to recognise that health – like all sectors – is embedded in *politics*. If health actors are to rise to the challenge of being effective political players, they will need to move beyond the narrow bio-medical paradigm, equip themselves with requisite advocacy skills and tools, and participate vigorously in the politics of development.

Opportunities for gaining greater political prominence for health include such key forums as the five-year review of the World Summit for Social Development, the World Trade Organization negotiations, G8 meetings, World Bank and IMF meetings, and country-level poverty-reduction and debt-relief processes. In many of them, the voice of health has only recently begun to be heard.

Despite the criticism of the inadequate pace of change, overall there was agreement that health was far higher on the international development agenda than at any recent time, and that opportunities flowing from this must be seized. The participation of such a broad range of development actors at this meeting was itself proof of this, namely the high stature of health and the growing consensus within the international development community that it must act to promote health.

B. Health of the poor: the need for strong commitment and a broader approach

There was widespread recognition at the meeting that for poor people their bodies are critically important assets – often their only asset -- for sustaining their survival and

livelihood. Consequently, good health is of vital importance to them and ill-health a calamity.

Promoting health for the poor requires raising access to affordable, appropriate, quality health services as well as creating an enabling environment to protect their health. Consequently, strategies to promote the health of the poor must take a *rights* approach, factoring for disadvantages engendered by gender, social exclusion, locale and other factors. They must also build on and strengthen poor people's capacity, skills and knowledge; assure them dignity and respect; and reinforce their connections to political and social systems that promote their well-being. These are essential elements for the poor to be able to ensure that informal and formal health systems respond to their felt needs and are accountable to them.

There was also strong consensus about the need for greater participatory research with the poor. Much more needs to be known about their circumstances, needs and views. This knowledge is needed both to design health systems that are responsive to them and to clearly understand what actions outside the health sector will positively influence the broader determinants of their health.

On a different front, participants cautioned that strategies to promote the health of the poor must build on past policies and efforts that have been effective in promoting their health, such as Primary Health Care and the Health for All initiative. While efforts to promote the health of the poor are urgently needed, they must take stock of both the best practices and the cautionary lessons of the past.

They also emphasized the need to ensure that societies and their governments are truly committed to the effort of improving the health of the poor. Otherwise, this effort will remain an initiative led by development agencies and donor governments, jeopardizing the chances of success.

III. Strategic Actions for 'health for the poor, health and development'

To realize the goals of promoting the health of the poor and making investments for health a central part of the development agenda, the following key strategic actions were recommended by the meeting, relating to health systems, development policies, country-level processes, and development partners.

- To make health systems more effective in addressing the needs of poor people requires: establishing more affordable and equitable payment systems (with pre-payment/insurance instead of user charges); ensuring that health-sector actors respect the poor; developing mechanisms to meaningfully involve poor people in analysis and decisions; implementing explicit strategies to tackle causes of particular disadvantages or deprivation, such as gender, social exclusion or geographical isolation.

- Health data need to be disaggregated by income, age, sex and locality if we are to build a clearer understanding of poverty and who and where the poor are.

This is especially important with data used in health planning and monitoring, so that actions can be geared to the real and local causes and consequences of poverty, and the impact of investments measured. This disaggregated data must be part of a larger 'knowledge creation' effort to rapidly analyse, document and disseminate what does and does not work for the poor. This knowledge base will need to be informed by both quantitative and qualitative studies, and by research that documents the expressed health needs of the poor.

- The health threats and disadvantages that are primarily responsible for creating and perpetuating poverty need to be tackled urgently. These include major infectious diseases, maternal illness and mortality, poor environmental health, violence and accidents, and major emergent threats like tobacco and other unhealthy consumer and food products. The particular health risks facing a community need to be assessed at a local level rather than be set on the basis of aggregated national or international data. These assessments must also highlight the different needs and risks faced by men, women and children.

- More effective resource mobilization is needed to multiply the financial and human resources available for health systems. These resources can be secured by strengthening the commitment of existing partners and by establishing partnerships with new allies.

- At the same time, the underlying determinants of health must be addressed and made more pro-health. For significant and sustainable gains in health outcomes, beyond action on the immediate manifestations of disease, action is needed on the underlying determinants of health. For instance, there is little point in building clinics if people cannot reach nor afford them, or are turned away because of discrimination.

- To bring health to the centre of poverty-reduction and development strategies requires building public-private partnerships between governments, civil society organizations, the private sector and international agencies at both the country and international levels. These partnerships must link the health community to other development actors. Within government, health ministries must become equal partners of ministries of finance, planning and trade.

- Action at the country level must be accompanied by action at the global level to stimulate the development of global public goods in health and to ensure that health is protected and promoted in the globalization process.

IV. Conclusions

The strong consensus of the participants was that this meeting was an important step forward in developing a common agenda on promoting both the health of the poor and the role of health in development. As the first meeting within the UN system on these issues, it had laid the foundations for several essential elements: a common, holistic knowledge base; a working-consensus on key actions and strategies; and a partnership for action. To make further rapid and real progress in achieving this common agenda, participants said that three things had to be ensured. First, that WHO – as the lead health agency -- and all other institutions present had to continue to place top priority on these issues. Second, that all participants needed to sustain this partnership with their firm individual and organizational commitment. Third, that they needed to advocate within their own organizations for action on these fronts.

For other information or to provide comments, please contact Meeting Coordinator Margareta Skold HSD/WHO Geneva E-mail: skoldm@who.int

Partnership in Health and Poverty: towards a common agenda
Executive Board Meeting Room
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World Health Organization, Geneva, Switzerland

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