

B1 | Health care systems and approaches to health care

Introduction

An estimated 30,000 children die every day, mainly from preventable and easily treatable causes (Black, Morris and Bryce 2003). Millions of people do not have access to health care because health care systems in many countries are either non-existent or moribund. In many countries in Sub-Saharan Africa and in war-ravaged countries such as Afghanistan, health care systems are in a state of collapse. Life expectancy in two regions, Sub-Saharan Africa and the republics of the former Soviet Union (FSU), is deteriorating. In the FSU, although health status and health care systems are better than in Africa, health status is deteriorating at the same time that health care systems are struggling to ensure universal access to care (Box B1.1). In middle- and high-income countries, health care systems also struggle with widening disparities in health and health care consumption; uncontrolled rises in health care costs; profit-driven inefficiencies; and a deterioration in trust between citizens and providers.

Instead of focusing on particular diseases or issues such as HIV/AIDS, 'mental health' or 'child health', this chapter is focused on developing an agenda for health care systems development. In doing so, it advocates looking back to the 1978 Alma Ata Declaration on Health (WHO/UNICEF 1978) and the pledge made to achieve 'Health for All' through the *Primary Health Care (PHC) Approach*.

The principles of the PHC Approach are as relevant today as they were nearly 30 years ago and provide a guide not just for the organization of health care systems, but also for how health care systems should act as an engine for promoting health and development more generally, and as an instrument for promoting equity and empowering the poor. Section 1 of this chapter reasserts these principles.

Section 2 goes on to explore how the principles of the PHC Approach have been undermined by various policies and events in five thematic areas:

- 1) macro-economic factors;
- 2) health sector reform, neoliberalism and the commercialization of health care;
- 3) 'selective' health care and verticalization;

- 4) selective and efficiency driven cost-effectiveness analysis; and
- 5) public sector failures.

It would be impossible to provide a detailed chronological or historical account of how health care systems have been undermined in recent decades, not least because the ways in which health care systems have developed or deteriorated have varied from country to country. However, the wide-ranging factors and policies that have undermined the PHC Approach are discussed so as to produce guiding principles for health care systems development in the future. The chapter then sets out in section 3 a case for the central role of governments and the public sector within health care systems, and concludes by outlining an agenda of principles and priorities for the revitalizing of health care systems in section 4.

1 Remembering Alma Ata and the Primary Health Care Approach

The Alma Ata Declaration, sponsored by WHO and UNICEF, arose from the observation of failings in health care systems, as well as the positive results from health programmes in countries such as Nicaragua, Costa Rica, Guatemala, Honduras, Mexico, India, Cuba, Bangladesh, the Philippines and China (Commission on the Social Determinants of Health 2005). The term ‘Primary Health Care Approach’ came to be associated with the health care elements of the Declaration and can be summarised as follows:

- First, it stresses a *comprehensive* approach to health by emphasizing ‘up-stream interventions’ aimed at promoting and protecting health such as improving household food security, promoting women’s literacy and increasing access to clean water. This places a greater emphasis on preventive interventions and counters the biomedical and curative bias of many health care systems, and promotes a multi-sectoral approach to health.
- Second, it promotes *integration* – of different clinical services within health facilities, of health programmes and of different levels of the health care system. This recommendation was partially in response to the limitations of ‘vertical’, stand-alone disease control programmes and to the observation that hospitals in many countries were not adequately involved in strengthening primary-level health care.
- Third, it emphasizes *equity*. This recommendation would, for example, aim to correct the neglect of rural populations, as well as socially and economically marginalized groups, within many health care systems.
- Fourth, it advocates the use of ‘*appropriate*’ health technology, and health care that is socially and culturally acceptable.

Box B1.1 Countries in decline – health and health care in Africa, the former Soviet Union and Afghanistan

Life expectancy in many Sub-Saharan Africa (SSA) countries has now dropped below 50 years. Much of this is due to HIV/AIDS, fuelled and compounded by high levels of poverty, food insecurity and conflict. While the burden of disease has been increasing, health care systems have been deteriorating. The best evidence of this is stagnating or decreasing rates of child immunization and maternal mortality – two indicators that are particularly sensitive to the functioning of health care systems. Immunization coverage rates peaked at 55% in 1990 and stagnated throughout the 1990s. By 2000, only 53% of children in the SSA region were immunized against diphtheria, tetanus and whooping cough (WHO, UNICEF and World Bank 2002). Of 41 SSA countries, only six had maternal mortality ratios of less than 500 per 100,000 live births in 2004 (UNFPA 2004). In 35 countries, at least one woman died for every 200 live births. Seventeen countries had a maternal mortality ratio of 1000 or more – one death per 100 live births. In 12 countries, the maternal mortality ratio worsened between 1994 and 2004 (UNFPA 2004, WHO, UNICEF and UNFPA 2001).

In all 15 of the new republics of the former Soviet Union, life expectancy at birth fell between 1990 and 2000. Although there are several reasons for this reversal of human development, an underlying problem has been the effects of post-Soviet political and economic change upon the health care systems of these countries (see: <http://www.ghwatch.healthformersovietunion>)

More than 20 years of conflict have contributed to the destruction of Afghanistan's health care infrastructure (Waldman and Hanif 2002). In 2002, 60% of Afghans had no access to basic health services and two-thirds of Afghanistan's districts lacked maternal and child health services (Transitional Islamic Government of Afghanistan 2002). The maternal mortality ratio is 1600 per 100,000 live births – every 20 to 30 minutes a woman dies because of pregnancy-related complications (Ahmad 2004). The government has very weak institutions and a lack of both military and administrative control in large parts of the country which remain under the control of warlords and local commanders (World Bank 2004).

- Fifth, it emphasizes appropriate and effective *community involvement* within the health care system.

- And sixth, it adopts a strong *human rights perspective* on health by affirming the fundamental human right to health and the responsibility of governments to formulate the required policies, strategies and plans of action.

Significantly, the Alma Ata Declaration also placed the challenge of ‘Health for All’ within a global and political context by calling for peace, reduced military expenditure and a ‘New International Economic Order’ to reduce the health status gap between developing and developed countries.

Since 1978, however, the term ‘PHC Approach’ has been frequently misunderstood and confused with the ‘primary level’ of the health care system. It is also often wrongly associated with cheap, low-technology care supposedly best suited to developing countries. In fact, the PHC Approach refers to a set of concepts and principles that are as relevant and applicable to a university teaching hospital as to a rural clinic; to a poor African country as to an industrialized European country; and to a highly specialized doctor as much as to a community-based lay health worker.

In the years immediately after Alma Ata, the District Health System (DHS) model was formulated as an organizational framework for a health care system to deliver the PHC Approach. For many health care practitioners, the PHC Approach and DHS model formed the conceptual and organizational pillars respectively for the attainment of Health for All. The DHS model (WHO 1988; WHO 1992) consists of:

- a health care system organized on the basis of clearly demarcated geographical areas (known as ‘health districts’), ideally corresponding to an administrative area of government.
- the health district as the basis for the seamless integration of community-based, primary level and Level 1 hospital services. Level 1 hospitals were considered a vital hub in which to locate medical expertise, pharmaceutical supply systems, and transport to support a network of clinics and community-based health care.
- health districts sharing the same administrative boundaries as other key sectors (such as water, education and agriculture).
- a district-level health management team with the authority and capacity to manage the comprehensive and integrated mix of community-based, clinic and Level 1 hospital services; to facilitate effective multi-sectoral action on health; and to work with local private and non-government providers.

Guidance was provided on the size of ‘health districts’ based on a balance between being small enough to facilitate community involvement and context-specific health planning, but large enough to justify investment in a decen-

tralized management structure. Central and intermediate-level policy makers and managers would ensure national coherence and coordination, common standards and equitable resource distribution amongst districts.

2 The demise of health for all

Macro-economic factors Health care systems require the availability of basic physical and human infrastructure throughout a country if they are to be effective and equitable. Countries need to invest in the development of this infrastructure, but many have no resources to do so.

Low- and lower middle-income countries need to spend at least US\$30–40 (2002 prices) each year per person if they are to provide their populations with ‘essential’ health care (Commission on Macroeconomics and Health 2001). This sum is about three times the current average spending on health in the least developed countries and more than current spending in other low-income and lower middle-income countries. More to the point, it is over five times the average *government* health spending of the least developed countries and about three times that of other low-income countries. Estimates of this kind are fraught with methodological limitations and assumptions, but they indicate the size of the resource gap facing most developing countries.

The causes of impoverished health care systems are varied. Many countries with low levels of health care expenditure are in fact able to invest much more than they do. However, many macro-economic factors (discussed in part A) that help to keep poor countries poor, by extension, keep levels of health care expenditure low.

Historically, a key macro-economic event was the hikes in oil prices during 1979–1981, which precipitated an economic recession in industrialized countries, prompting governments in those countries to raise interest rates. The combination of recession in the industrialized world, higher oil prices and raised interest rates precipitated a macro-economic crisis in many developing countries, especially in Latin America and Sub-Saharan Africa. These countries experienced reduced export demand, declines in primary commodity (non-fuel) prices, deteriorating real terms of trade, lower capital inflows and soaring debt service payments. Many countries had negative economic growth, reduced government revenue and increasing poverty.

The effects on health care systems, so soon after the bold and visionary aspirations of the Alma Ata Declaration, were nothing short of disastrous. Most health care systems have never had a chance to recover from these effects which included:

- declines in real public health expenditure and increasing donor dependency;
- deterioration of health facilities and equipment;
- shortages of drugs and other supplies;
- dwindling patient attendance at public facilities as the quality of care worsened; and
- a catastrophic loss of morale and motivation of public health workers as the value of their salaries plummeted and as expenditure constraints undermined their ability to work.

Demoralization, cynicism and unethical behaviour grew among public sector health workers. This included treating patients uncaringly, levying ‘under the counter’ charges, ‘moonlighting’ in the private sector and stealing drugs for private use (Bassett, Bijlmakers and Sanders, 1997). Public sector downsizing and resignations led to health workers migrating to the private sector, adding to the growing numbers of informal and unregulated drug vendors, ‘pavement doctors’ and other private practitioners. As public services deteriorated, households resorted increasingly to over the counter drug purchases and the use of private practitioners. While informal health care practice has always existed in developing countries, this economic crisis resulted in its significant expansion independently of any health sector reforms, a process that is called ‘passive privatization’.

The macro-economic crisis also had an indirect effect on health care systems. It provided the IMF and the World Bank with an on-going opportunity to intervene in and shape the health sector of poorer countries through structural adjustment programmes and conditionalities attached to grants, loans and debt relief.

Health sector reform, neoliberalism and the commercialization of health care

‘Health sector reform’ is the term used to describe a set of policies initially promoted by the World Bank and IMF, often through structural adjustment programmes, from the mid 1980s onwards. These have included imposing tight and reduced fiscal limits on public health care expenditure; promoting direct cost-recovery (user fees) and community-based financing; and transferring or out-sourcing functions to the private sector. Later, the ascendance of neoliberalism (Box B1.2) added an ideological impetus to the privatization of health care. More recently, the World Trade Organization (WTO), together with a number of bilateral and regional trade agreements (usually involving the United States), have influenced the design of health care systems by reducing

the capacity of governments to regulate health care markets, encouraging cross border ‘trade’ in health care, and facilitating the entry of corporate health businesses to operate more freely within health care systems of other countries (Hilary 2001, Shaffer et al. 2005).

The following sub-sections discuss three aspects of these effects on health care systems: the growth in user fees; the segmentation of health care systems; and the ‘commercialization’ of health care.

Box B1.2 Neoliberalism

The term ‘neoliberalism’ is used in different ways. Its origins may be in economic theory, but it is used in this chapter to describe a particular orientation to public policy. The US government under President Ronald Reagan and the UK government under Prime Minister Margaret Thatcher were at the heart of the emergence of neoliberalism in the 1980s. It was then propagated globally by institutions such as the IMF and World Bank.

Neoliberalism is taken to mean the vigorous promotion of markets – networks in which buyers and sellers interact to exchange goods and services for money – combined with a reduction in government or multi-lateral regulation. It was initially associated with promoting the maximum freedom of movement for finance capital, goods and commercial services, but now embraces the promotion of a minimally regulated market economy in sectors that used to be considered the responsibility of the state. These include sectors that provide essential services and public goods such as health care, education, social security, water and sewerage, and policing and prison services.

Concerns with neoliberalism relate to the weakening of governments’ ability to discharge their public duties such as reducing poverty; protecting the public and environment from unregulated economic activity; and providing a fair framework for the redistribution of wealth and profits.

USER FEES AND THE DENIAL OF ACCESS TO ESSENTIAL HEALTH CARE One effect of health sector reform was the promotion of a greater privatization of health care financing (Box B1.3), including out-of-pocket payments for health care in the public sector (Akin, Birdsall and Ferranti 1987), partly to offset reduced levels of public expenditure. Such privatization added to the growth in

user charges that arose from the ‘passive privatization’ of health care and the increase in informal, under-the-counter charges in the public sector.

The impact of this transfer of responsibility for health care financing onto households has been disastrous, particularly for the poor. It has deterred people from accessing health care and resulted in untreated sickness and avoidable death (Whitehead, Dahlgren and Evans 2001, Theodore 1999, World Bank 1999, Yu, Cao and Lucas 1997 and Fu 1999). User fees have also discouraged people from taking full doses of their medication; evidence is emerging that they undermine adherence to anti-retroviral treatment and increase the risk of drug resistance (WHO 2004). Even when health care is nominally free, financial barriers may still put health care beyond the reach of many families. Maternity services in Bangladesh, for instance, are free but in practice are accompanied by hidden and unofficial payments; for more than one fifth of families, these payments are the equivalent of 50–100% of their monthly income (Nahar and Costello 1998).

User fees also generate poverty, or deepen the poverty of those who are already poor. In rural North Vietnam, an estimated one fifth of poor households

Box B1.3 Public and private health care financing

Private financing takes many forms. Private health insurance is often paid by individuals, but some private sector employers contribute to their employees’ private health insurance. In some places, households contribute to a community-financing scheme, which pools funds that are managed on behalf of all members of the scheme. User charges refer to out-of-pocket payments that service users make directly to providers. Medical savings accounts are promoted as a mechanism for households to build up a reserve of money to enable them to meet the cost of user fees in the future.

Public financing is generally based on general tax revenue or national health insurance. In developing countries, external grants and aid from donors can constitute anything between 20% and 80% of total public sector health care spending.

Public and private sources of financing often co-exist – for example, community-financing schemes may complement public funds used to pay the salaries of some health workers, while private medical insurance may receive tax breaks that amount in practice to a public subsidy.

were in debt primarily because of paying for health care (Ensor and Pham 1996). Patients who borrow money to pay for treatment can end up paying extortionate interest rates. To offset the cost of borrowing, households may cut down on their food consumption, sell off precious assets such as land or cattle, or withdraw children (particularly girls) from school to save on school fees (Whitehead, Dahlgren and Evans 2001, Tipping 2000).

It is argued that exemption schemes can protect the poor from user fees. But such schemes are rarely effective (Russell and Gilson 1997) and can encourage extortion and patronage when service providers are poorly remunerated. Neither is there any evidence that user fees prevent the ‘frivolous’ overuse of health services – for most people, cost barriers result in an *under*-use of health care services.

Given the evidence that user fees are a major and widespread barrier to essential health care, as well as a cause of long-term impoverishment, it is paradoxical that the poorer a country, the more likely its people will face out-of-pocket health care expenditure. In stark contrast, high-income countries tend to have ‘socialized’ financing systems based on general taxation, national health insurance or mandated social health insurance (Mackintosh and Koivusalo 2004).

THE SEGMENTATION OF HEALTH CARE SYSTEMS The ‘segmentation of health care systems’ refers to the phenomenon of separate health care systems for richer and poorer people, as opposed to one universal health care system for all. The World Bank in particular has advocated that governments in poorer countries should focus their scarce public resources on providing a free ‘basic’ or ‘minimum’ package of preventative and curative services for the poor, while withdrawing from the direct provision of other services. By encouraging the relatively rich sections of society to use the private sector, it argues that the public sector will be able to redirect its resources to those most in need (IFC 2002, Gwatkin 2003). In some middle- and high-income countries, tax breaks on private insurance are used to entice higher-income groups away from publicly provided services. Health care systems in some countries are being segmented even further by the processes of globalization – in India, Mexico and South Africa private providers cater to foreign ‘medical tourists’ from high-income countries or from high-income groups in low- and middle-income countries.

The assumption behind these policies is that it is more efficient and equitable to segment health care according to income level – a public sector focused on the poor and a private system for the rich that allows the public sector to

focus on the poor. But there is no evidence that such a system is more equitable or efficient. The greater likelihood is that it would result in increased inequality as the middle-classes opt out of public sector provision, take their financial resources and stronger political voice with them, and leave the public service as a 'poor service for poor people'.

Even if private medical services are entirely privately financed, they still draw on a limited pool of health professionals and, in developing countries, on limited foreign exchange for the import of drugs and equipment. A large private medical sector weakens the public provision of health care, especially as the ratio of resources to patient load is more favourable in the private sector – it sucks out more health care resources than it relieves the public sector of workload.

However, the notion of a public sector for the poor has strong advocates. If higher income groups can be segmented out, there is more opportunity to provide health care as a profitable, commercial product to these groups. Segmentation is therefore attractive to private investors in health care, especially in countries where there is a large enough or rich enough upper- and middle-class market to sustain the development and financing of a private health sector. Latin America, Asia and transitional Europe – all regions with histories of social health insurance and direct public health care provision – are now seeing rising levels of private insurance and corporate investment (Stocker, Waitzkin and Iriat 1999), as governments come under pressure from the private sector and trade-related policies to break up universal social security funds, and to open up the market to foreign investment. Finally, some health care providers, who benefit from providing care to the privileged and better resourced market, will challenge any reforms aimed at universalizing health care systems, often claiming that they would reduce standards of care and invoking the rights of individuals to the best care they can afford. The implication is that equity is a secondary concern.

Besides separating out higher income groups from lower income ones, a parallel public and private health care system can result in private sector 'cherry-picking' – private medical insurance schemes will adopt strategies to recruit low-risk consumers, corner healthy and profitable markets, and leave the sick and the elderly dependent on the public sector. Private medical schemes worked this way in South Africa until the post-apartheid government enacted legislation to enforce 'community rating' (whereby insurance premiums cannot be weighted according to individual risk) and a nationally prescribed minimum level of cover to make it harder for private companies to dump patients arbitrarily onto the public sector when their health care costs became too great.

These trends towards segmentation of a health care system, structured through health care financing arrangements, appear to be driven by a policy to institute health care systems that reflect and reinforce socio-economic inequities rather than to mitigate them.

THE COMMERCIALIZATION OF HEALTH CARE The growth of private sector health care provision in developing countries has largely been a consequence of 'passive privatization'. The collapse of the public sector has led to the emergence of a disorganized, unregulated and even chaotic provider market in many developing countries, particularly at the primary level of health care. The incapacity of public services has also resulted in governments and donors relying upon NGOs, UN agencies, charities, religious groups and humanitarian organizations to plug the gaps in public provision not only in primary care but also in essential hospital services and in response to humanitarian emergencies.

In middle- and high-income countries, the private provider market is also heterogeneous and may include non-profit, charitable organizations; single, stand-alone private hospitals or group practices; employer-based health maintenance organizations; and large corporate or business entities with public shareholders. Private providers also operate in more formal markets that include intermediary agents such as insurance companies. Such provision may emerge as a consequence of demand from consumers as well as from active encouragement through policy-levers, such as tax subsidies to the private sector or the use of public money to out-source functions, including to the for-profit, income-maximizing private sector (see Box B1.4).

The heterogeneous group of private providers operate in many different contexts. For millions of people, private providers provide a lifeline to health care in the absence of any effective public alternative. At the same time, however, private health care is clearly associated with profit, exploitation and preferential service of higher income groups. What is at issue, therefore, is not simply private provision, but a certain type or aspect of private health care provision – that of market- and income-driven provision when payments for health care are directly linked to provider income or shareholder profit.

What is relevant is the influence of such provision on provider behaviour that results in inefficient, inequitable and poor quality care (Woolhandler and Himmelstein 2004, Devereaux et al. 2002, Evans 1997). Such behaviour includes pricing health care to maximize income rather than to maximize access and benefit; 'over-servicing' (for example, conducting unnecessary and inappropriate laboratory tests and diagnostic investigations); inducing demand

for health care that is unnecessary or inappropriate; providing sub-optimal (cheaper) health care in order to maximize net income; and providing inappropriate care in order to market a supposed difference from other providers (for example, advocating injections as better quality care when oral treatment or simple health advice would be better).

Commercialization also affects the nature of health care itself. It encourages a commodification of health care and a bias towards biomedical and curative interventions because it is easier to market and sell tangible health care products and services. Such commercialization benefits, and is therefore encouraged by, the medical profession, pharmaceutical companies and the

Box B1.4 New Public Management

New Public Management (NPM) is a term used to describe private sector solutions to public sector constraints. It is based on the idea that the monopoly power of government, and the lack of competition to government departments and civil servants that would otherwise compel them to be efficient and accountable to service users, are responsible for bureaucratic rigidity, corruption and inefficiency.

One NPM solution is to introduce competition between different public sector departments and 'internal markets' (purchaser-provider splits) within the public sector. Another is to restrict the role of government from being a funder and supplier of services to that of a funder and contractor of services. Public sector bureaucracy would then shrink as it moved away from public management via bureaucratic control to 'management by contract' of independent private sector providers, semi-independent parastatal agencies or local government bodies. In some instances, public sector entities are 'corporatized' (granted a greater degree of autonomy) and expected to enter the provider market to compete for government contracts and tenders.

The extent to which NPM has achieved its stated goals is contested (Stewart 1998, Evans 1997, Maynard 1998, Khalegian and Das Gupta 2004). Critics point to the high transaction costs associated with the management of internal markets; the use of internal markets as a staging post towards the eventual privatization of public services; the emphasis on competition over collaboration; and the emergence of an inappropriately excessive 'target-driven' culture (see <http://www.ghwatch.org/targetcultureNHS>).

medical-industrial complex. Public health measures to prevent illness and promote good health are easily neglected in the process.

Although commercial behaviour is associated with for-profit private providers, it can occur in the public sector as well. The under-financing of public health care systems and the growth in informal (under-the-counter) charges have resulted in the neglect of patients who cannot afford fees and a higher quality of care given to those who can. Similarly, public hospitals that have been granted greater autonomy, including the responsibility of raising some or all of their own finance, become motivated by the imperative to raise income and to balance their accounts. Managers and clinicians have a further incentive to prioritize the maximization of income if they can exceed civil service pay-scales. Although these hospitals remain publicly-owned, their character and nature mimic those of the private sector operating in a market.

Market-driven health care often does not promote efficiency or quality for several obvious reasons (Bloom 1991, Roemer 1984, Arrow 1963, Rice 1997). First, most patients do not have enough knowledge to make informed choices about the relative quality or merits of different health care providers, nor are they willing, able or assertive enough to negotiate on price and quality, especially when care is urgent, when sickness results in vulnerability, or when illiteracy and poverty are prevalent. Most people do not want 'choice' in health care, but an assurance that their local and accessible health care provider will provide good, if not the best, quality care. Instead, commercialized health care eats away at provider-patient trust, adding to the stress of being sick or injured. A trusting, caring and compassionate relationship between patient and health worker is in itself a therapeutic intervention that is corrupted by the market-based relationship between consumer and provider.

Second, the theory that provider competition will drive up quality and efficiency does not apply in many settings, particularly when it would be either unaffordable or wasteful to have several providers competing with each other. Rather than managing available health resources in a strategic way to achieve equitable coverage, competition results in duplication and inequity as for-profit providers gravitate towards affluent populations (McPake 1997). The promotion of choice and competition implies a need to differentiate the standard of care rather than to ensure high quality care for all.

Third, commercialized health care systems often have significant transaction costs accompanying attempts to manage or regulate the market (Himmelstein et al. 1999). Similar cost issues accompany the management of public contracts with private providers, especially those providers motivated to maximize income, who may strive to make short-cuts or manipulate data to achieve

their contract specifications at the lowest cost, even at the expense of patients and the public good. To counteract this, purchasers end up spending large amounts of money on systems designed to catch out contractees in a ‘cat and mouse’ game of detection and deception, or end up being drawn into costly contract disputes.

Fourth, market-based systems with multiple independent providers are inefficient because of the loss of economies-of-scale in the purchasing, supply and distribution of drugs and equipment (Robinson and White 2001). They can pose barriers to developing important public health instruments that need to be applied consistently and universally, such as disease surveillance systems, if they are to be effective.

Finally, competition harms collaboration between different providers, often an important ingredient of good quality care, especially in relation to referrals between different kinds of specialists or between different levels of the health care system. Fragmented performance contracts can also undermine collaboration within health care systems. In China, for instance, competition *within* the public sector harmed the inter-provider cooperation that was necessary for effective disease surveillance (Liu and Mills 2002).

Selective health care and verticalization ‘Selective health care’ refers to a limited focus on certain health care interventions, as distinct from comprehensive or holistic health care. The most common argument in favour of selective health care is that, until health care systems are adequately resourced and organized, it is better to deliver a few proven interventions of high efficacy at high levels of coverage, aimed at diseases responsible for the greatest mortality (Walsh and Warren 1979).

Selective health care tends to be associated with ‘vertical programmes’ – generally meaning separate health structures with strong central management dedicated to the planning, management and implementation of selected interventions – partly because of a lack of adequate health care infrastructure, but also because it often reflects a scientific and biomedical orientation that emphasizes the delivery of ‘medical technologies’ amenable to vertical programmes. Just as smallpox was eradicated through a concerted global effort, for instance, it is argued that diarrhoeal disease, malaria and other common diseases can be tackled in a similar way.

By the early 1980s, WHO, UNICEF and major bilateral donors, notably USAID, had endorsed this approach, epitomized by the ‘Child Survival Revolution’ launched in 1982. This prioritized seven child health interventions: growth monitoring, oral rehydration therapy (ORT), breastfeeding, immunization,

family planning, food supplements and female education, which collectively became known as the acronym GOBI-FFF.

In many ways, the logic of prioritizing cost-effective interventions to reduce child mortality is sound, and the practice can even be considered successful. Many countries made substantial progress in reducing child mortality following the launch of GOBI-FFF: the average number of under-5 deaths fell from 117 per 1000 in 1980 to 93 per 1000 in 1990, while immunization coverage expanded rapidly between 1980 and 1990 (UNICEF 2001).

However, there are problems with vertically-organized selective health care interventions (Smith and Bryant 1988, Rifkin and Walt 1986, Newell 1988, Unger and Killingsworth 1986). In the case of the 'child survival revolution', it has been argued that the focus on a limited set of technological interventions detracted attention from a more comprehensive approach to child health. For example, treating children with acute diarrhoeal disease would not be accompanied by interventions to improve childcare, feeding or access to water. Complex health problems with underlying social and economic determinants were recast as problems to be treated or prevented through the delivery of effective technologies. The participatory and bottom-up orientation of the PHC Approach has been downgraded, and the socio-political orientation of Alma Ata, with its emphasis on community empowerment and socio-economic equity, replaced by an approach that treated poorer communities more as passive recipients of health care than as active participants.

Questions have also been raised about the appropriateness of certain technologies. In the case of diarrhoeal disease, for example, the biomedical orientation resulted in the promotion of manufactured oral rehydration salts rather than more appropriate and accessible rehydration fluids that could be prepared locally (Werner and Sanders 1997).

In many countries, the selective health care approach has manifested itself as a set of multiple, parallel programmes operating in separate and fragmented 'stovepipes', disrupting the development of comprehensive health systems and the delivery of integrated essential health care. Multiple and centralized lines of command, frequently originating from within donor or international health agencies and often uncoordinated, tended to subvert local and more appropriate health planning. Information systems often comprise separate reporting forms sent directly to the central level without informing local service development. In Laos, 'Primary Health Care' itself was a separate programme, competing for resources with the immunization, malaria and TB programmes (Toole et al. 2003).

Multiple, vertical programmes can also lead to the de-skilling of primary

health care workers as their focus narrows to achieving selected targets rather than addressing the immediate and pressing needs of sick people when they present to health care services. Instead of training scarce health workers to provide essential and appropriate health care, such programmes train them to be efficient conduits of medical technology. Thousands of family planning volunteers have been deployed in many countries, for instance, but many opportunities to promote health were lost because their training focused on the single technical issue of contraception and did not include other elements of community health promotion, such as nutrition and hygiene education (Toole et al. 2003).

Vertically organized health services are inconvenient to service users. The need to make several visits to access different services constitutes a significant barrier to access, while the inability of some selective programmes to address co-existing conditions could result in untreated morbidity – for example, family planning workers being unable to treat sexually transmitted infections; or ante-natal care providers being unable to provide immunization services (Brown 2000).

Although selective health care is often advocated on the grounds that basic health care infrastructure is inadequate, it is rarely implemented in conjunction with a plan to strengthen such infrastructure at the same time. As a result, many selective and vertical programmes have short-lived results because they are not followed by the establishment of permanent health services to sustain the on-going control and prevention of disease. Worse still, they may actually undermine the development of health care systems. Mass immunization campaigns, for example, have often been prioritized to such an extent that other services have been disrupted and the long-term development of sustainable routine immunization services hindered.

The inadequate development and protection of basic health care infrastructure, and the lack of sustained donor funding for child health, is more apparent now than a decade ago. In spite of the child survival revolution, 11 million children die each year from mainly preventable causes. Globally, the target set by the World Summit for Children in 1990 to reduce child mortality below 70 deaths per 1000 live births by the year 2000 (or a one-third reduction if it yielded a lower mortality rate than this target) has not been met (UNICEF 2001). In many countries, immunization coverage rates are stagnant or declining (see Figure B1.1). In others, the reduction in child mortality rates has slowed down (Black, Morris and Bryce 2003).

Some argue that the gains in child health made between 1980 and 2000 were a result of tackling illnesses that are most amenable to vertical interven-

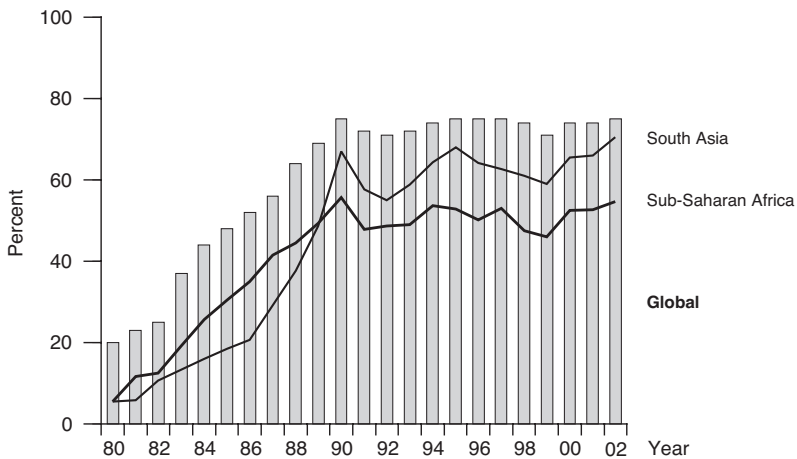


Figure B1.1 Immunization coverage 1980–2001, 3 doses DPT – global and by region (Source: WHO/UNICEF/World Bank 2002)

tions, and that any further improvements will need major efforts to strengthen the overall quality of health services (Box B1.5). Moreover, reductions in child mortality may not be sustained unless national health systems take over some of the roles played by donors and international NGOs in funding and deliver-

Box B1.5 Integrated Management of Childhood Illness

WHO and UNICEF have promoted the Integrated Management of Childhood Illness (IMCI) to reduce child mortality and morbidity. IMCI has a proven efficacy (Schellenberg et al 2004) and governments in more than 100 countries have committed themselves to implementing it. However, a systematic multi-country evaluation of IMCI has shown that, in most countries, fewer than 10% of all health workers providing child care have been trained, and that the rate of training was not sufficient to achieve high coverage in the foreseeable future (Amaral et al, forthcoming). Barriers to scaling up and sustaining high-quality care over time include the cost of training, problems caused by health workers being removed from clinical duties for a significant period to attend training courses, the limited availability of trainers and high rates of staff turnover – up to 40% in a two-year period in some countries (Bryce et al. 2003). IMCI programmes, no matter how good in theory, will struggle to make a widespread and long-lasting impact unless they are integrated into a comprehensive strategy for health systems development, especially in terms of human infrastructure.

ing services, highlighting the ephemeral nature of gains secured by vertical initiatives.

Today, selective approaches are a prominent feature of the international health policy landscape. Despite rhetoric about the need to improve coordination between different disease-based programmes and to complement vertical initiatives with a health systems development agenda, the multitude of single-focus or single-disease initiatives is reminiscent of the heyday of vertical programmes in the 1980s. At the country level, recipient governments are expected to dance to the tune of an international agenda rather than developing targets, policies and plans based on their own circumstances. Health care responses to high morbidity and mortality reflect a biomedical and 'technological' bias (vaccines, medicines or new technologies such as insecticide treated bednets) while a coherent and financially-backed agenda for the long-term and sustainable development of equitable health systems remains absent.

The Millennium Development Goals are also placing health services under pressure to achieve the MDG targets through selective interventions. It has been calculated that making 15 preventive interventions and eight treatment interventions universally available in 42 countries would achieve the MDG child mortality target (Jones et al. 2003). The pressure on governments to apply for and disburse quickly resources from new financing instruments, such as the Global Fund to fight AIDS, TB and Malaria (GFATM), so as to show the positive impact of such bodies, could also undermine cohesive health systems development (Box B1.6).

According to one group of child health experts, although many of the current disease-specific initiatives relate at least indirectly to child survival, and in this sense have expanded the resources available to child health, 'the result is a set of fragmented delivery systems, rather than a coordinated effort to meet the needs of children and families' (Bellagio Study Group on Child Survival 2003). They note that 'in today's environment of disease-specific initiatives, cross-disease planning, implementation, and monitoring are hard to establish and maintain'. Paradoxically, the threat of narrow, disease-based programmes disrupting health care systems is most acute where such systems are already fragile and under-resourced (Victora et al. 2003).

Many of the selective health care initiatives now operate as Global Public Private Initiatives (Box B1.7), introducing a much higher level of involvement from the commercial/private sector. This brings in private financing and private sector 'know-how', but at the same time provides the commercial sector with further public subsidies, and the opportunity to capture a share of the resulting market for their products.

Box B1.6 The pitfalls of expanding anti-retroviral treatment in developing countries

On the back of inspiring civil society campaigns to reduce the price of anti-retroviral treatment (ART), millions of dollars are now being directed at expanding access to these medicines. However, there are several pitfalls in this largesse that are particularly relevant to countries with under-resourced, disorganized and inequitable health care systems (McCoy et al 2005).

One is that access to ART could be expanded at the expense of other vital health care services, or could divert resources away from the prevention of HIV transmission. A focus on ART could also ‘over-medicalize’ the response to HIV/AIDS, and turn attention away from the political, social and economic determinants of the epidemic.

A second pitfall is that ART programmes may take inappropriate ‘short-cuts’ to achieve ambitious coverage targets and compromise on the quality and long-term outcome of care. Insufficient community and patient preparation, erratic and unsustainable drug supplies, and inadequate training and support of health care providers could result in low levels of treatment adherence, tending to an increased threat of drug resistance.

A third pitfall arising out of the pressure to achieve quick results is the use of non-government supply and delivery systems for ART because of their ability to set projects up quickly. Apart from the additional burden of coordinating and monitoring multiple non-government treatment services, this approach can weaken the capacity of the public sector health care system still further by draining skilled personnel into the better-paid independent sector.

Finally, ambitious ART coverage targets may lead to a preferential targeting of easier-to-reach, higher-income groups, typically those living in urban areas, and thereby widening existing health care inequities. A treatment-focused approach that inadequately addresses the basic needs of households, such as food security and access to water, will limit the capacity of the poor to benefit from ART.

Narrow, ‘selective’ or disease-based programmes or initiatives are not inherently bad, nor are they always influenced by undue commercial considerations. For some health interventions, for example those related to the control

Box B1.7 Global Public Private Initiatives (GPPIs)

There are currently about 80 GPPIs, the overwhelming number of which are linked to a specific disease or to the development of a new drug or vaccine. Examples include the Global Fund for HIV/AIDS, TB and Malaria; Roll Back Malaria; Stop TB; Global Alliance for Vaccines and Immunization; Global Polio Eradication Initiative; and the Global Alliance for the Elimination of Lymphatic Filariasis. WHO and UNICEF are the principal international governmental or multilateral actors involved, but the World Bank also plays a prominent role. On the private side, the Bill and Melinda Gates and Rockefeller Foundations are prominent, as are several for-profit pharmaceutical companies. Some NGOs are also involved, particularly with GPPIs they have helped to launch. However, certain groups are systematically under-represented, particularly poorer countries' governments and civil society organizations. On the whole, decision-making power sits in the hands of multilateral institutions and the commercial sector. (*Source: Wemos 2004*)

of vectors for infectious diseases such as mosquitoes, or those related to the control of acute disease outbreaks, a vertical and centralized approach may be entirely appropriate. Today, however, there is a growing proliferation of initiatives and programmes that collectively undermine national planning and coordination; a biomedical, technological bias towards health improvement; inappropriate public-private 'partnerships'; and the lack of more long-term and sustainable approaches to health systems development.

The rise of selective and efficiency-driven cost effectiveness analysis Cost effectiveness analysis (CEA) is a tool designed to rank the relative worth of different health care interventions. In 1993, the World Bank published a ranking of common health care interventions according to their cost effectiveness and used it to propose a minimum package of services for use in low- and middle-income countries (World Bank 1993). Its proposal appears rational at one level, but reinforced a selective approach to health care and undermined equity.

First, the Bank proposed that only this package should qualify for public funding – services outside the package that it deemed were not cost effective were considered discretionary and would have to be funded by individuals out-of-pocket or through insurance. Middle-income countries could be less restrictive than low-income ones in determining the content of a minimum

package, although the same principles would apply. A closer inspection of the package reveals its serious shortcomings. At best, the minimum package would avert no more than one third of the estimated burden of disease in low-income countries and less than a fifth in middle-income countries. Examples of care that would be excluded from public funding in poorer countries include: emergency treatment of moderately severe injuries; treatment of childhood meningitis; and treatment of chronic conditions including diabetes, cataract, hypertension, mental illness and cervical cancer (Segall 2003).

Secondly, the health maximizing approach used by the Bank relied on a limited definition of health outcome. Consider the case of a single-handed poor farmer who develops a disabling inguinal (groin) hernia. His condition would be excluded from publicly funded treatment because the number of 'disability-adjusted life years' that would be gained by the farmer would not represent good value for money. What is not considered is how the hernia could undermine the farmer's ability to provide for his family, thus impoverishing them and thereby undermining their health. The calculation of 'disability-adjusted life years' gained would be different if these considerations were taken into account.

The World Bank also tended to apply CEA to discrete interventions rather than those interventions that have more complex direct and indirect impacts on health. Water provision is a good example. Access to adequate volumes of clean water not only reduces the incidence of diarrhoeal disease, intestinal worms, skin and eye diseases, but also improves child and maternal health indirectly by enabling women (who are usually the ones collecting water) to spend more time on other activities such as child care or household and economic tasks. However, the Bank did not classify improving access to clean water as a cost-effective health intervention.

Finally, although priority setting exercises are sound in principle, the Bank defined the goal of efficiency to mean the maximization of *aggregate* health gain for a given expenditure. The issue as to which people or population groups gained additional health was less important as the policy focus moved away from the prioritization of people in greatest need to the prioritization of interventions that would contribute most to aggregate health gain. The links between this approach with the Bank's stated intention to help the poor were only indirect. First, the interventions for inclusion in the minimum package were also selected according to the estimated population burden of disease they would address – as the poor constitute a high proportion of the population and make a substantial contribution to the total burden of disease, their disease patterns would be influential in the selection of interventions. Second,

many of the diseases associated with poverty are amenable to simple and cost-effective interventions. However, from the standpoint of equity, resources should be allocated first towards tackling the health problems of poor people and only then between different programmes or interventions.

Public sector failure In many countries, the principles of Alma Ata have also been undermined by public sector failures. Illegitimate and corrupt governments that steal from the public purse, practise and tolerate human rights abuses, and allocate inappropriately high budgets to the military or to projects that benefit the elites of society are clearly one root cause of public sector failure – although these characteristics are by no means the sole preserve of poor countries. Corrupt and abusive regimes undermine the attainment of health for all and clearly require political solutions arising from within the countries themselves.

But corruption, abuse and state expenditure are far from being the consequence of local factors alone. Enabling all countries to have stable and effective governments that can improve people's health requires an international response to address the various ways in which richer countries or institutions endorse and support corrupt governments: the arms trade; banks and tax havens harbouring money that elites have looted from poor countries; Western corporations paying bribes; foreign government interference and collusion with illegitimate regimes; and the 'legitimate' and illegitimate economic transactions involving the purchase of natural resources (diamonds, minerals, oil, timber) from repressive and undemocratic countries (Pogge 2002).

Within countries, the ways in which societies organize themselves through their political systems and how these systems support health and development is clearly important. Some research suggests an independent positive association between health and democracy, political rights and civil liberties (Franco, Alvarez-Dardet and Ruiz 2004). However, the underlying mechanisms for the association between democracy and health are complex and may also depend on how democracy and rights are formulated and thought of – millions of people in the United States, for instance, have the political freedom to vote in a rich country but this is not a sufficient requirement for their access to health care. At the same time, countries without democratic political systems, such as China and Cuba, have achieved good and equitable health outcomes due to their commitment to ensuring universal access to the basic requirements of good health (Commission on the Social Determinants of Health 2005). The ways in which different social, political and economic systems influence the capacity for health systems to function effectively and



4 Effective clinical care is vital to the health and well-being of children. But the mother of this child will also need to be given appropriate advice and practical support on child care and nutrition.

equitably need more discussion and research amongst the international public health community.

Health care systems can also fail people as a result of bureaucratic failures. Rigid civil service rules and regulations combined with poor management and leadership can impair innovation, motivation, efficiency and community responsiveness. Civil servants can bend the rules or use their positions to serve their own personal needs. Many countries do not have the capacity for effective administration – for example, there may be no experts in the field of ‘personnel management’ working in the entire Ministry of Health in spite of the central importance of people to health care systems. Government health departments have vast responsibilities and varied challenges; they simply cannot succeed without a minimum degree of management and administrative capacity and competence at all levels of the health care system. At present, however, efforts are inadequate to ensure this level of capacity and competence.

In countries in which donor funds contribute a significant proportion of public health expenditure, public sector failure must be regarded as ‘donor and international agency failure’ as well. The influence of donors and international agencies on the functioning of the Ministries of Health in developing countries can be enormous – and is often not positive. One problem is

the lack of coordination amongst donors and other external agents, more so now with the recent proliferation of global health initiatives. Ministries of Health in developing countries are faced with a circus of multiple external initiatives and programmes (often focused narrowly on specific diseases or interventions), donors, creditors and international NGOs (Figure B1.2) – this is hardly conducive to nationally-led decision-making; coordinated and coherent policy-making and planning; long-term development; or stable and efficient administration.

Furthermore, external policies and programmes imposed from the outside are inadequately tailored to local contexts. Policies, approaches and conceptual tools are often produced within donor circles and then applied worldwide – but supposedly ‘owned’ by recipients. Many agencies are staffed by individuals who have little or no understanding of local culture and history, a problem compounded by high staff turnover (Pfeiffer 2003).

Even in countries where a formal sector-wide approach (SWAp) has been established to create a health sector strategy shared by all stakeholders and to enable greater government leadership, the role of government can often be cosmetic (Hill 2002, Foster, Brown and Conway 2000), while international agencies preserve their own priorities, working styles, reporting formats, data collecting forms, financial procedures and short funding cycles. Only where there is firm government leadership, a clear vision based on a good understanding of health care problems on the ground, and a demand from NGOs and civil society for more national coordination, are countries able to resist the imposition of top-down, blueprint models of health development.

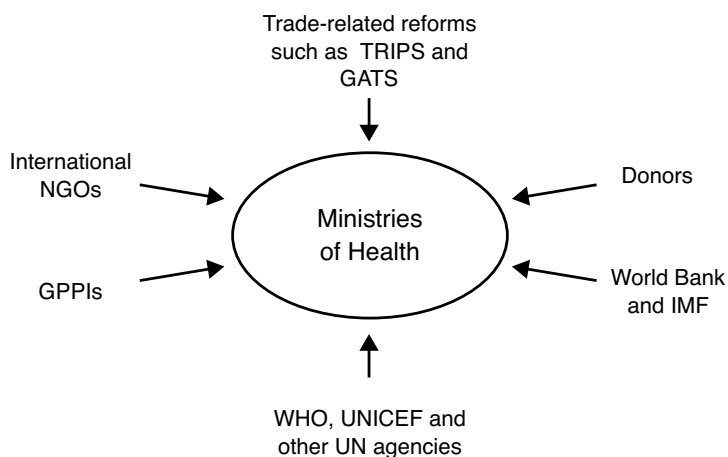


Figure B1.2 The circus of external agencies and initiatives

3 Resurrecting the 'public' in health care systems

The previous sections have outlined the key processes that have undermined the PHC Approach, while recognizing that different factors and forces have had different effects in different contexts. Figure B1.3 below illustrates the interactions and pathways that have hindered equity and efficiency within health care systems. Reversing these trends sustainably and effectively requires addressing all these factors simultaneously – simple, quick fixes will not suffice or be effective. It requires the involvement of more than health care providers, managers and health sector policy makers – many of the solutions involve political, social and economic interventions.

There is a need to resurrect and revitalize the 'public' within health care systems as part of an agenda for change. The goals of such an agenda should be to restore a proper balance and relationships between the public and private sectors as well as between public health care (population and community-based approaches to health) and individual private health care.

For several years, a prevailing view in certain media and amongst many policy makers has been that the private sector is better than the public sector. This is usually accompanied by another view that suggests that incentives formed through market dynamics result in 'better' and more efficient performance of health care systems than those of bureaucratic systems. While there are certainly problems within the public sector that need addressing, the record of public sector success is substantial. Added to this are the achievements of non-government actors, universities and charities, which may not be part of the public sector but which operate with a public ethic rather than one driven by competition, self-interest or market signals.

Public sector social welfare has been the bedrock of European social and economic development since the Second World War. Furthermore, low-income countries like Sri Lanka, Costa Rica and Cuba have had well-performing public health services for decades. The rapid and equitable decline in maternal mortality in Malaysia after independence from Britain in 1957 was due to government leadership (Pathmanathan et al 2003). Publicly-funded research in national institutes of science and universities has laid the foundations for many, if not most, developments in the medical sciences. Hundreds of thousands of public servants across the world are currently helping to make societies work in hundreds of different ways through bureaucracies – forms of organization characterized by a clear division of labour; clearly defined authority and responsibility; and administration and decision-making based on transparent rules.

For health care systems, several arguments point to the need for the public sector to take a central role. The first is that people have a right to health care

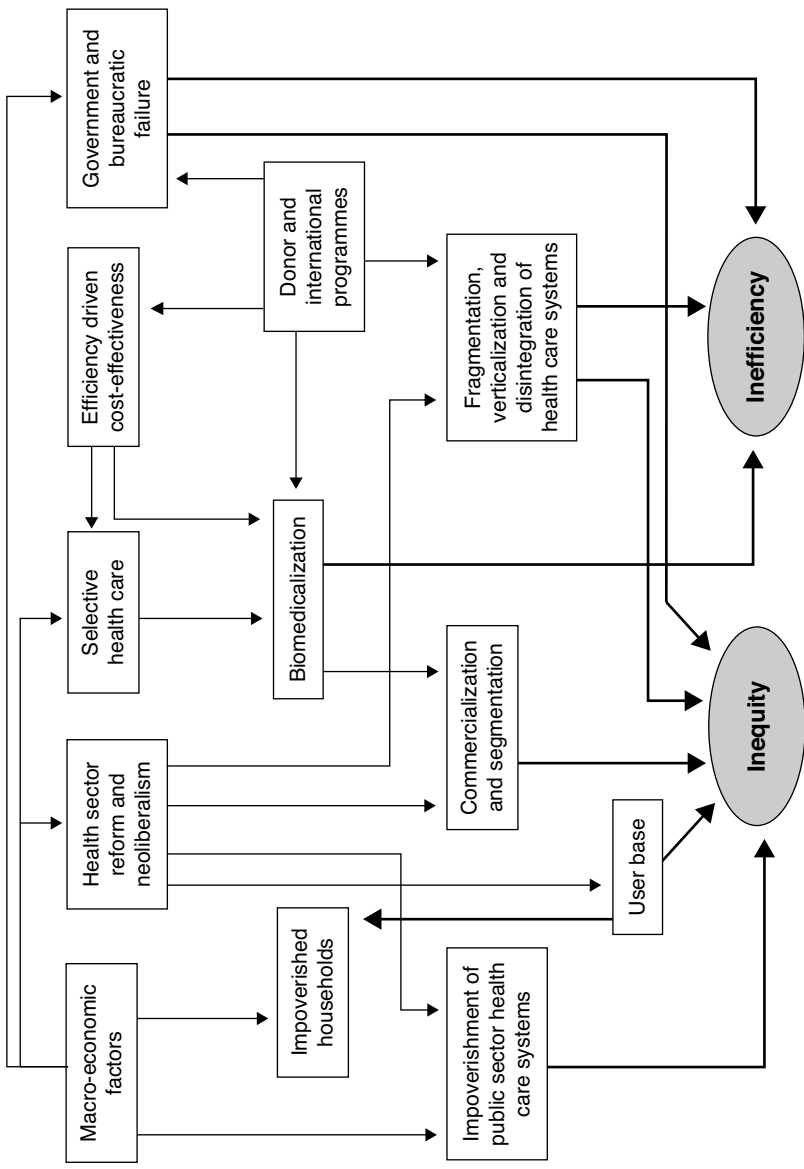


Figure B 1.3 Factors undermining the PHC approach

that is not dependent on their ability to pay or on the vagaries of the market. Governments are critical to ensuring that these rights are fulfilled. Public sector health services are people's ultimate recourse for health care, especially poorer people. But public services must not become marginalized as 'poor care for the poor'. Societies should strive instead to use the health care system to promote social solidarity and to mitigate the effects of socio-economic disparities; they must be bold enough to make the idea of universal public-funded health care systems not just acceptable but aspirational.

Second, equitable and efficient health care systems require careful organization – fragmented, disorganized and market-driven health care systems are inefficient and inequitable. Public sector provision allows for direct planning of the location and types of health facilities and the organization of a coherent service to respond to the health care needs of a population. It allows the right balance to be struck between public health and clinical services, and between preventive and curative services.

Third, an adequately financed public service offers the best means of breaking the link between the income of health care providers and the delivery of health care – arguably one of the most critical conditions for the development of ethical behaviour and values within health systems and for avoiding the harm associated with 'commercial behaviour'.

This is not to deny any role for non-government actors. In many countries, the lack of public sector capacity is so great that a dependence on non-government providers is unavoidable. Non-government actors can also enhance community involvement within health programmes, help ensure public sector accountability and support public sector development. It is the role of commercially-driven private sector actors and the weakening of the public sector that has clashed most fundamentally with the aim of cost-effective and equitable health for all.

These arguments are based on socially-determined values. But there is also evidence that the larger the role of the public sector in health care systems, the better the outcome (Mackintosh and Koivusalo 2004). Healthy life expectancy (HALE), for instance, is significantly higher, and child mortality significantly lower, in countries with lower levels of private health expenditure relative to public expenditure, after allowing for level of economic development and the influence of AIDS in Sub-Saharan Africa (see Figure B1.4).

Countries that spend more of their GDP on health through public expenditure or social insurance also have significantly better health outcomes in terms of HALE and child mortality (see Figure B1.5). Better health in richer countries is therefore associated with higher incomes *and* with more public and so-

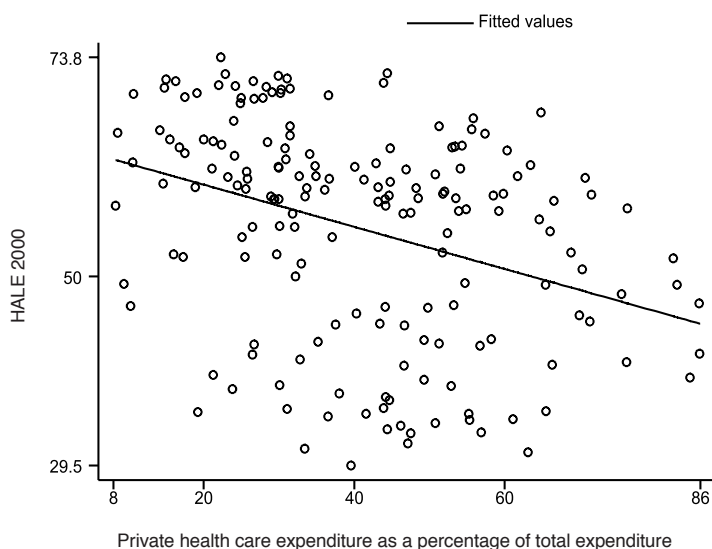


Figure B1.4 Association between healthy life expectancy and private health care expenditure as a percentage of total health care expenditure, 2000
(Source: Mackintosh and Koivusalo forthcoming 2005)

cial health expenditure relative to GDP. Conversely, countries that apportion more of their GDP to private health expenditure do not display better health outcomes in terms of HALE or child mortality, after allowing for the effect of higher incomes on health outcomes. In fact, there is a mild (non-significant) association with worse outcomes (Mackintosh and Koivusalo 2004).

These observations are corroborated by Demographic and Health Survey (DHS) data from 44 low- and middle-income countries (Mackintosh and Koivusalo 2004) suggesting that:

- The proportion of deliveries with a skilled birth attendant is positively associated with higher government health expenditure as a share of GDP.
- Countries with a high proportion of children with acute respiratory infections (ARI) or diarrhoea who are treated privately generally have a lower proportion of children who are treated for these conditions at all, suggesting that higher levels of private provision are associated with higher levels of exclusion from health care.
- The percentage of children from the poorest 20% of households who were treated for ARI was more comparable (more equitable) to the percentage of children treated for ARI from the richest 20% of households in countries with a lower level of private primary care provision, suggesting that a greater privatization of primary care is associated with greater inequality.

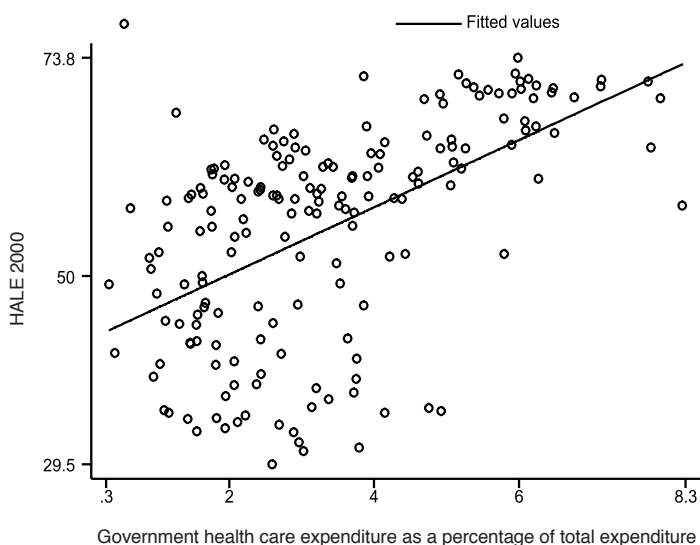


Figure B1.5 Association between healthy life expectancy and government health care expenditure as a percentage of GDP, 2000 (Source: Mackintosh and Koivusalo forthcoming 2005)

4 Agenda for health systems development

This section sets out an agenda to repair the damage to the public sector, uphold the role of accountable government in health care provision and reassert the principles of the PHC Approach. Its ten recommendations are not stand-alone options but need to be implemented together, and tailored to the particular social, political and economic realities of a given country.

Valuing and revitalising the public sector health worker – the lifeblood of health services Changing and improving how health personnel behave and function is so central to the rebuilding of health services, especially in developing countries, that it cannot be treated as just another administrative or bureaucratic task.

The performance of public sector health workers is affected by many factors and calls for a concerted, coordinated programme of health worker support and development. The re-establishment of a living wage is one requirement if health workers are to behave ethically and function effectively – countries must make up lost ground in the deterioration of public service salaries. Ensuring the right number and mix of types of health personnel (for example, increasing the number of nurses, medical auxiliaries and community health workers relative to doctors) can help countries to create payrolls that are sustainable, efficient and inclusive of incentives for trained staff to work in under-served areas.

But improved health worker performance cannot be achieved through money alone. The problems of demoralization and demotivation are more complex and require a multi-dimensional programme involving:

- adequate supplies of essential equipment, consumables and medicines to enable health workers to exercise their skills;
- systematic quality improvement programmes, including the training of staff in health service quality, interpersonal relations and responsiveness of care;
- support for health workers, especially those who work in isolated and difficult circumstances;
- a participatory style of health service management; and
- an incentive structure of professional rewards for good performance.

At the same time, clear rules and sanctions must signal that theft, unethical practices, and uncaring and abusive behaviour towards patients, especially the poor, women, elderly and ethnic minorities, will not be tolerated. Disciplinary procedures, however, must be consistent, fair and transparent.

There are also a range of management tools and processes that can be employed to promote commitment, good performance and ethical behaviour within public sector bureaucracies – these include non-financial incentives such as peer recognition and public praise of good performance; and opportunities to advance career and learning prospects. Ensuring improved performance through a combination of rules, public accountability and non-financial incentives requires much more emphasis to counter the prevailing focus on economic and market-based incentives.

Resources to achieve health for all For many countries, the need for adequately financed public sector health care systems is the paramount objective. The outright cancellation of unpayable debt, fair trade reform, increased and improved levels of overseas development assistance and the creation of new forms of global financing (see part A, part E, chapters 5 and 6, and part F) have to be part of any agenda for global health care systems development and should be reflected more prominently in the lobbying of international health agencies, including those of the major philanthropic foundations operating in the health and development sector. External financing must, however, be guaranteed with medium- to long-term commitments, and directed in ways that will strengthen Ministries of Health.

Within countries, governments should strengthen their capacity to increase their tax revenue in a progressive and fair manner. All countries should aim

to raise an amount of tax revenue that is at least 20% of their GDP. Success in mobilizing public finance for health will then depend on the negotiating skills and credibility of the Ministry of Health, as well as an ability of social movements and other non-government actors to make effective demands on the political system. Civil society must also be encouraged and supported to monitor government budgetary allocations.

Financing health for all Health financing policies should aim to create a single national pool of funds, with the capacity for cross-subsidization between

Box B1.8 Millennium Development Goals for the financing of health care systems

The health-related MDGs have mostly been formulated in terms of outcome indicators. These are important, but do not chart a path to achieve the outcome goals. The following suggested targets for health systems financing may serve to explore how to map out such a path:

- countries to raise the level of tax revenue to *at least 20%* of their GDP;
- public health expenditure (including government and donor finance) to be at least 5% of GDP;
- government expenditure on health to be at least 15% of total government expenditure;
- direct out-of-pocket payments less than 20% of total health care expenditure;
- expenditure on district health services (up to and including Level 1 hospital services) at least 50% of total public health expenditure, of which half (25% of total) should be on primary level health care;
- expenditure on district health services (up to and including Level 1 hospital services) at least 40% of total public and private health expenditure;
- a ratio of total expenditure on district health services in the highest spending district to that of the lowest spending district of not more than 1.5.

These indicators would complement service output and outcome indicators such as immunization coverage, rates of skilled attendance at deliveries, TB completed-treatment rates, and maternal, peri-natal and child mortality rates.

high-income and low-income groups, and risk sharing between, for example, the young and the elderly. The more the system can be prevented from becoming polarized in terms of finance, the more it can ensure that better-off people do not separate themselves out institutionally from the public sector and distance themselves from the poor or from problems in the system (Mackintosh 2001).

To move towards more universalized health care systems, many countries should amalgamate existing forms of pooled financing and gradually reverse the segmentation of health care systems. The development of large-scale private insurance markets should be avoided at all costs. Where they exist, governments may pass laws to enforce community rating and prescribed minimum benefits, and insist on payment systems that discourage over-servicing and supplier induced demand.

Health systems should also work towards abolishing user fees for essential health care. This must be planned carefully and carried out in stages, depending on the medium- to long-term financing plan of the health care system.

Recommendations to make health care systems more equitable and to mitigate the harms of commercialized health care through financing reforms will meet varying levels of opposition from vested interests. Local civil society organizations and progressive international health NGOs can help to counter such opposition, while governments can promote public discussion on health sector financing reforms, ensuring the presence and voice of the poor in such discussions. WHO can promote and document a regular appraisal of health care financing systems on a country-by-country basis, making it easier for civil society to gauge the kind of reforms required in their countries.

Regulating and shaping the private sector In most of the poorest countries, the bulk of health care provision is carried out by the private sector, much of it in the form of small-scale, disorganized private dispensaries and clinics. Many governments do not have the capacity either to regulate the sector or to improve the quality and safety of care provided. Governments and donors must give issues of private sector regulation and quality assurance a much higher profile in their health policies and plans. Poor country governments with limited resources need to use their political and legal muscle to shift disorganized and commercialized health care markets towards a more equitable and efficient direction. The long-term goal must be a coherent primary level health care system operating under a clear national regulatory framework that governs standards quality and provider remuneration.

Private providers should also develop their own mechanisms to enhance

professionalism, good clinical practice and ethical behaviour. However, self-regulation in the private sector is often weak and must be complemented by government and civil society intervention. Governments could consider working with the non-profit private sector – good non-government providers can develop and publicize standards for access and quality, and help undercut providers of a lower standard.

Other policy instruments to regulate the private sector include licensing requirements, formal accreditation and price controls. Licences can also be used to negotiate explicit returns in the form of arrangements for the public sector to use private sector facilities and equipment at a reduced cost, or for the private sector to provide services for free or at low-cost to patients referred from the government sector (Mackintosh and Tibandebage 2004). These recommendations should be implemented in the context of broader reforms to universalize the health care system and constrain commercial behaviour.

A key requirement for strengthening the public sector relative to the private sector is to reduce the disparity in incomes between public and private providers. This disparity should be regularly measured and monitored to draw attention to the need for active measures to reduce the gap.

Governments should revoke any commitments they have made to liberalize their health care and health insurance markets through the World Trade Organization's General Agreement on Trade and Services (GATS) or regional and bilateral trade agreements, and should reverse any agreements that undermine their ability to regulate the health care sector.

Making the public sector work – strengthening management Much more investment needs to be directed at strengthening public sector health management capacity at all levels of the health care system. Too often, however, management-strengthening initiatives are ineffective, short-lived and de-contextualized, reflecting a general neglect of public administration in the development sector. Key elements of health systems management are highlighted below.

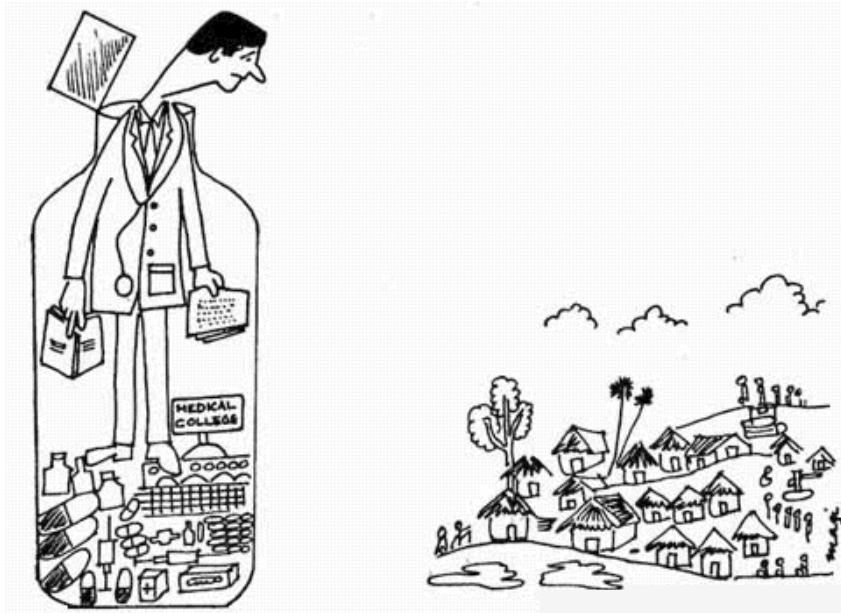
RESOURCE MANAGEMENT AND PLANNING Ministries of Health need to show where the money is spent, on whom and on what. A diagnostic health sector review, which characterizes health and health care inequalities and which describes resource levels and distribution, expenditure flows and the relative positions of public and private health sectors, including the role of non-government actors, is a necessity. Plans to reallocate and redistribute resources can follow on from a transparent evidence base.

Structural imbalances, such as the relative over-development of large city hospitals and under-development of primary and secondary level care in rural areas, are best addressed through a series of 3–5 year planning cycles. To ensure equitable resource allocation between geographic areas, decisions about financing and major resource allocation should be centralized and based on an equitable, population-weighted needs-based formula. Countries should be wary of decentralizing health financing, as this may increase inequity as richer areas spend more money and absorb more resources.

PRIORITIZING INTERVENTIONS With respect to programmatic areas, resources should be titrated against the level of priority: higher priority programmes (for example, basic maternal and child health services) will be more intensely resourced, while those of lower priority will be less well resourced. This is a flexible system of rationing that has been termed *dilution* – as distinct from the blanket exclusion of interventions (through ‘essential packages’ World Bank style) that has been termed *denial* (New, 1996). From an equity perspective, resources should first be allocated according to the relative health care need of people, and only then should considerations of cost-effectiveness be applied to the selection of treatments – this is in contrast to the selection of people for treatment which will happen if priorities are primarily set in terms of interventions.

IMPLEMENTING PHC PROGRAMMES Central to improving health outcomes is the effective provision of medical services in conjunction with a multi-sectoral approach to promote and protect health. Health care systems can act as the engine for such a model of health care through the appropriate design of PHC programmes. Such programmes would include the delivery of cost-effective medical care, aided by essential medicines lists and rational, standard treatment guidelines, as well as interventions to promote and protect health, such as improving access to clean water; ensuring household food security; providing for adequate shelter and housing; and raising levels of literacy. The design of PHC programmes must also incorporate the involvement and empowerment of communities. The revitalization of community health worker programmes may form a part of this. Too many health programmes are still implemented in a top-down, technocratic manner with an over-emphasis on medical services.

HEALTH SYSTEMS AND OPERATIONAL RESEARCH Enhancing the role of research in strengthening health care systems is often discussed but rarely implemented. Much more investment is required in health systems and problem-solving operational research relative to biomedical research and research



5 To make health care systems more equitable and effective, both the geographic and social distance between health professionals and communities must be shortened.

that is geared towards academic publications. However, health systems and management research needs to become more embedded in health management and planning activities and not run as a parallel activity. Policy makers and health managers should lead the development of research agendas more than they do at present. There is also a need to invest more in the development of health information and disease surveillance, and the capacity and time for staff of public health care systems to conduct their own research.

APPROPRIATE TIMEFRAMES In many countries with urgent health needs, longer timeframes are needed to plan, implement, integrate and sustain health efforts. Today, timeframes set by international agencies and donors are often unrealistic and too short. They can lead to, for example, an over-dependence on top-down vertical approaches rather than approaches that simultaneously build the longer-term capacity and sustainability of health care systems. The frequent changing of international priorities and the short-term funding cycles of donors also needs to change towards adopting realistic and sustainable timeframes.

Political and social mobilization Those living in urban areas (especially the more affluent) and the higher levels of the medical profession benefit from

the high technology and urban bias of resource distribution and will lobby against any measures to change this. Many parts of the private sector have reasons to block movement in the direction of the PHC Approach. These vested interests can be overcome only by a political effort, which includes the mobilization of those who are disadvantaged by the current system and their political and civil society representatives. Where communities face a commercially driven health care sector, they need to lobby for a regulatory framework to hold providers and the health system accountable. Where neo-liberal reforms are undermining public systems and shifting state obligations onto communities, they need to mobilize in support of the public sector.

The need to engage with actors and policies from beyond the local area poses a particular challenge. Social movements may need to bring together the concerns of several communities and find ways of presenting collective views and concerns at the national or international level. This form of community involvement requires an advanced level of organization, capacity building and civil society networking. Examples include the Treatment Action Campaign in South Africa, which challenged the patent monopolies of drug companies on anti-retroviral drugs and the failures of the South African government to provide treatment for HIV/AIDS, and the mobilization of civil society against the privatization of health services in El Salvador.

The role of international NGOs in acting as a conduit for the demands and needs of poor people in developing countries is important. International NGOs in developed countries should help develop the capacity of Southern-based NGOs and work with and through them. UN agencies must find ways to create a more prominent involvement of Southern-based NGOs, academics and health institutions in shaping the international health policy agenda.

Public and community involvement in health care systems For public sector bureaucracies to work effectively, efficiently and fairly, they need to be held accountable – internally through rules and codes of ethical conduct but, equally importantly, externally to communities and the public.

The spectrum of appropriate community involvement includes community mobilization to assert rights, challenge policies and present alternatives; monitoring of services by communities; involvement in planning and decision-making; and involvement in the implementation of PHC programmes and services. All too often, the role of civil society organizations within health care systems is given inadequate attention, or is used to cover up other agendas such as transferring government responsibility onto communities or rubber-stamping central decisions.

Appropriate community involvement should also be enhanced by health care systems through effectively empowered community structures and forums (such as district health committees, clinic committees and hospital boards), as well as by inculcating a culture of consultation and respect for lay people. Health care systems can disseminate information about local health services and the rights of service users, as well as publicize disparities in key indicators such as maternal mortality and immunization coverage to encourage a social commitment towards reducing inequity. However, because communities are themselves stratified, health workers need to make sure that community involvement does not entrench privilege.

More effective assistance from donors and global initiatives Donor and international health agencies must improve the quality, coordination and appropriateness of their programmes and initiatives. They must learn to develop a better understanding of local contexts and to adopt policies that place the long-term self determination and development of Ministries of Health and the citizens of recipient countries at the heart of all decision-making. Donors must reaffirm the generic principles of a coordinated sector-wide approach to health systems development. More investment should be aimed at developing, retaining and motivating public sector staff, and donors must be prepared to fund the recurrent costs of public sector health care systems in the poorest countries for at least the medium-term. Donors should also divert more funding away from agencies based in donor countries towards the public sector and NGOs in recipient countries.

Donor programmes and international health initiatives must translate the rhetoric of implementing disease-based programmes in ways that strengthen health care systems in practice. Disease-specific initiatives must explicitly explain and demonstrate *how* they are strengthening the overall development of comprehensive health care systems. Philanthropic agencies must recognize the need to balance investment in medical technologies with the need to invest in human resources, health systems and multi-sectoral approaches to health promotion and disease prevention.

Donors must avoid self-promotion and no longer insist that governments show quick results from their grants. Donor funding should be judged instead by the performance of the overall health care system over time. Donors should adopt a more incremental, problem-solving approach to health sector development, rather than the blueprint approach currently favoured by foreign technocrats. Technical assistants need to be selected with greater attention to the appropriateness of their skills; their willingness to learn the local cultural

and historical contexts before prescribing remedies; and their commitment to developing the self-sufficiency and capacity of local counterparts.

Donor programmes and international health initiatives should develop mechanisms to uncover transgressions in the management of aid on the part of both recipient governments and donor agencies. The auditing of the performance of donors and international health agencies should be encouraged and conducted by independent institutions that do not have any conflicts of interest in doing so.

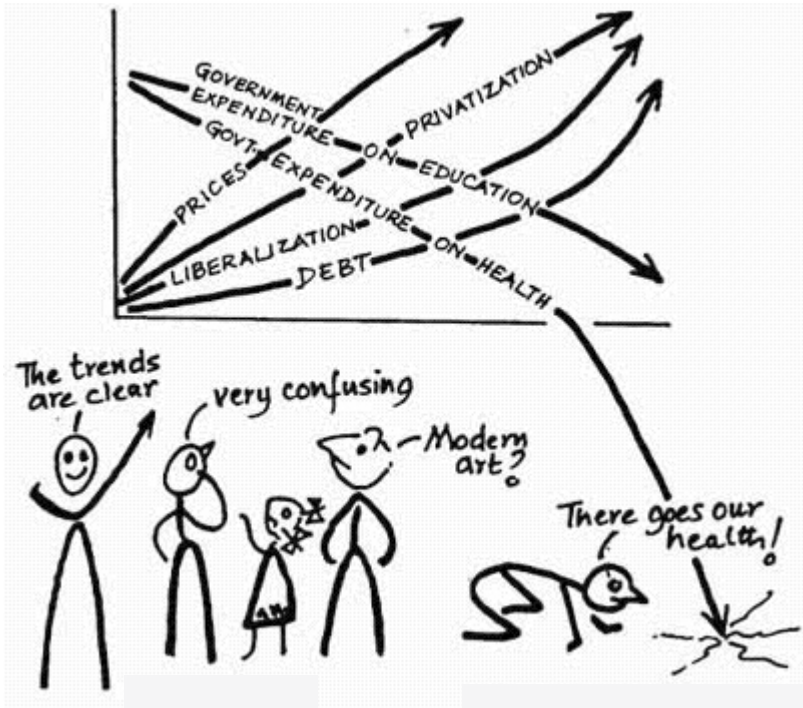
Finally, donors and international health agencies should fund and foster more partnerships between high-performing middle- and low-income countries that have been able to show above average health status and health care performance (such as Thailand, Sri Lanka, Cuba and Costa Rica) and other countries with struggling health care systems.

An organizational framework for the health care system – the District Health System The DHS model (described in section 1) provides an organizational framework for many of the other recommendations. It creates a decentralized system to allow health plans and programmes to be tailored to the needs and characteristics of the local population and topography. It provides a platform for the integration of policies and priorities emanating from different programmes and initiatives at the central level, and for getting the appropriate balance between top-down and bottom-up planning. Districts can form the basis for resource-allocation decisions informed by a population-based assessment of need, and can help central levels of the health care system to identify areas requiring additional capacity development or support.

The DHS represents a particular type of decentralization – one that promotes integration between hospitals, clinics and community-based health care within a single, coherent national health system – in contrast to the decentralization of neoliberal health sector reforms, which fragments the health care system. The organization of the health care system on a geographic basis adopts a more inclusive, population-based approach to health rather than the organization of health care according to segmented, socio-economic groups.

The DHS also provides an architecture for facilitating community involvement in health and organizing the comprehensive and multi-sectoral approach of Alma Ata. District-level health management structures could evaluate and monitor the quality of care provided in the private sector. The DHS could therefore be part of a strategy to reshape the performance and culture of the private health sector.

Establishing a DHS model implies more than just the demarcation of health



6 The demise of health for all and equity.

district boundaries. Most important is that district-level health management structures have the authority, status, skills and competencies to plan for and manage health care delivery for their local population without constant interference from central dictates and demands. Central-level policy makers and managers in turn have to change their function from directly managing health care services to developing guidelines, facilitating capacity development, providing support, and supervising and monitoring.

Although WHO has recently called for the revitalization of the PHC Approach, it did not set out an accompanying strategy for the organization of health care systems – instead it seems to advocate tacking on the PHC Approach to the various health sector reforms that have taken place since the 1980s.

Rebuilding trust The final recommendation involves promoting trust as a conceptual basis for encouraging a higher level of ethical behaviour within health care systems. Trust matters to health care systems for two reasons. First, it represents a moral value in itself, which is important because health care systems are social institutions that reflect and shape societal values and

norms (Loewy 1998, Mooney 1998). The design of health care systems – from financing and resource allocation mechanisms to the governance arrangements of clinical practice – influence the values that they signal to society. In this way, trust sustains the legitimacy of public health policy and action and stands as an important and much-neglected counter-balance to the pressures of commercialization (Gilson 2003).

Second, trust facilitates the co-operation among people and organizations that is fundamental to the provision of health care. Trust is a key element of the provider-patient relationship – it is essential that patients can trust providers to behave ethically and have their best interests at heart (Davies 1999, Mechanic 1996). Trust also facilitates patient communication, underpins the provider's role in encouraging patients to change their behaviour, and enables greater patient autonomy in decision-making.

Health care systems can actively nurture trust and ethical behaviour by acting against violations of trust and promoting norms or values, such as truthfulness, attitudes of solidarity, and a belief in fairness. To this end, they should develop the institutions that are able to influence the behaviour of providers, managers and insurers, including standards of professional conduct, clinical protocols and best-practice guidelines; systems to monitor adherence to standards and protocols; licensing and disciplinary procedures; an explicit recognition of rights to health care (Giddens 1990); and actions that constrain profit-seeking behaviour, such as capping prices, countering the use of informal payments or requiring free treatment of emergency cases.

Management practices can also enhance levels of trust and ethical behaviour. Improved communication and a two-way flow of information can increase levels of trust, as can establishing transparent procedures by which community members can monitor and evaluate health care practices. Transparent expenditure reviews can ensure probity in the use of funds and act as a bulwark against the misuse of resources. The accreditation of providers, especially if conducted in a spirit of cooperation, is another mechanism to promote good performance according to specified standards as well as to build trust and shared values. Transparent and fair decision-making practices also act as a source of self-esteem and intrinsic motivation that can build commitment and trust for the employer organization.

Political, social and health sector leadership that promotes ethical behaviour, good quality care and values of fairness and justice is important in shaping a culture of trust and ethics within health care systems. These actions will need to be complemented by international action and debate to signal to health systems and society at large that trustworthy behaviour matters, point-

ing to an important role for WHO and other international health agencies. Rather than seeing health systems as machines through which bio-medical interventions are delivered, health leaders must recognize them as social institutions comprised of chains of people, relationships and understandings.

References

- Ahmad K (2004). Health and money in Afghanistan. *Lancet* 364:1301–02.
- Akin J, Birdsall N, Ferranti D (1987). *Financing health services in developing countries: an agenda for reform*. Washington, World Bank.
- Amaral J et al. (forthcoming). Effect of Integrated Management of Childhood Illness (IMCI) on health worker performance in Northeast-Brazil. *Cadernos de Saude Publica*.
- Arrow K (1963). Uncertainty and the welfare economics of medical care. *American Economic Review* 53: 941–73.
- Bassett M, Bijlmakers L, Sanders D (1997). Professionalism, patient satisfaction and quality of health care: experience during Zimbabwe's structural adjustment programme. *Social Science and Medicine* 45; 12:1845–1852.
- Bellagio Study Group on Child Survival (2003). Knowledge into action for child survival. *Lancet*, 362:323–27.
- Black R, Morris S, Bryce J (2003). Where and why are 10 million children dying each year? *Lancet* 361:2226–34.
- Bloom G (1991). Managing health sector development: markets and institutional reform. In: Colclough C and Manor J, eds. *States or markets: neoliberalism and the development policy debate*. Oxford, Oxford University Press.
- Brown A (2000). *Integrating vertical programs into sector-wide approaches: experiences and lessons*. London, Institute for Health Sector Development.
- Bryce J et al. (2003). Reducing child mortality: can public health deliver? *Lancet* 362:159–64.
- Commission on Macroeconomics and Health (2001). *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, WHO.
- Commission on the Social Determinants of Health (2005). Action on the social determinants of health: learning from previous experiences. A Background paper prepared for the Commission on Social Determinants of Health (http://www.who.int/social_determinants/en/, accessed 19 March 2005).
- Davies H (1999). Falling public trust in health services: Implications for accountability. *Journal of Health Services Research and Policy* 4:193–194.
- Devereaux P et al. (2002). Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. *Journal of the American Medical Association* 288:2449–57.
- Ensor T, Pham S (1996). Access and payment for health care: the poor of Northern Vietnam. *International Journal of Health Planning and Management* 11:69–83.
- Evans R (1997). Health care reform: who's selling the market, and why? *Journal of Public Health Medicine* 19:45–9.
- Evans R (1997). Going for the gold: the redistributive agenda behind market-based health care reform. *Journal of Health Politics, Policy and Law* 22:427–66.

- Foster M, Brown A, Conway T (2000). *Sector-wide approaches for health development: a review of experience*. WHO, Geneva (http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.1.pdf, accessed 24 March 2005).
- Franco A, Alvarez-Dardet C, Ruiz M (2004). Effect of democracy on health: ecological study. *British Medical Journal* 329:1421–3.
- Fu W (1999). *Health care for China's rural poor*. Washington, World Bank.
- Giddens A (1990). *The consequences of modernity*. Cambridge, Polity Press.
- Gilson L (2003). Trust and the development of health care as a social institution. *Social Science and Medicine* 56:1453–1468.
- Gwatkin D (2003). Free government health services: are they the best way to reach the poor? (http://poverty.worldbank.org/files/13999_gwatkin0303.pdf, accessed 24 March 2005).
- Himmelstein D et al. (1999). Quality of care in investor-owned vs not-for-profit HMOs. *Journal of the American Medical Association* 282:159–63.
- Hilary J (2001). *The Wrong Model: GATS, trade liberalisation and children's right to health*. London, Save the Children (UK) (http://www.savethechildren.org.uk/temp/scuk/cache/cmsattach/986_wrongmodel.pdf, accessed 24 March 2005).
- Hill P (2002). The rhetoric of sector-wide approaches for health development. *Social Science and Medicine* 54:1725–1737.
- IFC (2002). *Investing in private health care: Strategic directions for IFC*. Washington DC, International Finance Corporation.
- Jones G et al. (2003). How many child deaths can we prevent this year? *Lancet* 362: 65–71.
- Khalegian P and Das Gupta M (2004). *Public Management and the Essential Public Health Functions*. World Bank Policy Research Working Paper 3220. Washington, World Bank.
- Liu X, Mills A (2002). Financing reforms of public health services in China: lessons for other nations. *Social Science and Medicine* 54:1691–8.
- Loewy E (1998). Justice and health care systems: What would an ideal health care system look like? *Health Care Analysis* 6:185–192.
- Mackintosh M and Koivusalo M (2004). *Health systems and commercialisation: in search of good sense*. Geneva, UNRISD ([http://www.unrisd.org/unrisd/website/projects.nsf/\(httpProjects\)/E90A28B15B255697C1256DB4004B2D63?OpenDocument](http://www.unrisd.org/unrisd/website/projects.nsf/(httpProjects)/E90A28B15B255697C1256DB4004B2D63?OpenDocument), accessed 24 March 2005).
- Mackintosh M and Koivusalo M (forthcoming 2005). Health systems and commercialization: in search of good sense. In Mackintosh M, Koivusalo M eds. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. Basingstoke, Palgrave.
- Mackintosh M (2001). Do health systems contribute to inequalities? In: Leon D, Walt G, eds. *Poverty, Inequality and Health: An International Perspective*. Oxford, OUP.
- Mackintosh M and Tibandebage P (2004). Inequality and redistribution in health care: analytical issues for developmental social policy. In: Mkandawire T, ed. *Social Policy in a Development Context*. Basingstoke, UK, Palgrave and UNRISD.
- Maynard A (1998). Competition and quality: rhetoric and reality. *International Journal for Quality in Health Care* 10:379–84.
- McCoy D et al. (2005). Expanding access to anti-retroviral therapy in sub-Saharan Africa: avoiding the pitfalls and dangers; capitalising on the opportunities. *American Journal of Public Health* 95:18–22

- McPake B (1997). The role of the private sector in health services provision. In: Bennett S, McPake B, Mills A. *Private Health Providers in Developing Countries: Serving the Public Interest?* London, Zed Books.
- Mechanic D (1996). Changing medical organization and the erosion of trust. *The Milbank Quarterly* 74:171–189.
- Mooney G (1998). Beyond health care outcomes: the benefits of health care. *Health Care Analysis* 6: 99–105
- Nahar S, Costello AM de (1998). The hidden cost of ‘free’ maternity care in Dhaka, Bangladesh. *Health Policy and Planning* 13:417–422.
- New B (on behalf of the Rationing Agenda Group) (1996). The rationing agenda in the NHS. *British Medical Journal* 312:1593–1601.
- Newell K (1988). Selective primary health care: the counter-revolution. *Social Science and Medicine* 26:903–6.
- Pathmanathan Indra et al. (2003). *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*. Washington DC, World Bank.
- Pfeiffer J (2003). International NGOs and primary health care in Mozambique: the need for a new model of collaboration. *Social Science and Medicine* 56:725–738
- Pogge T (2002). *World poverty and human rights*. Cambridge, Polity Press.
- Rice T (1997). Can markets give us the health system we want? *Journal of Health Politics, Policy and Law* 22:383–426
- Rifkin S, Walt G (1986). Why health improves: Defining the issues concerning ‘comprehensive primary health care’ and ‘selective primary health care’. *Social Science and Medicine* 23: 559–66.
- Robinson M, White G (2001). The Role of Civic Organizations in the Provision of Social Services: Towards Synergy. In: Mwabu G, Ugaz C, White G eds. *Social Provision in Low-Income Countries – New Patterns and Emerging Trends*. Oxford, OUP.
- Roemer M (1984). Private medical practice: Obstacle to health for all. *World Health Forum* 5:195–210.
- Russell S, Gilson L (1997). User fee policies to promote health service access for the poor: a wolf in sheep’s clothing? *International Journal of Health Services* 27:359–79.
- Schellenberg J et al (2004). Tanzania IMCI Multi-Country Evaluation Health Facility Survey Study Group. The effect of Integrated Management. of Childhood Illness on observed quality of care of under-fives in rural Tanzania. *Health Policy and Planning* 19:1–10.
- Segall M (2003). District health systems in a neoliberal world: a review of five key policy areas. *International Journal of Health Planning and Management* 18:S5–S26.
- Shaffer E et al. (2005). Global trade and public health. *American Journal of Public Health* 95: 23–34.
- Smith D, Bryant J (1988). Building the infra-structure for primary health care: an overview of vertical and integrated approaches. *Social Science and Medicine* 26: 909–17.
- Stewart J (1988). Advance or retreat: from the traditions of public administration to the new public management and beyond. *Public Policy and Administration* 13:27.
- Stocker K, Waitzkin H and Iriart C (1999). The exportation of Managed Care to Latin America. *New England Journal of Medicine* 340:1131–36.
- Theodore K (1999). *Health sector reform and equity in Jamaica: report to the Pan-American Health Organisation*. Washington DC, PAHO.
- Tipping G (2000). *The social impact of user fees for health care on poor households: commissioned report to the Ministry of Health*. Hanoi, Vietnam, Ministry of Health.

- Toole M et al. (2003). Harnessing the new global health resources to build sustainable health systems. Melbourne, Centre for International Health, Burnet Institute (<http://www.burnet.internationalhealth.edu.au/freestyler/gui/files/Health%20systems%20paper%2C%20April%202004.pdf>, accessed 24 March 2005).
- Transitional Islamic Government of Afghanistan (2002). *Afghanistan National Health Resources Assessment*. Prepared by Management Sciences for Health, HANDS and JICA (<http://www.msh.org/afghanistan/3.0.htm>, accessed 20 March 2005).
- UNFPA 2004. *State of the world population 2004*. Geneva, UNFPA (<http://www.unfpa.org/swp/swpmain.htm>, accessed 24 March 2005).
- Unger J, Killingsworth J (1986). Selective primary health care: a critical review of methods and results. *Social Science and Medicine* 22:1001.
- UNICEF (2001). *Progress since the World Summit for Children: a statistical review*. New York, UNICEF (http://www.unicef.org/pubsgen/swethechildren-stats/sgreport_adapted_stats_eng.pdf, accessed 28 March 2003).
- Victoria C, Wagstaff A, Schellenberg J et al. (2003). Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 362:233–41.
- Waldman R, Hanif H (2002). *The public health system in Afghanistan*. Afghanistan Research and Evaluation Unit (available at: http://www.areu.org.af/publications/waldman_health.pdf, accessed 17 December 2004).
- Walsh J and Warren K (1979). Selective primary health care: an interim strategy for disease control in developing countries. *New England Journal of Medicine* 301: 967–74.
- Wemos (2004). *Good Intentions with Side Effects: Information on Global Public Private Initiatives in Health*. 2004. Amsterdam, Wemos (<http://www.wemos.nl/documents/Goodintentionswithsideeffects.pdf>, accessed 29 March 2005).
- Werner D, Sanders D (1997). *Questioning the solution: The politics of primary health care and child survival*. California, HealthWrights.
- Whitehead M, Dahlgren G, Evans T (2001). Equity and health sector reforms: can low-income countries escape the medical poverty trap? *Lancet* 358:833–36
- WHO/UNICEF (1978). *Declaration of Alma Ata: International Conference on Primary Health Care, 6–12 September 1978*. Geneva, WHO (http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, accessed 15 March 2005).
- WHO (1988). *The Challenge of Implementation: District Health Systems for Primary Health Care*. Geneva, World Health Organization.
- WHO (1992). *The hospital in rural and urban districts: a report of a WHO study group on the functions of hospitals at the first referral level*. WHO Technical Report Series No. 819. Geneva, World Health Organization
- WHO (2004). *World Health Report 2004 – Changing History*. Geneva, WHO.
- WHO, UNICEF and UNFPA (2001). *Maternal Mortality in 1995 – Estimates developed by WHO, UNICEF, UNFPA* (http://www.who.int/reproductive-health/publications/RHR_01_9_maternal_mortality_estimates/index.en.html, accessed 24 March 2005).
- WHO, UNICEF and World Bank. (2002) *State of the world's vaccines and immunization*. Geneva: WHO (http://www.unicef.org/publications/files/pub_sowvi_en.pdf, accessed 24 March 2005).
- Woolhandler S, Himmelstein D (2004). The high costs of for-profit care. *Canadian Medical Association Journal* 170:1814–5.
- World Bank (1993). *World Development Report 1993: Investing in Health*. Washington DC, World Bank.

- World Bank (1999). *The Kyrgyz Republic: participatory poverty assessment*, prepared for the global synthesis workshop poverty programme. Washington DC, World Bank.
- World Bank (2004). *A guide to government in Afghanistan*. Washington DC, World Bank.
- Yu H, Cao S, Lucas H (1997). Equity in the utilisation of medical services: a survey in poor rural China. *Institute of Development Studies Bulletin* 28:16–23.