

Which Health Policies are Pro-Poor?

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1. Introduction

This paper is an initial working paper from IHSD as the first output of work on pro-poor health policies. The work represents an attempt to look at the options for health policies and health system developments which can improve the health of poor people.

The work to date has mainly comprised a review of literature, discussions with DFID staff and drawing from experience of staff in IHSD. Initial contacts have been made with others active in the field with a view to involving them in subsequent stages.

The purpose of this paper is to clarify issues and set out an agenda for further work. It does not review the literature but draws on others' findings of other literature reviews, particularly the excellent review paper by Gwatkin, and seeks to take forward the discussion by identifying aspects of policy where further work could provide useful guidance for health policy and programme development at national level. The paper has the following sections:

Section 2 : Defining and identifying the poor

Section 3: What is known about the health of the poor, their use of and need for health services

Section 4: What are the objectives for pro-poor health policies

Section 5: Initial findings and issues in defining pro-poor health policies

Section 6: Monitoring

Section 7: Issues for further work/next steps

2. Defining and identifying the poor

The poor are people who are deprived of basic needs. Poverty can be defined in relation to deprivation either as a lack of *means* (ie: purchasing power) to avoid deprivation, or as an *end* in its own right (ie: deprivation itself). The former can be defined as *relative* or *absolute* poverty, whilst the latter, deprivation *per se*, is purely a relative concept. Townsend defines deprivation as "*a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs*".

The poor are not a homogeneous group of people. There are large differences within the group based on age, sex, ethnicity, region, occupation, shelter, land, education, health and clothing (Sen & Begum). These differences can be used to identify and categorise the poor.

The number of people classified as poor (prevalence) depends on the measure (and therefore definition) used. Such measures should be relevant (ie: reflect the complexity of the concept) but also need to be sufficiently simple for everyday, practical use. It is also important to measure the severity and distribution of poverty within different groups so that policies can be targeted to, or so that their effects can be monitored amongst, specific people.

The means based approach to defining poverty is reflected in the *income/asset-based* approach by defining a *poverty line*, as used by DFID in the White Paper "Eliminating World Poverty". A poverty line can be absolute (e.g. less than \$1 daily) or relative (e.g. less than 50% of average earnings). Less than \$1 per day is an international standard used by DFID in the White paper, with the \$1 set in 1985 prices adjusted for local purchasing power. Relative poverty levels are usually defined at a national level.

The main problem with this approach is that it simplifies poverty to a uni-dimensional measure which cannot describe the distribution of poverty nor how any available resources are shared between members of a household, thereby masking potential inequalities such as those between men and women. In addition, this approach cannot encompass non-monetary resources obtained through, for example, barter or state provision.

Also, such an approach is based on a narrow interpretation of need (essentially physiological survival) that can be alleviated simply by increased purchasing power. This corresponds to the "hierarchy of needs" in which basics such as food and water must be available before health, housing, clothing etc. and, even more broadly, power, independence and social inclusion can be considered. However, sociological research suggests that these latter concepts are important, albeit in a different context, even in the absence of more basic needs.

Entitlement approaches to measuring poverty incorporate concepts such as access to services, vulnerability and the maintenance of a secure and sustainable livelihood (Chambers). Such concepts are affected by structural inequalities about how resources are shared and used as well as the absolute level of resources available.

It is much harder to measure these aspects of deprivation and, therefore, monitor whether they are being alleviated by health (or other) interventions. Rapid participatory appraisal is one approach that describes the ways in which the means of countering poverty (resources) are used to deliver the ends (reduced deprivation) thereby providing a more complete assessment of poverty.

Poverty can be measured on an individual or group basis. Small-sample measurement of individual or household poverty can be used to monitor the effect of policies or services designed to alleviate poverty but is time-consuming. Methods to measure poverty at household level include:

- direct methods eg: measuring caloric consumption
- indirect methods eg: using data on income/expenditure
- qualitative methods eg: self classification by the household

Individual approaches are usually seen as unsuitable for targeting anti-poverty projects since they encourage individuals to provide false information (to increase individual benefits) and possibly even reduce their own labour income in order to gain extra benefits. *Poverty profiles* are therefore used to define *group* characteristics (Lipto), which rely on correlating characteristics of the poor with assessments of their available resources collected by small-sample surveys.

Group targeting is more cost-effective than individual identification when applied in the field. The identified characteristics of the poor may include geographical or seasonal differences as well as household traits. The information provided can therefore be useful in targeting healthcare interventions without producing perverse incentives.

Examples of poverty profiles

Indicators should be both specific (ie: minimise leakage to the non-poor) and sensitive (ie: achieve broad coverage of those who are genuinely poor). Single indicators rarely achieve both conditions, so a number can be combined to achieve a representative basket. In addition, indicators may be selected in order to differentiate between moderate and extreme poverty.

In Bangladesh, three indicators (land ownership, type of housing and occupation) were shown to be both sensitive and reasonably specific for identifying rural poverty, particularly the extreme poor (Sen & Begum). Different indicators were required to measure urban poverty.

The Joseph Rowntree Foundation identified 46 indicators to capture the extent of poverty and social exclusion in the UK, thus enabling policy-makers to track changes over time¹. The criteria for selection of indicators were that the data were readily available, reliable, valid and relatively immune from manipulation through perverse incentives. The selected indicators reflected the definition of poverty used: hence both income/expenditure and access/entitlement were reflected. However, the main purpose of this dataset was to track changes in poverty, rather than identify particular areas where it is concentrated.

The UNDP has adopted a similar approach in developing a Human Poverty Index. This used a basket of five indicators to measure longevity, knowledge and the standard of living. The indicators used are:

¹ Howarth C, Kenway P, Palmer G, Street C. Monitoring poverty and social exclusion. Labour's inheritance. Joseph Rowntree Foundation. York. 1998.

- % of people dying before the age of 40 years
- % of illiterate adults
- % of people with access to health care
- % of people with access to clean water
- % of malnourished children under 5 years.

One of the problems with measuring poverty by these types of approaches is it tends to assume the poor are a static group, when in practice various studies show this is not the case - people can move in and out of poverty. There are thus also vulnerable groups who are at risk of poverty and who should be catered for in a pro-poor strategy.

In practice measurement of poverty tends to use one of three main approaches:

- household expenditure, often using household surveys; this approach is typically used for analysis of poverty levels and characteristics. It is used less often for specific targeting due to the problems of perverse incentives and difficulty of measuring income, particularly in peasant farming and informal sectors.
- household characteristics, drawn from surveys as in poverty profiling, which can be used for targeting groups (e.g. villages which are predominantly poor). The approach can also be used for targeting individuals although the criteria become known and may distort behaviour.
- community assessment of who is poor, for example village leaders deciding who should be exempt from user fees for health services.

It is concluded that for the present work, there is no need to choose a particular definition or single approach to measurement. Specific definitions will be set nationally, for example, the poverty line, and different measurement techniques will be used in different situations. What is important is to know the characteristics of the poor and those vulnerable to poverty at country level - where they live, how many there are of different types, family characteristics, living conditions and health problems, and what they want. This will form the basis for designing interventions and monitoring their impact.

3. What is known about the health of the poor, their use of and need for health services

Analysis of health status and problems is not generally available by income or for the poor specifically. However interesting new analysis of DHS data does show:

- the consistent pattern of worse health indicators for less household wealth families
- the lower coverage of health services for less well off households for most services analysed
- the extent of variation is very variable within and between countries in service coverage, e.g. in Peru in 1996, measles immunisation coverage ranges from 81% in lowest quintile to 89% in highest quintile, but having 2 antenatal visits ranged from 36% (lowest quintile) to 89% (highest). Compare Chad (in 1997), where measles immunisation rates range from 6% to 39%, and the proportion of women attending for 2 ante-natal visits ranges from 2% among the poorest to 8% in the top quintile.

Analysis of Household Survey data in 1994/5 in Uganda indicates:

- the poor report (slightly) greater illness but are much less likely to use modern providers; they are twice as likely to self treat and ten times more likely to do nothing
- family health expenditure in the highest quartile is over three times greater than that in the lowest
- private facilities are the preferred choice for all income groups
- women tend to be ill more often but spend more on curative services and are more likely to use modern providers than men
- key factors influencing utilisation are: income, distance from facility (rather than cost of services), sex, severity of illness and type of facility available (Government or NGO)

It is known that some diseases are more prevalent among the poor, although this data is not typically available at country level. In particular:

- some communicable diseases are strongly associated with poverty, e.g. those linked to poor water and housing
- there is less association for others e.g. HIV/AIDS, TB
- the better off have higher prevalence of chronic diseases. This transition may have taken place within countries, so the middle class can have a very different morbidity profile from the poor.
- Higher mortality rates indicate that the poor have worse health status, although this is not always borne out by surveys which ask people to report their recent illnesses, as the poor often report less illness.

Other evidence can be used to show differences in morbidity levels and disease patterns; for example in Bolivia, Uzbekistan and Georgia there is data that shows significant differences between urban and rural populations; in these countries urban:rural differences can be used as a proxy for income differences.

Further work is likely to be needed at country level to understand the pattern of disease - and this can also be addressed in monitoring the impact of policy on the poor (see section 6). In addition there are studies underway at country level into health and equity issues, as set out in Gwatkin & Fragueiro. Some of these studies should contribute to understanding of health issues and services use by the poor.

On use of services, benefit incidence studies, mainly from Africa, (ref.: Castro et al) indicate:

- the better off make heavy use of Government health services, particularly hospitals, (although this is not always the case e.g. South Africa)
- the poor report less illness, but this may be due to perceptions of illness
- among those reporting illness, the poor make less use of modern health services than the better off;
- the poor gain less benefit than the rich from public spending in both primary and hospital services, but the gap is much wider for hospitals, since the public subsidy per patient is higher in hospitals than primary care, and the better off use them more;
- however the benefit is progressive in the sense that as a percentage of income, the poor get more subsidy than the better off.

Other studies show:

- the poor tend to use the public sector more than private services, although this varies widely by country, presumably reflecting varying quality in the public sector and varying availability of alternatives;
- the poor tend to use different private providers from the better off, including traditional and informal providers. Experience supports this picture, as the range of providers in many countries is wide with various types of trained and untrained providers, ranging from people selling medicines in markets to private clinics run by staff of government health facilities on a part time basis.

Higher use of services by the better off is not surprising due to income effects - they can afford more. But also the lower use by the poor is not just about income - other factors include their distance from services (& time and travel costs), the services in poor areas may be worse quality than those in areas where the better off live so they decide quality is too low, they do not earn if they take time off to seek care. Basically they make a trade off between the costs of obtaining different services (including time and travel) and the perceived quality and hence judge value for money of different options available.

Based on this, the issues which need to be addressed in defining pro-poor health policies and strategies are:

- **How** to improve the health status of the poor

- **How** to ensure services of reasonable quality actually reach the poor and vulnerable
- **How** to ensure people are not driven into poverty (or more severe poverty) by the costs of health care.

4. What are the objectives for pro-poor health policies

What are the policy objectives implicit in being pro-poor? What effect does this have on health policies?

One major issue here is how far the focus is on **improving the health of the poor**, versus on **improving equity** in health status or in access to health care. The practical issue here is that improving equity in health could be served by reducing the benefits of the better off (e.g. not allowing heart transplants or CT scanners in private hospitals); also there may be strategies which would benefit the poor but would benefit the rich even more (e.g. ensuring drugs are available in public hospitals, or improving treatment of TB even if the disease (and hence beneficiaries of treatment) is more common among the better off).

Our understanding of DFID's view is that the issue is how to improve the health of the poor, accepting that the policies may also benefit others in the country. This is reflected in the classification of DFID programmes into enabling, inclusive and focused activities: enabling programmes support poverty reduction, for example via economic growth; inclusive benefit all or many of the population, including the poor and vulnerable; focused activities are targeted to the poor. Any of these can be accepted by DFID. Can we take this to imply that the target is to improve the health of the poor rather than to improve equity per se?

The second issue is whether a pro-poor focus implies efforts to **maximise improvements in health of the poor** versus a more usual health objective of **maximising improvements in health**. In practice maximising improvements in health would in many cases best be achieved by focusing on the poor - since many of the cost effective interventions are for diseases of the poor. This is also borne out by the findings linking higher income to lower morbidity (Ecob & Davey Smith). But it may not be as cost effective to focus on some of the poor or the poorest, as they may be difficult to reach and hence there may be higher costs to cover them (for example, if they live in remote areas or are unwilling to come forward for vaccinations). This raises the issue of the trade off between equity and efficiency - how much extra is it acceptable and desirable to spend in order to reach the poor?

The international development targets, which include reducing infant and child mortality rates as well as improving access to reproductive health care, suggest that the pro-poor focus does not require an objective as limited as 'maximising the health of the poor', although distributional factors are clearly

important. A broader policy objective is also likely to be more acceptable within country policies.

A third issue is the debate between improving health and improving welfare. The aim of pro-poor strategies is to improve the welfare of the poor, and improving their health is a means to this end. But it raises issues around the priorities within health, as discussed further below.

The choice of policy objectives is a country prerogative but DFID and other development partners will want to be satisfied that a country's policy addresses its concerns in developing its programmes of support. Based on the discussion above, it seems that it is not necessary for health policy to have improving equity as a specific goal; also it may not be realistic to expect Governments to prioritise improving the health of the poorest when this is very costly and would be at the expense of health gains for many others in the population. Thus the types of policy objectives which might be acceptable to both governments and donors include:

- to extend the provision of a basic health service to reach the whole population
- to ensure 90% of pregnant women receive ante-natal services etc.
- to improve the access of the under-served to services of reasonable quality
- to improve access for the poor to health care which is affordable and of reasonable quality
- to reorient existing services and focus new expenditure on the poor
- to focus capital development on under-served areas or primary services
- to reduce the gap in mortality rates between population groups
- to ensure new policies do not have a negative effect on the health of the poor
- to make the distribution of resources fairer, related to population and health needs.

While these policy statements are broad, they would be supported by country specific targets.

In order to address these broad objectives, three main areas of policy can be defined to improve the health of the poor:

- protecting them from ill health and reducing their burden of illness,
- ensuring the poor have access to a range of curative, preventive and promotive health services which are of reasonable quality, are affordable and appropriate to their health problems
- avoiding use of health services leading to worsening poverty.

Many other sectors have major impact on health, particularly for the poor. Improving water and sanitation, education and incomes will all have major (probably greater) impact. Moreover, improving transport, housing and

agricultural practices can also be key factors in enabling poor households to improve their health and benefit from health services. This applies in developed economies as much as the developing world (e.g. see Acheson report findings for the UK). However, this paper focuses only on health sector interventions and policies, not because the others are less important or effective but because this is the remit of the paper.

Within the health sector, the following major strategies can be defined to address the policy issues set out above:

- ensuring the poor are covered by public health services (meaning non-personal rather than public sector funded services)
- improving the access to, and quality of, personal health services
- avoiding heavy expenditures by the poor on health care which exacerbates their poverty

We have not addressed the issue of the consequences of ill health for families in terms of reduced earnings or the problems due to death of key household members (as discussed by Bloom and Lucas). Whilst these are undoubtedly important, the issues fall outside the health sector and are therefore not within our remit. We also have not sought to address the issue of whether health service provision will reduce poverty, since this issue is not the focus of this work and has been covered extensively elsewhere.

5. Initial findings and issues in defining pro-poor health policies

In considering pro-poor health policies, the 3 strategies identified can be considered in turn and we then cover two other topics - resource allocation and Sector Wide Approaches (SWAPs).

5.1 Ensuring the poor are covered by public health services

It is not usual to separate out public health services from the broader Primary Health Care or Essential Package. We have done so, however, because there are differences as well as similarities with the provision of personal curative and preventive services. Unlike the curative services, people do not generally choose to consume or purchase public health services, therefore the issues around whether the poor are choosing to use public or private services or preferring to treat themselves or use informal provision, (which will be discussed further below), do not apply. Public health services are generally public goods with externalities and should be provided (or at least funded) by Government (even for the better off).

Key public health issues for the poor which are typically seen and organised as the responsibility of the health sector, include health education and information about ways to improve health; promotion of sanitation and

development of simple sanitation and water schemes and inspecting hygiene standards, for example in restaurants. In many countries there is a health inspectorate or environmental health service responsible for several of these roles.

The role of such services in improving health of the poor will obviously depend on the nature of health problems faced by the poor in each country. Typically water and sanitation related diseases are a major cause of ill health, particularly among children. In terms of targeting the poor, improving their sanitation is one of the ways of reaching them - as indicated by findings for Ghana, Brazil and the Philippines, that public investments in sanitation benefited households with least education more than the well educated, (which was not true for health services as a whole) (Alderman & Lavy). Health education is also a key area and some of the existing initiatives, such as school health education, may miss the poor if their children are not in school. In such cases, different interventions would be required to reach the poor. Immunisation can be defined as part of public health and the evidence cited in section 3 for example, shows that the poor are less likely to have their children fully immunised.

Public health services therefore seem a key aspect of services where the Government can affect the health of the poor. The critical issue will be how best to ensure that those services actually reach the poor.

One option is to consider targeting of services - and Gwatkin's paper has a very useful discussion of possible means of targeting and evidence for these. It is summarised here, although the discussion is also relevant to targeting other types of provision or support for the poor. He identifies:

- **individual targeting** - where poor families are selected and given particular benefits such as free access to services; there has been some success in Thailand (where reviews showed the family exemption cards were reaching about 80% of the poor population) but less success elsewhere such as Indonesia (where there was very low take up) and in Africa. A study showed only 9 out of 29 such initiatives were considered successful. Health card mechanisms do not cater well for the dynamic aspect of families moving in and out of poverty. New initiatives such as vouchers can target specific groups, but the choice of recipients suffers the same problems as other mechanisms of individual targeting.
- **geographic targeting** - to the poorer states or villages. The success of this depends how spatially concentrated poverty is; however it may be difficult to gain agreement to provide additional support such areas and their implementation capacity is often weak;
- **targeting by age** - for example, targeting children since the disparities in health status in middle income countries are greater among children than adults; however, the problem remains to ensure such programmes reach the poor

- **targeting by disease** - focus on common diseases which affect the poor; this is in effect the approach in selecting the basic package and hence the range of public health and other services which will be provided but ,in itself, this does not ensure they will reach the poor.
- **targeting by quality** - so that the standard of services is only accepted by the poor while the better off prefer to pay more for better services; this could apply to hotel aspects of hospital care (e.g. as in Indonesia) and to waiting times for outpatients. It may happen in practice rather than as a conscious strategy.

In the context of public health services, geographic targeting would seem to be a realistic option, in terms of ensuring that villages and urban areas where the poor live are covered and adequately staffed. The poverty profiles approach can assist with geographic targeting at a local level - for example to select villages which merit particular attention, and even households which should be targeted for advice and assistance.

Targeting by disease is implicit in terms of the choice of services offered in an area, but it will be important to check the relevance of the basic package to the poor population and whether services need to be adapted (e.g. in the example above, finding alternatives to the delivery of health education through schools). In policy terms, the main issue is to ensure that adequate resources and attention are devoted to such activities.

However, the problems still remain of how to ensure that any public health services are efficient and of reasonable quality. This is covered in the next section.

5.2 Improving access to and quality of health services used by the poor.

The idea of Primary Health Care (PHC) was to deliver services to the population in an affordable way, through providing local primary level services for prevention, promotion and curative care. Typically, this was organised through community services backed up by public sector health clinics and health centres. There was a major expansion of primary level care in many countries with improvements in geographical accessibility. As the availability of drugs in these facilities emerged as a recurring problem in the mid eighties, the idea of charging patients a fee (below cost) and using this to support running costs of the facility was encouraged.

However, despite these developments and the considerable investment by many Governments in their primary care system, the services are often of poor quality and hence under used. Poor attendance by staff and unofficial charging are common problems reflecting declining real staff salaries. Inadequate supplies of drugs in public clinics and hospitals, run down equipment and buildings, and low coverage of preventive programmes are

also common. In response to the decline in service quality, there has been a growth in private provision in many countries, which may include the public sector health staff providing services privately or independent practitioners, some of whom are not qualified. Users may also self treat or use drug suppliers, who can range from trained pharmacists to market traders with no training selling a selection of unlabelled medicines.

Whilst most countries have some regulations on medical practice and pharmacies, they are often not applied in practice. Experience in such cases shows that the development of an unregulated market in medical care results in inappropriate treatment through lack of knowledge or for financial gain; inadequate provision of preventive services; and exclusion of the poor if they cannot pay. As a consequence, many people will receive poor value from their expenditure on health and may actually be harmed by incorrect treatment. The poor are particularly vulnerable to this because they are likely to use the cheapest and least trained providers who may give inappropriate treatment. Also they are less likely to be informed and educated about appropriate treatment. (For example, they may be given only half a course of anti-malarial or antibiotic drugs, because that is all they can afford, which not only fails to cure them but also increases resistance and future treatment effectiveness).

These problems are a reflection of the fact that health care is not like other markets: Government has a major role for three main reasons:

- in terms of the particular nature of the health market, with market failures due to the inability of consumers to identify whether they are being given appropriate health care, which calls for a role of government (and self regulation) to ensure appropriate care is provided
- in terms of the externalities in health services such as immunisation and other communicable disease control, which means people would tend to under-invest in such services if left to the market.
- in terms of social equity, and the importance of developing human capital in order to achieve economic development, Governments have a key role in ensuring access to social services for the population and particularly those who cannot afford to provide for themselves

For these reasons, there is a need for active Government participation in the health care market in general, and not just to provide for the poor. The major options for improving the market for health services in such cases, and ensuring it serves the needs of the poor, would seem to be:

- improving the performance of the existing public and private sectors;
- privatisation of public providers and strengthening regulation and standards for all providers,
- linking public subsidies to performance and delivery of specific services, whether by public or private providers
- closing down untrained or poor performing private providers

Apart from the political difficulties of doing so, the privatisation of public providers does not seem to be a solution, since many of the same problems of poor quality and inappropriate treatment apply in both sectors. The policies selected by many countries are:

- identifying a basic package or Essential Service Package (ESP) which contains the key interventions and focus on providing these services.
- management and organisational reforms in the public sector, often giving public providers more freedom to manage their resources and focus on their performance in terms of service quality. This may also alternatively involve decentralisation to district or institutional level, with a change in the role of central government to setting and assuring standards.
- For the private sector, the policies which have been promoted tend to be strengthening regulation and to look at channelling public support through effective providers in order to improve access to services.

The following sections review these elements of health sector reform, to consider how well they address the pro-poor agenda and the issues this raises.

5.2.1 Defining a Basic Package or Essential Service Package (ESP)

Starting with the ESP, the approach of defining a basic package of services which is affordable for the whole population is attractive. The method proposed by the World Bank in the 1993 World Development Report, involves identifying the most cost-effective interventions for reducing the burden of disease. However, the method can be questioned in terms of its appropriateness for ensuring a pro-poor strategy. Firstly, because the method is essentially an economic approach which regards the saving of a DALY as equally valid whoever is concerned, it does not consider distribution or equity issues in the assessment. Thus, there may be diseases of the poor which have limited impact on the overall burden of disease and would not appear as a priority in an analysis of the national burden of disease, but are a priority for the poor, or for the poor in particular environments or areas. In low income countries it seems that this is less of a problem, because so many of the major disease problems which can be addressed cost effectively are diseases of the poor, but in middle income countries, this may not be the case.

Another issue (discussed by Bloom and Lucas) is the way the calculation is carried out, which effectively values infants and children more highly than an adult (more DALYs for saving the life of children); this may not correspond well with the concerns of the poor, where the impact of the death or disability of an adult is likely to have a major impact on household capacity to move out of poverty.

In practice, many countries have determined their basic package or ESP by judicious selection rather than by mechanistic application of DALY analysis. However, it is an issue to be considered in identifying the services to be

provided for the poor, and considering whether there are services which will particularly meet the needs of the poor. This may require more specific analysis of disease patterns by social group to ensure the package includes components which would have most impact on the health of the poor.

Since health services are normally provided through facilities offering a range of services, rather than through disease based vertical programmes, the adaptation of the service package in line with the needs of the poor in particular areas should be feasible, by including appropriate drugs, equipment and training for those diseases in relevant facilities.

One issue which arises is how to deal with the fact that people will seek treatment for other illnesses, treatment of which is not in the basic package. To some extent, the treatment will be limited by the range of equipment and drugs at each facility, but if the facility is to be seen as useful by the population, it will need to offer treatment for a range of common conditions. Differential pricing is one option, so basic package services are heavily subsidised or free, but this may bring in perverse incentives - for example, health workers may not want to offer free basic services as they would prefer to be providing income generating services; alternatively, sympathetic staff may want to save patients money by mis-classifying their illness so it qualifies for free drugs. This issue is not specific to catering for the poor, but may affect them disproportionately. Further work on this issue is suggested to consider options for encouraging appropriate incentives and provision.

5.2.2 Management and Organisational Reforms in the Public Sector

The reforms in the public sector are intended to improve the efficiency of resource use, so that the limited funding can go further; and improve effectiveness, so that users receive better quality care. The underlying approach is to change the incentives and pressures in the system so that service providers have more incentive to be efficient and effective. The reforms usually include a combination of the following policies:

- separating the provider of health care from the commissioner or purchaser, with performance targets and review
- decentralising authority to hospital, district or health facility level, which may include giving the facility authority over staff as well as capacity to manage its funding, and to charge/increase and retain fees, for use in improving services
- giving the community a role in managing decentralised units, through a hospital board or similar.
- introducing quality assurance mechanisms including standards and/or clinical audit.

The following paragraphs look at each of these in turn, to see whether their potential impact on provider incentives and hence on performance will help the poor or could bring disadvantages:

a) Separating purchasers/commissioners from providers of health care:

The idea is that the purchaser, such as a district health board or health insurance fund, can specify clearly the services it wants the provider to deliver, leaving the provider to manage its resources as efficiently as possible. This provides an opportunity to specify the types of services that should be provided for poor populations in particular, for example, whether outreach should be taken to poor areas, the mix of patients who should be covered by services, or whether services should be free to target groups. The second of these concepts is being introduced in the UK NHS as part of the new national performance framework. However, as discussed above, targeting is difficult. Furthermore, there are risks of perverse incentives (staff may be deterred from treating the poor if they do not pay). The alternative is simply to use the performance management process to focus on improving service quality, without making special efforts to cater for the poor, and assume such an enabling policy will benefit the poor. Some further review of experience and thought on approaches is suggested.

In principle, this approach could also allow the purchaser to choose which service provider to use, including the possibility of funding NGO or private facilities instead or as well as public services. This introduces some incentives for providers to perform well and hence attract funding. It may also improve access for the poor, as they can use more convenient services or use better quality services at a subsidised price (e.g. in Uganda, where the government provided support to mission hospitals which was tied to reductions in their fee rates). On the other hand, there are risks of choice of inappropriate providers (possibly due to corruption), and political constraints on using this mechanism to penalise poor performing public units. Further work is suggested to identify the pre-conditions for such policies, - for example, whether there is a commitment and capacity to monitor performance and take steps where it is inadequate. This work should also identify practical policy guidelines to make sure effective implementation.

b) Decentralising authority to district, hospital or primary facility level:

Decentralisation should allow services to be more responsive to their local environment, including the needs of their catchment populations. This should provide opportunities for services to be better tailored to the poor and designed to reach them; however, it is not clear that it brings enough incentives to do so especially if decentralisation includes allowing units to raise fees and retain the income - since this gives the facilities incentives to target the better off who can pay. Therefore, as in the previous discussion, policy measures to give decentralised units incentives to serve the poor need careful design. Further thought is required on this and the related issue of fees and exemptions (which is discussed further below), to look at conditions in which the option is relevant and measures which can help avoid distortions.

Decentralisation can include delegating authority to hire and fire staff. This should allow for significant improvements in efficiency as surplus staff and poor performers can be removed, and managers' authority over staff is increased. It could be argued that staff reductions would increase poverty, especially in rural areas with few employment options especially because the surplus is often in low skilled and casual workers who have less chance of self employment. However, this is not a reason not to improve efficiency of the service - though there may be issues in the choice of who is laid off.

c) Giving the community a role in managing decentralised units, through a hospital board or similar:

This type of approach has been introduced over the last 10 years or more with the idea of making health facilities more responsive and responsible to the community. It is consistent with current thinking about participation as a means to improve and monitor services. It should provide an opportunity for the local community to ensure their poorer members are looked after and to ensure the staff treat all members of the community fairly. For example, a review, quoted by Gwatkin, of schemes for individual targeting showed that schemes worked better where it was not the health staff who selected who should be exempted. Local committees can play this role.

Lessons from experience in Uganda suggest there can be some good effects at local level, where health unit management committees were locally elected. However, there were also bad experiences of committees taking opportunities to benefit from clinic revenues and services, without a concern for the poor. This partly depends on the composition of Committees or Boards, particularly for hospitals: it is usual to recommend that Hospital Management Boards are selected for their expertise and they may not be interested or able to represent interests of poor users. Further thought and review of experience on the issue of how to make the local participation effective would be useful.

d) Introducing quality assurance arrangements:

In general, quality assurance should benefit all users of services, poor or rich. However, there is a question around the impact of specifying relatively high standards for services, such as those considered desirable by the leading national specialists in the referral hospitals. If the standards can only just be achieved by the leading hospitals, they may use this as a lever for arguing their funding should be protected or even increased, making it more difficult to increase the funding for peripheral units. However this effect is not inevitable - politicians may conclude that the smaller units, which have a greater gap between existing quality and the standards, merit more resources.

With relatively high standards, it can also be argued (as in the UK) that the standards can only be achieved in these leading institutions so smaller providers should be shut down. Given the findings of Alderman and Lavy, one

can conclude that a centralisation of facilities would tend to reduce access for the poor (assuming there would otherwise have been reasonable quality levels at a more local facility).

Thus, while quality assurance mechanisms are likely to benefit all users, it is important to implement them realistically. Lessons from experience on this may be worth further analysis.

Key issues: staff incentives and the role of the public

The range of management reform measures have the potential to improve service delivery in the public sector and can also enhance the focus on services for the poor. However, they may not be sufficient without addressing further the key issue of creating the motivation for health workers to improve their services and in particular to offer services to the poor. Various options are available such as involving the community in supervision, topping up salaries, paying allowances for specific activities, using fee revenues to pay staff. Filmer et al conclude a range of measures are likely to be required. At present the development agencies do not have a common view on this issue even at country level there are rival approaches in operation, and it seems an issue worth further work.

An interesting paper by Tendler and Freedheim describes a preventive health programme set up in Ceara state in Brazil, in which 7,300 preventive workers were hired to work in their local community. The programme was successful in that the infant mortality rates was halved and vaccination rates tripled, and the staff were enthusiastic despite receiving only the minimum wage. The article describes factors in the design of the programme which helped to motivate the staff and help its implementation, including the fact that the staff were selected by the state, not by the local government, reducing opportunities for patronage; the programme was publicised heavily to the community so they knew what to expect; and the programme only began in an area if the local mayor chose it and provided funding for the supervisors. What the article indicated is that careful design and selection methods, plus community involvement, led to a public sector programme of remarkable success.

It also demonstrates the key role that public pressure and information can play in motivating staff and helping the community to supervise them. Frequent publicity campaigns, including boasting about the effects of the programme on mortality and prizes for the workers, seem to have helped. It would be useful to know if there are other examples where this type of public awareness have been successful and whether this should be encouraged in other countries as a policy to help improve service performance. This could also cover other lessons from public information and communications efforts and whether these reach the poor.

5.2.3 Regulating and improving performance of the private health sector

Whilst all agree this is critical, how to achieve it is less clear. The scope for simply closing down or prohibiting some of the untrained and unskilled practitioners varies from country to country and may not be realistic in many cases. Furthermore, it may not be desirable if these are the providers which actually reach the poor - there may be more mileage in trying to improve their performance.

The mechanism in many developed countries is for professional self regulation, since it is in the professions' interest to maintain quality and restrict entry. This can help with ensuring practitioners are registered and not using actively harmful practices. It does not protect against general over treatment and unnecessary diagnostic procedures. Options for this could include prohibiting medical doctors from selling drugs or owning diagnostic facilities; developing capitation funding and related approaches; and inspection. The history of professional self regulation in Europe may also provide some useful lessons.

One issue which seems to be key is the regulation of drug quality, maintaining affordable drug prices and limiting distribution to those with some knowledge of appropriate use. Most countries have an essential drug list and many have policies for use of generic drugs but these may not extend in practice or in principle to the private sector. Ensuring the drugs which people buy are of proper efficacy and at reasonable cost is a critical role and one which will have a major influence on the health of the poor, particularly since they are likely to purchase drugs from shops or traders without professional advice. The importance of access to drugs is shown by the estimate, quoted by Alderman and Lavy that a doubling of the price of antibiotics increased child mortality by 50% in Ghana. This is a policy issue in which Governments can have a major role, and there are various options including strict control of drug licensing, testing, price controls, generic drug policies, increased competition in supply, local production and training of pharmacies. However, it is also a difficult area with vested interests domestically and internationally. Further work on the policy options available and the implementation issues encountered in practice would be useful.

Another issue is the case for providing training and supplies for unqualified health workers. Traditional Birth Attendants have been given training and sometimes supplies in many countries over the years, but there is disillusionment about the value of such approaches, partly because in many cases, there are so many TBAs that training all of them was seen as too costly, and the projects were found to have limited impact. Clearly to be effective, they should all be trained. Recently attention has shifted to training drug shop workers, often linked to their role in offering social marketed products such as contraceptives and in some cases, medicines. As these are the providers the poor actually use, this seems a sound approach. It may face opposition from professional interests - for example, in Bangladesh

discussions with the MOH on devising initiatives to improve the private sector, the MOH steered consultants to focus on qualified providers.

Training is not enough - there needs to be a mechanism for prospective users to know the provider is trained and monitored. Options such as franchising and certifying trained providers have been tested for informal providers, mainly in the FP field. Further work on experience from this and its relevance to the poor is required.

5.3 Avoiding heavy expenditures by the poor on health care which exacerbates their poverty

Policies considered here include

- user fees for services used by the poor, possibly with exemptions or waivers for target groups
- health insurance through formal social schemes
- community and local insurance type initiatives

5.3.1 User fees:

This is one of the controversial areas about which there is a huge literature. There is some evidence (e.g. Litvack & Bodart's case/control study in Cameroon) to show the poor can benefit if increased fees are accompanied by improved quality (measured in this case by drug availability). This was the premise of the Bamako Initiative and is supported by Alderman and Lavy's analysis, which found that increases in quality can more than offset the deterrent effect of increased fees, and this applies to the poor as well although to a lesser degree - they see distance to services as more important than quality in attracting the poor. However, the fact that fees can be more than offset by quality improvements does not mean it will - the key is the way fees are introduced and the incentives to achieve those gains in quality.

Without quality gains, it is clear the poor are deterred by fees. Exemptions for individuals have had limited success. Does this suggest user fees policies should be abandoned in low income areas, or are there ways to protect the poor from fees or assure their drug supplies? There are options for design which will limit the cost for individual patients, such as:

- setting a limit on total fees or the number of inpatient days for which fees are payable (as in Kenya); is there evidence that this benefits the poor or are they unable to support the non-fee costs of hospital care such as extra drug purchases and providing food and personal care for the patient?
- The practice of having free or low cost beds for the poor as is common in Asia, with lower quality to deter the better off patients. Yet it is criticised for still subsidising the better off patients who pay subsidised fees.

- Health facilities can allow credit, so patients without money available can pay later when they have money (as in Kenya and by local decisions, in Uganda).
- Exemption schemes for the poor can be backed by funding, as in Ghana.

Since so much attention given to this issue it may be appropriate simply to summarise experience and lessons in this area, using materials already available such as the SPA guidelines on fees for social services.

5.3.2 Health insurance, particularly social insurance:

Many countries are considering social insurance as a means to cover the population against high costs of severe illness, and it has been introduced in many countries for the employed population. There are fewer cases where it also covers the informal sector and poor, through a contribution for the latter from the Government. This is the case in much of Europe and in some middle income countries such as Chile. The feasibility of this model is probably limited to countries which have a relatively small non-employed sector/poor population and to a reasonable level of funding per capita - it is difficult to see it achieving an adequate level of funding in a low income country (except to the extent that state funded services are a sort of social insurance). Indonesia is aiming to try this model with managed care schemes for the entire population, using social safety net funds to fund contributions for the poor. In general we have doubts about the financial feasibility of this model in low income countries; further work could look at the conditions for success of such a model.

The alternative is to see such insurance as a means to get the non-poor to fund their own health care so that government funding can be freed up to fund services for the poor. There are major risks however: firstly, that the scheme will not in fact be self financing, so Government ends up subsidising a scheme which excludes the poor; and secondly, the risk that this will lead to the sort of two tier system seen in some Latin American countries, and declining interest at a political level for supporting health services for the poor.

5.3.3 Community health insurance and local solidarity schemes:

There have been many initiatives to develop community based health insurance, so that community members contribute a small amount of income which covers their health care costs. There have only been two schemes on a large scale, in China (which has now declined) and to a lesser extent in Thailand, and there have been few initiatives that raise enough for hospital services. Yet it is for hospital care that the highest costs are incurred, and for which risk sharing is most appropriate as the probability of a family needing hospital care is small. There are exceptions, such as Bwamanda in Zaire and Kisiizi in Uganda which covered hospital care.

The WHO led review of 82 health insurance schemes for people outside formal employment (Bennett et al) found great diversity in the schemes, but concluded that very few reached the poorest households. This is not to say they can not reach the poor rather than the poorest. However the many problems in scheme design and the substantial administrative complexity and costs have militated against their proliferation in poor communities. Furthermore, in low income countries the pre-requisites for schemes to take off in poor communities are often lacking - in particular, sufficiently reliable quality in health providers so the community trusts they will receive care when they need it; and substantial user fees for using services if one is not insured.

Recent initiatives are looking at a micro-credit model for improving access for health funding. This has advantages but could also carry the risk of encouraging high expenditure on an illness which a poor family or community cannot really afford. The model for community insurance is often local solidarity and traditional arrangements for sharing the costs of burials or even for transport to hospital. However, there is a big difference between community pooling resources for activities such as transporting patients to hospitals or funerals, where the total cost is limited; and the case of medical treatment, where (particularly for conditions like AIDS) the costs are almost limitless and it is difficult for the community to manage. Basically, a village is likely to be too small a risk pool to cope with high cost treatment, when this is the main role for such a fund.

The Bennett study and other work has shown the importance of Government setting an appropriate regulatory framework or design principles for development of insurance schemes, in order to avoid problems in implementation including cost escalation and exclusion which would tend to make the scheme unaffordable for the poor. Government can also provide support to assist development of such schemes. Further work could expand on the scope of such policies and the conditions for their success of schemes serving the poor.

5.4 Other policy issues

5.4.1 Resource allocation

A common issue in many countries is that although they have stated their priority to be Primary Health Care or basic services, in practice they have not been able to shift the share of government resources in favour of the primary sector. This reflects the fact that much of the health budget is absorbed by salaries and running costs for existing facilities, particularly hospitals which are resource intensive. Despite this, public hospital services in low income and many middle income countries have declined with a fall in real funding levels and efforts to replace this with fee income have had a limited impact. In practice, hospital costs are supplemented by additional private expenditure

on drugs, food and unofficial fees, (which reduces access for the poor who cannot afford the extra inputs).

The rational approach is to review the number and distribution of hospitals, with a view to closing or reducing the size of some of them, in order to improve others and release resources for other services. In practice these are extremely difficult decisions to take, in any country.

The case for shifting resources to primary care is sometimes argued based on the findings of benefit incidence studies (see section 3 above) which show the poor benefit more from these subsidies than the subsidies to hospitals. It is argued that if more subsidy goes to primary services, more reaches the poor. Whilst this is true, it is not clear that this argument should be followed too far since hospital care is too expensive for the poor and in low income countries, for many others in the population. The approach would make sense if it were possible to target the remaining hospital subsidies so they reach the poor - but as discussed above, success in targeting the poor is limited. Therefore one could argue the opposite case - that public subsidies should be targeted on hospitals since hospital care is too costly for the poor - whereas they can usually afford basic primary curative services.

There is also the issue of geographic equity in allocation. Since resources typically follow facilities, the variation in allocation per province depends on how equitably facilities are distributed. Commonly the capital has a high proportion of hospitals and expenditure, as well as the highest average income. Some countries have managed to introduce measures to improve allocation, for example in Uganda, decentralisation provided the impetus for allocating PHC resources on the basis of population and need factors (including the Human Development Index for the district). This demonstrates the feasibility of such a policy although it may be useful to consider other examples to learn lessons for implementation of such policies. It would seem that at least for public health, a population based approach to resource allocation (preferably also with need factors) should be an accepted policy.

Whilst allocation of finance is part of the issue, a major problem in some countries is allocation of staff - with difficulty getting staff to move to the less favoured regions and services. There are many approaches to this issue but few have been shown to work well. A funding arrangement which recognises the problem can allow for extra incentives for staff who work in hardship posts (as tried in Uganda unofficially, with some success). Other approaches include training people from those regions and other motivation such as access to further training. It returns again to the issue of staff incentives which has been raised above, on which development agencies need to develop clearer policies.

5.4.2 Sector Wide Approaches (SWAPs)

The idea of a SWAP is that Government and development partners negotiate and agree on sector policies and resource allocation, and then the partners support a joint programme of work to implement those policies. A SWAP therefore provides an ideal opportunity for discussing and agreeing on the types of policy discussed above, and on how best to ensure the poor are catered for in the health sector. If a sound policy can be agreed, this approach should have greater impact on the poor than the more conventional approach of supporting projects in districts which are relatively poor or supporting programmes for particular diseases of the poor, while neglecting other of their health problems.

If, however, the government is not interested or able to agree on pro-poor policies, then it may be preferable to earmark support for the health sector. This could as well be for drugs and supplies which address needs of the poor (e.g. vaccines, TB drugs and family planning supplies) as for geographically targeted services; support through NGOs; or support to communities so they can choose how best to address their problems (eg through social funds).

Basically therefore the suitability of a SWAP will depend on the policy debate and this is not an issue in itself which requires further work.

6. Monitoring the impact of health policies

It will be important to monitor the impact of health policies on the health of the poor and on their access to and use of health services. The discussion above suggests that the impact on the poor will often depend on the details of policy and strategy design and implementation, rather than the broad policies adopted, so monitoring becomes increasingly important in a way which allows for fine tuning during implementation.

Much of the health information collected routinely by the health system is not particularly useful for monitoring illness or service use by income group. The idea of poverty profiling, referred to above, may be useful in some situations. In this approach, certain indicators are used to define characteristics of the poor. If this is then used to identify where they live more work can be done on their use of services - as with post code analysis in the UK. Similarly surveys can draw on this type of profiling to classify responses, without the need to assess incomes.

One concern is to avoid duplicating work. We understand there is already considerable interest in the World Bank to develop an approach (particularly for Africa) that would be more comprehensive than the previous Living Standards Measurement Surveys. DFID is also interested in the issue and concerned to combine participatory assessment with survey based techniques. UNDP is testing approaches in selected countries. In Asia there are various poverty assessment mechanisms in place, and others being proposed - e.g. in Indonesia. There are also various existing sources

including household expenditure surveys, DHS and UN Habitat urban surveys.

Further work is needed first to specify the information that would be required, and how detailed it needs to be. Then we can review the adequacy of existing sources and consider cost effective ways to monitor impact of health policies on the poor. This will need to consider how far the needs of the health sector can be met by broader poverty monitoring and what more specific health related monitoring would be useful and cost effective.

7. Summary of issues for further work

Further work could help to elucidate guidance on pro-poor policy options. Some of the key outstanding issues are set out in the following pages.

1. Demand Side

a) How to encourage the poor to access appropriate health services when they need it

Problem : the poor suffer more ill health than the better off. They are far less likely to access appropriate care, either not seeking care at all or seeking inappropriate care which may exacerbate their poverty e.g. self treatment, costly yet ineffective treatment in the private sector

- Evidence and guidance on the potential for public awareness and education so they know what to expect from services and what are sound medical practices (as opposed to more traditional health education) as a means of promoting improved health seeking behaviour
- How to get better evidence on constraints to access (financial, social, physical etc)

b) How the poor can influence which services are delivered, and the way they are delivered

Problem : the poor have little or no say in what services are provided. The way services are provided often presents a further barrier to access

- How to identify which types of community participation are required/demanded
- How to involve the poor in defining the basic package/influencing the purchaser
- How to develop appropriate models of community participation
- How to ensure such models actually influence the decision making process e.g. ensuring the effective composition of management committees and inputs of the local community

c) How to achieve better intersectoral collaboration

Problem : health interventions have a relatively minor impact on health status certainly in comparison with interventions in other sectors. Health impact could be enhanced if intersectoral efforts could be more coherent

d) How can Ministries of Health become better advocates of non health interventions which have a major impact on health e.g. water and sanitation, female education

How can Ministries of Health collaborate better with donors and with other key sectoral Ministries notably Ministries of Finance and Local Government)

- Process – how do they do it?
- Institutional structures – which structures work?

2. Supply Side

a) Whether to, and how to, develop a Pro Poor Basic Package

Problem : Ministries of Health try to do too much with too little. As a result quality suffers. There is a need to define an affordable range of services which can have a significant impact on health status.

- Is the definition of a basic package the best way forward
- Is the package sensitive to the needs of the poor
- Which criteria should be used to ensure the basic package is pro poor? (DALYs and Burden of Disease approaches are not intrinsically pro poor)
- How should chronic/debilitating diseases which affect livelihoods of individuals and households be covered in the basic package

b) How to deliver a Pro Poor Basic Package

Problem : Generally very little current public finance is currently being used to deliver elements of the basic package; it is difficult to dramatically reorient health systems.

- Need to identify who will deliver it – e.g. what is the role of the private sector, can incentives be used to increase the role of the private sector in the delivery of public health services/personal services within the basic package
- Which institutional approaches are best placed to ensure the effective delivery of a basic package. How can the purchasing function be strengthened? Is a purchaser provider split required or can it be done in other ways? What preconditions must be met for this to work? What incentives are required to ensure that there is active purchasing in the interests of the poor?
- How should the basic package be financed (role of user fees and exemptions),
- How to reconcile the supply led basic package approach with the demands for other (non-package) services by health facilities and prevent crowding out of basic package.

c) How to improve the performance of the public sector

- i) in delivering basic package services and
- ii) (in the short term) in delivering non core services

Problems : Although often acting as a safety net for poor groups public services have systematic weaknesses which mean services are usually not of acceptable quality.

Organisational Structure/Management

- How to strengthen Ministries of Health in their role as overseer/moderator of health services (restructuring, training etc)
- How to identify mechanisms which would help make decentralisation effective and pro-poor in impact
- What forms of autonomy can improve the performance of health services. What are the preconditions.
- Is there a role for more explicit contracting for services? Can pro poor service agreements be developed and implemented? What is the role for contracting out of non clinical and even clinical services – impact on cost and quality?

Resource Allocation

- How, and how quickly, can resources be reallocated to pro poor focused services given political constraints. Is it feasible to close hospitals? How? How can savings be redirected to PHC
- How to assist Ministries of Health/districts develop appropriate capital development programmes i.e. focusing on investment in providing basic package services in underserved areas not new hospitals. Developing appropriate physical planning guidelines. (Key role of donors in this as financiers)
- How to ensure that facilities serving the poorest are adequately financed and staffed. How to define appropriate funding levels.

Human Resources

- What approaches are effective in encouraging appropriate staff to serve in remote areas and work productively
- Develop thinking on incentives for staff to improve performance in both public and private sectors (and the position of donors on this issue)
- Review experience on training and certifying the unqualified health workers used by the poor
- How to control the private activities of public servants and leakage of publicly funded goods e.g. drugs into the private sector. How to control unofficial fees
- How to control corruption more generally

Monitoring/Supervision Role

- How to monitor the delivery of services. How can the quality assurance function be best carried out. Which tools are available to ensure that the

poor have access to services e.g. definition of service standards, service agreements explicitly referring to the poor

- What other tools are available for influencing the performance of health facilities

Drugs

- Review drug policies to control/restrict the range, price and distributors of drugs – especially those used by the poor. Which approaches work? Where are the current weaknesses? (This is vital – e.g. 75% of private expenditure which may account for 60-75% of total health expenditure is accounted for by drugs)

d) How to improve the performance of the private sector

Problem : the poor spend significant amounts of money on accessing services from the formal and non formal private sector. Much of this treatment is either ineffective or harmful; the financial consequences are also often severe.

- Which forms of regulation work in which circumstances? Can self regulation work? What skills are required.
- What role for other approaches – legislation, training, accreditation, quality assurance, franchising
- Incentives – what incentives are available to improve the performance of the private sector (i.e. the carrot rather than the stick)

e) Health financing

Problem : in most developing countries private expenditure accounts for the majority of health expenditure. This is an inequitable means of financing health care. How can the limited public funds be best used in such circumstances to reduce such inequities

- Clarity on how the basic package should be financed. Publicly financed or public financing as a last resort? Should MoH fund PHC which people will pay for and not hospitals which they won't or vice versa?
- Which overall health financing approaches are the most equitable (general taxation, social insurance, user fees etc). Does MoH have control over this? Some MoHs wish to recapture the private expenditure or are we realistically looking at living with the inevitable growth in the importance of private expenditure
- Summarise thinking on user fees, exemptions and how best they can be designed to enable access for the poor
- Further analysis of when it is appropriate to channel Government funding through health insurance agencies and how to introduce insurance in ways which will not disadvantage the poor
- How to provide protection to the poorest from catastrophic expenditure

- How to improve the allocation of scarce resources. How should resources be reoriented to best help the poor? Which criteria can be used to ensure that resource allocation formulae take account of the extent of poverty? How quickly can reorientation be achieved?

e) Improving The Evidence Base

Problems : we know too little about what causes ill health in the poor, too little about determinants or indicators of poverty and lack the tools for monitoring the impact of health policies on the poorest

- How to improve our knowledge on the determinants of ill health
- How to improve our ability to better identify the poor
- Monitoring and evaluation of the impact of health policies on the poor
- What are key issues to monitor
- how far will existing and proposed mechanisms meet this need and what new information would be required

Key Questions

- Do we have answers to any of the above questions?
- What work is currently ongoing in these areas?
- Is the list comprehensive?
- Should further work be commissioned? By whom? Who will do it?
- How should the work be prioritised

Bibliography/references

- D Acheson et al, 1998, **Independent Inquiry into inequalities in health**, Stationery Office
- H Alderman & V Lavy, 1996, **Household responses to public health services: cost and quality trade-offs**, The World Bank Research Observer, vol 11, no. 1, pp 3-22
- S Bennett, A Creese & R Monasch, 1998, **Health Insurance Schemes for People outside formal sector employment**, WHO [check ref]
- G Bloom & H Lucas, **Health and Poverty**, draft paper for a meeting on Africa, March 1999.
- G Bloom & D McIntyre, 1998, **Towards Equity in health in an unequal society**, Soc Sci Med, Vol 47, No 10, pp 1529-1538
- G Carrin & C Polliti, 1996, **Exploring the impact of economic growth, poverty reduction and health expenditure**, WHO Macroeconomics and Health Series, No 18
- F Castro et al, 1997, **Public Social Spending in Africa: Do the Poor benefit?**
- Chambers. **Poverty and Livelihood: Whose reality counts?** Institute of Development Studies. Discussion paper 347.
- DFID, 1997, **Eliminating world poverty**. A challenge for the 21st century.
- Ecob & Davey Smith, 1999, **Income and Health: what is the nature of the relationship?**
Social Science & Medicine 48 (1999) 693-705
- D Filmer, J Hammer & L Pritchett, 1998, **Health Policy in Poor Countries: Weak Links in the Chain**, World Bank Policy Research working Paper 1874
- D Filmer & L Pritchett, 1997, **Child Mortality and public spending on health: How much does money matter?**, World Bank
- D Gwatkin, 1999, **Poverty, Equity and health in the developing World - an overview**, Draft, 1999
- Gwatkin & Fragueiro, 1998, **Multi-country study programs on Equity, Poverty and Health** under way as of June 1998 - a compendium of information for the World Bank.

Howarth C, Kenway P, Palmer G, Street C. **Monitoring poverty and social exclusion**. Labour's inheritance. Joseph Rowntree Foundation. York. 1998.

K Jayasinghe, D De Silva, N Mendis, RK Lie, 1998, **Ethics of Resource Allocation in developing countries: the case of Sri Lanka**, Soc Sci Med, vol 47, No 10, pp 1619-1625

M Lipto, **Defining and measuring poverty: conceptual issues**. Background paper for Human Development report 1997. 1996 (Mimeo).

J Litvack & C Bodart, 1993, **User fees plus quality equals improved access to health care: results of a field experiment in Cameroon**, Soc Sci Med, Vol 37, no 3, pp 369-383

Binayak Sen, 1997, **Health and poverty in the context of country development strategy: a case study on Bangladesh**, WHO Macroeconomics, Health and Development Series No 26

Sen,B, Begum,S. **Methodology for identifying the poorest at local level**. WHO Feb 1998. Technical paper WHO/ICO/MESD27

M Skold, 1998, **Poverty & Health: Who lives, who dies, who cares?**, WHO Macroeconomics Health & Development Series No 28.

J Strauss & D Thomas, 1998, **Health, Nutrition and Economic Development**, Journal of Economic Literature, Vol 36, June, pp 766-817

J Tendler & S Freedheim, 1994, **Trust in a rent-seeking world: Health and Government transformed in North East Brazil**, World Development, Vol 22, 12 pp 1771-1791

Townsend P, **Deprivation**. Journal of social policy. 1987:16;125-146.

D van de Walle, **The Distribution of subsidies through public health services in Indonesia**, 1978-1987, in van de Walle and Nead, 1995, Public Spending and the Poor, World Bank