FROM ALMA ATA TO MILLENNIUM DEVELOPMENT GOALS: TO WHAT EXTENT HAS EQUITY BEEN ACHIEVED?

"Not until the creation and maintenance of decent conditions of life for all people are recognised and accepted as a common obligation of all people and all countries—not until then shall we, with a certain degree of justification, be able to speak of mankind as civilized"

[*A*lbert Einstein (1945) as in Werner & Sanders, 1997]

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Abstract

Equity was a core value in the Alma Ata declaration on PHC. However, the interpretation of equity varied and its application became difficult. Equity goals and objectives have often been rhetoric rather than practical. Policy reforms since Alma Ata have been dominated by the neo-liberal economic ideology, which does not include equity as its core value. After 25 years, reforms such as the essential health package, sector-wide approach, user-fees and decentralization have not achieved the key goals of PHC such as equity, and of health sector reforms such as cost recovery, efficiency and sustainability.

Introduction

The Alma Ata declaration of 1978 advocated for Equity as the core value for health for all, and many states signed to undertake policies that would ensure equity in health and health care. To what extent has this promise been fulfilled, 25 years down the road?

Before answering this question, it is important to have a common understanding of the term equity, a concept often charged with values.

Equity is a moral or ethical principle, which refers to fairness or justice in the distribution of resources and welfare. Thus Inequity implies that there are disparities in resource and welfare (such as health status) distribution; and, importantly, that these disparities are potentially avoidable, and are, therefore, deemed *unfair* and *unjust* (Evans T. et al, 2001; Feachem RGA 2002). In other words, a disparity is considered unfair if it derives from some form of social injustices, and is morally unacceptable to that society (Evans T et al, 2001). Thus, differences arising from individual or social preferences, or from biological and geographical variations, do not constitute inequity because they have nothing to do with decisions of "third parties" in the society. Therefore, to describe a situation as inequitable, the cause must be examined and *judged* to be unfair in the *context* of what is going on in the rest of the society.

In the health domain, equity implies that, ideally, everyone should have a fair opportunity to attain their full health potential, and, more pragmatically, that no-one should be disadvantaged from achieving this potential (Raberg M. & Jeene H, 2001).

Thus, considerations are made of *equity in access* to health care services so that financial, geographical and cultural barriers are *deliberately* minimized; or *equity in utilisation* of health care services so that there would not be any "underserved" groups; and *equity in financing* of health care services so that the burden of paying for health care services falls more on the richer income groups; and that government subsidies benefit the poor more than the better-offs.

To what extent have these parameters been achieved?

It is recognised that no health system can achieve perfect equity, however defined (Evans T et al 2001). Therefore, it is not surprising that, twenty five years after Alma Ata, unacceptable disparities still exist, both between and within countries, regardless of their levels of development and wealth and regardless of their aggregate levels of health

The question of whether health differentials have been mimised or not implies that there should have been an on-going monitoring of equity trends in health and health care. Unfortunately, there have been no significant efforts to develop data oriented towards the distribution of health conditions and health services-use across economic groups. Only recently have there been some attempts to develop monitoring data comparable to what economists have routinely done for income and poverty (Gwatkin, 2000). As such, data necessary to analyse *progress* towards attainment of equity goals have not been available.

Thus to answer the question posed, this paper looks more at the extent to which emerging policies have given attention to equity over the period.

Extent of equity orientation of goals

The importance of strong political commitment as a prerequisite for attaining equity has been documented elsewhere (Werner & Sanders, 1997). Being equity-conscious means that equity ought to be a central objective in any given policy or programme (Gwatkin, 2002). Uganda is often cited as a "best practice" showpiece in this regard (Foster 2001). This is because of the emphasis given to poverty reduction and or equity, by integrating health programs within a coherent poverty reduction strategy in the framework of which all pro-poor programmes are funded through the poverty action fund (PAF). For example, for an intervention to qualify as PAF program, it must, among other criteria, a) be delivering services to the poor (addresses the needs of the poorest 20%, and is accessible to them recognizing barriers e.g. costs); b) directly contribute to poverty reduction by raising the income or improving the quality of life of the poor. In addition, there must be a clearly costed strategy of how all these will be realised, with monitorable targets).

Being equity conscious also means that the policies ought to be formulated in terms that are *distributional* in nature—paying more attention to the specific health problems of the poor, which distinguish them from the rich (Gwatkin, 2002).

Although equity is often stated as one of the objectives of health programs, in most cases these statements are mere rhetoric. In addition, health goals have invariably been stated in terms of societal averages such as a decline of x% in infant mortality rate, and an increase of y% in life expectancy (Gwatkin 2000). Aggregate indicators are not useful for monitoring progress in equity as they can not reflect differences between population groups.

Even if policies were well structured in equity sense, translation into action requires clear, specific strategies and guidelines that take into account the health system as a whole, as well as the broader country context. There has been weakness in translating equity objectives (however stated) into explicit recommendations and guidelines in the health sector, (as opposed to what the economists have routinely done with income poverty (Gwatkin 2000). For example, there has been poor linkage between equity objectives and strategies on financing, mechanism of resource distribution, and incentive mechanisms for health personnel to provide quality services to target groups, and to people to use these services. The linkage between equity and other health sector reforms (such as coordination with private providers, decentralisation, contracting and insurance arrangements) has also been weak.

The policy reforms since Alma Ata

The concern for equity has been swinging like a pendulum. In the mid 1970s to mid 1980s, the economic climate was strongly oriented to the satisfaction of basic human needs, which, in the health sector, was manifested in the form of the "health for all" movement. The "health for all" notion became one of the mainstays of the Alma Ata conference. It advocated for community-based approaches to health care, which ought to be publicly funded, and free to all at the point of delivery (Werner & Sanders, 1997).

Owing to economic difficulties, coupled by the mystical faith in the "free-market" paradigm after the mid 1980s, concerns started to shift away from equity, to *efficiency* and *sustainability*. The neoliberal economic paradigm led to a move away from "health for all" to "health sector reforms" (Werner & Sanders, 1997; Gwatkin 2002).

Of recent (1990s), there has been a renewed concern for equity, as indicated by the number of equity oriented researches, including researches on appropriate data for monitoring equity trends. Another sign is the call by the international agencies (especially the WHO and the World Bank) for reforms and development programs to be mindful of poverty and equity issues.

Hence a number of reforms have taken place in the health sector since the Alma Ata conference, reflecting the ideological trends. The main ones that have dominated the health policy debates include: a) prioritizing public sector resource allocation using cost-effectiveness analysis (benefit packages—"essential" or "minimal" packages); b) financing reforms (user fees, community health financing schemes); c) provision reforms (Public Private Partnership for Health, contracting out services, provider payment mechanisms, decentralisation of services).

Others include coordination mechanisms, including Sector Wide Approaches, and the integration of development programmes into the so-called Poverty Reduction Strategy Papers (PRSP)

The crucial question, of course, is whether these reforms have promoted more equitable opportunities for attaining good health, and whether they have minimized health differentials.

Unfortunately little can be learnt from reviewing data on the equity impact of these reforms as there has been too little attempt at evaluating them. Nevertheless, SWAp and the "essential services package" are widely viewed as being pro-poor.

"Essential" and "Minimal" package concepts

One of the concepts that have characterized health sector reforms since the Alma Ata declaration is the benefit package approach to service delivery, variously referred to as the "essential care package" or "minimal healthcare package".

Although receiving greater attention in the 1990s, the package concept is not new and dates back to the arguments advanced as early as 1979 by Walsh & Warren, that comprehensive Primary Health Care as formulated at Alma Ata in 1978 was too costly and unrealistic for most countries Walsh and Warren 1979). They argued that if people's health were to improve, high risk groups ought to be "targeted" with carefully selected, cost-effective "selected" interventions—and hence selective primary health care (Ensor, 2002; Werner & Sanders, 1997).

Since the publication of the World Bank World Development Report of 1993, *Investing in Health,* this concept has been widely embraced by a number of countries—ranging from middle income ones such as Uruguay and Turkey, to low-income countries such as Indonesia and Uganda (Word Bank 1993; Bobadilla & Cowley 1995 in Ensor 2002)

The package approach is often publicly funded. It is also viewed by its proponents as being pro-poor, because it is thought to concentrate resources on services with the greatest benefit to the most vulnerable—the poor, women and children (Ensor T. et al, 2002).

However, the concept has been adopted and applied differently in different countries. In Uganda, for example, the "national Minimum Health Care Package" is supposed to be accessible to all, and consists of interventions against conditions affecting the majority of the population. This is consistent with a utilitarian notion of pursuing the greatest good for the majority. However, improving the health conditions of the majority of the population does not necessarily translate into a narrowing of the gap between the disadvantaged and the better-off.

The approach in Bangladesh has been more focused, basing on a previous benefit incidence analysis which revealed that the poorest quintile of the population was accessing the sub-district services more than the better-off. Yet the public expenditures above the sub-district level favoured the relatively rich. Thus the Ministry of health budget (raised through SWAP) is concentrated on essential package delivered at sub-district level and below, whereas the municipalities and corporations are responsible for the services at the district hospitals and above. The evidence is that, at the sub-district level, the uptake of the essential services package is more favourable to the poorest quintile than to the relatively better-off (Ensor T. et al 2002).

Despite the widespread adoption, and the different ways the concept has been applied in different countries, relatively little attention has been given to the evaluation of the impact of the approach on the poor. Wider research agenda are required to establish whether the poor benefit more from these services than the relatively rich.

What is certain, however, is that the concept has attracted some criticisms. The first one being that diagnostic and treatment strategies are necessarily inter-related and may include a range of diseases and procedures, some of which may be outside the package (Ensor et al 2002), thereby paying insufficient attention to the pervading problems of the poor. This is illustrated by the fact that childhood diseases are best managed in an integrated approach. Having recognised this fact, some countries (for example Uganda) have included the "Integrated Management of Childhood Illness" in their package.

There is also evidence in Bangladesh (Ensor et al, 2002) that it is the large, unexpected, catastrophic illnesses that are often responsible for pushing households into poverty. Therefore, while essential services packages might, in theory, be pro-poor, it does not seem to protect them (the poor) from catastrophic financial risk through illness.

Sector-Wide Approaches (SWAps) and resource allocation criteria

Another common reform in the developing countries has been the so-called Sector-Wide Approaches (SWAps). SWAp refers to a transition from donor-led, project dominated development assistance to a more coordinated budget-support type of development assistance (Angers M, 2000). It was born out the realization that the project type of approach had fragmented development assistance, thus creating islands of excellence (Schacter M, 2001).

The basic features of SWAps are that all significant funding for the sector supports a single policy and expenditure program (the government budget); and the government provides leadership in setting the priorities and developing the program. Thus much of the resources that would normally flow through the vertical programs are now channeled through the budget support to finance commonly agreed-upon strategies (Angers M., 2000).

The evidence suggests that SWAP has been successful in harnessing funding at the national level and redirecting them according to national priorities (Ensor, 2002; Foster M. & McKintosh-Walker, 2001). To this extent, therefore, it can be argued that SWAP is a potential tool for minimizing health differentials. However, this depends on a number of factors, including, first and foremost, whether or not equity is a central objective of relevant programmes. The evidence in this regard is encouraging. A number of countries where SWAps have been adopted do include "improving access to services by the poor and marginalised groups" as a central objective of their programmes; and poverty issues have indeed been satisfactorily addressed in those SWAps where "benefiting the poor" was stated as a central objective, and had political endorsement (Foster M. & Mackintosh-Walker, 2001).

As earlier mentioned, the right objectives must be accompanied by clear mechanisms by which resources can benefit the poor. The extent to which public spending is "well targeted" to the poor often depends on two related determinants: first is the supply-side factor, consisting of the allocation of health budgets across different levels of service (preventive vs. curative; health centers vs. hospitals, etc); and second, the extent of utilisation (demand) of the services by the different groups of the population (Castro-Leal, et al., 2002).

In equity sense, public spending is considered "well targeted" if the poorest quintile (the poorest 20 per cent) of the population receives more of the subsidy than the richest quintile. Public spending is also described as progressive if the subsidies to the poorest quintile constitute a higher proportion of their health expenditure as compared with the richest 20 per cent (WHO, 2000; Pearson M, undated).

A review of benefit incidence studies carried out between 1978 and 1995 in developing and transition countries found that public expenditures were progressive in all the countries for which data were available (Pearson M, undated).

However, the picture on the extent to which the poor were targeted by public health expenditures was mixed, irrespective of whether the resources were harnessed through SWAps (Foster & Mackintosh 2001) or otherwise (Pearson M, undated).

Public subsidies were found to be poorly targeted in sub-Saharan Africa and transition countries. In sub-Saharan Africa, expenditures at all levels of curative services tended to favour the better off, with the exception of S.Africa (Castro-Leal, et al 2000). However, they were well targeted in Asia and Latin America across all service levels, except the hospitals. The notable success stories in targeted public spending on health (in Asia and Latin America) include the state of Kerala in India, Costa Rica, Sri Lanka, China, and Cuba.

Are resource allocation criteria pro-poor?

The inequitable spending on curative services across Africa could partially be explained by the fact that hitherto, in many countries, resource allocations have been based on the capacities of the health facilities (number of beds, number of staff in positions, etc). Yet the sizes and distribution of facilities have tended to be historically and politically determined, and invariant to the size and population needs. Hence resources (and services) tend to be concentrated at the secondary and tertiary levels where the capacities are high. Typically, less than 25% of the recurrent expenditures accrue to the primary level in rural areas (Castro-Leal, et al 2000). Yet the majority of the population, and especially the poorest quintile, tend to live in rural areas, where resources are comparatively scarce.

Because of the historical nature in which capacities have been established, some locations have tended to be systematically disadvantaged. As such formula allocations have been adopted in some countries (e.g. Uganda and the UK) as a way of addressing the disparities created by input-based allocations. In this case, public subsidies for health care are allocated on a per capita basis, and adjusted for equity (or health needs) related factors such as population structures, remoteness, security situation, health facility coverage, etc.

Thus, whereas SWAP has been successful in harnessing resources at the national level, formula allocation has, to some extent, minimised inter-district disparities. For example, in Uganda, disadvantaged districts like Adjumani and Bundibugyo are now among the top districts in terms of per capita public health budget allocations. The better-off districts like Kampala and Jinja are at the bottom of the ranking (Ministry of Health, 2003)

Effect of reforms on the utilisation of services by the poor

It has already been stated that the benefit potentials of essential services package and SWAp are limited by the fact that they do not usually address the factors that influence the health seeking behavior of users. To increase the benefit incidence to the poor, budget allocations must be accompanied by increased use of primary facilities by poor households. However, some of the reforms that have taken place have tended to adversely impact on the utilisation of services by the poor, thus countering any potential benefits of SWAp and essential services package to them. The most notable example is the private contribution to health financing (user fees and community based pre-payment schemes).

Impact of private payment on equity

A call for private contributions to publicly funded health care dates back to the "Alma Ata declaration" itself, and the World Bank "Agenda for Reform" of 1987 and the "Bamako initiative" of 1988.

Most of the private financing schemes were introduced in the context of health sector reforms, with cost recovery, efficiency and sustainability as primary objectives (Werner & Sanders, 1997; Arhin-Tenkorang, 2000). According to the WHO, the main objective of any financing scheme is that the contributions should be fair to the households (WHO 2000).

Fairness in financial contribution relates to three concerns: avoiding catastrophic payments, equal payment for

equivalent households (horizontal equity), and progressivity of payment (where the poor pay a lower proportion of their income than the other income groups—vertical equity) (WHO, 2000; Pearson M, undated). Given the objectives and design, the potentials of these schemes in achieving fairness in financial contribution is questionable.

a) User fees and equity

There is ample evidence from many developing countries suggesting that user fees are regressive, and that when prices are raised through costs recovery schemes, the poor are more likely than the non poor to cut back on their use of health services (Arhin-Tenkorang D., 2000, WHO, 2000; WHO undated).

In most cases, this has been because income-related pricing and exemption measures, though present in most countries, have proved difficult to implement. There is also no evidence to suggest that fee revenues have been used explicitly to extend service availability to poor persons. Although fee retention to improve quality in peripheral facilities has the potential of improving the availability of better quality services to the local population, there have been very few examples documenting an improvement in access by the poor (WHO undated).

b) Equity of payments through Community based pre-payment schemes

Community-based health insurance or pre-payment schemes have been proposed by many (WHO, 2000; Arhin-Tenkorang D., 2001; Preker AS, 2002) as an alternative to user fees.

Although community-based pre-payment schemes are less regressive than user fees, they are not a panacea to the equity problems related to the user fees. For example these schemes have typically targeted the informal, often poor, sector. They are usually structured in such a way that the beneficiaries pay flat premiums, regardless of the level of income. Sliding scales premiums or exemption policies for the poor, if existent at all, are usually difficult to implement.

By targeting the informal sector, there has been no possibility of the rich subsdising the poor; and by charging flat rate premiums, the schemes are inherently regressive (although less regressive than user fees).

Moreover, they frequently entail substantial co-payment to prevent "frivolous" use of services, thereby presenting additional barrier at the point of service delivery.
Coverage is often limited to small proportions of the population, often those close to the facility. Because the benefit package typically excludes severe conditions the schemes do not, usually, protect the poor from catastrophic financial losses through illness.

Therefore, the equity impacts of these schemes have been as disappointing as can be suspected from their very designs.

Healthcare delivery systems—decentralization

As earlier mentioned, distance to health facilities is an important factor restricting access to care for large numbers of people in poor countries. Members of poor households typically face long journeys and high opportunity costs to obtain healthcare. Time and distance in effect rations the market in favour of the better-off. Consequently, one way to improve equity is to reduce the distance between health facilities and people.

Decentralisation of health services, investing in primary care facilities and establishing outreach services have been important ways of improving equitable access to care in many African countries.

There has also been a strong partnership with the Private Not For Profit sector in a number of areas, including service provision. Given that NGO providers offer a substantial proportion of primary care, an approach that incorporates them into the health system appears to address equity goals.

Conclusion

In the absence of adequate and convincing evidence, we can only base our judgement on the policy environment; which has been rapidly changing since 1978, in pursuit of cost recovery, efficiency, and sustainability.

In terms of what can happen, one could argue that SWAP and the "essential healthcare package" approach have got great potentials of expanding the healthcare budget and redirecting them towards the poor. However, these potentials are limited: firstly because allocation frameworks limit resource flows to the poor; and secondly because they usually do not pay attention to the health seeking behavior of the users.

The reform area for which there is most evidence in low- and middle-income countries is that of healthcare financing. In most cases, user fees have had negative consequences for equity. Although income-related pricing and exemption measures exist in most countries, they have proved difficult to implement. As a result, fees have posed a greater barrier to service use by poorer persons; and have tended to counter the potential benefits of SWAp and the essential or minimum healthcare package.

Therefore, if we base our judgment on the policy environment, then it is evident that the equity goals have not been realised. Even though some countries, particularly in Asia and Latin America, have pursued equity-oriented paths of development, these might prove difficult to sustain

in an international climate that places the demands of the global market before the basic needs of the population.

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