Beyond health gain: 
the range of health system benefits expressed by social groups 
in Mexico and Central America

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Abstract

Current health reform proposals in most developing countries stress health gain as the chief evaluation criterion. Essential service packages are formulated using cost-effectiveness methods for the selection of interventions without sufficient regard for other factors that are significant for successful implementation and acceptance by the needy. This paper presents the results of research undertaken in Mexico and Central America to test the hypothesis that population groups view health gain as only one among several benefits derived from health systems. The goal at this stage was two-fold: (a) to identify through qualitative methods the range of benefits that are significant for a wide cross-section of social groups and (b) to classify such benefits in types amenable to be used in the development of instruments to measure the benefits intended and actually produced by health systems. Fourteen focus groups were undertaken in Costa Rica, El Salvador, Guatemala, Mexico and Nicaragua representing diverse age, gender, occupation and social conditions. Six major types of health system benefits were identified besides health gain: reassurance/uncertainty reduction, economic security, confidence in health system quality, financial benefits derived from the system, health care process utility and health system fairness. Benefits most often mentioned can be classed under health care process utility and confidence in system quality. They also have the most consensus across social groups. Other benefits mentioned have an affinity with social conditions. Human resource-derived utility stands out by its frequency in the range of benefits mentioned. Health systems and health sector reform proposals must emphasise those aspects of quality related to human resources to be in accord with population expectations. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

It has been standard practice to assess the benefits of health systems in terms of health gain and the cost-effectiveness of service delivery. The World Bank’s 1993 World Development Report stressed the merits of guiding health investments by these tenets, arguing that such decisions would allocate resources to safe, socially acceptable and equitable interventions producing maximum health gain (World Bank, 1993). Effectiveness is thus subsuming the issues of equity, quality and social acceptability. However, population groups view health gain as only one among several benefits derived from health systems (Mooney, 1994, 1995; Mooney, Jan, & Wiseman, 1995), while policy makers combine decision criteria informed by poverty reduction and individual welfare concerns as much as by health gain (Hammer & Berman, 1995).
The current trend in the design of health care packages promoting cost-efficiency considerations at the expense of other methods risks renewing past trends in rational policy making that have been previously proven unsuccessful (Zwi & Mills, 1995). There is also the danger of furthering a particular ideology that reduces the health benefits of individualised services, undermining their value as public goods (Ugalde & Jackson, 1995; Laurell & Arellano, 1996).

Health gain, as defined by medical science and practice, is normally considered by decision makers as the chief benefit of health services. However, this value is accompanied by latent benefits valued, but not always voiced, by a wide range of actors in the health system. Taken as a whole, these other values may play a more important role than health gain in the shaping of health systems. These wider ranging values, such as a sense of security or justice, involve socially constructed perceptions of the health system as a complex set of present and future expectations at various levels of reality. It is thus necessary to conceptualise the range of benefits that health systems have for users and the population at large, how they are related to health gain, and the trade-offs and demands social groups are prepared to make across them.

An understanding of the range of benefits that are important to the population is a necessary component of effective and participatory policy-making. Studies leading to the understanding of such benefits as well as strategies involving the community are currently being undertaken to design health plans facing competitive pressures (Preus, 1995; Sainfort & Booske, 1996) or where service rationing has been the chief policy to extend insurance coverage to the poor (Brannigan, 1995). The shaping of local health service programmes by social participation has also been a subject of study (Cohn, 1992). Other studies have sought to obtain the public’s views towards wider health reforms affecting whole health systems (Blendon, Knox, Brodie, Benson, & Chervinsky, 1994; Donelan, Blendon, Benson, Leitman, & Taylor, 1996; Ahmed, Urassa, Gherardi, & Game, 1996; Shmueli, 1996; Barraclough 1993). Perceived social benefits of health systems beyond health gain have been recently studied in the context of health reforms (Jacobs & Shapiro, 1994). The interaction of different health care process benefits have also been studied in relationship to overall satisfaction (Zapka et al., 1995).

On the whole, these studies explore the determinants of user or beneficiary satisfaction at two extremes: system-wide satisfaction and the delivery processes in very specific health organisations. The former, by their very nature, say little on the perception of system components and the weight of each towards overall evaluation. The latter focus on very specific processes which are useful to re-design the delivery process but that fail to give an appraisal of benefits that are beyond health gain or the process of service delivery. None of these studies have asked the fundamental question of the quality, range and hierarchy of benefits that are behind the public’s demands and expectations at the various levels of the health system. Furthermore, instruments developed so far are inappropriate to ensure social participation in developing countries, where whole health systems are rapidly evolving in the face of cultural differences and inequality and where health markets and competition are only emerging issues.

The attainment of efficiency in the production of health gain in developing countries has been counterpoised to the seemingly irrational logic of other perceived benefits. Social participation has been eschewed as it leads to seemingly irrational choices perceived by policy-makers as harmful to the same social groups. This widening gap between policy-makers and society has not yet been studied. This is of concern as health system reforms are being introduced without the kind of social participation that can assure their acceptability and success.

The purpose of this paper is to describe the quality and interconnections of the widest possible range of health system benefits as perceived by various social groups in developing countries undergoing health reforms. Mexico and Central America was selected as an appropriate sub-region where these benefits can be identified given that important health reforms affecting diverse population groups are being implemented with similar technologies and bases of support. Research is currently being undertaken to provide further evidence on the range and characteristics of benefits that are actually produced by health systems in the region. These benefits will be contrasted with the reform initiatives that are transforming health systems. Guidelines will be proposed to design instruments to support the measurement and co-ordination of diverse health system benefits in the decision-making process.

Mexico and Central America provide appropriate countries to study in a comparative framework as they share, with one exception, a similar health system segmented into a Ministry of Health, social security and the private sector, providing services to largely exclusive groups with little coordination and regulation. Ministry of Health services cater mostly to the rural poor and the urban uninsured. Social security systems are tri-partite contributive systems catering for the employees of the formal sector, mostly in urban areas. These range from as high as 55% in Mexico to as little as 6% in Nicaragua. In contrast, Costa Rica has a unified public system covering 95% of the population, yet it faces the problems of a public monopoly, expressed in low quality and efficiency.

In segmented systems governments are facing inequality and exclusion through similar policies. Guatemala is
reducing the 46% gap in services through basic care delivered in part by the non-government sector. In Mexico a package of basic services is being introduced to substantially reduce the population that lacks access to services, standing at 10% in 1994. Sweeping reforms are also being introduced to the social security services covering 55% of the population. In Nicaragua access to services is being expanded through a basic package of services addressing the 25% of the population without access. El Salvador is extending health services as part of a poverty reduction initiative. Approximately 16% of its population are covered through social security services. Costa Rica is addressing the problems of a public monopoly by decentralising the universal social security provider and introducing performance agreements.

Methodology

A multiple-country design was chosen as a means to obtain data that could serve to construct in the future instruments to assess and compare health reforms internationally and particularly in Mexico and Central America. Focus group methodology was chosen as a proven method to obtain the widest possible range of interpretations concerning the benefits of health systems. Focus groups with contrasting social characteristics were selected to obtain a cross-section of the population with access to public or private modern health systems (Table 1). This meant selecting approximately three quarters of the groups in urban areas and a quarter in the rural. Groups were observed in those countries where they were most representative and easy to observe.

The selection of focus group participants is a fundamental feature of this methodology, seeking homogeneity within each group so as to enhance its peculiar characteristics and the group consensus vis-à-vis other groups. Accordingly, selection criteria were rigorously specified and followed with only minor exceptions in the recruitment of participants. The weight of individual variation across group participants due to personality traits such as leadership or shyness were minimised through appropriate motivation on the part of the moderator and the monitoring of group dynamics by an observer. In 10 out of the 14 focus group discussions the participants’ profile and participation was considered excellent after evaluation. In the remaining four, minor problems were experienced, such as small groups, lack of motivation and inadequate profile of some attendees.

In all, 122 individuals participated in 14 focus groups. Adolescents, adults and elderly were covered, although most participants were adults (76%). Females accounted for 58% of the total. General occupation groups were home-makers (26%), students (6%), pensioners (8%), peasants (7%), workers (30%), service sector workers (14%) and informal sector workers or under-employed (9%). Rural informants accounted for 23% and urban for the rest. Insured participants were 78% of the total. This group is over-represented with respect to the reality in the different countries, yet this study did not aim to be representative, but rather to capture cultural and social differences.

Among the uninsured are very poor urban slum dwellers (FG4), very poor indians (FG7), poor urban women (FG3) and small land-holder peasants (FG6). Among the insured are included unionised agricultural

<table>
<thead>
<tr>
<th>Insured</th>
<th>Participants</th>
<th>Sex/age</th>
<th>Context</th>
<th>Country and city</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle class home-makers (12)</td>
<td>4</td>
<td>F 35–45</td>
<td>Urban</td>
<td>Mexico, D.F.</td>
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<td>Middle class students (11)</td>
<td>8</td>
<td>F 14–18</td>
<td>Urban</td>
<td>Mexico, D.F.</td>
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<tr>
<td>Female service workers (1)</td>
<td>10</td>
<td>F 20–50</td>
<td>Urban</td>
<td>Costa Rica, San Jose</td>
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<tr>
<td>Bureaucrats (8)</td>
<td>7</td>
<td>M 25–50</td>
<td>Urban</td>
<td>Guatemala, Guatemala</td>
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<td>Pensioners (10)</td>
<td>10</td>
<td>M 50–65</td>
<td>Urban</td>
<td>Mexico, D.F.</td>
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<tr>
<td>Industrial workers with benefits (13)</td>
<td>6</td>
<td>M 35–45</td>
<td>Urban</td>
<td>Mexico, D.F.</td>
</tr>
<tr>
<td>Industrial workers without benefits (5)</td>
<td>10</td>
<td>M 25–60</td>
<td>Urban</td>
<td>El Salvador, San Salvador</td>
</tr>
<tr>
<td>Insured agricultural labourers (8)</td>
<td>9</td>
<td>M 22–40</td>
<td>Rural</td>
<td>Costa Rica, Guapiles</td>
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<td>Female assembly plant workers (9)</td>
<td>10</td>
<td>F 20–35</td>
<td>Urban</td>
<td>Mexico, Tijuana</td>
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<td>Poor urban women (14)</td>
<td>8</td>
<td>F 25–60</td>
<td>Urban</td>
<td>Mexico, D.F.</td>
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<td>Not insured</td>
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<tr>
<td>Small land-holder peasants (6)</td>
<td>9</td>
<td>M 20–50</td>
<td>Rural</td>
<td>El Salvador, San Salvador</td>
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<tr>
<td>Poor urban women (3)</td>
<td>10</td>
<td>F 30–50</td>
<td>Urban</td>
<td>Nicaragua, Managua</td>
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<tr>
<td>Indians (7)</td>
<td>10</td>
<td>F 20–50</td>
<td>Rural</td>
<td>Guatemala, San Juan Sacatepequez</td>
</tr>
<tr>
<td>Adolescents in extrema poverty (4)</td>
<td>11</td>
<td>F 14–21</td>
<td>Urban</td>
<td>Nicaragua, Managua</td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>F=71 M=51</td>
<td></td>
<td>U=11 R = 3</td>
</tr>
</tbody>
</table>
labourers (FG2), poor urban women with partners mostly in the formal sector (FG14), service sector women (FG1), male industrial workers with very low wages (FG5), female maquiladora workers (FG9), unionised industrial workers with extensive benefits (low middle class) (FG13) and middle class homemakers and students with both insurance and access to private services (FG11 and FG12).

The standard format for focus groups was followed, identifying through local contacts and leaders six to 10 individuals of homogeneous social, gender and age characteristics. In-kind or small cash compensation amounting to a day’s work were given to most participants. Two trained facilitators co-ordinated the groups. One of them, female, conducted the group with participants. Two trained facilitators co-ordinated the amounting to a day’s work were given to most characteristics. In-kind or small cash compensation amounting to a day’s work were given to most participants. Two trained facilitators co-ordinated the groups. One of them, female, conducted the group with maquiladora women, while the other, male, conducted the rest.

A rapporteur gave feedback back to the co-ordinator on the basis of the discussion guide. An assistant provided comfort to participants and recorded the sessions. Sessions lasted for 1.5 h on average while the longest session took 2 h and 20 min.

Participants were introduced to the session by the facilitator stating that the project aimed to improve health services by finding out what were the groups’ expectations with the health system (see box with key prompts used). The facilitator was instructed to focus participants’ discussion on the health system as the whole set of financial, administrative, regulatory and service institutions, including private and public providers of modern and traditional care. The purpose of this wide definition was to avoid a moderator-induced bias towards health utilisation that would privilege health gain benefits. Participants were first encouraged to present their aims in life or their most important concerns in order to place the discussion in the widest social context and to avoid a bias towards curative health service utilisation. These descriptions were also useful in characterising each group. Thereafter participants were asked to discuss the importance of being healthy in order, again, to place the subject as far as possible in the field of health rather than disease.

Once participants were placed in the desired context, they were asked to narrate in detail experiences with health services or with persons or institutions that helped them remain healthy. The facilitator was instructed to orient description and discussion of all the stages of the illness episodes, when such episodes were narrated. After each narrative the group was asked to react with their opinion of alternative courses of action or outcome. The purpose of these descriptions was to provide the group with an opportunity to mention benefits expected of the health system in the context of concrete personal experiences. At this time participants were given the opportunity to describe and discuss complaints with and benefits expected from the health system.

The last segment of the session was dedicated to brainstorming of complaints or benefits of health systems, giving participants the opportunity to go beyond individual experiences. Benefits were listed on a flip chart and agreement was sought from the group on the definition and degree of generality of each complaint or benefit mentioned. At this stage the group was asked to identity repetitions of the benefits mentioned to arrive at a final list of non-repetitive, singular benefits (Fig. 1).

Benefits expected from health systems were expressed by group members both as complaints (and less often praise) of health services as experienced in their recent past, and as more formal expectations or benefits. For example, participants could complain of the limited range of drugs offered by government health services. This complaint was interpreted at the content analysis stage as a benefit derived from adequate access to services in order to reduce the uncertainty derived from ill-health.

Focus group recordings were transcribed literally by a professional typist, thus providing a highly accurate description of the dialogues. Transcription followed the order of the session topics (major life interests within each focus group, characterisation of experiences with health services and classification of complaints or benefits from the listings obtained in the last stage).

Fig. 1. Summary of focus group structure and prompts.
In the first stage of content analysis the lists produced at the end of each group session were complemented by adding benefits mentioned in the course of descriptions of experiences and discussion that were not reflected in the group’s final synthesis. The second stage of content analysis consisted of the production of a consolidated list of benefits by eliminating inter-group repetitions. Both stages were supported with the use of a qualitative database in Claris FileMaker Pro for Macintosh structured to classify benefits on an inductive basis.

The third stage of content analysis consisted of the construction of benefit types and sub-types. Analysis proceeded both deductively on the basis of theoretical classification and inductively on the basis of similarities across benefits. The theoretical classification was based on a view of the health system as structure, process and outcome elements.

Content analysis was also undertaken on the descriptions of life interests and experiences with health services described. General groups were established to characterise the types of interests and experiences and thus to establish the general context of benefits.

Results

Life interests and experiences with the health system

The life interests and major concerns expressed by all participants can be classed into six types. In order of the frequency with which they were mentioned they are: health, employment, education, culture and recreation, family and housing.

In all, 92 health system experiences were obtained from all groups. In spite of efforts to obtain experiences from the widest possible health context, most narratives mentioned disease or injury, with preventive activities being the focus of only 5% of narratives (Table 2). Chronic and degenerative illness accounted for 25%, violence and injury for 22%, infectious diseases and nutrition problems 16%, reproductive health 18% and not specified 14%. Out of all experiences 90% were placed in public institutions (social security and Ministry of Health) and 7% in private settings, with 3% not specified.

Most surprising was the medical setting in which the medical care experiences took place. First level services accounted for only 19%, second level hospitals for 13% while high-speciality national or regional concentration hospitals accounted for as much as 65%. This concentration in the third level, which was observed in all focus groups, could be tentatively explained as a result of participants’ selection bias for the most complex health care episodes which produced the greatest impact in their lives. However, most experiences had favourable outcomes: in 63% of cases health was regained completely or births were normal, 16% were still in recovery, 1% suffered some form of permanent disability and 5% resulted in death. In 13% of experiences the outcome was not identified.

Benefits expected from the health system

A total of 551 benefits (4.5 per participant) were mentioned by the 122 participants in the 14 focus groups after final synthesis by each group and complementation at the first content analysis stage. Reduction of inter-group benefit repetition using content analysis of the 14 lists led to 133 distinct benefits (1.07 per participant). In all, 76% of benefits in the first list were mentioned more than once.

Unique benefits can be grouped under 7 major types and 15 sub-types (including two types without sub-types) (Table 3). Confidence in health system quality is the most complex type, with 53 distinct benefits. On average, one of every two participants mentioned one of these benefits. Health gain and health care process utility follow, with 29 and 22. Benefit sub-types can be ranked according to the number of specific benefits included under them (Table 4). Health personnel clearly ranks at the top, with 26 mentions, followed by prevention/promotion with 17.

Benefits were repeated more often across focus groups under the types of health care process utility and economic security, with 87 and 85% of repetitions, respectively. These types have the highest congruence across groups. The type with greatest diversity across focus groups is financial benefits, although the number of benefits mentioned is low by comparison.

I. Health gain

Benefits classified as “health gain” include 29 statements where participants refer to obtaining or wishing to obtain distinct health benefits as a direct result of their interaction with the health system. Given their range these can be classified as promotive or preventive and curative care. (One mention was made of rehabilitation — better care for rape victims.) In spite of the fact that curative health experiences were mentioned more
often than promotive/preventive in the narratives of experiences with services, these latter became more prominent in the final listings and group syntheses. This may have been the result of the moderator’s emphasis in the discussion of a wider range of experiences.

A typical example of the urge for effective health gain is given by a poor urban woman who had a prolonged illness:

Health services should not protract disease, rather they should cure it.

Formal sector workers were particularly preoccupied with occupational health and accidents, thus demanding preventive services with more detail and insistence than other groups:

Labour tasks should be in agreement with a Health Commission so that it does not affect health or cause social consequences such as stress or psychological problems in the individual.

The government should disseminate information on health problems, not only on immunisations, but more especially on severe problems such as AIDS (Industrial workers with extensive benefits).

Bureaucrats in Guatemala, possibly reflecting an occupational slant, were the only group that mentioned the importance of government regulation to justify prevention of disease:

Government should put emphasis in formal education... to promote a culture on nutrition.

II. Reassurance and uncertainty reduction regarding the individual’s actual and future state of health

The benefits mentioned under this type (6) refer to obtaining information on the course of illness, treatment options and likely outcomes leading to the reduction of uncertainty over risks, disease conditions and general well-being and to reassurance on the current state of health. This sub-type has an overlap with preventive health gain in that as far as information is concerned it may both reduce uncertainty and directly contribute to prevent disease (i.e. knowledge of how AIDS is transmitted both reassures and prevents). Reassurance is also related to health gain as non-verbal behaviour may convey information leading to distress-reduction or enhancement and this, in turn, to health perceptions.
“We have a right to know what our illness is…we have a right to be informed” (Female service sector workers).

“We want information on the human rights of patients” (Adolescent middle class women). “Everybody should know of the services provided by social workers and psychologists” (Poor insured urban women).

III. Economic security

Benefits under this type (6) refer to the capacity of the health system to lower economic barriers to care, such as service or transportation costs.

“We should not be forced to contribute to social security so we can invest in whatever we want, such as private insurance” (Middle class women).

“We should be paid better so we can go with private physicians” (Industrial workers with extensive benefits).

Middle class women aspire to a less-regulated system that frees money to enable access to private insurance, an option generally perceived as leading to better quality services. Lower middle class workers would welcome the less-regulated system to become clients of private providers on a fee-for-service basis, just as the middle class women do now. Evidence suggests middle and lower middle class women make little routine use of prepaid social security services due to a lack of trust in them. Extensive private service use is typical and these groups consider their forced contributions an impediment to attain the economic security desired.

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“We employ employees and employees should contribute more to social security in order to have better services” (Pensioners).

Pensioners value a public financing system that would improve their services without incurring costs, as they no longer contribute.

IV. Confidence in the quality of health system structures

Benefits under this profuse type (56 mentions) refer to the confidence in having access to health system structures of adequate quality. Perceptions here are evidently related to economic security benefits described above and a generalised lack of trust in the public sector. Its wide range of meanings can in turn be classified into personnel (26), infrastructure (14) and drugs (13):

(i) Personnel: Refers to the availability of trained, certified and adequately supervised health personnel. This sub-type is by far the most coded across focus groups. This suggests the lack of trust in personnel, especially primary care physicians, and the bureaucratic context of interactions which lessen the opportunity to engage in personal forms of evaluation and control;

“We should be treated by specialists. Someone who knows well which cases merit faster care, because when we arrive the only personnel present are a secretary and a physician” (Agricultural labourers).

“The street should be fixed because it is of no use to have a good clinic if we cannot reach it” (Male bureaucrats).

“We should have access to good laboratories that don’t bungle the results” (Poor uninsured urban women).

“We should have hospitals that treat emergencies and births” (Indian women).

These examples show the lack of trust and the access barriers to the current systems, valuing improvements in their effectiveness and accessibility. The importance of cleanliness is exemplified by the following statements:

“We should have hospitals that treat emergencies and births” (Indian women).

These examples show the lack of trust and the access barriers to the current systems, valuing improvements in their effectiveness and accessibility. The importance of cleanliness is exemplified by the following statements:

“The street should be fixed because it is of no use to have a good clinic if we cannot reach it” (Small landholding peasants).

“We should have access to good laboratories that don’t bungle the results” (Poor uninsured urban women).

“We should have hospitals that treat emergencies and births” (Indian women).

These examples show the lack of trust and the access barriers to the current systems, valuing improvements in their effectiveness and accessibility. The importance of cleanliness is exemplified by the following statements:

“Health services’ buildings should be clean” (Female service workers).
“All the hospitals are very dirty” (Adolescent women in extreme poverty).

(iii) Drugs: Refers to access and availability of safe, effective and efficacious pharmaceuticals;

“Social security has its pharmacies full with naproxen and penicilin... natural medicine is very helpful if the social security institute would use it” (Maquiladora women).

“Physicians should give the drugs we truly need, not what they want to give us or what they have available” (Female service workers).

These examples question the adequacy of medical supplies. They would benefit from health systems that give them greater options, both with allopathic and traditional medicine.

V. Monetary benefits derived from health services

Monetary benefits from health services were mentioned sparingly (9), focusing on expected reduction in the overall cost of services for the population without altering accessibility. This benefit can be derived directly from fee or contribution reductions or indirectly from efficiency leading to less costs. This benefit would be expressed as increased disposable income to satisfy other needs besides health.

“Fees are too high for the services provided by the Caja Costarricense. I believe they charge too much. We are being squeezed” (Insured agricultural labourers).

“I consider that lowering fees is too difficult. Rather, they are going up. But they should worry about services, as the fees are very high. People use services [excessively] encumbering the collectivity” (Insured agricultural labourers).

“There is no need for me to take all the medicines that I am prescribed” (Poor uninsured urban women).

“Sometimes all nurses are on duty, they only crowd each other out and it’s of no use” (Poor uninsured urban women).

“What’s the use of so many buildings if there is not going to be good care. It would be best if they didn’t waste the money” (Agricultural labourers).

“If investments were made in preventive campaigns the cost would be less than in curative care” (Bureaucrats).

The first two statements from Costa Rican insured agricultural labourers suggest the strains on the poor of a universalised yet inefficient system. Contributors would benefit from a system that uses their contributions more efficiently.

VI. Health care process utility

The 22 mentions under this type refer to benefits derived from improvements in the process of obtaining care, once access has been assured. This can be divided into two sub-types: waiting time for appointments (9) and consultation and interpersonal relationships (13).

Waiting time for appointments and consultation: There are time scale and locational differences in these two aspects, leading to different opportunity costs and relationships to health gain.

“If too many people arrived and even if one arrives early [to the health centre] we cannot receive consultation and one has to go another day”.

“We lose all day if we go to consultation” (Maquiladora women).

“The longer we wait, the worse we feel just because we wait or we get even worse” (Uninsured poor urban women).

These examples illustrate the benefit derived from expeditious care. The last example shows its ambivalence with a health gain benefit.

Interpersonal relationships: Benefits under this sub-type refer to the respect and dignity expected from health providers. There is a blurred line with the sub-type of information in the reassurance and uncertainty reduction type. However, the population does seem to draw a line between process benefits whose value ends once service interaction has ceased and reassurance-related benefits whose value is more enduring.

“We should be treated as persons” (Service sector workers).

“We should not be treated with disdain” (Indian women).

“Receptionists are too offensive...” (Maquiladora women).

“If we are treated disrespectfully when one is sick, one feels even sicker” (Slum dweller).

These examples show the benefit of dignified treatment. The last elucidates the blurred line that can exist between health service process and health gain.
VII. Health system fairness benefits

This consists of a brief, although wide-ranging, set of eight benefits for the community at large and at the system level. They include attention grounded on equity considerations, care based on explicit priorities, access according to universal criteria and the avoidance of exclusion.

Equity: The benefit of a system that offers resources according to need and capacity to pay.

“The poor should be looked after more often because they are the ones that require most care” (Agricultural labourers).

“Public services should be charged to the non-insured according to their ability to pay” (Middle class home-makers).

Health service priorities: Benefits derived by the whole community from a health system that strives to meet political obligations or the approval of the community.

“We should demand at least what the Constitution prescribes to satisfy health needs as a social obligation that the government should obey” (Industrial workers).

“Health surveys should be undertaken and consensus arrived at concerning health priorities” (Industrial workers).

Universality: The benefit derived from a system that guarantees services to all as a basic human right.

“Health should be global, for everybody. We are human beings... health services should be extended to all the population. No sectors should be without health” (Pensioners).

Equal treatment: The caring for all patients as equal citizens.

“There should be no elitism. Sometimes they offer better care to those that are better dressed” (Middle class adolescents).

“We should all be treated equally, without influences” (Agricultural workers).

Analysis of benefits by social groups

The understanding of the benefits mentioned can be furthered by a comparative assessment of the list of 551 benefits mentioned by the 14 focus groups across socio-economic, age, gender and insurance status types. In order to simplify the analysis the seven benefit types were reduced to five by merging reassurance/uncertainty reduction, economic security and confidence in system quality into one general type “trust, reassurance and economic security”. This is justified because these three types of benefits are inter-related. Health services which obtain the most trust and produce most reassurance are also likely to be those that increase economic security.

On average groups produced lists of 39 distinct benefits. Four groups produced lists with under 17 benefits (male industrial workers, male peasants, Indian women and slum dweller women). This can be attributed mostly to their reduced contact with the modern health system and their reduced set of expectations, and less so to poor selection of informants (which was in fact noted for male industrial low-income workers). Two groups — middle class adolescent female students and middle class female home-makers — produced large benefit lists with over 70 items, perhaps the result of their higher education and greater contact with and expectations of the health system. Pensioners also were profuse in their listing, perhaps due to the broader range of experiences with the health system.

The kind of benefits mentioned varies across social groups. This analysis, however, can only be meaningful for the 10 groups that produced lists with more than 20 benefits.

Health gain: Health gain was mostly absent in the pensioners and little mentioned by maquiladora women and slum dwellers. This suggests either the perception of good health, reduced expectations of maintaining good health (pensioners) or greater concern with other aspects of the health system. The perception of good health among the predominantly young maquiladora workers has been reported in the literature (Guendelman & Silberg, 1993). The groups mentioning this type most often are industrial workers with extensive benefits (36%) and bureaucrats (33%). In both cases health is closely tied to productivity and formal labour contracts.

Trust, reassurance and economic security: This broad type shows gradual variation in frequency across the 10 groups considered for this analysis. The lowest frequency is 33% among adolescents in extreme poverty and the highest is 62% among male bureaucrats.

Financial benefits: These are mentioned sparsely across groups. However, 8% of benefits mentioned by insured agricultural labourers were in this type, mainly related to expectations that the public insurance could reduce their contribution. Poor urban women in Mexico also mentioned financial security benefits in 9% of the total. They referred to the redundant personnel they perceived in public services and the excess of drugs with which they were being supplied. These statements were perhaps a remark on the unfairness of employment conditions, with excesses in the public sector while misery reigned among them. The reference to the excess drugs could be attributed to the charge they often face for them.
Health care process utility: Health care process utility was mentioned frequently as a benefit, yet there is a wide range in frequency across groups. Two of them — male bureaucrats and industrial workers — mentioned it sparsely, at between 5 and 7% of the total. The rest mentioned benefits in this type in between 19 and 46% of cases.

Health system fairness: These benefits were hardly mentioned by any groups with the exception of pensioners, with 18% of the total, and industrial workers with extensive benefits, at 11%.

Analysis of benefits by social types

Focus groups can be meaningfully aggregated into gender and insurance categories to gain insights as to the meaning and possible determinants of benefit perception (Table 5). One important difference is the fact that male focus groups produced, on average, 7 benefits per participant against 2.7 for the female focus groups. This possibly significant difference does not seem to be an artefact brought about by the moderator’s gender. Two similar groups of female workers (one service sector, the other maquiladora) responded equally well to a male and female co-ordinator (5 and 4 benefits per participant, respectively). Furthermore, the two groups with least participation had male members while the two groups with highest participation had female members. Gender differences can be related to upbringing and a differentiated perception of social services.

Men emphasise more health care process utility benefits, with 37%, while women mention them in only 22% of cases. On the other hand, women are slightly more aware of trust, reassurance and economic security, expressing 49% of benefits in this general type, against 40% for men.

Out of all participants 78% were insured and the rest non-insured. This situation, however, does not significantly alter the mention of benefits across types. If anything, the non-insured show somewhat more emphasis of health care process utility benefits while the insured are more concerned about health system fairness benefits. Both these facts are contrary to what would be expected if the poorer participants were supposed to be more concerned with lack of access or equity, and the insured more concerned with the long waits and bad treatment more characteristic of their pre-paid services.

Discussion

Health as an aspect of the life interests of social groups in general was highly ranked, a finding that is not surprising given the focus of the study presented to participants. The most salient health experiences in the minds of participants refer to post-transitional health problems treated in high-speciality medical services with mostly positive outcomes, in spite of multiple complaints with the access and care processes. The predominance of curative care and its associated problems leads to the voicing of interests and expectations chiefly with curative health services. This situation suggests that post-transitional health problems and the
associated services generate undue conflict and uncertainty among the groups studied.

Benefits mentioned by participants were mostly, but not always, in the context of demands or complaints with assigned public services rather than with the voicing of preferences for treatments or providers. There is thus a need to translate complaints into utilities in order to derive the full range and quality of benefits expected from the health system.

In spite of the importance health gain has for the population, most expectations referred to the reduction of uncertainty, particularly with reference to health personnel. This shows the importance of the agency function in assuring quality care and reducing uncertainty for the population.

The degree of coding of specific benefit types and subtypes seems to be a function of socio-economic groups and their world outlook, and not only a function of general education. Thus, bureaucrats have a keen sense of government regulations, industrial workers of occupational health, and the middle class of the need for options within the system. Indigenous women participated actively in the discussions, but came up with very sparse and basic demands. Organised peasants in Costa Rica under a universal, compulsory health insurance system had a more developed knowledge and opinion of efficiency and costs of the public sector as well as of value for money.

Women offered a more restricted set of benefits even though they are the principal organisers of health care in the household. The exception is middle class women, whose better education, options to exercise citizenship rights and contact with a wider set of providers makes them keenly aware of benefits that can be derived from the health system.

Pensioners coded more the health system fairness benefits — on which they rely more given their condition — than health gain, of which perhaps they are less concerned given their reduced dependence on health to fulfil their social responsibilities. However, they are engaged more often with services for curative purposes than other groups.

Equity in health has assumed today a high degree of saliency among policy makers in developing countries. In contrast, individuals do not perceive this to be a prominent benefit of the system. However, when coded by the most politically aware social groups the benefit acquires the full range of meanings associated with in policy circles. This suggests that equity in health can become a powerful issue to drive health sector reform.

Further analysis is warranted of the linguistic codes employed by the various socio-economic and gender groups in formulating their health benefits. Such analysis would offer the opportunity to study the logic used for the conception of utility and the relationship among the various benefits.

There are several health system benefits that were not mentioned by focus groups and that could constitute a type of “other”. Among them are the following: health certification, fertility control, cosmetic improvement, physical security from custodial functions, etc.

Conclusions

The fact that expected benefits are mentioned mostly in the context of demands from public services rather than the voicing of preferences among options underscores the need to develop appropriate instruments that do not rely on standard gamble or contingent valuation, as such a logic is mostly foreign to the population accustomed to single-provider public services. Rather, the methodology should be more in line with the identification of policy priorities and trade-offs. Willingness to pay could be included as a strategy if fiscal resources are considered.

The results presented can help develop hypotheses to test the most valued benefits beyond health gain. However, care has to be taken to adjust for the purposeful over-representation of insured and urban groups used in this study. If benefit sub-types are ordered by response frequency a ranking can be presumed (Table 5). Health personnel benefits classed in the type of benefits relating to trust with the system rank at the top by a wide margin. Hence more stringent personnel training and supervision would most likely be at the top of the list of priorities, followed by prevention/promotion demands. At the bottom of the list would appear the issue of equity and the alleviation of poverty.

In contrast to the findings, proposals for health sector reform in Mexico and Central America do not put in centre stage the improvement of the population’s confidence in health system quality. While most proposals do state the need to improve quality, the issue of improving human resources — one of the main preoccupations of the population according to this study — is generally relegated.

The research undertaken so far has offered valuable empirical evidence upon which to elaborate a classification of health-system derived utility that can form the basis of future work in measuring health-system performance and in identifying health service priorities that respond to the full range of social expectations, needs and desires of beneficiaries. The hypothesis that has guided this research — that health gain is not the only nor even the predominant consideration of diverse social groups — is certainly given some credence by the outcome of this qualitative work, even if further research must be undertaken to quantify the relative importance given to each type of utility.
The main limitation of this methodology clearly lies in its ability to establish an unambiguous link between the preferences and values expressed by respondents, and the corresponding categories of health system derived utility. Often, rather than describing benefits per se, respondents describe changes in the services that they would like to see take place or problems that they encounter in using the health system. In either case, the respondent obviously believes that the implied changes will produce actual or potential benefits but does not make explicit what s/he expects these benefits to be. In some cases it is obvious. For example, when a respondent states that “We should not be treated with disdain” she is clearly making a plea for greater process utility. However, when the respondent says “Physicians should give us the drugs we truly need, not what they want to give us or what they have available”, it is not clear whether the implication is that they are not receiving: (a) sufficient health gain (because they are receiving drugs that do not solve their health problems); (b) sufficient monetary benefit (because they are not being given the drugs they need and have to buy them at private pharmacies); or (c) sufficient peace of mind (because they are kept unaware of what the appropriate medical treatment for their condition would be, or because they have no confidence in the quality of the drugs being prescribed). Careful probing by the researcher is needed to clarify any such ambiguities and this can be both time-consuming and perhaps tedious for respondents.

So far the methods used have demonstrated that people do indeed expect a broader range of benefits from their health services than just health gain. This in itself is an important revelation, given that much of the health sector reform agenda (see for example World Bank, 1993) is based around promoting cost-effectiveness which values services primarily in terms of the cost per DALY produced (Hammer & Berman, 1995). The challenge now is to find a way to quantify these expectations so that the techniques offer a means to establish priorities based on the real values held by citizens and not by technical “fixes” that ignore or conceal the value judgements inherent in them.

Before this is possible, two methodological obstacles need to be overcome. One is the selection bias or difficulty in obtaining a sample of views that can be said to be representative of the society or community in question, whilst ensuring that information is neither biased nor ambiguous. As has already been pointed out, obtaining unambiguous expressions of unmet health system derived benefits is neither simple nor quick. To do so with a representative sample of respondents may be prohibitively expensive. Moreover, the format in which the information is gathered, namely through focus group discussions, does not lend itself to representative samples and indeed the composition of these groups is explicitly not representative (but instead focussed).

There are two ways that this particular problem might be circumvented. One would be by altering the technique to make it more amenable to representative samples by having, for example, respondents individually rank their preferences from a set of service provision possibilities that represent relatively “pure” examples of each type of benefit (and for which the cost is similar). The other would be to sacrifice representativeness for detailed information from contrasting groups within society such as: old and young; wealthy, poor and middle class; male and female; employed, unemployed and retired; and different racial/ethnic groups. To the extent that these contrasting groups express preferences that are congruent there would be clear guidance for policy. Where differences exist, they would be readily identified through such a technique and could be taken into consideration in determining priorities and subsidies.

The second obstacle is the lack of a means to quantitatively trade-off benefits of one type against those of another. How much health gain are people prepared to sacrifice for better process utility or greater equity? There are both theoretical and practical difficulties facing this issue as those who have attempted to use DALYs (disability adjusted life years) or QALYs (quality adjusted life years) to establish preferences between different programmes or health policy options are well aware (McGuire, Henderson & Mooney, 1988). Though it is beyond the scope of this paper to describe these in any detail, suffice it to say that DALYs reflect experts’ preferences for health states while QALYs reflect citizens’ or patients’ preferences for health states. But none of the two approaches considers the effects of health services that go beyond health state. These difficulties are not insurmountable, and in particular, some attempts have been made to incorporate equity aspects into the QALY approach by weighting the QALYs gained by a given individual according to the equity concerns of society for different population groups. Indeed, within the present project a new approach is being developed — the willingness to assign a budget — which precisely aims at eliciting the collective preferences of society for programmes and policy options, taking into account all types of benefits that accrue to society (Costa i Font, 1998). The core of the approach consists in an exercise where a group of people is asked to act as representatives of their society in allocating a limited public budget among a set of health programmes. The exercise requires individuals to make choices and, at least implicitly, trade-offs between programmes and benefits, that can be indirectly elicited from their responses.

An important point to be aware of when considering potential application of such priority setting techniques is that although people may value a variety of different
health system derived benefits, this does not mean that it is the responsibility of the public sector to maximise an aggregate of these benefits. There are convincing arguments that concern for equity, for example, is meaningless outside the bounds of equity in health status (or health gain) and so, as Culyer and Wagstaff (1993) point out, while it may be “fair” to allow “the market” to allocate complementary hotel services in hospitals (such as private rooms, telephones and televisions), it would not be for the distribution of health status itself to be determined in this fashion.

Even if it were possible to identify an alternative “basket” of health services which would increase social welfare (as opposed to just the population’s health status), this also does not necessarily imply a need for increased government intervention. Indeed the correct response could be less government intervention if the cause of sub-optimal social welfare is due to, say, market failure from excessive regulation. However, there are at least two “non-health” benefits derived from health systems whose neglect to date may warrant greater government intervention. These are health equity and the economic security produced from insurance against catastrophic health expenditures. The prevailing emphasis on prioritisation by cost-effectiveness, apart from the folly of ignoring the effects of private substitution when using it to define publicly subsidised “basic packages”, neglects the fundamental role of government policy in ensuring both of these additional health system derived benefits (Gilson, 1998).

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References


3The former prohibition of private medical practice in Tanzania, though never particularly effective, might be one example of this.