

Increasing Investments in Health Outcomes for the Poor
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Pro-Poor Health Reforms-Why, What and How
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1. Introduction

Wide-ranging reforms in health sector have been aggressively promoted by multilateral institutions, particularly the World Bank, in the last two decades in the developing and transitional economies. The record of these efforts, especially in respect of the poor, has been mixed. In many cases, the benefits did not really reach the poor, and in some, they seem to have been adversely impacted. Examples of the latter include indiscriminate privatisation, introduction of cost recovery without safety nets for the poor and hasty decentralisation. The focus of many of these efforts was not necessarily the health of the poor, but macroeconomic stabilisation and fiscal compression. Part of the problem was a serious misunderstanding of the role of the state in the wake of economic liberalisation and euphoria about the markets following the collapse of the socialist model. However, there is now a clearer perception of the central role of the state in the health sector in general and in protecting the vulnerable population in particular. The World Development Report 1993, devoted exclusively to health, set the ball rolling by defining the role of the state in providing public goods, merit goods and provisioning essential health services. The World Development Report 1997 greatly helped to clear the air by squarely placing the responsibility for protecting the vulnerable on the state. Finally, the World Health Report 2000 brought out forcefully the stewardship role of the state in steering the health system.

Despite the recognition of the central role of the state in health, doubts still persisted about its importance in the context of development and poverty alleviation. The Millennium Development Goals (MDGs) adopted by the Millennium Summit of the United Nations in September 2000 put health of the poor in the forefront of the global battle against poverty and disease, and thus represents an unprecedented global consensus on the subject. The WHO Commission for Macroeconomics and Health (2001) represented a pioneering effort to understand the linkages between economic growth and poverty on the one hand, and health status on the other. It not only underscored the importance of investments in health for economic growth and alleviation of poverty, but also laid out a

blueprint for both the developing countries and the donor community to move forward towards the achievement of the MDGs.

What poor countries need urgently is not only greater investment in health along with wide ranging systemic reforms, but also that these specifically target the poor. As we shall see subsequently, investments made ostensibly for the poor have often been misappropriated by the rich. And even donor agencies have often shied away from investing in the backward areas on account of poor governance, weak health infrastructure and consequently higher risk of failure. Needless to say, that the poor generally lack political influence and are unlikely to receive the desired attention without a special focus. This paper attempts to present the rationale (why), the main ingredients (what) and the methodology (how) of pro-poor health reforms based largely upon the experience in India with very diverse health outcomes in different states ranging from Kerala at one end, comparable to the high-performing middle income countries, and UP and Bihar on the other, only slightly above the level of Sub-Saharan Africa. The CMH arguments establishing linkages between investments in health, and economic growth and poverty are not repeated as they are well covered by other background papers.

Why?

The case for a pro-poor approach in respect of a basic human right like health could be strongly made purely on ethical and moral considerations. Many have argued that by trying to justify investments in the health of the poor on economic arguments, we are diluting the moral argument-health being a desirable end in itself and pursued not only for its contribution to economic welfare. Nevertheless, the compelling case made out by the CMH for investments in health, especially of the poor, on macroeconomic considerations will, hopefully, persuade those who hold the purse strings (finance and planning ministries and donor agencies) to give this matter greater attention. But there are other equally strong arguments in favour of special focus to the health of the poor as discussed below.

1. The poor are subjected to a disproportionate, and to a large extent avoidable, burden of disease (BOD) from pre-transition diseases (infectious diseases, perinatal and maternal conditions and nutritional disorders). The BOD in low and middle-income countries on this account was estimated at 44% as against 7% in high-income countries (World Health Report 1999). All these conditions are capable of being controlled very cost effectively with relatively simple and easily available

technologies. Investment in the health of the poor could, therefore, not only yield quick results but also maximise the returns on such investments. **If the world desires to move ahead rapidly towards the MDGs, the poor would be the best place to direct the efforts.** Besides the pre-transition diseases, the new pandemic of HIV/AIDS is causing unimaginable consequences in the poorest regions of the world. A recent World Bank study (2001) in India has also shown the poorest quintile to be having almost double the exposure to lifestyle risk factors like tobacco use and smoking as compared to the richest 20% of the population. The poor are often concentrated in backward and remote areas having very weak infrastructure, degraded environment, poor sanitation, lack of access to safe drinking water, which combined with under-nutrition and poor hygiene makes them highly vulnerable to ill health. The tables below bring out clearly the striking disparities in health status among different income groups in India.

Table 1
Health Status Indicators – Comparison Between the Poorest and Richest Quintiles of the Population, India, 1992-93

	<i>Poorest 20 %</i>	<i>Richest 20 %</i>	<i>Poor / Rich Risk Ratio</i>
Infant Mortality (Deaths under 12 months per 1000 births)	109.0	44.0	2.5
Under 5 Mortality (Deaths under 5 years per 1000 births)	155.0	54.0	2.8
Childhood Underweight (Percent below -2 sd z-score, weight/age, children under 4 years)	60.0	34.0	1.7
Total Fertility Rate (Births per woman age 15-49 years)	4.1	2.1	2.0

Source: Gwatkin et al, Socio-Economic Differences in Health, Nutrition, and Population in India, 2000. HNP Poverty Thematic Group of the World Bank, based on NFHS, 1992-93. Reproduced from India: Raising the Sights – Better Health Systems for India’s Poor, World Bank, 2001

Reproduced from : India Health Report, Oxford University Press, 2003.

Table 2
Health Outcomes According to Standard of Living, India 1998-99

Standard of living index	Infant Mortality (per 1000 births)	Under Five Mortality (per 1000 births)	Total Fertility Rate	Children Underweight (% below -2 SD)	Children with anemia (%)	Children with acute respiratory infection in past 2 weeks (%)	Children with diarrhea in past 2 weeks (%)	Anemia among women (%)
Low	88.8	130	3.37	56.9	78.7	21	19.9	60.2
Medium	70.3	94.6	2.85	46.8	73.5	19.4	19.7	50.3
High	42.7	51.5	2.1	26.8	67.3	15.7	16.1	41.9
Low/High Ratio	2.08	2.52	1.6	2.12	1.17	1.34	1.24	1.44

Source: National Family Health Survey 1998-99 (IIPS 2000), Reproduced from India: Raising the Sights – Better Health Systems for India's Poor, World Bank, 2001

Reproduced from : India Health Report, Oxford University Press, 2003.

Although significant progress has been made in monitoring of health status by income groups in India by national surveys in the last decade, the information still remains limited. A better source of information is the status of Scheduled Castes (SC) and Scheduled Tribes (ST), which are socio-economically the most backward sections of society eligible for affirmative action under the Indian Constitution. A comparison of the infant and child mortality levels in these groups with the general population brings out clearly the wide disparity in health status.

Table 3
Health Indicators among SC/ST and Others (Rate per 1000)

Mortality Indicators	SC	ST	Others
Neo-Natal	53.2	53.3	40.7
Post Neo Natal	29.8	30.9	21.1
Infant <1 year	83	84.2	61.8
Under 5 Years	119.3	126.6	82.6

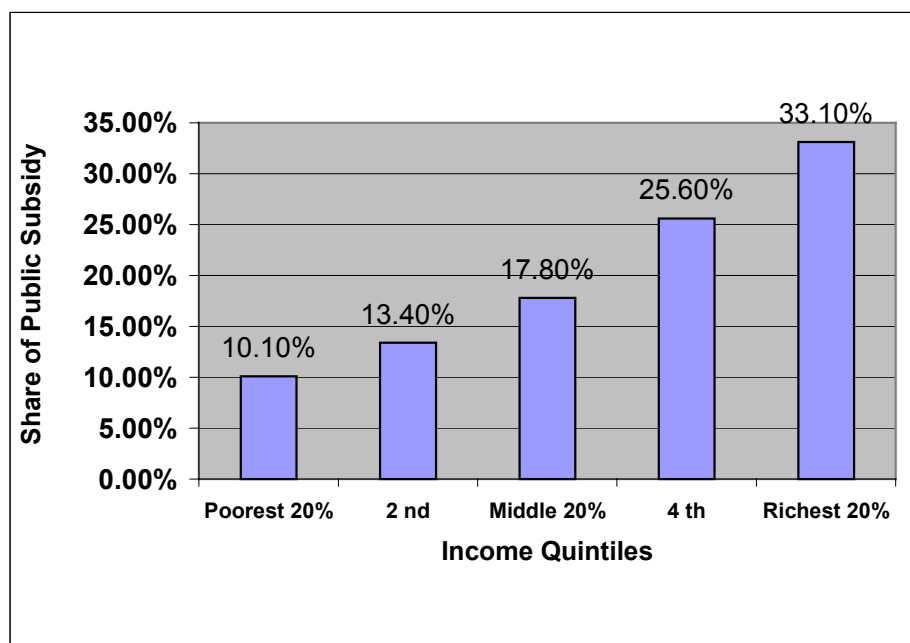
Source: National Family Health Survey II.

Reproduced from : India Health Report, Oxford University Press, 2003.

Therefore, if global health is to be improved quickly, there is no alternative but to concentrate on those that carry the maximum burden-the poorest sections of society.

- The poor suffer much higher mortality and morbidity due to lack of access to both public health and medical services. A recent benefit incidence analysis done by the National Council of Applied Economic Research (NCAER) shows that even public subsidies in health have been disproportionately utilised by the rich.

Figure 1
Share of Public Subsidy for Curative Care Benefiting Income Groups



Source: Who Benefits From Public Health Spending In India, unpublished paper, NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

The private sector is expectedly concentrated in more developed areas, which offer better commercial prospects. The poor thus have very limited access to the qualified private sector due both to locational disadvantages and financial constraints. A large number in India have no alternative but to depend on unqualified providers-often with disastrous results. The low literacy levels, poor health information and often persistence of traditional beliefs and superstitions compounds the problem by making the poor ill-equipped to make rational choices in health related matters.

- The employment of the poor is, by and large, in the informal unorganised sector, making it difficult to organise any risk pooling arrangements, like health insurance. They are thus subject to the most regressive method of health finance-fee for

service paid as out of pocket expenses- a major contributing factor in perpetuation and aggravation of poverty. A recent World Bank (2001) study on India concludes that out of pocket medical costs (estimated to be more than 80% of the total medical expenditure) alone may push 2.2% of the population below the poverty line each year.

4. The neglect of the poor is leading to unacceptable imbalances in development within the country as well as within each state- a major source of social tension and unrest. Disaggregated data on health status of the backward and remote areas is not available but the comparison of health facilities utilisation statistics between a relatively prosperous state, like Punjab and a backward state like Bihar brings out the huge distortions quite clearly. While the poor suffer a higher burden of disease, their poor utilisation of medical facilities is clearly due to lack of access and financial constraints. While all groups have lower utilisation in Bihar as compared to Punjab, the contrast is more marked in the poorest (Q1), where the utilisation is around four fold higher in Punjab both in outpatients and hospitalisation. Only a very concentrated effort on backward and remote areas inhabiting the poor can correct these imbalances and distortions.

Table 4
Rate per 1000 of Treatment during last 15 days

State	POP<BPL In millions	%BPL Families	QI	QV	Total
Bihar	49	55	14	36	24
Punjab	25	12	63	94	72
All	320	36	28	61	42

BPL = Below Poverty Line; Q = Quintile; All = the whole country
Source: 52ND NSSO From Benefit Incidence Analysis (BIA) Study of
NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

Table 5
Rate per 100,000 of Hospitalisation

State	POP<BPL in millions	%BPL Families	QI	QV	Total
Bihar	49	55	198	1728	722
Punjab	25	12	754	2998	1622
All	320	36	563	3447	1653

Source: 52nd NSSO From BIA Study of NCAER, 2000

Reproduced from : India Health Report, Oxford University Press, 2003.

It would thus be seen that the argument for a pro-poor focus in health investment extends far beyond macroeconomic and ethical arguments. It is not possible to make an impact on the health status of the population in a poor country without addressing the areas and the populace where most of the disease burden exists. Also, addressing the major causes of morbidity and mortality among the poor-the so called pre-transition diseases- is the most cost effective solution giving the maximum and the most rapid return on health investments. Also, since the maximum problem resides in backward and remote areas where the majority of the poor live, the only way to promote balanced and harmonious development is by concentrating on the upgradation of such areas- an absolute must for political stability in the long run. **Investment in the health of the poor is thus not only good economics but also good politics.**

What?

- 1. The CMH deserves to be congratulated on bringing home one long obscured truth before the world that no system can be expected to deliver without a minimum of financial resources.** Unfortunately, the minimum level of financial support is rarely in evidence among low-income countries. The average per capita public spending is estimated at \$ 6 in the least developed countries and \$13 in other low-income countries by the CMH. In India, the latest estimate by the World Bank (2001) is just \$ 3-4 per capita at 1993-4 constant prices. The CMH also conducted detailed exercises to estimate the cost of the essential services, which the state must provide and came up with a range from \$30-\$45 per capita. At current levels of expenditure, the resources devoted to health in most low-income countries would fall woefully

below this target. The CMH must get full credit for bringing these harsh truths before the international community, as prior to this report, the focus was primarily on what the WDR 93 termed as greater allocative and technical efficiency. It is nobody's case that there isn't misallocation of resources or that the available resources could not be more efficiently employed in the poor countries. Certainly there is considerable room for improvement in that direction and that the same deserves urgent attention. However, that problem is relatively small compared to the gross inadequacy of financial resources. **The bottom line, therefore, is that public investments in health have to be raised significantly before any impact on the health outcomes can be expected.** A vigorous and sustained effort to mobilise resources both by developing countries themselves and by the donor community would need to be made on the lines suggested by the CMH, and the bulk of these additional resources would have to be invested in interventions that principally target the poor.

2. Every reform effort invariably comes up against vested interests, which try to create political roadblocks. The political leadership is understandably against taking political risks of antagonising any section of the population unless the political benefits clearly outweigh the risks. Therefore, where a significant political advantage can be seen by infusion of substantial additional resources, the political leadership would be willing to support reform even though it involves antagonising some sections. In the early nineties, a number of categorical programmes supported by the World Bank had brought to light serious systemic problems at the state level, which were impeding the success of these as well as other programmes. But the proposals for reform never found a receptive audience till the introduction of the State Health System Projects. Despite the wide-ranging reforms contained in the projects, the states were most eager to take them up because the substantial investment in upgradation of infrastructure promised significant political benefits. **The additionality of resources is thus a necessary sweetener for reforms.**
3. The foremost priority is to have a universal health services delivery system including both public health and basic health care performing efficiently. This has been given different names at different times from Health for All in Alma Ata Declaration to 'essential health services' in WDR 93, and to 'close to client services' in the CMH. They basically mean the

same thing with minor shifts of emphasis. As highlighted by the Working Group 5 of CMH, the foremost priority should be local health delivery structure, well equipped and staffed with motivated health workers, categorical programmes to provide technical and financial resources, and effective management with a well integrated surveillance and monitoring mechanisms. The primary and secondary level services must incorporate an effective referral system for more serious cases. The health delivery systems are most dysfunctional and inefficient in the backward and remote areas having poor governance and infrastructure, and therefore foremost attention deserves to be devoted to these areas. This is also necessary for removing the developmental imbalances referred to earlier.

4. The other priorities flow from the rationale for pro poor reforms discussed in the earlier section. The conditions causing the maximum disease burden on the poor need to be tackled first. These are HIV/AIDS, infectious diseases, maternal and perinatal conditions, micronutrient deficiencies and tobacco related illnesses. Besides, the poor need to be provided easy access to health services and protected against the financial costs of serious illness either through direct provision of services by the state or through appropriate risk pooling arrangements, like health insurance. Eventually, the reduction of out of pocket expense as a source of health finance should be a principal objective in any reform exercise. Recently Mexico announced a universal health insurance programme, which sought to reduce drastically the current level of out of pocket expenditure (around 50%). In the case of India with over 80% out of pocket expenses, even reaching a level of 50% appears a far cry.
5. The complementary and synergistic development of other health related sectors like education, sanitation drinking water supply, nutrition and environment is equally important. The development of institutional mechanisms for coordination and convergence between these sectors both at the policy-making level as well as at the cutting edge is the key to achieving this objective. This is critical for the poor as the deficiencies in related sectors often negate the gains made in the health sector.
6. A sensitive and yet a very important question in all reform processes is the quality of governance. Normally in discussions of health related reforms this issue is not brought up, as it is an all-encompassing problem affecting all activities

of the government and not health alone. Yet it is too important an issue to be swept under the carpet: the success of the entire reform effort hinges on it. This is particularly so as poor governance affects the poor much more. Their lack of both political influence and awareness makes them easy targets for exploitation and neglect by unscrupulous functionaries. It has been a common experience of backward and remote areas that much of the funds for the welfare of the poor are siphoned away by corrupt officials. Obviously, it is not possible to change the administrative and political milieu of a country as the same depends on so many factors outside the purview of any health reform programme. **However, an effort to inject accountability and transparency and reduce the avenues for political and bureaucratic malfeasance and corruption should be an integral part of any such exercise.**

How?

No generalisation can be made, or indeed even attempted, about the process of reform, which has necessarily to be country specific. Each country, and in some cases each region, would need to determine the precise modalities of implementing the aforesaid reforms taking into account, inter alia, the socio-economic, political and cultural milieu, the level of development, the availability of financial resources and the capacity of the health infrastructure. It is neither possible nor even desirable to try to fit reforms all over the developing world in 'one size fits all' formula. We cannot even think of attempting such an exercise for a large and very diverse country like India, what to say of the world at large with its infinite diversity of political, cultural and economic situations and health problems. The maximum that can be attempted globally is the identification of a set of guiding principles and essential elements, which should underpin the process of reform.

The principal actors in the reform movement have necessarily to be the developing countries themselves as they bear the primary responsibility for the welfare of their citizens. However, with their limited financial and technical resources, their efforts would require sustained and generous help by the international community, as brought out very forcefully by the CMH. The MDGs represent a new awareness and an unprecedented international consensus, but the same has yet to be effectively translated into significantly higher commitments of financial assistance or new mechanisms for coordinated international action with the sole exception of the Global Fund for AIDS, Tuberculosis and Malaria (GFTAM). **As pointed out earlier, the reform process cannot survive without substantial increase in donor assistance, which needs to be**

insulated from the usual fluctuations arising out of regime changes and economic prospects in industrialised countries. The political and economic factors influencing the aid climate in the donor countries are beyond our control. However, two steps could greatly improve the sustainability of external assistance and minimise its volatility. First, aggressive and sustained global advocacy of the importance of supporting pro-poor health reforms- and the CMH has already laid out all the arguments in its favour: secondly, the channelling of aid for this effort primarily through multilateral institutions (WHO, World Bank, GFTAM) to minimise the possibility of shifting political preferences influencing the quantum of assistance. Side by side, international agencies need to provide technical support to the developing countries to the extent necessary, both for the formulation of the investment and reform package and guiding and monitoring its implementation, and the WHO is ideally situated to play a leadership role in this behalf. The extent of this support would naturally vary widely on the level of development and in-house technical expertise available in each country. **It is, however, most important that the external technical and financial support should not in any way compromise the ownership of the reform process in the host country-it should not only be entirely domestically owned and driven but also seen to be so.**

Notwithstanding the country specific nature of the process, an attempt has been made to list out some of the essential and critical elements to facilitate discussion:

1. First and foremost is the generation of awareness and political support in the developing countries for health in general and for pro-poor reforms in particular. As of today, there is appalling indifference and absence of informed debate on health issues, which is reflected in the abysmally low financial allocations. The need of the hour is aggressive and sustained advocacy involving political institutions, media, and the civil society. The campaign necessarily should be totally non-partisan with a view to develop a political consensus. The advocacy campaign might need external financial and technical support.
2. The mobilisation of domestic resources would depend largely on the strength of the political support generated by the advocacy campaign. It must be recognised that the developing countries are facing varying degrees of fiscal constraints and there is strong competition to health for the available funds. It has often been argued that the resources should be found by increasing taxes, reducing subsidies, privatisation of public

sector enterprises and reallocating resources from items like defence. First of all, all these prescriptions are not necessarily desirable, and even where that is so, they are often politically infeasible. It would therefore, be idle to place too much reliance on mobilisation of additional resources from these measures although their validity in many cases is not disputed. The promotion of these solutions should be tempered by the realisation that even in the mature western democracies, there are severe political limitations to some of the suggested measures, e.g. the huge subsidies on agriculture. While some reallocation of resources can be attempted, it will always remain vulnerable to fiscal crises, political upheavals and other competing claims. Investments in health can produce results only in the long and medium term. Therefore, the stability of financial support is critical. Each country will have to find ways of protecting health outlays from financial crises and political upheavals. The earmarking of funds and imposition of dedicated levies is one possible solution of promise to this vexed problem. In India, the best performing sector in the recent past has been the upgradation and building of new highways, which is largely financed out of a cess on petroleum products- an assured and growing source of revenue. Dedicated levies on alcohol and tobacco are obvious candidates for consideration.

3. The success of the health system depends largely on people's participation and involvement. **The challenge is to develop a participatory system in which the community has a sense of belonging and ownership without the state losing technical control and stewardship.** It can be attempted through decentralised institutions of local self-government, wherever possible. It is important to ensure that the health workers feel accountable to the community they serve and important health related decisions are taken in consultation with the beneficiaries. The bottom line is that a top down approach is unlikely to work. In the state of Kerala in India, where the responsibility for the health system at the primary and secondary level has been transferred entirely to the local elected bodies, the improvement in efficiency is significant. For instance, the local community has solved the chronic problem of shortage of health personnel by hiring staff on contract. They have mobilised funds for repair of buildings, purchase of equipment and have greatly improved the supervision and accountability of the health workers. Part of the success of this effort is due to very elaborate preparation for the transfer of responsibilities including the extensive training of elected leaders.

4. The institutional capacity in the health ministries and subordinate offices for planning, analyses and monitoring is often very weak, and expertise in critical areas, like public health, epidemiology, health economics and finance are either totally lacking or highly deficient. **What is needed is a culture of evidence-based and well-informed decision making.** There is often no institutional arrangement for interaction between researchers and decision makers both in setting the research agenda and utilisation of research outputs. Similarly the arrangements for monitoring and evaluation are generally deficient. The development of these essential capacities would require sustained effort and external technical help, which is critical to the success of the reform effort.
5. There is a growing private sector in most developing countries, which is not generally involved in the achievement of national health goals. It must be recognised that the state alone would not be able to achieve the desired goals without the active involvement and support of the private sector. Public-private partnerships need to be promoted not only in respect of public health interventions, but also for provisioning health services for the poor. Also the private sector, particularly non-profit would need to be encouraged to set up services in under-served and backward areas with attractive incentives. The cooperation of the private sector in adoption of agreed treatment protocols for important infectious diseases (like TB), preventing indiscriminate use of anti-microbials, and epidemiological surveillance, is critical.
6. A credible and dependable system of identification of the poor for the purpose of targeting special concessions and facilities needs to be put in place. This is not an easy task as the experience in India suggests. The introduction of transparent criteria and subjecting the selection to scrutiny by village councils (Gram Sabha) comprising all adults, has generally proved effective in preventing irregularities. **Special monitoring of health outcomes in designated backward areas and disaggregated data on health status at different income levels is critical to monitoring the impact of reforms on the poor.** External technical help, wherever required, would need to be provided to develop these instruments.
7. The key to the success of any health related programme is the quality and commitment of the health workers, particularly at the cutting edge. A careful assessment of manpower

requirements, identification of current deficiencies, and the planning of remedial measures would be a critical element of the exercise. **Health workers need to be motivated to work in remote and difficult areas by generous compensation combined with transparent and attractive incentives.**

8. Finally, the systemic constraints impeding efficient delivery of interventions and optimal utilisation of services would need to be identified and a detailed blueprint drawn up for their time bound elimination. The objective identification of these constraints could be facilitated by surveys and analyses by agencies independent of the government. The exercise would require many reforms in management systems to improve accountability, efficiency and transparency.
9. The development of a strategic framework and an investment plan including clearly targeted pro-poor interventions and reforms, would require detailed work by expert groups with oversight of key ministries like finance, planning and health, support of international agencies (WHO, World Bank) and other important donor agencies for health. The CMH had suggested constitution of national commissions on macroeconomics and health co-chaired by the ministers of finance and health. Each country could devise a mechanism suitable to its own situation as long as it is capable of completing the challenging task in a time bound manner. Already the process has been initiated in several countries.

Conclusion

Pro-poor reforms in health are desirable not only from a moral and ethical standpoint, they are indeed the best strategy for rapid improvement in health outcomes and progress towards MDGs besides maximising returns from investments in health. They could also contribute significantly towards balanced, harmonious and participatory development as well as empowerment and well being of the poor. The need of the hour is generation of political will both in the developing countries and the donor community in favour of a strong and sustained effort in this regard. This could be achieved through an international compact- the main objective of this consultation. The world shall be watching eagerly and expectantly for the outcome.

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