

Box 2.4 The robustness of PHC-led health systems: 20 years of expanding performance in Rutshuru, the Democratic Republic of the Congo

Rutshuru is a health district in the east of the country. It has a network of health centres, a referral hospital and a district management team where community participation has been fostered for years through local committees. Rutshuru has experienced severe stress over the years, testing the robustness of the district health system.

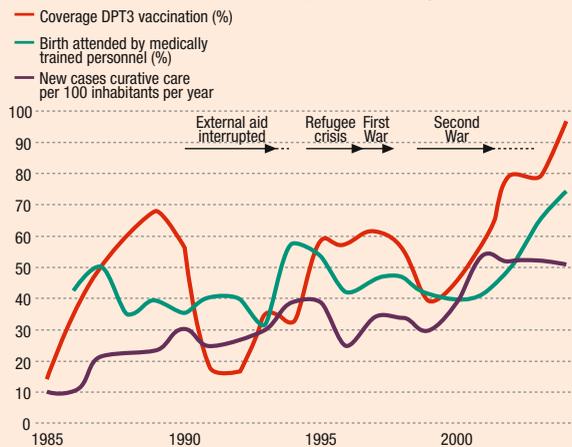
Over the last 30 years, the economy of the country has gone into a sharp decline. GDP dropped from US\$ 300 per capita in the 1980s to below US\$ 100 at the end of the 1990s. Massive impoverishment was made worse as the State retreated from the health sector. This was compounded by an interruption of overseas development aid in the early 1990s. In that context, Rutshuru suffered inter-ethnic strife, a massive influx of refugees and two successive wars. This complex of disasters severely affected the working conditions of health professionals and access to health services for the 200 000 people living in the district.

Nevertheless, instead of collapsing, PHC services continued their expansion over the years. The number of health centres and their output increased (Figure 2.6), and quality of care improved for acute cases (case-fatality rate after caesarean section dropped from 7% to less than 3%) as well as for chronic patients (at least 60% of tuberculosis patients were treated successfully). With no more than 70 nurses and three medical doctors at a time, and in the midst of war and havoc, the

health centres and the district hospital took care of more than 1 500 000 disease episodes in 20 years, immunized more than 100 000 infants, provided midwifery care to 70 000 women and carried out 8 000 surgical procedures. This shows that, even in disastrous circumstances, a robust district health system can improve health-care outputs.

These results were achieved with modest means. Out-of-pocket payments amounted to US\$ 0.5 per capita per year. Nongovernmental organizations subsidized the district with an average of US\$ 1.5 per capita per year. The Government's contribution was virtually nil during most of these 20 years. The continuity of the work under extremely difficult circumstances can be explained by team work and collegial decision-making, unrelenting efforts to build up and maintain a critical mass of dedicated human resources, and limited but constant nongovernmental support, which provided a minimum of resources for health facilities and gave the district management team the opportunity to maintain contact with the outside world.

Figure 2.6 Improving health-care outputs in the midst of disaster: Rutshuru, the Democratic Republic of the Congo, 1985–2004³³



Three lessons can be learnt from this experience. In the long run, PHC-led health districts are an organizational model that has the robustness to resist extremely adverse conditions. Maintaining minimal financial support and supervision to such districts can yield very significant results, while empowering and retaining national health professionals. Local health services have a considerable potential for coping with crises³³.

can enable less skilled frontline health-centre staff to be advised and guided by experts at a distance in real time³⁶. Finally, the financing of health care for dispersed populations poses specific challenges, which often require larger per capita expenditure compared to more clustered populations. In countries whose territories include both high-density and low-density populations, it is expected that dispersed populations will receive some subsidy of care. After all, equity does not come without solidarity.

Providing alternatives to unregulated commercial services

In urban and periurban contexts, health services are physically within reach of the poor and other vulnerable populations. The presence of multiple health-care providers does not mean, however, that these groups are protected from diseases, nor that they can get quality care when they need it: the more privileged tend to get better access to the best services, public and private, easily coming out on top in a *de facto* competition for scarce

resources. In the urban and increasingly in the rural areas of many low- and middle-income countries – from India and Viet Nam to sub-Saharan Africa – much health care for the poor is provided by small-scale, largely unregulated and often unlicensed providers, both commercial and not-for-profit. Often, they work alongside dysfunctional public services and capture an overwhelmingly large part of the health-care market, while the health promotion and prevention agenda is totally ignored. Vested interests make the promotion of universal coverage paradoxically more difficult in these circumstances than in areas where the challenge is to build health-care delivery networks from scratch.

These contexts often combine problems of financial exploitation, bad quality and unsafe care, and exclusion from needed services^{37,38,39,40,41,42,43,44,45,46}. The Pan American Health Organization (PAHO) has estimated that 47% of Latin America's population is excluded from needed services⁴⁷. This may be for broader reasons of poverty, ethnicity or gender, or because the resources of the health system are not correctly targeted. It may be because there are no adequate systems to protect people against catastrophic expenditure or from financial exploitation by unscrupulous or insensitive providers. It may have to do with the way people, rightly or wrongly, perceive health services: lack of trust, the expectation of ill-treatment or discrimination, uncertainty about the cost-of-care, or the anticipation that the cost will be unaffordable or catastrophic. Services may also be untimely, ineffective, unresponsive or plain discriminatory, providing poorer patients with inferior treatment^{48,49,21}. As a result, health outcomes vary considerably by social class, even in well-regulated and well-funded health-care systems.

In addressing these patterns of exclusion within the health-care sector, the starting point is to create or strengthen networks of accessible quality primary-care services that rely on pooled pre-payment or public resources for their funding. Whether these networks are expanded by contracting commercial or not-for-profit providers, or by revitalizing dysfunctional public facilities is not the critical issue. The point is to ensure that they offer care of an acceptable standard. A

critical mass of primary-care centres that provide an essential package of quality services free-of-charge, provides an important alternative to sub-standard, exploitative commercial care. Furthermore, peer pressure and consumer demand can help to create an environment in which regulation of the commercial sector becomes possible. More active involvement of municipal authorities in pre-payment and pooling schemes to improve the supply of quality care is probably one of the avenues to follow, particularly where ministries of health with budgetary constraints also have to extend services to underserved rural areas.

Targeted interventions to complement universal coverage mechanisms

Rising average national income, a growing supply of health-care providers and accelerated progress towards universal coverage are, unfortunately, not sufficient to eliminate health inequities. Socially determined health differences among population groups persist in high-income countries with robust, universal health-care and social-service systems, such as Finland and France^{11,50}. Health inequalities do not just exist between the poor and the non-poor, but across the entire socioeconomic gradient. There are circumstances where other forms of exclusion are of prime concern, including the exclusion of adolescents, ethnic groups, drug users and those affected by stigmatizing diseases⁵¹. In Australia, Canada and New Zealand, among others, health equity gaps between Aboriginal and non-Aboriginal populations have emerged as national political issues^{52,53,54}. In other settings, inequalities in women's access to health care merit attention⁵⁵. In the United States, for example, declines in female life expectancy of up to five years in over 1000 counties point to differential exposure and clustering of risks to health even as the country's economy and health sector continues to grow⁵⁶. For a variety of reasons, some groups within these societies are either not reached or insufficiently reached by opportunities for health or services and continue to experience health outcomes systematically inferior to those of more advantaged groups.

Thus, it is necessary to embed universal coverage in wider social protection schemes and to complement it with specially designed, targeted forms of outreach to vulnerable and excluded groups⁵⁷. Established health-care networks often do not make all possible efforts to ensure that everyone in their target population has access to the full range of health benefits they need, as this requires extra efforts, such as home visits, outreach services, specialized language and cultural facilitation, evening consultations, etc. These may, however, mitigate the effect of social stratification and inequalities in the uptake of services⁵⁸. They may also offer the opportunity to construct comprehensive support packages to foster social inclusion of historically marginalized populations, in collaboration with other government sectors and with affected communities. Chile's *Chile Solidario* (Chilean Solidarity) model of outreach to families in long-term poverty is one example (Box 2.5)⁵⁹. Such targeted measures may include subsidizing people – not services – to take up specific health services, for example, through vouchers^{60,61} for maternal care as in India and Yemen, for bednets as in the United Republic of Tanzania^{62,63}, for contraceptive uptake by adolescents⁶⁴ or care for the elderly uninsured as in the United States⁶⁵. Conditional cash transfers, where the beneficiary is not only enabled, but compelled to take up services is another model, which has been introduced in several countries in

Latin America. A recent systematic review of six such programmes suggests that conditional cash transfers can be effective in increasing the use of preventive services and improving nutritional and anthropometric outcomes, sometimes improving health status⁶⁶. However, their overall effect on health status remains less clear and so does their comparative advantage over traditional, unconditional, income maintenance, through universal entitlements, social insurance or – less-effective – means-tested social assistance.

Targeted measures are not substitutes for the long-term drive towards universal coverage. They can be useful and necessary complements, but without simultaneous institutionalization of the financing models and system structures that support universal coverage, targeted approaches are unlikely to overcome the inequalities generated by socioeconomic stratification and exclusion. This is all the more important since systematic evaluation of methods to target the excluded is scarce and marred by the limited number of documented experiences and a bias towards reporting preferentially on successful pilots⁶⁷. If anything definite can be said today, it is that the strategies for reaching the unreached will have to be multiple and contextualized, and that no single targeting measure will suffice to correct health inequalities effectively, certainly not in the absence of a universal coverage policy.

Box 2.5 Targeting social protection in Chile⁵⁹

Established by law, the Chilean social protection programme (*Chile Solidario*) involves three main components to improve conditions for people living in extreme poverty: direct psycho-social support, financial support and priority access to social programmes. The direct psycho-social support component involves families in extreme poverty being identified according to pre-defined criteria and invited to enter into an agreement with a designated social worker. The social worker assists them to build individual and family capacities that help them to strengthen their links with social networks and to gain access to the social benefits to which they are entitled. In addition to psycho-social support, there is also financial support in terms of cash transfers and pensions, as well as subsidies for raising families or covering water and sanitation costs. Finally, the social protection programme also provides preferential access to pre-school programmes, adult literacy courses, employment programmes and preventive health visits for women and children.

This social protection programme complements a multisectoral effort targeting all children aged 0–18 years (*Chile Crece Contigo* – Chile Grows with You). The aim is to promote early childhood development through pre-school education programmes, preventive health checks, improved parental leave and increased child benefits. Better access to child-care services is also included as is enforcing the right of working mothers to nurse their babies, which is designed to stimulate women's insertion into the employment market.

Mobilizing for health equity

Health systems are invariably inequitable. More and higher quality services gravitate to the well-off who need them less than the poor and marginalized⁸. The universal coverage reforms required to move towards greater equity demand the enduring commitment of the highest political levels of society. Two levers may be especially important in accelerating action on health equity and maintaining momentum over time. The first is raising the visibility of health inequities in public awareness and policy debates: the history of progress in the health of populations is intimately linked to the measurement of health inequalities. It was the observation of excess mortality among the working class that informed the “Great Sanitary Awakening” reforms of the Poor Laws Commission in the United Kingdom in the 1830s⁶⁸. The second is the creation of space for civil society participation in shaping the PHC reforms that are to advance health equity: the history of progress in universal coverage is intimately linked to that of social movements.

Increasing the visibility of health inequities

With the economic optimism of the 1960s and 1970s (and the expansion of social insurance in industrialized countries), poverty ceased being a priority issue for many policy-makers. It took Alma-Ata to put equity back on the political agenda. The lack of systematic measurement and monitoring to translate this agenda into concrete challenges has long been a major constraint in advancing the PHC agenda. In recent years, income-related and other health inequalities have been studied in greater depth. The introduction of composite asset indices has made it possible to re-analyze demographic and health surveys from an equity viewpoint⁶⁹. This has generated a wealth of documentary evidence on socioeconomic differentials in health outcomes and access to care. It took this acceleration of the measurement of poverty and inequalities, particularly since the mid-1990s, to bring first poverty and then, more generally, the challenge of persisting inequalities to the centre of the health policy debate.

Measurement of health inequities is paramount when confronting the common misper-

ceptions that strongly influence health policy debates^{70,71}.

- Simple population averages are sufficient to assess progress – they are not.
- Health systems designed for universal access are equitable – they are a necessary, but not a sufficient condition.
- In poor countries, everybody is equally poor and equally unhealthy – all societies are stratified.
- The main concern is between countries’ differences – inequalities within countries matter most to people.
- Well-intended reforms to improve efficiency will ultimately benefit everybody – they often have unintended inequitable consequences. Measurement matters for a variety of reasons².
- It is important to know the extent and understand the nature of health inequalities and exclusion in a given society, so as to be able to share that information and translate it into objectives for change.
- It is equally important, for the same reasons, to identify and understand the determinants of health inequality not only in general terms, but also within each specific national context. Health authorities must be informed of the extent to which current or planned health policies contribute to inequalities, so as to be able to correct them.
- Progress with reforms designed to reduce health inequalities, i.e. progress in moving towards universal coverage, needs to be monitored, so as to steer and correct these reforms as they unfold.

Despite policy-makers’ long-held commitment to the value of equity in health, its definition and measurement represent a more recent public health science. Unless health information systems collect data using standardized social stratifiers, such as socioeconomic status, gender, ethnicity and geographical area, it is difficult to identify and locate inequalities and, unless their magnitude and nature are uncovered, it is unlikely that they will be adequately addressed⁷². The now widely available analyses of Demographic and Health Survey (DHS) data by asset quintiles

have made a major difference in the awareness of policy-makers about health equity problems in their countries. There are also examples of how domestic capacities and capabilities can be strengthened to better understand and manage equity problems. For example, Chile has recently embarked on integrating health sector information systems in order to have more comprehensive information on determinants and to improve the ability to disaggregate information according to socioeconomic groups. Indonesia has added health modules to household expenditure and demographic surveys. Building in capabilities, across administrative database systems, to link health and socioeconomic data through unique identifiers (national insurance numbers or census geo-codes) is key to socioeconomic stratification and provides information that is usually inaccessible. However, this is more than a technical challenge. Measuring health systems' progress towards equity requires an explicit deliberative process to identify what constitutes a fair distribution of health against shortfalls and gaps that can be measured⁷³. It relies on the development of institutional collaboration between multiple stakeholders to ensure that measurement and monitoring translates into concrete political proposals for better equity and solidarity.

Creating space for civil society participation and empowerment

Knowledge about health inequalities can only be translated into political proposals if there is organized social demand. Demand from the communities that bear the burden of existing inequities and other concerned groups in civil society are among the most powerful motors driving universal coverage reforms and efforts to reach the unreached and the excluded.

The amount of grassroots advocacy to improve the health and welfare of populations in need has grown enormously in the last 30 years, mostly within countries, but also globally. There are now thousands of groups around the world, large and small, local and global, calling for action to improve the health of particularly deprived social groups or those suffering from specific health conditions. These groups, which were virtually non-existent in the days of the Alma-Ata, constitute a powerful voice of collective action.

Box 2.6 Social policy in the city of Ghent, Belgium: how local authorities can support intersectoral collaboration between health and welfare organizations⁷⁶

In 2004, a regional government decree in Flanders, Belgium, institutionalized the direct participation of local stakeholders and citizens in intersectoral collaboration on social rights. This now applies at the level of cities and villages in the region. In one of these cities, Ghent, some 450 local actors of the health and welfare sector have been clustered in 11 thematic forums: legal help; support and security of minors; services for young people and adolescents; child care; ethnic cultural minorities; people with a handicap; the elderly; housing; work and employment; people living on a "critical income"; and health.

The local authorities facilitate and support the collaboration of the various organizations and sectors, for example, through the collection and monitoring of data, information and communication, access to services, and efforts to make services more pro-active. They are also responsible for networking between all the sectors with a view to improving coordination. They pick up the signals, bottlenecks, proposals and plans, and are responsible for channelling them, if appropriate, to the province, region, federal state or the European Union for translation into relevant political decisions and legislation.

A steering committee reports directly to the city council and integrates the work of the 11 forums. The support of the administration and a permanent working party is critical for the sustainability and quality of the work in the different groups. Participation of all stakeholders is particularly prominent in the health forum: it includes local hospitals, family physicians, primary-care services, pharmacists, mental health facilities, self-help groups, home care, health promotion agencies, academia sector, psychiatric home care, and community health centres.

This complex web of collaboration is showing results. Intersectoral coordination contributes to a more efficient local social policy. For the period 2008–2013, four priority themes have been identified in a bottom-up process: sustainable housing, access to health care, reduced thresholds to social rights, and optimization of growth and development. The yearly action plan operationalizes the policy through improvement projects in areas that include financial access to health care, educational support, care for the homeless, and affordable and flexible child care. Among the concrete realizations is the creation of Ghent's "social house", a network of service entry points situated in the different neighbourhoods of the city, where delivery of primary care is organized with special attention to the most vulnerable groups of people. The participating organizations report that the creation of the sectoral forums, in conjunction with the organization of intersectoral cooperation, has significantly improved the way social determinants of health are tackled in the city.

The mobilization of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to assessing social inequalities and determining priorities for action.

Many of these groups have become capable lobbyists, for example, by gaining access to HIV/AIDS treatment, abolishing user fees and promoting universal coverage. However, these achievements should not mask the contributions that the direct engagement of affected communities and civil society organizations can have in eliminating sources of exclusion within local health services. Costa Rica's "bias-free framework" is one example among many. It has been used successfully to foster dialogue with and among members of vulnerable communities by uncovering local practices of exclusion and barriers to access not readily perceived by providers and by spurring action to address the underlying causes of ill-health. Concrete results, such as the reorganization of a maternity hospital around the people's needs and expectations can transcend the local dimension, as was the case in Costa Rica when local reorganization was used as a template for a national effort⁷⁴.

However, there is much the health system itself can do to mitigate the effects of social inequities and promote fairer access to health services at local level. Social participation in health action becomes a reality at the local level and, at times, it is there that intersectoral action most effectively engages the material and social factors that shape people's health prospects, widening or reducing health equity gaps. One such example is the Health Action Zones in the United Kingdom, which were partner-based entities whose mission was to improve the well-being of disadvantaged groups. Another example is the work of the municipality of Barcelona, in Spain, where a set of interventions, including the reform of primary care, was followed by health improvements in a number of disadvantaged groups, showing that local governments can help reduce health inequities⁷⁵.

Local action can also be the starting point for broader structural changes, if it feeds into relevant political decisions and legislation (Box 2.6). Local health services have a critical role to play in this regard, as it is at this level that universal coverage and service delivery reforms meet. Primary care is the way of organizing health-care delivery that is best geared not only to improving health equity, but also to meeting people's other basic needs and expectations.



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