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Towards equitable financing strategies for reproductive health

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Summary

This paper examines the impact of different financing regimes on the delivery of reproductive health services in low and middle income countries. Financing is an important entry point for examining the impact of health sector reforms on reproductive health. It is likely that different financing regimes have different implications for access to reproductive health services. Health systems are increasingly funded from a multiplicity of sources and through a wide range of fiscal mechanisms. The effects of these changes in modes of financing on reproductive health services are not well understood.

The paper explores three issues. First, it looks at the broad trends in health financing in low and middle income countries and how they relate to the provision of reproductive health services. At international level, these include transfer mechanisms, such as project and programme aid, social funds and the growing influence of verticality in multilateral funding strategies. At national level, these include cost recovery measures such as fees, pre-payments and insurances, as well as safety nets.

Second, it asks whether and how the balance has shifted between collective and individual responsibility for reproductive health and what are the implications for outcomes. There has been an increasing trend towards use of the private sector, even by poor people, as public sector health provision has come under strain. Rising costs of medical care also mean decreasing access to services, particularly for the very poor. To what extent have changing financing modes shifted the cost burden of reproductive health related conditions towards the end user?

Third, it considers what kinds of monitoring, oversight and advocacy can be undertaken nationally to improve the financing and implementation of effective reproductive health care. Several methodologies have been developed which could potentially be adapted to monitor reproductive health spending, such as National Health Accounts and Women's Budgets. It notes their advantages and limitations.

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1 Background

Health systems in low and middle income countries have been undergoing profound changes over the last decade. These changes have been encapsulated in the term health sector reform. A large literature on reform has built up over this period (see e.g. Berman 1995). This has in turn stimulated much further debate on broader issues of what constitutes equity, quality and cost effectiveness, particularly in highly resource constrained environments and contexts of high levels of social and economic inequality.

The aim of this paper is explore the impact of different financing regimes on the delivery of reproductive health services. However, in practice, financing cannot be separated from either the surrounding reforms or the political contexts within which decisions are taken (international, national, regional or local). Similarly, reproductive health is embedded in wider health systems and their transformation. This means that many sideways excursions are required. At the same time, the context specificity of how reforms are actually implemented cannot be overstressed. This paper is thus a highly selective review in the choice of themes and empirical material presented and in its analytical orientation. It is not intended to be a comprehensive overview either of health sector financing or reproductive health programmes.[1]

Generally, the emphasis in financing concerns under health sector reform has been on supply side modelling of costs for particular packages of services and on devising different kinds of payment mechanisms. Apart from the now quite substantial body of work that has looked at the impact of user charges on health service access, little attention has been paid to *outcomes* except as hypothetical exercises (see for e.g. Gertler and Hammer 1997). We need to explore these more empirically from the point of view of both service access and reproductive health outcomes.

Financing is an important entry point for examining the impact of health sector reforms on reproductive health. It is likely that different financing regimes have different implications for access to reproductive health services. Health systems are increasingly funded from a multiplicity of sources and through a wide range of fiscal mechanisms. The effects of these changes in modes of financing on reproductive health services are not well understood. For instance, at a macro level, multilateral and bilateral agencies have a major influence on national resource allocation for health care. The implications for reproductive health provision of Sector Wide Approaches for budgetary support in the health sector of aid dependent countries, and of the increasing use of social funds in Latin American and African countries are as yet unclear.

At national level, many countries are experiencing severe crises in public sector funding of health services and a decline in the availability of low cost, high quality services, particularly for the poor. Increasing use of often poorly regulated private providers is noted across regions, including for reproductive health services. Health care costs for many end users are escalating. High levels of inequality in many poor and middle income countries have translated into an increasingly segmented approach to

[1] As will become apparent, I write from the point of view of a non-economist social scientist whose main work in this field has been on gender and health sector reform.

financing health care across the population. Many governments are moving towards greater use of private insurance for formal sector workers alongside a more selective targeting of public resources to the poor through basic packages and support for social insurance, micro-finance schemes and catastrophic illness cover. Again, the implications of this for access to reproductive health services are largely unexplored.

One major reason for these lacunae is because until fairly recently, the discourses and debates about health sector reform and about reproductive health remained distinct and separate (Standing 2000). This is changing, as both reproductive health advocates and those involved in reforms have begun to address the interface between the two (DeJong 2000).

From the point of view of health reformers, this has entailed paying greater attention to demand side issues (badly neglected in first generation reforms). From the point of view of reproductive health specialists and advocates, it has meant greater attention to both supply side 'systems' issues and the macro-economic context of health reforms. Mixed in with this is greater international attention to poverty and the consequences of increasing global inequality. At least one of the International Development Targets focuses on reproductive health related needs. To this, should be added the consequences of high levels of endemic instability and conflict in many parts of the world and the enormous challenges that these pose for effective action in improving reproductive health for all.

2 Objectives

The paper is structured around three main questions:

- *What are the broad trends in health financing in low and middle income countries and how do they relate to the provision of reproductive health services?*

  At international level, these include transfer mechanisms, such as project and programme aid, social funds and the growing influence of verticality in multilateral funding strategies. At national level, these include cost recovery measures such as fees, pre-payments and insurances, as well as safety nets. Decentralisation has financial implications. Can financing for reproductive health be disentangled from these?

- *How has the balance shifted between collective and individual responsibility for reproductive health and what are the implications for outcomes?*

  There has been an increasing trend towards use of the private sector, even by poor people, as public sector health provision has come under strain. Rising costs of medical care also mean decreasing access to services, particularly for the very poor. To what extent have changing financing modes shifted the cost burden of reproductive health related conditions towards the end user? What counter measures have been or can be taken?

- *What kinds of monitoring, oversight and advocacy can be undertaken nationally to improve the financing and implementation of effective reproductive health care?*

  Several methodologies have been developed which could potentially be adapted to monitor reproductive health spending (e.g. National Health Accounts, Women's Budgets). What are their advantages and limitations? Which audiences can they engage in this?

3 Key concepts and issues

Before proceeding further, some basic ground clearing and clarifications are necessary. Detailed definitions of reproductive health, health sector reform, equity and health sector financing are more than adequately covered in the existing literature. I simply note some key points which are relevant to the discussion which follows.

3.1 Reproductive health

The Programme of Action which came out of the Cairo International Conference on Population and Development (1994) provides the internationally accepted understanding of reproductive health and of the international and national actions required to implement it (Petchetsky 2000). From the point of view of financing, this expanded view of reproductive health is particularly important as the global cost of implementation by the target date of 2015 has been calculated at an estimated $17 billion and commitments (albeit insufficient) have been made to it (Forman and Ghosh 1999).

Whilst Cairo provided the generally accepted definition, it is important to acknowledge some tensions in subsequent debates and implementation strategies. Cairo provides a vision, rooted in a rights based approach, of a much broader view of what reproductive health should mean and be. Practice often falls well short of this (Petchesky op.cit.). In many countries, it continues to mean MCH and Family Planning delivered in vertical programmes. As many commentators have pointed out, most attention and funding has gone to family planning – a consequence of the high level of donor involvement in funding, and associated concern over demographic targets (e.g. AbouZahr 1999)

This is not just a legacy of donor priorities and vertical programmes (although that continues to be the way most basic services in reproductive health get funded and run). The broader concept of reproductive health may be accepted in principle but where resource constraints are severe, there are compelling arguments for focusing on priority problems and populations (e.g. poor rural women) and on key target areas like maternal health.

Reproductive health is thus likely to remain a flexible construction for the foreseeable future. Some middle income countries can and should be expected to take a more encompassing view and to expend resources accordingly. Others will struggle to manage the most pressing reproductive health problems. An obvious point is the overwhelming impact of HIV/AIDS on epidemiological profiles, health systems and coping strategies in severely affected poor countries.

3.2 Equity and health

This is similarly a very well covered area with a long history. Like reproductive health, equity is a visionary concept, an aim towards which to work. In a highly unequal world, disagreements and compromises on equity abound. Wagstaff and van Doorslaer (2001) capture what is probably the most widely accepted general principles of equity as they apply to health care. Starting from the twin principles that health care should be distributed according to need and financed according to ability to pay, they note the distinction between vertical and horizontal equity:

- Vertical equity is the requirement that those of unequal ability to pay should pay appropriately unequal amounts for health care
- Horizontal equity is the requirement that those of the same ability to pay should make the same contribution.

Judgements as to the degree to which financing mechanisms approximate these conditions can then be made. This generally favours greater pre-payment via general taxation or compulsory social health insurance, and setting payment levels according to ability to pay (WHO 1999).

Baker and van der Gaag (2001) provide a more substantive account of equity in health financing from evidence from five developing countries. They note that there is a close correlation between per capita income levels and health outcomes but that some countries have been much more successful at given levels in converting expenditure into better outcomes for their populations. In other words, there are system related reasons for differences between countries at similar economic levels. They conclude that the main reasons are (a) financial allocations continue to favour urban, tertiary care at the expense of poor, rural populations, and (b) the better off are much more likely to get physician and hospital based care than the poor. Both of these have clear implications for reproductive health services.

3.3 Health sector financing reforms

Financing has been a key arena for reform. The most notable shift has been towards a far greater mix of financing sources and mechanisms for cost recovery beyond public finance. Many countries are also experimenting with various degrees of separation between purchasing and service delivery functions. There has been a move to much greater reliance on private financing through encouraging greater official private sector involvement. The Cairo Programme of Action itself called for a mixed financing strategy of mobilising resources from the private sector, the selective use of user fees, social marketing and other forms of cost recovery.

The main sources of health sector finance are taxes, social insurance, private insurance, out of pocket payments, multilateral and bilateral aid and loan transfers. However, the balance between these is highly dynamic and varies greatly across countries.

Further, as Kutzin (1995) stresses, financing reforms cannot be separated from organisational reforms, particularly those of decentralisation and who acts as third party payer. Relevant key restructuring

concepts in health sector reform are cost recovery (user charges, pre-payment schemes, mixed funds), decentralisation and moves to greater community based involvement in financing and managing health care.

3.4 The relationship between spending on health care and health outcomes

This is a contested area. According to Sahn and Bernier (1995), links between official health expenditure and health status are tenuous (partly because there are many other variables which affect it) but there is a generally accepted view that greater expenditure on primary and preventive care is related to improved health outcomes.

However, there are dissenting voices. Ablo and Ritva (n.d.) looked at evidence from public spending on education and health in Uganda. They argue that budgetary allocations as measured through public expenditure reviews are misleading in explaining outcomes where government institutions are weak, as in much of sub-Saharan Africa. They note that whilst public spending on basic services, much of it from donors, has increased considerably since 1987 (recurrent health expenditure increased by two and half times between 1991–5), official outcome indicators on health and education have remained the same.

They examine what happens to the flow of funds from the centre to service facilities. They compare health and education, finding that the availability and quality of financial information is much worse in health than in education. This is because in education there is greater answerability to parents, who provide a large amount of subsidy to schools and have a greater say in management and monitoring as a consequence.

There has been a major growth in the private health sector (both for and not-for profit) in Uganda, as in many African countries. They note that the public sector itself is increasingly a fiction as poorly paid and supervised health staff become personal entrepreneurs: 'Almost all elements of the system which were once public have been incorporated into the private business activity of the health workers' (quoted from Asiimwe *et al.* 1997, and see also Bloom and Standing 2001). They conclude that budget allocations are almost irrelevant when the institutions which manage them are weak and there is no accountability to constituencies of citizens.

Other literature echoes this assessment of the often contingent link between public expenditure and welfare outcomes. Svennson (1997) notes the link between ineffective public policy and high levels of polarisation and social conflict, which means that higher public spending then simply translates into a worse supply of public goods. Filmer and Pritchett (1997) claim to show that 95 per cent of the cross national variation in child mortality is a consequence of other factors than national budget allocations to health. These include per capita income levels and income distribution, levels of female education and other broader determinants of health status.

Sahn and Bernier (op.cit.) take issue with the view that structural adjustment programmes in Africa led to reduced public health expenditures (although they concur that spending fell in Latin America). Many countries did experience real increases in their overall expenditure post adjustment. However, at the same time, a number of health status indicators deteriorated in the 1980s. They argue that this was due to

biases in the intrasectoral allocation of public expenditures towards tertiary and curative care together with poor systemic capacity to deliver services.

From another perspective, DeJong (op.cit.) questions the realism of the estimates of funding required to implement the ICPD agenda. She notes that much can be done within existing resources to strengthen the capacity of health systems to implement reproductive health care.

On the other hand, Merrick (1999) underlines the importance of the absolute lack of financial resources as well as the institutional constraints. The spending base in most African countries and in some Asian ones is still extremely low. In sub-Saharan Africa, average per capita incomes are now lower than they were in the late 1960s (World Bank 2000a). Analysis of health expenditures across 40 Heavily Indebted Poor Countries (HIPCs) showed average per capita health expenditure of under $10. This is up to 40 per cent below the level necessary to fund even the World Bank recommended basic service package and far below that required to finance expanded service packages (Simms *et al.* 2001).

Some obvious general lessons can be drawn from this. First, resource availability is a significant constraint. Below a certain level of funding, it is literally not possible to provide even basic services. But provision of effective services is not just a question of resources. Systems also have to function with a reasonable level of efficiency and some minimum probity, which points to the oft stated need to improve institutional and government accountability. Second, in understanding the relationship between financing and outcomes at the level of service delivery and health gain, unofficial financial flows, such as informal payments and other costs of access to services, are as important as official ones. Third, more attention needs to be paid to the serious consequences of political instability and conflict in eroding the link between resource allocations and outcomes.

3.5 What is happening to reproductive health?

This can only be answered meaningfully where appropriately disaggregated time series data are available. Certain standard indicators, for instance MMR and TFR, are available for most countries (although their accuracy for some is another matter). However, systematic and comparable data on other dimensions of reproductive health are much harder to find. DHS surveys (done in 66 countries) allow for some comparisons, for instance on teenage pregnancies, but there are many gaps and insufficient years to show trends.

Trained assistance in childbirth is one useful proxy for access to basic health services in the reproductive health domain. Simms *et al.* (2001) analysed data on this from DHS surveys in 22 countries. These showed national declines in 15 of these countries and improvements in only seven of them. More work needs to be done on assessing and developing suitable indicators for monitoring what is happening and how it correlates with financial reforms (Subramaniam 1999). The picture is bound to be very mixed, with some areas/countries/regions making progress and others lagging or experiencing actual reverses. Again, the impact of HIV/AIDS on health status and on health resources in severely affected countries cannot be over stressed.

4 Reproductive health in the context of financing reforms

There are some obvious methodological difficulties in understanding reproductive health financing as it is not a sector or subsector. Data generally only pertain to MCH and other vertical programmes. But reproductive health cuts across a number of standard breakdowns of financing. It has both curative and preventive elements. Though much reproductive health, particularly in poor rural areas, comes under the rubric of basic services, it also cuts across the primary-tertiary distinction (obstetric emergencies, reproductive health related cancers etc.). HIV/AIDS and other STDs sit ambiguously in the reproductive health frame. Nor is reproductive health the same as women's health (although in some contexts this may be the case de facto). This makes it more difficult to assess what is happening to spending or to ascertain whether attempts are made to ringfence or protect budgets and commitments in times of change.

Costing of reproductive health programmes is also a contentious area. It is not at all clear whether integrated programmes are cheaper or more expensive than vertical ones. Forman and Ghosh (1999) suggest that integrated delivery systems (one stop shops) can save money. For instance in Mexico, a 50 per cent reduction in staff time was found when three services are provided per consultation rather than one. Also, there is considerable duplication of resources through having separate programmes. On the other hand, this has to be set against the considerable cost of reconfiguring management systems, including retraining of staff and setting up new structures.

Mahmud and Mahmud (2000) also doubt the capacity for much reduction of cost through integrated programmes. They quote an analysis which concludes that cost reduction in specific services would only be possible if staff 'eliminated unauthorised leave, reduced unused time at work and increased working time . . . from four to five hours per day (40).'

4.1 The general context of international financial flows

The extent of international aid dependence for support of national health budgets in low and middle income countries is very variable. Many middle income countries receive only small amounts of bilateral and multilateral aid. However, more may be in receipt of World Bank lending, particularly for large infrastructure rehabilitation programmes. The Bank is now the biggest external financing agent of health activities in low and middle income countries and exerts an enormous influence over international and national health policy. A further and more recent area of international transfer is through global programmes dedicated to specific public health goods (notably control of communicable diseases).

Walt *et al.* (1999) note that by the early 1990s, aid was more than 10 per cent of sub-Saharan Africa's GDP and in ten countries it was more than 20 per cent. Most of this was bilateral aid. However, this has been declining and they predict that bilateral aid for health has stagnated and is likely to decline in future. World Bank funding for health, on the other hand, did increase substantially in the 1990s. Additional funds have also been targeted at specific diseases, such as AIDS and TB. The picture is therefore one of a much greater proliferation of agencies involved in different funding initiatives, including the private sector and NGOs.

Forman and Ghosh (1999) examine the international funding picture for reproductive health in the context of the commitments made to implementing the Cairo Programme of Action. In 1995, the bilateral donor commitment to population assistance was $1.4 billion which was $3.6 billion short of the total bilateral and multilateral commitments for implementing ICPD by 2000. 73 per cent of this came from just four donors – the US, UK, Germany and Japan. They note that the 2015 target of $21.7 billion stands little chance of being met and support the view that aid from international donors has declined, especially from the US.

This makes the priorities of this small group of donors significant in determining the policy direction of aid dependent countries. The United States Agency for International Development (USAID) has been a major contributor to family planning programmes, favouring project aid and a vertical approach, rather than donor coordination and moves towards programme aid and pooling of funds. It remains to be seen what impact the new political administration will have on USAID's commitments to family planning.

The UK's Department for International Development (DFID) spends one third of its health budget on reproductive health and has an explicit commitment to support ICPD, but health is only 8 per cent of its total aid spend. It gives priority to increased governmental engagement with the private sector and civil society and is relatively enthusiastic about sector wide approaches. The Swedish International Development Agency (SIDA) spends 30 per cent of its total budget on health but it is not possible to extract a figure for specific commitments on reproductive health. However, both agencies support health systems strengthening, which arguably contributes to reproductive health objectives

Goodburn and Campbell (2001) estimate that in 1990, 46 per cent of external assistance to health and population sectors went to general health services (of which 5 per cent was spent on hospitals), and 46 per cent to reproductive health. Of this, 42 per cent went to family planning. Safer motherhood programmes got just 0.2 per cent of total funds.

Few commentators discuss new sources of funds which are increasingly affecting the picture of international transfers. Massive Effort is a coordinated approach, emanating from the World Health Organization (WHO) to gain commitment from a wide range of stakeholders, including governments and private corporations, for action on what are described as the 'diseases of the poor'. These are notably HIV/AIDS, malaria and tuberculosis. The G8 countries have promised action through the Global Health Fund and some funding commitments were recently made to combating HIV/AIDS in Africa. Much of this international effort appears to be focused on a fairly narrow range of biomedical interventions such as vaccine development and drug supply.

Another international player worth noting is the Gates Foundation (Bill and Melinda Gates Foundation 2000). In 2000, this awarded $212m (15 per cent of its budget) to reproductive and child health. However, it awarded $367m (26 per cent of its budget) to 'conditions associated with poverty' (i.e. HIV/AIDS, malaria and tuberculosis). In 1999, grants in this latter category totalled $1.2 billion.

Attention to the diseases particularly associated with poverty is welcome. But these kinds of transfers do raise some important questions about how priorities are set, who sets them and whether what looks like a de facto return to vertical interventions is the most effective use of funding of this magnitude.

Whilst commitments currently fall far short of target, it is worth noting the disparity between this and corresponding commitments for instance to safe motherhood.

From an advocacy point of view, there may be some 'discourse' lessons in this. Whilst reproductive health has been grounded entirely in a rights based approach, Massive Effort and the Global Health Fund are much more strongly grounded in a public goods approach (Kaul 2001) which uses social justice language but alongside a language of the enlightened self-interest of states. Health conditions such as infectious diseases transcend national boundaries and therefore constitute a global concern requiring an international response. However, definitions of public goods have a degree of political flexibility in a globalised world which international advocacy for reproductive health may be able to exploit further.[2]

4.2 International aid modalities – SWAps

The proliferation of players has pushed aid coordination up the agenda of bilateral and multilateral agencies. There will continue to be high levels of aid dependence in some countries and aid increasingly cannot be seen as simply short term support before national sustainability is established. This has resulted in some important shifts in donor funding modalities.

Sector Wide Approaches (SWAps) are increasingly favoured by bilateral donors. Sometimes described as a move from project aid to programme aid, they entail a collaborative approach among donors, national governments and other national stakeholders (in theory including civil society) to provide sector or sub sector level financing to national governments within an agreed expenditure framework over a specified timeframe. This is meant to replace the multitude of project based funding by individual donors, criticised for setting up competing activities, distorting priorities and failing to build sustainability (Cassels 1997). SWAps were first developed in the health sector.

It is still too early to judge the impact of SWAps on reproductive health. Few countries are yet operating fully within a SWAp environment, with some donors operating outside the framework (for instance, USAID refuses to participate in SWAps) and much funding continuing to be channelled through project based aid. Recent assessments of SWAps have been equivocal about the extent to which they represent real partnerships between national governments and donors (or 'development partners'), and the degree of involvement by wider stakeholders and particularly grass roots organisations is mostly weak (Foster 1999).

However, SWAps may represent opportunities to agree shifts in sectoral priorities against specified resource commitments. Goodburn and Campbell (2001) suggest that SWAps may be the key to reducing maternal mortality in poor countries, offering a better alternative to either vertical programmes or reproductive health programmes in improving maternal health.

They argue that vertical programmes enable only short term gains to be made while broader based reproductive health programmes do not give priority to maternal health interventions. Both tend to be

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2 I acknowledge and thank Gemma Wilson-Clark, whose recent IDS MPhil dissertation focuses on this issue, for her insights on these discourses.

dominated by family planning. SWAps, on the other hand, enable maternal health to be part of a strategy for creating a functioning health system. However, few SWAps explicitly have maternal health targets as part of their goals and they suggest linking SWAps to key outcome indicators which can be monitored as part of their progress. These would include Safe Motherhood goals.

This argument is attractive in theory. The test is less policy commitment, however, than implementation, as the case of Bangladesh demonstrates. The Government of Bangladesh is implementing a SWAp in the health sector. The flagship of this is the Health and Population Sector Programme (HPSP), funded by a consortium of donors and the World Bank. The aims are laudable. After an extended period of national consultation, the reforms aimed to shift resources downwards to basic health care, and particularly towards improving the health status of poor rural women and girls. A key component of this is an Essential Services Package (ESP) which comprises reproductive health care, child health care, communicable diseases, limited curative cure and behaviour change (Mahmud and Mahmud 2000)

As Mahmud and Mahmud note, many of the service components of ICPD are covered by the HPSP which is now in its third year. Outcome indicators are intended to measure progress in a number of these dimensions. However, the health status of poor women and girls is showing little sign of clear improvement and there are major problems in service delivery. Among them are the difficulties in unifying health and family planning services and cadres at local level and issues of political commitment among both politicians and the bureaucracy to what is substantially a donor driven agenda.[3]

How can efforts such as this be judged? It may simply be too early to expect this kind of system level approach to deliver major improvements. It is clear, however, that more than financial reforms is required to bridge the gap between policy and implementation.

4.3 International aid modalities – Social Funds

Social Funds (sometimes called Social Investment Funds) are closer to the other end of the spectrum from SWAps. Initiated by the World Bank, they take somewhat different forms in different parts of the world but their aim is to get funds for sectoral improvements directly to local communities. In Africa, they typically concentrate on infrastructure improvement but there is increasing use of social funds for improving services.

Social Funds began in the late 1980s as a response to the adverse impacts of economic adjustment. They are now seen as a way of reaching poor populations bypassed by standard investment programmes (Sherburne-Benz 2001). They allow communities to bid for resources against a priority development activity that they have identified. Matching funds must be provided nationally and through the community (this can be in the form of kind payments such as labour). Loans of nearly $3 billion have been made to 57 countries.

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[3] Observations are also taken from the author's own recent experience in Bangladesh.

Social Funds are a contentious area. There is concern that they bypass national and local governments and decision making processes. A recent evaluation (World Bank 2000b) found that there was too little learning between social funds and the public sector. Because of its institutional autonomy, the social fund apparatus risks becoming like a parallel government. From the point of view of reproductive health, it is worth examining the proclaimed benefits of social funds in improving health infrastructure and performance.

Recent reviews from within the Bank (World Bank 1999; 2000b; Sherburne-Benz 2001) offer a fairly upbeat assessment, while expressing concerns on capacity to reach the very poor, insufficient attention to building technical capacity and the problem of the parallel organisation. Sherburne-Benz gives some preliminary findings for Bolivia, Honduras and Nicaragua. The other reviews also include Zambia:

Targeting

- Resources went mainly to the poor.

Access

- Social Funds accounted for a substantial amount of new health infrastructure (but on a narrow geographical definition of access).

Infrastructure

- Social fund facilities were typically better supplied with equipment and furniture. Drugs and supplies were better in Bolivia but not in Honduras and Zambia.

Staffing

- Social fund facilities were as well or better supplied than other facilities.

Utilisation

- There were modest increases in most countries but not always at a higher rate than in other facilities. Rates were unchanged in Bolivia and Zambia.

Outcomes

- The only country where mortality change could be assessed was Bolivia, where infant and child mortality fell by 50 per cent between 1993–7 among families served by social fund facilities, as compared to a 10–15 per cent increase in mortality in other families.
- Some increase was found in the numbers of antenatal visits, institutional and attended births.

The review also noted greater institutional and geographical flexibility with low overheads and administrative costs, much cheaper infrastructure than traditional public sector agencies, greater trust and accountability, and capacity to attract matching funds.

4.4 Implications of different modalities for reproductive health

In table 4.1, an attempt is made to summarise some of the possible implications of these modalities for reproductive health.

Table 4.1 International aid/loan funding modalities – implications for reproductive health

Funding modality	*Advantages*	*Issues and limitations*
Project aid to national/local stakeholders (e.g. NGOs)	• Can target priority needs • Can enable experimentation and innovation, e.g. through NGOs, partnerships (e.g. USAID supported ReproSalud – Cuellar 2000)	• Can distort national or local priorities • Tends to maintain vertical programmes • Projects may remain as 'good demonstration' projects only • Does not necessarily contribute to building overall system and sector capacity
Programme aid to national governments (e.g. SWAps)	• Encourages system level reforms tied to Medium Term Expenditure Frameworks • Conditionalities may force resource shift to basic service provision • Improves donor coordination and aids shift to programme integration • Should involve greater stakeholder consultation on priorities	• Conditionalities can also distort priorities and discourage national and local ownership • Little evidence so far of wider stakeholder involvement, including grass roots and advocacy organisations • Zeal to create more integrated financial and management systems has resulted in some countries in collapse or disarray in functioning programmes • Withdrawal of funding from NGOs in favour of pool funding has resulted in ending of some high quality service delivery projects
Direct transfers to communities (e.g. Social Funds)	• Gives communities a voice in priority setting • Fosters community ownership of facilities and services	• Communities may not prioritise reproductive health services – women, the very poor and minorities (e.g. adolescents) may not be part of the consultations on priorities
International vertical initiatives (e.g. Massive Effort, Global Health Fund)	• Acknowledges the links between poverty and health and the need to involve a wide range of actors in addressing these • Should increase the overall resources available for addressing global public health goods, including HIV/AIDS • Could provide opening for further international advocacy on priority reproductive health needs	• Narrowly bio-medically focused on interventions like drugs and vaccines, little concern with strengthening basic services or preventive and public health measures • Partnerships with private capital unlikely to focus on producing effective, low cost interventions in reproductive health

4.5 National public financing for reproductive health

As noted above, the most significant feature of health financing is the multiplicity of forms of financing, including increasingly hybrid forms of funding which cut across conventional divides between public, private and aid flows. Again, reproductive health is difficult to extrapolate from these. Increasingly, also, macro-economic policy has been framed by policy instruments and conditionalities set by the International Financial Institutions (IFIs).

In the 1980s and 90s these were structural adjustment policies. Intense concern with the adverse impacts of these on vulnerable populations led to greater attention to national poverty reduction strategies. Sectors figure ambiguously in these – they are framed at a higher level of abstraction. It is particularly difficult to contextualise subsectors such as reproductive health as they are subsumed under broader socio-economic policy remits. However, all World Bank IDA lending countries are required to prepare Poverty Reduction Strategy Papers (PRSPs) based on some form of consultation with poor people. Health concerns have been found to figure widely in these (Narayan 2001). A particular concern of the poor is with the financial consequences of major illness. This has influenced lenders and governments to focus much more on measures to enable households to manage these.

The general picture on the proportion of national public expenditure going to reproductive health is almost certainly a mixed one. Forman and Ghosh (2000) report on a series of country studies on reproductive health financing. These find that health and population sector financing increased in Bangladesh, Egypt and South Africa post 1994. In Bangladesh, for instance, expenditure on health and family planning in 1997 was 7.3 per cent of total public sector expenditure (1.3 per cent of GDP) – an increase from 4.8 per cent in 1984. However, it fell in Tanzania and also in Mexico and Indonesia due to economic crisis. In Tanzania the bulk of earmarked funds are for contraceptive procurement. In 1996, 98.5 per cent of population and reproductive health expenditures were externally funded by four main donors. South Africa has managed to shift resources more towards primary care.

The examples of Bangladesh and South Africa again underline the importance of the political context within which allocations are made. Bangladesh, from a very low spending base, shifted resources into health as a consequence of negotiations with powerful donors providing matching funds for the Health and Population Sector Programme. South Africa – which is not aid dependent – was able to act in the context of a new political climate.

Again, it is important to note the major differences in the magnitude of public spending on health across even low income countries. For instance, in 1994–5, Bangladesh spent $7.3 per capita, India $21, Sri Lanka $18 and Pakistan $12.4. As already noted, 40 HIPCs, mainly in sub-Saharan Africa, showed average per capita health expenditure of under $10.

In China, the proportion of public funds provided to health care has declined during its transition to a more market based economy, with central funds mainly providing a modest subsidy to health workers' salaries. They make up the remainder by selling drugs. With the collapse of rural medical co-operatives which provided basic services, the shortfall is made up from out of pocket expenditure (Fang Jing 2001). Detailed studies in a poor rural province have charted the adverse impact of China's financial and

structural reforms on reproductive health in poor rural areas, with very low levels of reproductive health service utilisation due to poor quality, problems of access and high costs (Fang Jing 2000).

The use of National Health Accounts (NHAs) has enabled better understanding of how funds are allocated between categories of expenditure. In sub-Saharan Africa, NHAs found that spending on preventive and primary care was particularly low, ranging from 4 per cent of the total budget in Kenya, to 14 per cent in Uganda (USAID).

4.6 National financing from private sources

One of the reasons why limited conclusions can be drawn from the extent of public financing is the major role played by private spending in the health sector. Very little hard evidence is available on the role of private providers in the provision of reproductive health services. Partly, this is because of the sheer heterogeneity of the sector, ranging from a wide range of indigenous practitioners through a variety of NGO providers (missions play a very prominent role in health care in sub-Saharan Africa) to a spectrum of for-profit individual providers and organisations. There are also increasing numbers of hybrid forms, such as social marketing and various types of partnership arrangements.

Table 4.2 gives some estimates of the extent of private health expenditure from selected low and middle income countries. These are inevitably very approximate.

Table 4.2 Private health expenditure in selected countries

Country	Estimated amount of private health expenditure (% of total per capita exp)
Zimbabwe	37
Malawi	45 (mission and voluntary sector)
Ethiopia	65
Burundi	30 (missions)
Uganda	53
Kenya	37 (53 according to USAID – PHR)
Bolivia	40
Colombia	55
Guatamala	43
Paraguay	57
Indonesia	65
Morocco	61
Tunisia	33

Adapted from Sahn and Bernier (1995) and Berman and Rose (1996).

In Bangladesh, analysis of 1994–5 data showed that households provide 46 per cent of total health and population expenditures. But 97 per cent of household expenditure went on private sector services, with

poorer groups spending significant amounts on unqualified doctors (Mahmud and Mahmud op.cit.). It is not clear how much reproductive health services figure in this expenditure.

Berman and Rose (op.cit.) use DHS data from 11 developing countries to examine the role of private providers in MCH and family services. While noting the problems of comparability over what is the private sector, they find that in most countries private providers play a minor role in provision of more public goods type services such as immunisation. They play a much larger role in symptomatic and curative treatment (e.g. diarrhoea and ARI). In Latin American countries, family planning is much more commonly provided in the private sector (including not-for-profit) – over 60 per cent in some countries – as a consequence of the political influence of the church on governments.

More information is needed on the role of private provision in reproductive health and this needs to separate out different kinds of provision. Data on private expenditure comes mainly from household expenditure surveys. These use different methodologies. For instance, it is not clear whether they distinguish between payments made to providers outside the public sector, and payments made unofficially in public facilities which can be considerable. A study in Bangladesh found that unofficial fees represent up to 10–12 times the cost of official facilities fees (quoted in Mahmud and Mahmud op.cit.).

Many commentators, particularly from an advocacy perspective, have argued that service provision is becoming increasingly privatised. But there are important differences between private providers which are not adequately captured by privatisation language. As important is the relationship between 'private' and 'public' and the extent or lack of regulation and stewardship of private providers.

Increasing attention is being paid to the role of NGO and for-profit private providers and ways of improving their accountability and quality in contexts where they are major providers of services. Strategies such as branding and accreditation through franchising are being piloted in a number of countries and often focus on reproductive health services, for e.g. reproductive tract infection (RTI) treatment, contraceptive provision and preventive health checks (Smith *et al.* 2001). This is an important area for further empirical work.

4.7 Decentralisation

Much of the experience of different forms of decentralisation underlines the point that its successes or failures rests on whether sufficient capacity is available or has been built at the level required (Aitken 1998). However, resources are also a major issue. China's radical fiscal decentralisation transferred much of the responsibility of health financing to County and Township level, with little central regulation over how centrally provided funds were allocated. This has left facilities in poor rural areas in serious difficulties and resulted in a shift to more profitable curative services and drug selling (Fang Jing 2000; 2001). As a result, health status indicators are widening as between poor and rich areas.

Decentralisation to lower levels of government is often done in the name of increasing local autonomy and accountability. At the same time, as the case of China shows, it may also shift the burden of resource mobilisation too far and too quickly, creating a problem of unfunded mandates (Loewenson and

Nyanjom 2000). If populations are poor and local accountability mechanisms are too weak to ensure ringfencing of essential services, basic service provision is likely to suffer.

There are few analyses of the impact of decentralisation on reproductive health services specifically. The experience of South Africa shows some of the methodological and political challenges of understanding resource allocation in a system in transition to decentralisation through local government. Budlender's work on women's budgets gives a flavour of the challenges of understanding municipal budgets (1999). They were found to lack uniformity, were very complex with diverse forms of revenue, there was a lack of knowledge among those responsible for them, along with poor record keeping and chaotic management systems.

The decentralisation of functions such as health and housing place much greater service delivery burdens on municipalities. There were complaints about unfunded mandates and about duplication of resources (one provincial health department allocated funds for a new maternity unit to be built less than two kilometres from the main hospital which already had a fully equipped unit). There was also blurring of responsibilities – municipal health services are shared between local, provincial and national governments. Budgets often exceed income, leaving health as a loss making service, exacerbated by a decrease in the provincial subsidy in late 1990s (ibid.).

Despite these problems, there was evidence of some very active and committed municipalities, albeit struggling with underfunded budgets. Again, more work is needed on how different forms of decentralisation affect the financial and political capacity of authorities to deliver effective reproductive health services and what actions might be taken by which stakeholders to strengthen capacity.

5 Cost recovery mechanisms – shifting the cost burdens of reproductive health further to the end user?

5.1 Health expenditure, poverty and gender

Cost recovery has been a key area of debate and experimentation over the last decade. Different systems can have very important consequences for the capacity of poor people and women in particular to access services. Economic crisis and adjustment policies, the breakdown of publicly funded health systems in many poor countries, increasing social and economic inequalities, and the recognition of the major role of private provision have all contributed to a rethinking of health financing strategies for preventive and curative care.

User charges have been the most visible manifestation of health financing reform at this level, but user charges need to be seen as part of a broader question of how services are funded nationally and how financing strategies as a whole affect women and men, poor and less poor, and access to different types of services. Cost recovery modes reflect an increasing segmentation of populations in terms of how health care needs are met (Standing 2000). There is also a view that they consolidate a shift to greater individual and household cost burdens, particularly for the poor.

Utilisation rates for health care among the poor are highly price sensitive (Gertler and van der Gaag 1990). Anecdotally, expenditure on preventive care and medical care for women and girls in some contexts is even more sensitive to price changes. Prevention may be considered optional and women's and girls' health is often less valued than that of men and boys. Current evidence suggests (a) that health costs are rising as a proportion of household expenditure in many countries, (b) that poor people pay disproportionately more than the better off for health care which is often of worse quality and (c) experience greater problems coping with the lumpy costs of health care (summarised in Sen *et al.* forthcoming).

Sen *et al.* also note that non-treatment is highest in the reproductive age-groups as women tend to leave untreated conditions like reproductive problems that are chronic but not incapacitating, thus contributing to greater disease and cost burdens at a later stage (see also Fang Jing op.cit.). The opportunity costs of time spent in travelling to facilities, waiting to see staff and other indirect costs of treatment seeking in overstressed facilities also determine utilisation of health care particularly for women.

Except for the studies cited, the evidence base on how these trends are affecting reproductive health care is thin. National Health Account methodologies hold out promise for improving this (see section 6). A recent NHA study of health financing in Rwanda provides an analysis of the impact of HIV/AIDS on poor households (Barnett *et al.* 2001). Results from this analysis show that Rwanda spent $12.70 per capita on health care. Of this, 40 per cent came from donors, 40 per cent from private sources, and the remaining 10 per cent from the Rwandan government.

Around 10 per cent of total health expenditures was spent on HIV/AIDS prevention and treatment for those who were HIV positive. Out of this 10 per cent, household out-of-pocket expenditures made up 93 per cent, donor contributions 6 per cent, and government financing 1 per cent of total HIV/AIDS spending. These figures highlight the severe financial impact of the disease on AIDS affected households. They indicate that treatment and care costs for people affected with AIDS are borne by patients and their families (ibid: 15). We need similar studies for other areas of reproductive health.

5.2 User charges and out of pocket payments

Formal user charges are one of several elements of shifting financial burdens which have affected utilisation rates for basic services. User fees began to be introduced in the 1980s, mainly for hospital care in the beginning but increasingly for some basic curative services. The clearest evidence on impact comes from maternal health services, where user fees have had a disproportionate impact on access to maternity services. Studies from a number of countries, mainly in sub-Saharan Africa, suggest that the introduction of fees in hospitals has produced a decline in obstetric admissions and increased mortality rates among mothers and babies as high risk mothers delivered at home or delayed going to hospital (summarised in Simms *et al.* 2001). Reductions in utilisation rates for Sexually Transmitted Disease (STD) services in Kenya and Zambia have also been noted (Gertler and Hammer 1997).

However, the link between point of service charging and utilisation is a complex one. The South African Government introduced free health care for pregnant and lactating women and children under six,

but Schneider and Gilson (1999) note that the removal of user charges for MCH services did not result in any increase in take up of maternity services apart from a modest increase in the number of antenatal visits. They suggest that a wider set of measures is needed, including significant improvements in the quality of care provided.

Nahar and Costello (1998) looked at the hidden cost of 'free' maternity care in Dhaka, Bangladesh. Utilisation of public maternity facilities is very low in Dhaka compared to other South Asian cities (less than 15 per cent). This is despite the existence of a supposedly free service. They examined the actual costs incurred by families in using such facilities. These included informal payments to hospital staff, drugs and the costs of travel and food expenses. They found that the mean cost for a normal delivery was a quarter of the average monthly household income. More than 20 per cent of families were spending 50–100 per cent of their monthly income and 27 per cent of families between 1–8 times their monthly income. The mean cost of a caesarean operation was almost equivalent to the average monthly income (see also Gumber and Kulkarni 2000 on actual maternity care costs in rural and urban Gujarat).

Lucas and Nuwagaba (1999) looked at how households financed health care in poor rural communities in Uganda. They found that many households face difficulties with the multiplicity of demands for cash payments for services, notably in health and education. Women faced particular difficulties as they rarely had access to cash, yet mostly had to take responsibility for both their own and their children's health. At issue was not so much official user charges per se (which were small) but the wide range of informal, illicit payments which were effectively a user subsidy to underpaid health workers.

User fees have been the most obvious manifestation of cost shifting and have received the most coverage. However, these examples indicate the complexity of the issue, given the realities of the informal cost burdens in many health systems under stress. The debate on user charges has produced different points of view. Many have argued for their abolition as an unacceptable burden particularly on the poor and in the light of the relatively small amounts of income that they raise – as low as around 5 per cent of total costs in most of sub-Saharan Africa (Simms *et al.* op.cit.). Nahar and Costello (op.cit.) among others, argue for a fixed, transparent user charge set below the level of current informal costs and with a clear exemption regime and proceeds put back into the facilities to improve quality. Some kind of charging is common in many NGO and mission facilities that are nevertheless well utilised by the poor. The argument goes that it is preferable to have affordable, transparent charging for good quality services than 'free' poor quality services carrying hidden costs.

The experience of user fee exemptions is mixed. Many have not worked well. They have proved difficult to implement and monitor in any fair and transparent way. Clear criteria for exemption are hard to come up with, coverage of the poor is often erratic and systems are prone to leakage. In some contexts, community based decision making on who should be exempt has worked better. In others, it has resulted in exclusion of the poorest (Mackintosh and Gilson 1999).

Other mechanisms, such as exempting all referred maternity deliveries from payment, or developing better pre-payment or medical safety net mechanisms for the poor – may be more effective in maintaining or improving utilisation rates.

5.3 Insurance based cost recovery

Insurance based mechanisms take many different forms and are highly segmented in terms of the populations they serve. In low income countries, a small percentage of the population, usually corresponding to the formal sector workforce, has been covered by employment based or government sponsored insurance schemes. In middle income countries, coverage is again mainly confined to formal sector workers, but the number of people covered will be greater and there may be a proliferation of schemes and types of coverage (e.g. Brazil – see Lewis and Medici 1995, for the Latin American region, see Fiedler 1996).

There is a considerable technical literature on different forms of health insurance and on social security reform and their implications for formal equity (see e.g. Jack n.d.; Waters 2000 on Latin America) and on experiences of developing schemes in low and middle income countries (e.g. Gertler 1998 on Asia; Criel 1998 on sub-Saharan Africa). Mackintosh and Gilson (1999) provide an interesting perspective on the implications of different types of insurance schemes for increasing or decreasing social solidarity, both vertically and horizontally. There is evidence that women may experience poorer access to insurance than men due to either their position as dependants or their lack of employment credits (e.g. Lambrew 2001). Issues relevant to managing the cost burdens of reproductive health care will simply be noted here.

The most recent World Development Report highlighted social insurance and mechanisms for managing catastrophic illness as key interventions for reducing the cost and impoverishing impact of ill health for existing non-insured populations, particular the problems caused by lumpy health expenditure (see also Dror and Jacquier 1999). Experience of schemes geared to the poor is relatively recent and still largely under evaluation.

McCord (2001) describes the experience of using micro-insurance to cover health risks in low income populations in sub-Saharan Africa and Asia. A key concern is the extent of the risk sharing pool and hence the viability of the scheme in the longer term. Incentives for sick people to join are often greater than for the healthy, leading to the problem of adverse selection. These affect the levels of payout and the risks covered. Such schemes vary greatly in what they cover from a reproductive health point of view. Many do not cover preventive care and maternity cover varies considerably. Even where it is provided, the co-payment required may be considerable (Gumber and Kulkarni op.cit.). Some studies report overmedicalisation, with higher rates of caesarean operations than would normally be expected on clinical criteria (Criel op.cit.).[4]

Aside from maternity care, few studies have looked specifically at reproductive health coverage in social and community based insurance schemes. It is clearly an area for further work and experimentation. For instance, what types of modalities have the capacity to produce greater or less cost sharing and redistribution? What risk pools are viable and what kind of subsidy do they realistically need to enable

[4] Vimla Ramachandran also notes the sudden increase in the numbers of hysterectomies among rural women in a microfinance scheme she examined in India (personal communication).

poor people to benefit? Are community based schemes simply redistributing the burden among the poor? What happens within the household in terms of the allocation of resources to particular medical needs?

5.4 Cost bearing and cost sharing

Evidence for household expenditure surveys, combined with low levels of per capita public spending on health in many countries, indicates that households and individuals are picking up an increasing proportion of the cost of health care. Studies on health seeking behaviour also suggest that there are increasing levels of unmet need, as treatment is foregone due to high costs and poor service quality. Financing reforms have in response promoted private (but not necessarily privatised) solutions to meeting health care needs through means such as user fees. Insurance solutions sit somewhere in the middle of this. On the one hand, they underline a shift to individual and household based forms of provision and a correspondingly greater emphasis on curative services than on basic public health and preventive care. On the other, they can also promote cost and risk sharing.

The overwhelming focus on user fees has perhaps detracted from attention to the more complex financing arrangements which are starting to emerge in a number of countries, involving a wide range of prepayment and social protection mechanisms as well as insurance based models (USAID). Particularly from the point of view of what is happening to access to reproductive health care, it is important to look across the range of mechanisms.

It is also important for reproductive health advocates to develop a clear view of what they want to see given priority or protected within these different modalities. It may be that hard choices are required in the short and medium term to deal selectively with particular problems. Basic and expanded packages have been another response to the crisis in public funding and which have a relatively high potential for including reproductive health components.

6 Methodologies for monitoring reproductive health spending at national level

This section is concerned with what kinds of monitoring, oversight and advocacy could therefore be undertaken nationally to improve the financing and implementation of effective reproductive health care. It discusses a number of initiatives deriving from institutional, research and advocacy standpoints and considers their advantages and limitations from a reproductive health perspective. This is not, however, a definitive list.

6.1 Public Expenditure Reviews (PER)

According to Sen *et al.* (2001), Public Expenditure Reviews examine government revenues and expenditures from the point of view of how far they meet expressed policy intentions and national

development plans. They began as a donor driven tool, but there is now greater national ownership of the process. PERs focus on analysis of the following:

- Projected resource availability based on the macro economic climate and cost recovery modes
- The budget process – preparation, management and accountability
- Inter and intra-sectoral expenditures, their impact and efficiency (ibid.).

A good example of the use of PER methods is from Bangladesh. In their monitoring of the Health and Population Sector Programme, Sen and Ensor (2001) are able to show that while gross expenditures are still dominated by family planning, a breakdown of information on the costs and use of staff time reveals a much wider distribution of funding. Taking these into account, child health took up 36 per cent, followed by 28 per cent for family planning and 13 per cent for both maternal health services and for limited curative care. Other reproductive health spending was only 4 per cent. This comparison suggests that while family planning and child health spending are close to World Bank recommended targets, in maternal health, there is a shortfall of nearly 60 per cent.

What are some of the advantages of this approach to monitoring financing reforms, particularly from the standpoint of reproductive health?

- It is particularly helpful in an environment where public policy commitment to shift resources to basic services in rural areas has been made, for instance through the provision of an Essential Services Package (as in the Bangladesh HPSP).
- Where there are clear commitments of finance and resources to specific target areas (e.g. Safe Motherhood), PERs can show whether these have been fulfilled.
- It can be used to monitor future impacts of new financing mechanisms such as the introduction of user fees.
- Because it targets public sector spending it is a useful accountability tool for advocacy groups to make demands on governments.

What are the limitations?

- It covers public sector spending only so cannot address pluralistic financing mechanisms.
- Even where there are systems in place capable of monitoring public spending, disentangling reproductive health related expenditure is complex and time consuming.
- Allocative decisions do not bridge the perceived gap between commitment of public expenditure and the actual experience by users of public services.

6.2 National Health Accounts (NHA)

The aim of National Health Accounts (NHA) is to provide a detailed overview of the sources and uses of funds within the health sector of individual countries (Harvey 2000). They can potentially describe changes in the sources and uses of funds over time by tracking flows of funds from sources through intermediaries to end uses (Berman 1997). NHAs aim to capture all expenditures, including households, firms, and NGOs. Policy makers can use them as an aid to decision making in the health sector, particularly in the context of health sector reform where they are increasingly being used predictively to understand the consequences of different financing regimes.

They have been used in a number of developing countries, though probably more successfully in middle income ones. Thailand is one example where NHAs have been used to monitor health expenditure patterns. There, they were defined very broadly as spending on activities whose primary purpose is health improvement (Tangcharoensathien 1999).

Another tool with similar predictive use is the Health Sector Finance Reform Model (HSFRM) which was developed to model the consequences of introducing alternative financing and organisational reforms.

According to Harvey (ibid: 19), the purpose of NHAs is to:

- measure *expenditure* on 'health' (discretionary health services, personal health services, personal and population promotion and prevention programs, and health related activities such as research and administration) in any year; and,
- show the *uses* of these funds: who the funds are spent on, for what purposes, and how much goes for recurrent and capital purposes.

Whilst the purpose of HRSMs is to:

- project health expenditure, service use and resource use, by health care providers and by functions, by user groups and by regions. The projections are based on defined policy options, explicit behavioural assumptions, and assumptions about rates of change of key parameters.

In other words, NHAs can measure change over time in health expenditure to functions and users (if systematically collected). HSFRMs are a modelling tool, intended to be predictive and allowing comparisons of the impacts of different policy options. Both are concerned with the flow of funds and resources from initial sources of funds to end users within the health sector. According to Harvey, NHAs do not directly consider physical resource availability or the distribution of resources geographically or across population groups, whereas HSFRMs are able to model these. Table 6.1 shows Harvey's framework for synthesising these two approaches.

Table 6.1 Proposed generic classification of sources and uses of funds

Level 1	Level 2	Level 3	Level 4
Sources	Sources – Primary	Government Households Employers (public and private) Loans, AID	Country specific classifications
	Sources – Secondary Financing Agents/ Financial Intermediaries	Ministry of Health Other Government (Incl. Social Security) Private Insurance Non-Government health service agencies Households	
Uses	Providers	Hospitals Clinics Private practice providers Pharmacies Administration Research	e.g. Hospitals – Govt; Private-for-profit, Private-not-for-profit; etc Private providers – GPs, specialists, diagnostic services etc.
	Functions (Functions marked with * can also be referred to as Services or Personal Services).	Ambulatory care * Personal preventive and promotive care * Population based preventive and promotive care Inpatient care * Research Administration	e.g. Acute inpatient care, acute, rehabilitation, palliative. Acute inpatient care may be further classified by DRG, ICD etc.
	Resources	Labour Drugs Medical Supplies Other Supplies Equipment Other	Labour: Doctors, nurses, pharmacists etc.
	Users	Demography – Age/sex Souci-economic Geographic/Regional Health program.	

Note: 'Level' refers to the level of classification of data within the framework.
(From Harvey 2000: 23)

What are some of the advantages of this approach to monitoring financing, particularly from the standpoint of reproductive health?

- According to Berman (op.cit.), it is particularly helpful in monitoring trends in pluralistic health systems with multiple sources of finance as it does not just track public sector finance.
- The distinction between the sources and uses of finance makes the methodology more flexible and powerful.
- It is flexible in terms of how sources and uses are broken down, so reproductive health indicators could be developed, if there is a constituency which pushes for them. The NHA study by Barnett *et al.* (2001) in Rwanda, which treated HIV/AIDS as a sub-sector is a potential model for doing this by including a separate household survey for HIV/AIDS.

What are some of the limitations?

- It requires the collection of very large amounts of administrative, survey and other data, and/or a very complex set of methodological comparisons across inconsistent data (and probably a lot of guesswork).
- Most poor countries do not have the systems in place, or the available resources, to collect and tabulate the necessary information. What is available has generally been collected for other purposes and data quality is often poor.
- Political commitment to a process such as NHA may be lacking – transparency is not always desired or welcomed by governments.
- Decentralisation may mean that the necessary systems for data collection are not in place at regional or district level.
- It is not particularly lay user friendly, requiring an understanding of algorithms and the assumptions underlying their use (although the Harvard developed software circumvents this and is said to be 'simple' to use). It would have to be mediated by experienced researchers.
- The private sector generally provides little or no publicly accessible information.
- From the point of view of comparative work, there is no internationally accepted set of definitions of the elements that make up National Health Accounts, although work has been done by a number of organisations towards developing these (ibid: 20). SIDA has been sponsoring efforts to improve the reliability of NHA data and to provide consistent definitions across countries to make accounts comparable (SIDA 2001).

6.3 Women's budgets

Underpinning the concept of the women's budget is a set of gender indicators developed by Diane Elson and others in a series of papers and interventions (Budlender 1998). These range across the whole apparatus of government and include:

- Gender equality targeted expenditure
- Gender balance in public sector employment
- Women's priority public services
- Gender machinery, e.g. gender units
- Women's income transfers
- Gender balance on decision making bodies
- Gender balance in training opportunities

(ibid: 24–25)

The first women's budget was conducted by the Australian government in 1984. However, the initiative took off as a social movement in the context of social reconstruction in post-apartheid South Africa (Budlender 1996; 1997; 1998; 1999). Women's budgets are concerned particularly with recognising and revaluing the contributions of women in both 'domestic' and formal production. They are not intended as

a budget for women but as a way of analysing and revealing the gendered nature of allocative decision making. Since the South African initiative began in 1994, it has generated enormous international interest and initiatives have been conducted in other countries.

The Women's Budget Initiative in South Africa analyses how public revenues are divided at different levels and across different departments and agencies from the point of view of how gender sensitive these are. It also looks at how these commitments translate into expenditure. Expenditures are considered in three ways:

- Gender specific allocations for women's or gender issues
- Equal opportunities to address employment imbalances
- Mainstream expenditures to cover allocations broken down by gender, class, race and location.

Women's Budgets share some of the methodological features of PERs, and from the point of view of thinking about reproductive health spending, they share many of the advantages and limitations.

What are some of the advantages of this approach to monitoring financing reforms, particularly from the standpoint of reproductive health?

- It includes expenditure on basic services, many of which are reproductive health oriented.
- As developed in a number of countries, the initiative has reached out to advocacy groups and created much stronger linkages between the research and advocacy communities. In some countries (notably South Africa) it has attracted support from progressive politicians.

What are the limitations?

- It covers public sector expenditure only.
- It is very broad ranging and thus not particularly geared to reproductive health spending.

6.4 Monitoring frameworks for gender and health equity in health sector reform

These are largely still in the making, but PAHO is currently piloting a draft evaluation guide in Chile. This aims to be a practical tool which can be used both by health planners and senior managers in government departments who are developing systems for monitoring reform impacts on specific population groups, and by advocacy groups and research institutions concerned with women's health and with the equity effects of health reforms.

As both an evaluation and an advocacy tool it can assist in:

- deciding on key indicators for measuring the impact of reforms
- improving the gender sensitivity of monitoring and evaluation systems
- setting aims for advocacy work with politicians and official stakeholders in the health sector.

The framework draws on and amalgamates a number of different sources. The two main ones are Standing (1997; 1999) and Daniels *et al.* (1996). Standing's work specifically addresses the gender impacts of different elements of health sector reform as it came to be practised in the 1990s by donors and by many national governments. She raises a series of issues and questions for each of these elements. Daniels has developed the concept of benchmarking as a policy tool for assessing the impact of health reforms in developing countries. Benchmarks cover a range of important dimensions of fairness in health care, such as financing mechanisms, promotion of needs based coverage, reductions in barriers to access and public accountability. Fairness was chosen rather than equity as it was considered to be a broader term encompassing access, outcomes, efficiency and accountability.

The guide is not prescriptive. Not all components of the framework or all issues raised will be equally applicable to every country or locality within the country, so users can select those which are most relevant or feasible for them. It takes the form of a set of issues with associated questions and guidance on data sources.

The components are:

- intersectoral public health
- health systems barriers to access
- non-health systems barriers to access
- equitable financing and resource allocation
- equitable planning and priority setting
- quality of care
- equitable and efficient treatment of human resources
- democratic accountability and empowerment
- progress towards meeting international commitments.

Because of its significance for gender, reproductive health is treated as a cross cutting issue in all components. Table 6.2 gives the example of the component on financing.

What are some of the advantages of this approach to monitoring financing reforms, particularly from the standpoint of reproductive health?

- It can be adapted quite easily to different contexts and problem areas and can be scaled up or down as required.
- It involves stakeholders from both government and civil society.
- It is a more qualitative tool, and should be easier for a wider range of stakeholders to understand and use.

What are the limitations?

- It has a focus on gender rather than reproductive health.
- It is still at testing stage to determine its viability as a method.
- The amount of data to be collected may mean that it is only feasible in less resource constrained countries.
- It needs the development of teams with research and advocacy skills.

Table 6.2 Equitable financing and resource allocation

Issues	Questions	Data sources and needs
Overall financing regime	*What are the financing mechanisms through which health care is provided?* *Are there potential gender imbalances in the access and coverage which they provide?* *e.g. the impact of user charges on access to basic services* *Do reforms address equity implications of health financing modalities?*	• National policies – ministries of health, finance, employment, social security • Field level research studies ❑ Extent of segmentation of financing mechanisms ❑ Gender breakdown of access and coverage
Formal sector insurance schemes	*Who is covered and how does this relate to gender?* *Are there features of schemes which are discriminatory, e.g. requiring full time or uninterrupted service?*	• Data from government, employers' and private insurance schemes • Trade unions ❑ Gender breakdown of coverage ❑ 'Typical' contracts
Community based financing	*Which groups are covered and for what services/ conditions?* *Are reproductive health needs adequately covered?*	• Data from national and local health bodies • NGOs and other voluntary sector providers ❑ 'Typical' contracts
Safety nets/Micro-credit	*What mechanisms are in place to assist the very poorest to obtain health care?* *Does gender affect access to credit and safety nets?*	• National and local social security bodies • National and local credit schemes, e.g. Grameen banks, rotating funds ❑ Gender breakdown of participation
Transparency in resource allocation	*What are the formulas for resource allocation in health and how are they affected by decentralisation?* *Is information available to the public and in what form?* *Are there means by which community and women's groups can raise issues or challenge allocations?* *Are there moves to produce a women's budget or gendered national accounts?*	• Ministries of health and finance • Local authorities • Women's and other advocacy groups ❑ Views of civil society stakeholders

7 Concluding thoughts

Whilst it is possible to delineate some general global trends in financing, it is impossible to draw any global conclusions from them as the experience of different regions is very mixed. The following points may be made:

- There are obvious data and methodological gaps on how to link reproductive health access and outcomes to financing modalities.
- The greater individualisation of responsibility for health has produced a plethora of new financing arrangements. We do not know what these mean for reproductive health. What are they costing and are there fairer, more cost effective alternatives? What actions in the public domain are most likely to promote reproductive health and how can coalitions in their favour be built?
- In pressing for greater international and national funding for reproductive health, what is the balance between concern with health system strengthening and more delivery focused actions?
- There is little attention in the financing literature to looking at future trends. There is a need to cost 'coming conditions' such as osteoporosis, and reproductive health conditions associated with longer lifespans.

In an interesting comment on the business of advocacy, Palma and Palma (2000) note the need to translate the discourse of reproductive health for both users and providers, in order to construct a 'bridge' between ICPD and the everyday activities of health personnel. This paper notes the need to construct other bridges:

- Between policy commitments and implementation. There are many good policies around, but what makes the difference on implementation and outcomes?
- Between advocacy for the ICPD and Beijing programmes of action and the macro-economic environment, including the changed environment of international financial transfers.
- Between rights based advocacy approaches and other discourses around global spending commitments, such as public goods.
- Between an international vision of reproductive health and action on priority conditions.

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