EQUITY IN HEALTH IN UNEQUAL SOCIETIES: TOWARDS HEALTH EQUITY DURING RAPID SOCIAL CHANGE[1]

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SUMMARY

The paper explores the implications for health policy of the segmentation of society into social groups with very different levels of income and wealth. It focuses particularly on societies undergoing rapid social change, such as Southern Africa and China. Governments can influence access to health benefits, to some extent. However, they are unlikely to achieve equality in the consumption of health goods, whilst access to all other resources is very unequal. They need to identify how to use their limited powers to reduce the most damaging health inequalities. This is particularly important in societies where social groups are re-negotiating their relative entitlements to health benefits.

Discourses on equity in health are presently dominated by a debate between so-called 'European' and 'American' models of health delivery. This has led to a rather static focus on ideal outcomes, rather than on practical options for organising and financing health services in poor countries undergoing rapid change. The paper argues for a more explicit acknowledgement of the dynamic character of health development and the political nature of the negotiations regarding the use of government powers.

Unregulated markets for health care are widely acknowledged to be neither equitable nor efficient. Government must play a role in supporting the organisation of health services used by different social groups. Countries with low levels of inequality may be able to provide universal access to relatively sophisticated health services. Otherwise, governments will need to operate within a segmented system. This means the negotiation of strategies to reduce the burden of sickness and premature death, whilst meeting the needs of different social groups. The discussion is organised in terms of the powers of government to require individuals and institutions to transfer resources for social use, enforce regulations and generate and disseminate information.

The paper concludes that governments committed to equity-enhancing health development need to increase their capacity to facilitate coalition building and manage change. It calls for an international public health legal framework that might include a definition of minimum standards for certain health services, to be underwritten by national and international financial commitments. It will be very difficult to reach agreement on this kind of framework. However, an important first step is to move beyond idealised visions of a future international health system to a clear acknowledgement of reality and the strategic options for change. This will provide a starting point for serious negotiations.

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1. INTRODUCTION

Fifty years ago Babasaheb Ambedkar wrote about the contradiction policy-makers faced in managing India's post-colonial transition:

> '… we are going to enter into a life of contradictions. In politics we will have equality and in social and economic life we will have inequality ... We must remove this contradiction at the earliest possible moment or else those who suffer from inequality will blow up the structure of political democracy which this Assembly has so laboriously built up'.[3]

This is a stark expression of the reality in much of Africa, Asia and Latin America in the years following the Second World War. That was a period of great social optimism, following a global war, which had been understood as a confrontation between opposing ideologies (Mazower 1999). The victors proclaimed themselves the representatives of democracy and social justice. The post-war decades were dominated by major projects for social change such as the rehabilitation of Western Europe through the Marshall Plan, post-revolutionary construction of command economies and the ending of the political structures of colonialism. There was a great deal of optimism about the possibilities for restructuring societies. In practice, however, international social policy debates were dominated by the conflict between the different visions of opposing political and military blocs.

The international community's expression in the health sector of this vision of social reconstruction was the primary health care concept, which viewed health in the context of an agenda for broad social change[4]. The 1978 Alma Ata Declaration, set a target of 'Health for All by the Year 2000':

> '… A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice'.[5]

Health sector development strategies, based on this concept, included construction of a network of basic health facilities, training and deployment of large numbers of health workers and the establishment of preventive programmes. In a number of countries they also involved training community members in basic health skills so they could lead preventive health programmes and provide basic medical care. Some advocates of primary health care argued that health should motivate a wide range of social reforms such as

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[3] Ambedkar, B.R., 1994; *Dr Babasaheb Ambedkar, Writings and Speeches*, Vol 13, Department of Education, Government of Maharashtra, Bombay, p.1216), cited in Thimmaiah 1996.

[4] The ideas underlying this concept emerged from the experience of the post-revolutionary command economies, social democratic regimes in Latin America and some of the more equitable post-colonial societies. However, it won acceptance as the cornerstone of the development policy of international health-related institutions in the late 1970s.

[5] World Health Organisation 1978.

reducing malnutrition, improving the environment, expanding literacy and so forth)[6]. Others argued for a narrower focus on basic health services for the poor.

Half a century later, the projects for radical social reconstruction are only partly successful. The hopes for a rapid removal of socio-economic inequalities have not been fulfilled. One of the most marked characteristics of the global social structure is the existence of substantial inequalities in wealth and income. These are paralleled by major differences in health between countries and between social groups within countries (Bloom and Lucas 2000; Gwatkin 1999). Many regions have experienced reductions in absolute poverty and excess mortality, however, the targets set in Alma Ata have not been attained. Sub-Saharan Africa and the former Soviet Union are experiencing a reversal of previous health gains (WHO 1999).

The persistence of these inequalities attests to the enormity of the attempt to manage national and international structural change. It is largely due to the great difficulties involved in overcoming deeply rooted economic and social inequalities and the resistance to change by political elite groups. However, it also reflects weaknesses in change management strategies based on an inadequate understanding of the process of social sector development.

There has been a recent upsurge of international interest in global inequality and the need to address poverty. International organisations and foreign aid agencies of the advanced market economies have become proponents of change. There is a growing international debate between what Deacon (1999) characterises as advocates of 'European universalistic social expenditure' and 'USA residualism'. This characterisation of the debate points to its focus on the social arrangements in advanced market economies (or idealised versions of them)[7].

It can be argued that the reference to arrangements in the above countries diverts attention from the real issues and options other countries face (Moore 1999a). Low and middle-income countries with substantial structural inequalities cannot provide equal social benefits to all, although they might aspire to do so. The real debate in these countries concerns the use of limited state power to alter the balance of benefits between social groups and influence sectoral development[8].

Toye (1999) calls for a shift of attention from debates about ideal arrangements in the social sector to a 'nationalisation of the anti-poverty agenda'. He argues this will involve the identification of strategies that governments wishing to implement change can employ to overcome structural inequalities and political

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[6] In so doing, they hoped to replicate the experience of Nineteenth Century Britain, where mobilisation around issues of public health influenced government policies on a wide range of issues (Porter 1999).

[7] It also draws attention to the need to identify the interests of the principal constituency of these agencies (the national electorate, the poorly defined governance structure of international agencies) in assessing the intention of their policy recommendations.

[8] The debate between advocates and opponents of state participation in the social sector of low and middle-income countries has a familiar echo for those, familiar with the literature on health economics before the 1980s. Much of it took the form of a stylised battle between proponents of an idealised version of the British National Health Service and an equally idealised version of an American market economy. By the early 1980s it had become clear that the state plays a very significant role in the health sector of all advanced market economies. Debates have increasingly been about the impact of alternative organisational structures on the performance of national health systems.

constraints. He emphasises the need to convince national elite groups that the needs of the poor can be met at an acceptable cost to themselves[9].

This paper explores what nationalising the reform agenda means for the health sector. It rejects universalising models that set simple, but unachievable, targets or aim at the transfer of organisational structures between different societies. It calls for strategies that begin with a country's reality and explicitly recognise the political nature of the management of health sector change. It concludes with a discussion of the implications of this understanding of the policy process for donor health policies.

2. TOWARDS EQUITY IN HEALTH IN UNEQUAL SOCIETIES

2.1 Health and health services

Health is influenced by many factors including access to nutritious food, clean water, adequate clothing and shelter, and the means for hygienic dispose of human wastes; freedom from contamination by hazardous substances and environmental pollutants; and availability of relevant information and skills. Declining levels of poverty are generally associated with better health. Europe experienced considerable improvements in life expectancy during the Eighteenth and Nineteenth Centuries, in spite of the virtual absence of effective medical interventions (McKeown 1976).

Social and economic inequalities are bad for health, even where most people do not live in absolute poverty. Wilkinson (1996) argues that health status in OECD countries is more strongly related to levels of equality than average income. He presents evidence of major differences in mortality between income groups within a society to demonstrate that patterns of social development still strongly influence health.

In spite of the multi-factorial influences on health, all societies organise specific activities to prevent and cure sickness and support the severely ill and their families. Collectively, these are known as the health sector. Effective health care technologies have developed and a complex industry has evolved during the Twentieth Century. There is evidence that effective health services substantially reduce mortality in low-income countries. The remainder of this paper focuses on strategies for spreading access to effective health services, whilst accepting they will have a much greater impact if part of a broader effort to meet the requirements identified above[10].

2.2 Vision and health sector transition

The concept of *equity* is a statement of the morally unacceptable nature of certain inequalities in access to social benefits. The argument that a policy is *equitable* is likely to win political support. This is one reason why

[9] Toye argues that there seem to be common conditions for catalysing state action to reduce poverty: the belief in the social interdependence of rich and poor; the existence of a credible threat from the poor; and the belief that state action can make a significant difference to the situation. Toye emphasises the need for a belief that the state can act effectively.

[10] The precedent of 19th Century Europe highlights the potential role of public health leaders in supporting political efforts to reduce inequalities. At that time, a fear of cholera and other infectious diseases, led to major efforts to improve urban water supplies and sanitation and reduce poverty (Evans 1987).

many African governments have resisted measures that acknowledge a break with the post-colonial promise of equal access to health services on the basis of need. They have preferred to maintain highly subsidised, but grossly under-funded, referral hospitals than openly debate the most appropriate use of limited government health resources. Rather than providing equal access to ineffective care, they could focus public funding on high priority services and allow certain facilities to charge full cost fees. This would be an open admission that ability to pay is an important determinant of access. It is impossible to separate the meaning of equity from the political consequences.

There are two quite different approaches to the application of the concept of equity to health policy analysis. The first is to compare the existing situation with the kind of health system to which a more equal society might aspire. Contributions to health policy debates in South Africa prior to the political transition in the mid-1990s emphasised the divergence between reality and this goal. They highlighted dramatic differences in health and access to health services between racial groups and contrasted them with a vision of a comprehensive national health system. These analyses contributed to efforts to end a system that assigned entitlements to social benefits on the basis of race. They have been of limited use to those managing the health sector since the election of a popular government.

The second approach compares the impact of specific strategic alternatives on health outcomes and access to services by different social groups. Governments of countries with large structural inequalities have to choose between strategies which all imply major inequalities in access to health services. Decision-makers need tools to make explicit the trade-off between the interests of different groups so they can manage inequalities better and protect the interests of the poor (Normand 1997).

It is difficult when discussing equity to steer between setting unrealistic goals, on the one hand, and rationalising unacceptable inequalities, on the other. Herring (1999) makes this point with regard to decisions about rural reform in the South of the USA and Kerala State in India:

> 'To assume that much of any existing political system is in equilibrium, from which moving is difficult, is to assume a conservative stance that prescribes doing nothing – or tinkering at the margins. To assume that political systems, institutions and patterns of behaviour are infinitely malleable yields a wide range of policy options, but has little relevance on the ground.'

Moore (1999b) cites examples of governments that have negotiated coalitions in favour of pro-poor policies to argue against a conservative pessimism grounded in the belief that, barring a revolutionary change, powerful groups will always oppose measures that benefit the poor. Huber (1995) makes a similar point regarding differing approaches to the management of recent social sector reforms in Latin America. Birdsall and Hecht (1997) identify countries that have implemented pro-poor health policies, in spite of their underlying structural inequalities. These examples underline government's potential role in managing change (Reich 1995; Walt 1995). The remainder of this paper is largely concerned with the strategic options available to governments wishing to implement pro-poor health policies. Where governments do not have any interest in these issues, the discussion may be relevant to the negotiation of the health sector component of a programme for transition after political change.

2.3 Measuring inequality

The equity objectives commonly applied to health policy debates have been developed in the advanced market economies. They include equal distribution of resources between communities and distribution related to medical need (Mooney 1987; Wagstaff *et al.* 1991). The idea underlying the popularity of these notions is that these societies could achieve health equality without great sacrifice by the better off. This is linked to the belief that additional resources yield minimal health benefits at the high levels of expenditure on health in advanced market economies. It can reasonably be assumed, in these circumstances, that measures to improve equity will impose few health disadvantages on those who would otherwise be better served. The equation of politically relevant *inequity* with absolute measures of *inequality* of access and/or health outcome makes good sense in this context.

Some policy analysts have advocated the application of similar equity criteria in low and middle-income countries. Gilson (1998) calls for health care to be distributed according to need and financed according to the ability to pay. She opposes the use of minimum standards of access for policy purposes. Deacon (1999) makes a similar case for the spread of the 'European', as opposed to 'American', model of social development. The underlying vision appears to be either an equitable world order with equal access to all goods and services services, or a less equitable world where health services are distributed much more equally.

These broad visions of the future provide a powerful critique of current patterns of distribution of health benefits between and within countries. They emphasise the massive gap between visions of equity and the reality, in which some social groups spend less than $5 per person on health and others spend 400 times as much. However, they provide little guidance for defining the most policy-relevant inequalities or identifying the next steps in the transition to a system that meets the most important health needs[11].

A national government, which accepts widespread poverty alongside private ownership of cars and major household goods, is unlikely to prohibit the better off from purchasing costly medical care. Nor is it likely to subsidise health services so highly that everyone will have access to the kinds of services to which the better off aspire. Although, governments may be able to influence the allocation of health benefits so they are distributed more equally than others, they are unlikely to eliminate major inequalities in access to some health services[12]. Policy-makers need measures of the inequalities that have the greatest impact on health and/or livelihood strategies of the poor (Murray and Acharya 1997; Bloom and Lucas 2000). These measures need to refer to social groups relevant to government decisions such as residents of deprived areas, specific vulnerable groups, people with differing relationships to the labour market, and so forth. Section 3 discusses these issues in more detail. There is room for substantial struggle and debate over more and less acceptable patterns of inequality and the appropriate use of government resources and regulatory power.

Debates about health equity in the advanced market economies are usually based on the assumption that comparisons within a single nation are the only relevant ones. This leads to proposals for equitable

[11] For example, is it more important to provide universal access to basic health services or reduce inequalities between different social groups that all earn incomes greater than subsistence?

[12] This is particularly the case because even relatively better off social groups in many countries, are not consuming enough health services to have reached the point of very low marginal benefits to additional expenditure.

distribution of high levels of health benefit within each country. Governments are unlikely to find support for a tax on health expenditure to fund health services in another country. The aid policies of these countries support equity in health in low and middle-income countries. This has led to a consensus on the need to increase resources available for health services used by the poor. Policies sometimes imply judgements about appropriate levels of health care consumption by the non-poor in recipient countries. One example is the advocacy of reductions in government funding of hospitals, without efforts to establish alternative ways to finance these facilities. This suggests that the non-poor have weaker entitlements to health services in recipient countries than in donor ones.

This example highlights the need to relate concepts of equity to loci of decision-making. It highlights the different ways of treating intra and inter-country inequalities. Similar considerations pertain to inequalities within and between groups relevant to a country's social policy (based on place of residence, relationship to the labour market and so forth). Countries with major structural inequalities will almost certainly have parallel inequalities in consumption of health benefits[13]. The challenge for government is to negotiate policy-relevant inequalities and to ensure that its interventions reduce inequity.

2.4 Transfer of health care technologies

The residents of low and middle-income countries cannot derive benefits from existing health care technologies by simply importing health-related commodities. Their countries have to establish a local capacity to produce health benefits. This involves training and regulating a variety of personnel; establishing and managing small and large enterprises (clinics and hospitals); organising national programmes; importing drugs and equipment; and creating systems that enable individuals to manage lumpy and unpredictable expenditure on medical care. It is more fruitful to regard the establishment of an effective health sector as the creation of a national industry, than as a capacity to import and distribute goods and services.

Health sector analysts and political leaders in the advanced market economies mostly agree that governments must play a major role in the health care industry. Decades of debate have identified a variety of failures in the markets for (i) provision of public health services such as preventive measures and treatment of infectious diseases, (ii) management of major financial risks, and (iii) dissemination of information relevant to the choice of specialist medical services. Evans (1997) and Chernichovsky (1995) refer to an emerging consensus that an efficient and equitable health system includes the following institutions, which imply a major government involvement:

- health finance systems, which provide compulsory universal coverage for a large proportion of total health costs, with contributions based on income rather than individual risk;

[13] This is particularly important in a world where labour markets increasingly cross national boundaries and communications are dense and efficient. For example, skilled workers in low or middle-income countries increasingly compare their access to consumption goods and health benefits to that of their counterparts in advanced market economies. They would experience measures aimed at denying them and their families access to health services as unjust.

- a means of organisation and management of consumption of publicly financed care, which controls costs and encourage the provision of effective and cost-effective services; and
- mechanisms to regulate the technical performance of providers.

Hsiao (1994) argues that government also must play an active role in the health sector of middle and low-income countries. Katz and Miranda (1994) make a similar point with specific reference to Latin America. These analysts make a strong case for government involvement in the health sector. However, they leave major questions unanswered about the form it should take in different situations.

The development of the health care industry in the advanced market economies took place in a context conducive to the evolution of complex organisational structures including: high average incomes, financial stability and a relatively slow pace of social change, efficient tax or social security systems, low levels of absolute poverty, effective safety nets for the poor, a well-organised regulatory system and sufficient numbers of trained personnel to deliver the desired level of service.

The situation is very different in many low and middle income countries, where many people are excluded from the formal economy, welfare benefits are scarce or non-existent, government bureaucracies are fragile and function inefficiently, regulatory and licensing mechanisms are weak, and there are shortages of highly skilled personnel. These characteristics often vary between regions in a single country. Some countries are undergoing radical economic and institutional changes as they implement structural adjustment or a transition from a command economy. Policy analysts in these countries need to ask:

- Under what conditions is the consensus model, described above, appropriate?
- What alternative arrangements will meet needs when these conditions are not fulfilled?
- How should governments manage the development of the health sector in anticipation of the ultimate aim of establishing the kinds of structures that exist in the advanced market economies?

Government cannot concentrate solely on the poor. Affluent groups also depend on social institutions to regulate providers, organise health insurance, and so forth. There are strong arguments for government to use its power to support the creation of an efficient health sector for this social group. If the state does not play this role, a parallel 'quasi-state' could develop. The nationalisation of health development policy means the abandonment of ideal visions of government's role as, either funder and supplier of a unitary health system for all, or responsible solely for the protection of the poor. Government has an interest in the different segments of the health system. Its challenge is to balance the needs and demands of different social groups.

2.5 Politics and health sector organisation

Debates about health policy are highly political. Evans (1997) suggests, for example, that pressure for privatisation of health services in the advanced market economies comes from an alliance of providers, hoping to increase their income, and the better-off consumers, wishing to reduce their financial responsibility for the health care of the poor. The pressures are stronger in low and middle-income

countries, where institutional arrangements potentially have a greater impact on the well being of stakeholders.

The arguments for and against the creation of a universal health system are largely based on assumptions about the impact of different institutional arrangements on political outcomes. The experiences of countries with highly segmented health systems have demonstrated that powerful groups can use an institutional base to further their interests. In South Africa (Bloom and McIntyre 1998) and many countries of Latin America (Mesa-Lago 1997), the better-paid workers are enrolled in work-related health insurance schemes. They have been able to secure supplementary benefits from government in the form of tax exemptions, access to publicly subsidised health facilities and direct government subsidies to insurance schemes during economic downturns. Health workers have benefited as their hospitals invested in increasingly sophisticated equipment. The existence of these institutional arrangements has strengthened the ability of powerful groups to influence short and long-term sectoral development.

So-called unitary systems can also function in favour of the powerful. Recent studies have demonstrated that public health services finance in Africa substantially greater benefits for the better-off than for the poor (Peters *et al.* 1999). Savedoff (1999) argues that the advantage of public financing or provision of services in Latin America can be offset by the responses of wealthier individuals and public sector personnel. A government commitment to a unified health service can act as a veneer to hide major structural inequalities in the health sector. It may prevent government from taking actions, such as charging substantial fees for specialist hospital care used largely by the better-off, which could be construed as an admission of inequalities in access to care (Bloom 1997). It may also draw attention away from government failure to provide some social groups with access to the most basic services.

3. PRO-EQUITY HEALTH STRATEGIES IN UNEQUAL SOCIETIES

This section explores the options available to a government, genuinely committed to reforms aimed at creating a more equitable health sector. Such a government needs to negotiate a strategy for health sector development that enables all social groups to benefit from a well-organised health sector, whilst ensuring that the interests of the poor are adequately represented in the competition between stakeholders. The discussion is organised in terms of the powers of government to (i) require individuals and institutions to transfer resources for social use, (ii) enforce regulations, and (iii) generate and disseminate information.

3.1 Government powers to generate revenue

It is generally agreed that some form of social organisation of health finance, through taxes and/or social insurance, is beneficial (Whitehead *et al.* 1999). The ability of governments to raise revenue depends on the population's willingness to pay tax or other compulsory contributions. Moore (1999a) argues against a determinist argument that globalisation will inevitably make it increasingly difficult for governments to raise revenue. However, he underlines the need to learn more about the politics of public sector finance in low and middle-income countries.

As levels of consumption rise, people increasingly demand complex social services and benefits, and they have a growing interest in measures to reduce risk. It is difficult to organise these services without government involvement. This provides an incentive for people with incomes above subsistence to support the establishment of effective public administrations and/or work-related social insurance. There may also be pressure for redistribution of access to benefits in favour of the poor. Governments must have a level of political legitimacy to respond to these pressures effectively. This is the context within which negotiations regarding health finance take place.

Many countries have systems for arranging public sector finance that reflect a segmented social structure. Such systems institutionalise patterns of inequality that have achieved a certain level of political legitimacy. This stabilisation of social arrangements is essential for the government administrative system to function effectively. However, it also reinforces and legitimises the exclusion of some groups from social benefits (Kabeer 1999). There is a constant struggle in very unequal societies over the boundary between legitimate and illegitimate inequalities.

The most common principles for organising this segmentation are geography and relationship to the labour market. The first is reflected in decentralised public administrative systems with devolved tax authority and the second in social security systems. The following sub-sections discuss these, in turn. Ethnicity used to be another principle for the organisation of government powers, most recently in racist regimes in Southern Africa. One major advance during the past half century is that the legitimacy of this principle has almost universally been rejected.

3.1.1 Tax and the management of geographic inequalities

Governments are principally organised by geographic area. The most obvious division is between countries. National governments traditionally finance social expenditure from revenue or debt. Transfers of public resources between countries have mostly been viewed as investment in development projects (and military assistance). This perspective is changing, and aid flows increasingly take the form of programme funding of social services and/or budgetary support, with associated conditions. This may presage an acceptance of the need for international fiscal transfers to co-finance public services in low-income countries. For the foreseeable future, however, these transfers are likely to remain very small, compared to total government expenditure around the world.

Government expenditure generally accounts for a smaller share of GDP in low and middle-income countries than in advanced market economies (Burgess 1997). This is a major limit to public funding of social benefits, including health. A government's ability to increase social spending depends on its ability to establish a political coalition in support of reform and its capacity to enforce tax legislation (Huber 1995). A practical strategy for tax reform must address the needs of different social groups. It also has to take into account differences in institutional capacity between levels of government.

In theory, a government committed to equity could collect revenue on the basis of ability to pay and disburse it on the basis of need (Burgess 1997). In practice, governments have a limited capacity to redistribute access to resources through the tax system. Savedoff (1999) argues there is a trade-off between

the degree to which tax collection and expenditure is progressive and the total amount of government revenue. He illustrates how a regressive tax can sometimes provide greater net benefits to the poor than a more progressive one that generates much less revenue.[14] This raises the general issue of the need to reconcile the roles of public finance as a means for increasing efficiency of organisation of social goods and redistributing resources. Governments need to meet both objectives.

There is a considerable tension in many countries between the principles of national citizenship and government decentralisation. According to the former principle, the major locus of decision-making is the nation state. The right to tax and redistribute benefits between individuals is situated at that level. In practice, regions and categories of settlement (cities, towns, villages and so forth) differ considerably in their level of economic and institutional development. As incomes rise in a locality, the demand for government investment in infrastructure and organisation of social benefits may also rise. Policy-makers face difficult decisions regarding the trade-off between intra and inter-regional equity.

Since the early 1980s, China has decentralised government administration radically. (Wong *et al.* 1995). Local governments collect taxes and remit a share to higher levels. The poorest localities are net recipients of fiscal transfers, but their governments spend much less than in richer areas.[15] The decentralisation of government functions has had a mixed effect. Many local governments, particularly in areas experiencing rapid economic growth, are establishing complex systems of collective welfare, whose overall influence may be to reduce inequality locally (Cook 1999; Oi 1999). Poor localities, on the other hand, have experienced a deterioration of public services and inter-regional inequalities have increased. The national government is exploring options for increasing fiscal transfers to poor localities, but this is an area of intense negotiation.

The Government of South Africa faces a similar dilemma in reconstructing its social sector. The country has sophisticated cities with modern infrastructure and well-developed social services. It is essential for the development of the country that these cities create an environment for the establishment of industries that can compete in the international economy. Prior to the transition to democratic rule, city administrations were segregated by race. So-called 'African' municipalities had substantially fewer resources than 'White' ones. The government has required contiguous municipalities to integrate. This is encouraging the creation of more equal urban settlements with well-organised services. However, it may increase inequalities between urban and rural residents. Government needs to balance the need to establish cities capable of supporting an efficient workforce against the pressure to reduce inequalities between urban and rural areas.

[14] The basic argument is that the poor tend to benefit from increases in government expenditure. In a situation of great inequality, even if the poor pay a higher proportion of their income in tax than the rich, they contribute only a small share of total revenue. If a higher proportion of the total tax take is allocated to services they use, they will benefit. This supports Moore's (1999b) argument that pro-poor governments should seek coalitions in support of reforms that meet the needs of a broad spectrum of social groups, including the poor.

[15] Zuo (1997) illustrates by comparing Huacao, a rich township near Shanghai, with Taiping, a poor township in Guangxi Province. The former spends almost six times as much *per capita* on education and health than the latter. Huacao provides a wide range of welfare services. Taiping spends 90% of its education and health budgets on salaries and local people pay a high proportion of the cost of services, themselves Many poor rural townships are having similar difficulties in funding basic health services (World Bank 1997).

The complex realities of countries undergoing rapid social change militate against simple rules for allocating public health expenditure on the basis of population or health need. Such rules could limit the right of affluent localities or regions to provide the more sophisticated public services their population demands. This, in turn, could lead to an expansion of the private sector (regulated or unregulated). The alternative is to focus policy attention on meeting basic needs of residents of the poorer localities. For example, minimum levels of public funding could be established for local health services. These standards would have to be linked to mechanisms of fiscal transfer to ensure that poor areas could afford to meet them. These fiscal transfers could be made conditional on co-funding by local governments and/or communities. Sanctions would be needed to ensure that local governments met the standards.

3.1.2 Social insurance

One argument for government involvement in the health sector stems from failures of markets for insurance services (Normand 1997). Private companies have strong incentives to take individual risks into account in setting premiums. However, the informational problems are great and the net result is that insurance costs are high. The common solutions to this problem are either tax-funded services or compulsory social insurance. There is little difference between these institutional arrangements in advanced market economies, where coverage is close to universal. That is not the case in low and middle-income countries, where social insurance frequently co-exists with alternative systems of finance for those outside the organised economy (Guha 1994; Cook and Devereux 1999). In that case, government policies need to take interactions between the parallel systems into account.

Most countries have an organised economic sector with registered enterprises that pay taxes and report regularly to government. They have laws that regulate the relationship between employers and employees, including the finance of health benefits. Formal sector employment is often a principle for identifying those liable to pay health insurance and claim entitlements.

The arguments against the introduction of employment-related health insurance flow from the projected impact on the health services of those not covered. The introduction of compulsory health insurance can reduce the resources available for other health services by diminishing public willingness to pay taxes, attracting government subsidises for insured services, and diminishing the supply of health workers to the public sector. In the longer term, the institutionalisation of a parallel system may create a political base from which those covered by insurance can resist the extension of benefits to other social groups. In Latin America, for example, work-related insurance schemes resisted change during the economic crisis of the 1980s (Mesa Lago 1994). They made great efforts to maintain benefits for their politically powerful members and, in some cases, governments provided public subsidies, whilst neglecting the needs of other social groups.

In spite of these risks, it can be argued that socially funded health services enable those earning above subsistence incomes to make better use of their resources, without necessarily disadvantaging the poor. They also reduce inequalities between employees by protecting them against the impoverishing impact of serious illness. The establishment of cost-effective health services and risk-sharing mechanisms for workers is an

important component of an efficient industrial economy. It is possible to reduce the negative impact of work-related insurance on other social groups by (i) ending government subsidies to social insurance, (ii) publishing information on sources of finance and levels of expenditure of schemes, and (iii) representing the interests of the uninsured on governance structures of schemes. However, the experience of many countries during the last century illustrates how difficult it is for governments to balance the needs of insured workers against those of people outside the organised economy.

The demographic transition has created a further complication for government policy-makers. Measures of equity need to pay more attention to inter-generational transfers between social groups. Changing demographic patterns and the development of expensive technologies for dealing with the chronic diseases of older people have created unexpected increases in the cost of medical care. These changes raise particularly difficult problems for countries with substantial inequalities, where life expectancy varies between social groups.

The most immediate manifestation of these changes has been on work-related insurance schemes, which have mostly been financed on a pay-as-you-go basis. The ageing of the insured population is pushing costs up in South Africa (Bloom and McIntyre 1998), China (Liu and Xiao 1995), many countries of Latin America (Mesa-Lago 1997) and elsewhere. The first response is for schemes to redistribute resources between young and old workers, by increasing contributions. At a certain point, this may become politically unacceptable, leading schemes to pressure government for financial support. The principal beneficiaries of this support are ageing members of the more privileged social groups. Some governments, such as in the former Soviet Union, have simply reneged on entitlements they had negotiated in different circumstances.

In China, employees of state-owned enterprises have been covered by work-related insurance for years. As a consequence of state enterprise reforms, many companies can no longer afford to finance a benefit whose cost is rising every year. City governments are under pressure to support those losing their insurance entitlements. In Liaoning Province the richer cities have been asked to transfer funds to poorer ones, to assist pensioners who lose their health entitlements. The immediate impact is to enhance equity, but it could reduce the willingness of local governments to support increases in fiscal transfers to poor provinces and counties.

In South Africa, work-related insurance was previously reserved for the better paid. A large proportion of ageing workers and retired people with health insurance, has a history of high incomes. As the government encourages insurance schemes to extend their coverage to the lower paid it needs to address some difficult questions. Should expanded schemes finance the entitlements of retirees, or should new schemes be established which provide lower cost coverage to newly insured workers? What will happen to the entitlement of the privileged pensioners to high levels of insurance, and how will this entitlement be financed? This illustrates the issues that must be addressed in the management of transition to a more equitable system during a period of demographic change[16].

[16] There is an important contrast in the impact of economic transition on pension and health entitlements. Many governments have reduced the real cost of pensions for people who previously earned high salaries, through inflation. Health care costs generally outpace inflation. This leads to financial pressure on health insurance funds and ultimately, to a redefinition of the services to which beneficiaries are entitled.

3.1.3 Meeting the needs of those outside the organised economy

Large proportions of the population of many low and middle-income countries have weak links with the organised economy. They earn a living outside the regulated formal sector. They may live in a locality where public administration is weak. Mamdani (1996) highlights the dual nature of the relationship between people and the state in contrasting 'citizens', who function within an economic and institutional framework similar to an advanced market economy and 'subjects', who have few legal entitlements to benefits.

The long-term aim may be to integrate everyone into a uniform institutional system. However, it is hard to envisage this happening as long as access to the means of earning a living is highly segmented. Mesa-Lago (1997) argues that richer countries, and those with a lower proportion of their population outside the formal sector, could integrate the excluded into a uniform health insurance system, with the government financing their entitlement. Costa Rica has created such a system. In many other countries work-related insurance and publicly funded services for those outside the organised economy may co-exist for a long time.

The creation of parallel systems institutionalises the reality that those outside the organised economy have lower health entitlements than the rest of the population. Laurell and Arellano (1996) warn against the creation of a new form of poor relief, that consolidates the exclusion of large numbers of people from all but the most minimal services. This highlights the need for a better understanding of the implications of different strategies for financing health services for the poor.

Much of the discussion about the pros and cons of targeted benefits draws on recent debates about the welfare state in advanced market economies. In these countries it can plausibly be argued that governments are more likely to fund universal entitlements than those reserved for the poor and vulnerable. It is risky to draw simplistic parallels with governments in low and middle-income countries. In some cases, elite social groups may be more willing to take seriously a government commitment to reduce destitution than an open-ended promise to provide equal access to a social benefit. Strategies for targeting the poor are likely to combine a focus on poor localities, subsidies for facilities most used by the poor, funding of specific public health programmes and safety net arrangements for poor households.

Sen (1999) argues there is powerful evidence that countries can substantially improve health and contribute to poverty reduction by ensuring the availability of certain basic health services. He emphasises the protective impact of the existence of the right to safety net provisions in times of economic difficulty. He also points out the trade-off between the need to focus public expenditure on those who need it the most and the administrative costs and disincentive effects of certain kinds of targeting. This reinforces the need to combine targeting on poor localities and facilities that mostly serve the poor with some benefits reserved specifically for poor households.

Loewenson (1999) asks whether it may be possible to establish some form of hard entitlements (rights) for those outside the formal economy in Southern Africa. This would entail the allocation of public funds preferentially to the services they use. For example, the government could establish minimum standards for public funding of local health services. The national government would back these standards with the carrot of fiscal transfers to poor localities and the stick of sanctions against local authorities that do not meet them. Loewenson emphasises the need to provide civil society organisations with information about these

entitlements and the use of public resources. She envisages future political struggles around meeting clearly identified needs.

3.2 Regulation and structural inequalities

A second use of government power in the health sector is to influence the behaviour of stakeholders. It can be argued that government involvement increases efficiency, by reducing the risk of harm and improving the ability of users to select competent service providers; it also reduces the danger of unacceptably inequitable outcomes. This is achieved by structuring appropriate rules and incentives. Londono and Frenk (1997) use the term *modulation* to cover system development, co-ordination, design of financing systems, regulation, and consumer protection. For simplicity the discussion in this section focuses on the regulation of providers of services and drugs.

Governments of post-colonial societies and command economies influenced provider behaviour largely through bureaucratic structures of public sector health systems. Government employment and promotion practices defined the basic qualifications for different health service functions, and supervision systems monitored performance. Highly politicised societies, such as China and Vietnam of the 1960s and 1970s, complemented this with political pressures to 'serve the people' (Bloom 1998).

Some societies also created regulatory frameworks for a private sector modelled on health systems in the advanced market economies. These included professional licensing and regulatory bodies or laws to control drug distribution and sale. Professional bodies influenced public sector systems by insisting that certain jobs be reserved for licensed professionals.

There has been a move away from command and control methods for influencing health workers. This has largely taken place in parallel with a shift towards a market economy. Markets for health services (legal and illegal, regulated and unregulated) have grown substantially (Bloom and Standing 1999). It is now possible to buy a wide variety of health-related goods and services in many countries. This is partly due to supply-side changes such as the rapid increase in the number of trained health workers and the emergence of a variety of systems for the distribution and sale of drugs.

Another factor contributing to the marketisation of health services is the weakening of public sector administration. In a number of countries health workers have to supplement government salaries to meet their income expectations (Ensor and Killingsworth forthcoming; Leonard 2000). Systems of supervision and retraining have become less effective. Public health services increasingly function like weakly regulated, publicly subsidised private markets. The impact of this *de facto* marketisation has not been well documented, but there is reason to believe that it has been associated with increases in cost and higher transactions costs in identifying competent practitioners (Bloom and Standing 1999). Governments are exploring alternative strategies for influencing provider behaviour.

Governments of societies with major structural inequalities face particularly difficult problems in constructing regulatory frameworks. The influence of government may vary considerably between localities. Social segmentation is mirrored in segmented regulatory systems. Many countries have a relatively well-regulated formal sector, whose beneficiaries largely live in the cities and participate in the organised

economy; they also have many largely unsupervised health workers who provide services for the less affluent social groups.

Regulatory systems largely serve the needs of elite groups in some countries. A number of colonies imported the metropolitan medical regulatory system, to ensure that those who could pay had access to licensed practitioners. The indigenous people used 'traditional' practitioners, or 'assistant' health workers. This created a segmented market for health care providers. Over subsequent years, there has been a large increase in the number of trained personnel and many countries have a spectrum of practitioners from highly regulated super-specialists to a variety of informal health service providers. Stakeholders influence regulatory bodies. For example, the doctor-dominated Health Professions Council in Zimbabwe has denied nurses the right to prescribe drugs privately, although they provide this service in the public system (Ndlovu 1999). The case for this kind of control is to protect people against bad advice. However, it may force the poor to consult providers operating outside the law.

The above example illustrates the contradictory characteristics of regulatory regimes, which limit the right to provide certain services to specified categories of personnel. They make it easier for users of services to select practitioners, labelled as competent and ethical (or liable to loss of license for inappropriate behaviour), however they give practitioners opportunities to earn rents. They also provide licensed practitioners with the ability to restrict access by other practitioners to specialised knowledge. This is particularly problematic in segmented societies, where measures to regulate a market providing services to the more affluent may exclude large numbers of practitioners from the regulatory system.

China attempted to address these issues during the Cultural Revolution of the 1960s and 1970s, when its government identified the privileged position of doctors as a major constraint to the spread of health care benefits to the rural poor (Gong *et al.* 1997). It closed medical schools and required doctors to move to rural health facilities. It trained large numbers of peasants as 'barefoot doctors' who provided basic services in rural areas. Professional licensure of health workers was discontinued. These measures resulted in a rapid spread of health-related skills so that almost the entire population had access to some kind of health worker. This contributed to a dramatic improvement in health status (Bloom and Gu 1997).

With the transition to a market economy and the liberalisation of management of health workers, the most highly trained doctors have returned to urban health facilities. During the late 1970s and early 1980s many medically unqualified people, who had worked for years in rural facilities, were promoted to the status of doctor[17]. Concerns have been raised about the quality of services they provide. There is also a perceived need to regulate the quality of professional practice in urban facilities, linked to rapid rises in disposable income and increasing demands for sophisticated medical care. The government is drafting a bill to re-instate licensing of doctors. It will reserve certain interventions for registered professionals. This raises difficult problems for poor rural localities, where non-professionals provide many services. It is not clear how this problem will be resolved.

China's experience has been extreme, but the basic issues are similar in other low and middle-income countries, many of which have experienced rapid expansion in the number of personnel and the emergence

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[17] A large proportion of doctors in rural health facilities has no formal training at all (Gong *et al.* 1997).

of complex markets for health services. Regulatory systems do not reflect the segmented nature of health care labour markets. Poor people have little support from the regulatory system in selecting sellers of drugs and providers of medical advice. This highlights several dilemmas faced by governments:

- Can they ensure that participants in the organised economy obtain the benefits of modern health care technology (through use of regulated specialised providers) whilst extending access to safe and effective services to the rest of the population?
- Can they establish mechanisms, other than command and control bureaucratic systems, to regulate the quality of providers used by social groups outside the organised economy?
- Can they protect regulatory structures against capture by interest groups?

3.3 Provision and use of information

Governments have the power to generate and disseminate information and organise negotiation and governance procedures that strengthen the influence of stakeholders (Loewenson 1999). In a command and control system of health service organisation, governments tend to retain information, as a means of exercising power. As their ability to control resources diminishes, they may be able to exert more influence by disseminating information. This information needs to be in a format that various stakeholders can use. Data on health needs, resource use and health service performance could be organised in terms of categories relevant to political debate such as (i) political/administrative localities; (ii) categories of settlement (urban and rural); (iii) relationship to the labour market and state regulatory systems (internationally mobile, the organised workforce, other workers and peasants, those without means of support); (iv) gender and stage in the life cycle; (v) ethnicity (in countries where this is relevant to resource allocation); and (vi) vulnerable groups (landless, peri-urban squatters, displaced persons).

Government can also use its powers to ensure that stakeholders are represented on governance structures such as professional bodies, social insurance schemes, district health boards, and hospital boards. The purpose is to give previously disenfranchised groups access to information and enable them to use it in negotiating health benefits. Londono and Frenk (1997) describe experiments in Latin America to establish 'organisations for health services articulation', which purchase services from providers, using funds transferred by government or social security bodies. In some cases these bodies include representatives of the community.

4. CONCLUSIONS

Discussions about strategies for increasing equity in health in highly unequal societies must move beyond arid discussions about the pros and cons of different ideal models. Simplistic debates about whether to finance and provide a comprehensive public health service or only a safety net for the very poor bear little resemblance to the real options governments face. They need to support the development of a national

health care industry that meets the needs of all social groups, whilst taking measures to improve access to effective and affordable services by the poor.

There are a number of reasons why elite social groups might be willing to support the development of health services that meet the needs of the rest of the population. The most compelling is that living in proximity to people who are infected with a serious illness is dangerous. This was a strong motivating factor behind public health reforms in 19th Century Europe. This motivation may have decreased because of advances in water treatment, the physical separation of social groups in urban areas and the development of effective medical treatment for many diseases. The resurgence of malaria and tuberculosis and the HIV/AIDS epidemic suggest that barriers to the spread of infection are breaking down. Also, the emergence of drug resistant bacteria has demonstrated that everyone is affected by bad quality medical services for the poor. These changes could contribute to a new awareness amongst national elite groups of the benefits of universal access to preventive programmes and basic medical services.

People earning above subsistence incomes expect access to modern health services. The experience of the advanced market economies suggests that government intervention is required to ensure that effective and affordable health services are available. Systems of health finance and public provision and/or regulation need to have political legitimacy in order to work well. Stakeholders in the health sector must believe that the basic rules of behaviour will persist for a long time. This should encourage those with economic and political influence to support effective government involvement in the health sector. This involvement must meet the needs of the poor, if it is to retain political support.

The preceding paragraphs suggest it could be in the interest of the economically powerful to support equity enhancing health development. Local elite groups do not necessarily see things this way. Even if they are willing to support measures to improve health, they may not be convinced that the government's strategy is realistic. Deacon (1999) suggests that the development of transnational companies offering health insurance and medical care provides an alternative means for those with money to meet their health needs. This could reduce their willingness to support effective government involvement in the health sector. It is too early to assess the importance of this development. The remainder of this section outlines some elements of equity enhancing health strategies at national and international levels.

4.1 National strategies

It is impossible to define a simple rule that differentiates countries that can realistically attempt to establish a unitary health service from those that will need to manage a segmented system. A unitary system is more likely to meet the needs of different social groups in societies with relatively high average income, low levels of inequality between regions and between social groups, effective public sector administration throughout the country, efficient systems of tax collection, and mechanisms to make institutions accountable for their use of public funds. Once a government has decided to create a universal health service, the struggle for resources will be internalised in debates about system design.

Governments in low income and/or very unequal countries will find it difficult to impose a universal model of health service organisation. Even pro-poor governments may have to manage a highly segmented

health sector. This will involve measures to meet the demands of the better off, whilst improving access to the most important health services by the poor.

Once governments have accepted they cannot create a universal health system they can consider pluralist arrangements involving a variety of stakeholders. For example, a combination of government budgetary support, local government finance, work-related insurance and contributions by local enterprises could finance health care for urban workers. Similarly, local governments, civil society organisations and a variety of local organisations could play a role in rural health services. Governments need to find strategies to channel as many resources as possible to meet the needs of the poor, whilst encouraging a range of stakeholders to contribute to health development.

Several analysts have highlighted the path dependent nature of health system development (Mackintosh 1997). They point out that measures taken to meet short term needs, can create an institutional framework that increases the influence of interest groups on future decisions. For example, the decision to provide government subsidies to a financially distressed work-related insurance scheme can lead to permanent public finance of health services used by the better off. These dangers are political and must be addressed that way. One strategy is to make information on resource use public[18]. Also, governance of institutions could include representatives of a variety of social groups. The board of a social insurance scheme might include representatives of those not covered, as a means of reducing the tendency to increase the level of coverage rather than extend it to more people.

Another strategy for promoting equity is to establish government norms for minimum service delivery. The norms could be included in public health law, to ensure that local governments take them seriously. Governments would ensure these basic services were financed and focus their regulatory efforts on achieving these norms. The government would also establish mechanisms to make information available on the performance of local health services, and provide opportunities for continuing debate about the kinds of services to be provided.

Governments need to recognise that efforts to reduce health inequalities constantly 'swim against the stream' of pressure from powerful interest groups (Birdsall and Hecht 1997). They need to find ways to put together a reasonably broad-based coalition in favour of a believable development programme. This can be very difficult, particularly where there are potential winners and losers. Whatever the overall political agreement on health development strategies, competition between stakeholders will continue. This is particularly the case in highly unequal societies where the cost of failure in negotiations can be very high. Governments, which have previously established competence as an investor in health system development and provider of public health services, will need to make considerable efforts to become effective managers of sectoral change.

[18] In South Africa, for example, a Parliamentary Committee on Health has requested routine information on progress in the re-allocation of public funds.

4.2 International strategies

There is a growing international interest in reducing poverty and ill health, expressed in agreement on international development targets to reduce childhood and maternal mortality. The case for investment in health improvement reflects international interests, much as in individual countries during the 19th Century. Poor countries are a source of potentially damaging infections around the world. And poor populations, who feel excluded from social benefits, are liable to infection with violent ideologies. There is also a general sense in the advanced market economies that certain levels of deprivation are morally unacceptable.

There is considerable interest in extending the concept of rights to social benefits, such as health care (Koivusalo and Olliala 1997). There is little point in establishing rights unless the loci of responsibility for delivering on them are clearly defined. It may be possible to establish international public health laws that set minimum standards for certain activities (Bloom and Lucas 2000). This would define the responsibilities of the international community and national governments. The minimum standards could cover:

- public health programmes and services that address basic health care needs of the poor;
- essential regulation of the systems for training and supervision of health workers and distribution of drugs;
- provision and dissemination of information on health problems, resource use and health sector performance; and
- participation of a wide spectrum of stakeholders in decisions about resource use.

The development of a global medical care industry will raise, at international level, the same regulatory issues that national governments face. This may involve, for example, trading off measures to establish high standards for health insurance and provision of health care against the need to ensure that the poor have access to effective and affordable services. International governance structures will be needed with the political legitimacy necessary to make and enforce this kind of decision.

It will be very difficult to reach international agreement on the kind of framework described above. However, an important first step is to move beyond discussions of idealised visions of a future international health system to a clear acknowledgement of reality and of the strategic options for change. This would provide a starting point for serious negotiations.

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