Executive Summary

The 1980s saw a decline in public sector health services in developing countries. A number of health sector reforms were proposed in the early 1990s to deal with this crisis, and were implemented over the ensuing decade. They included financing reforms, new approaches to priority-setting, decentralisation, the integration of services, public-private interactions, and the setting up of structures and systems for improved community participation. While in theory sexual and reproductive health services could have been advanced by these reforms, in practice only limited improvements have materialised. In some instances there have been significant setbacks in improving the equity, quality, efficiency, sustainability, coherence and accountability of sexual and reproductive health services. Amongst the many reasons for this are: fundamental differences in the agendas of health sector reformers and the sexual and reproductive health services lobby; the lack of dialogue between these two agendas; and the chronic under-funding of the public health sector. In the present era of high HIV/AIDS prevalence, the revitalisation of the sexual and reproductive health services agenda depends on: affirmation of the role of the state as a provider of health services; increased donor aid and debt relief for developing countries; the sensitising of health sector reforms to women’s needs; and the generation of much improved information with which to document and judge the progress of reform. Above all the improvement of equity and the quality of care needs to feature more prominently in health sector reform.

What is the issue?

The issue is how can current health sector reforms in developing countries be harnessed in support of sexual and reproductive health service objectives?

Background

What were the key health sector reforms in developing countries in the 1990s?

- Financing reforms to mobilise additional funds for the health sector. This led mainly to the introduction and expansion of user fees, but
also to the development of various forms of health insurance (pre-paid community financing, social health insurance and private insurance).

- A new approach to priority-setting based on an assessment of the chief causes of the burden of disease and the most cost-effective interventions to address these causes. This led to resource allocation targeted at the implementation of an essential package of health care services.

- Reform of the organisation of health services to improve performance. This led to:
  - varying forms of decentralisation of authority and responsibility for health service delivery to lower levels of the health service, local government and the private sector;
  - increased involvement of the private sector in the financing and provision of services hitherto seen to be the responsibility of government; and
  - the integration of services that had previously been delivered in a fragmented fashion.

- The setting up of structures and systems to achieve community participation in order to improve the accountability of health services.

The objectives and impact of each of the above reforms is discussed in detail in the accompanying policy briefs. This policy brief provides an overview of the implications of these reforms for the achievement of the International Conference on Population and Development’s Programme of Action (ICPD POA) formulated during the same decade.

What prompted health sector reforms?

The 1980s saw a decline in public sector health services in developing countries. This was due to a number of factors: unfavourable macroeconomic conditions (including declining prices for raw materials and increased oil prices); structural adjustment policies which put downward pressure on government expenditure; declining donor support; public sector inefficiencies; and popular disaffection with the quality of care offered by public facilities.

Reforms to the health sector were proposed in the early 1990s to deal with this crisis and implemented over the ensuing decade in many developing countries. The agenda for reform was initially driven by the World Bank.

What were the objectives of health sector reforms?

A host of objectives has been associated with health sector reforms, including the improvement of sustainability, efficiency, quality, equity and accountability. However, because reforms took place within the context of acute resource shortages, much of the focus was on finding additional funding (mainly through placing the financing burden on users of health services), containing costs, improving management and encouraging the use of private sector providers. Thus, for many, the reforms are associated most closely with economic concerns and the concept of efficiency, despite arguments by reform proponents that the objective behind greater efficiency is the freeing up of resources to provide for the indigent. For critics of the reforms, they are the expression of an ideological position which holds that the role of the state should be narrowed to certain essential functions, and that market-style reforms are the key to development.

What are the objectives of sexual and reproductive health services?

A well-functioning health system is essential to the achievement of sexual and reproductive health. At first glance, then, proponents of sexual and reproductive health and rights should have much in common with health sector reforms. However, for the sexual and reproductive health services lobby, the over-riding concern is ensuring that citizens – whether women, men or adolescents – receive the range of sexual and reproductive health services to which they have a right, that the distribution and funding of these services is equitable, and that services are of an appropriate quality. Here the prime focus is on entitlement, fairness and serving the poor. Because women tend to be the poorest of the poor and as sexual and reproductive health services benefit women in particular, the sexual and reproductive health and rights lobby is particularly associated with the promotion of gender equity. At a conceptual level then, it is easy to see that what is perceived to have been the driving objective behind health sector reforms in the 1990s, namely efficiency, could conflict with the achievement of the sexual and reproductive health services agenda.
What is the impact of health system reforms on women’s access to sexual and reproductive health services?

What is the quality of the evidence regarding impact?
Generally, solid data on the impact of health sector reforms are scant, of poor quality and provide mixed evidence. This reflects, in part, poor documentation of health sector reform initiatives (in fact, many of these reforms were themselves implemented on the basis of limited evidence). It reflects, too, difficulties in analysing the effect of complex interventions on complex health systems. The central importance of context means that, often, what may be an advantage of an intervention in one setting becomes a disadvantage in another. In addition, many countries have had a relatively short experience of what are, after all, long-term reforms. It is thus somewhat difficult to make categorical statements about the impact of health sector reforms, especially on access to sexual and reproductive health services and gender equity which have seldom benefited from particular scrutiny.

Nonetheless, the available data do suggest that reforms have often failed to achieve their objectives to the extent initially intended, and have frequently had unintended negative effects. While there have been gains for certain service components and certain populations in certain settings, one should be cautious about the ability of health sector reforms – at least in the format in which they have been implemented to date – to ensure access to comprehensive, high quality, affordable sexual and reproductive health services.

What are the key impacts on equity?

• Many of the reforms appear to have increased the cost of, and constrained access to, care for poor women. This is related to the implementation of user fees as well as limited cover for sexual and reproductive health services under many insurance arrangements, and is aggravated by gender relations within households which de-prioritise preventive care and treatment for women. It is ironic that health sector reforms have manifested in this way, given that the Millennium Development Goals seek, amongst other things, to reduce maternal and child mortality through better access to care.

• The differentials in access to care of good quality appear to be widening, between geographic areas, income groups, users of public and private services, and users of different components of sexual and reproductive health services. Increasingly, public subsidies are captured by the better-off.

• Issues of equity have been de-prioritised in relation to efficiency.

What are the key impacts on quality?

• The concept of comprehensive sexual and reproductive health services is on the retreat. Only the more traditional forms of services – such as family planning, pregnancy care and delivery care – tend to be provided. The more recently conceptualised components of sexual and reproductive health are neglected. These include: contested services (such as abortion, and services dealing with violence against women); new health agendas (such as services for adolescents); services of perceived low priority (such as prevention and treatment of infertility and reproductive cancers); and, until very recently, high priority but expensive interventions (such as the treatment of STIs, including HIV/AIDS). This is partly due to methodological problems and data deficiencies that undermine priority-setting activities, and partly due to the marginalisation of the poor in decision-making processes.

• The quality of individual components of sexual and reproductive health services is increasingly jeopardised. Contrary to expectations, this is a problem even in the private sector, and not only for services that, in some countries, are clandestine (such as abortion and certain types of contraception). Quality problems in the public sector are associated with resource shortages and declining staff morale, some of the unintended consequences of reform.

What are the key impacts on efficiency and sustainability?

• It is unclear whether resources have been shifted to the most cost-effective interventions. This is partly because of failures in implementation, but also because of a failure to prioritise and
fund services identified by proponents of women’s sexual and reproductive health as important. While there are many reasons why these services have not been prioritised, an important one is the lack of appropriate data to measure the true extent of the burden of disease faced by women and to assess new interventions properly, especially those with a multi-sectoral focus.

- There is disappointing progress in cost-containment. Reforms have not been able to deter ‘frivolous’ use of health services, and in many instances have generated additional costs for the public sector. The brain drain, corruption and theft remain worrying problems.

- Reforms have not provided a substantial injection of new resources. A shortage of resources remains the over-arching problem faced by the public health sector. Even NGOs find themselves increasingly constrained in their ability to provide the full range of sexual and reproductive health services.

What are the key impacts on the coherence of the health system?

- Despite initial attempts to co-ordinate donor projects and integrate services, the more recent trend appears to be towards increasing fragmentation of services. This is occurring between the public and private sectors and, within the public sector, between disease-oriented programmes.

- There has been limited integration of traditionally fragmented sexual and reproductive health services. Where integration has occurred, this has typically been in the form of ‘adding on’ STI and HIV/AIDS services to either family planning or maternal services. Sometimes, the viability of successful vertical programmes has been harmed by integration into inefficient existing services.

What are the key impacts on the accountability of the health system?

- Except in some forms of decentralisation, the gains in community participation have been limited mainly to consultation around improvements in management and outreach, rather than active decision-making around policy, priority-setting and resource allocation.

- There is a tendency to transform the patient from a citizen with rights to a consumer who participates according to the ability to pay. This occurs especially in the for-profit private sector.

- The state’s role is narrowing to regulator and steward, rather than direct provider of services. The market is seldom willing to provide all aspects of sexual and reproductive health services. Even the public sector can be insensitive to the needs of marginalised members of the community, typically poor women and the youth. This is a particular problem when local level capacity and decision-making processes are weak.

- There is disproportionate influence of donors and global policy elites over government decision-making.

Factors explaining impacts

The reasons why, in general, health sector reforms have not led to gains in access to sexual and reproductive health services and gender equity are numerous. They include:

- the design of the reforms, which have seldom had equity as their central goal, have sometimes, in themselves, been contradictory, and have often failed to take sexual and reproductive health needs into account;

- the context in which reforms have been implemented, such as severely resource-constrained environments confronted with HIV/AIDS;

- the behaviours of the actors involved in the reforms, some of whom have actively resisted progress towards sexual and reproductive health rights and gender equity, others of whom have not been incentivised to promote women’s access to sexual and reproductive health services; and

- the process through which reforms were conceptualised and implemented, a common problem being the failure to take implementation concerns into account during the policy-making
phase, especially with respect to identifying the resources, authority and supportive legislation required to effect positive change.

Above all, however, there was seldom direct dialogue between health sector reformers and the proponents of sexual and reproductive health and rights. This partly reflects ideological differences between the two groups, with health sector reformers promoting an agenda of reduced state spending and the development of public-private interactions. It also reflects the relative power of health sector reformers, backed as they were by influential international agencies. Consequently, health sector reforms dominated the attention of policy makers during the 1990s and did not explicitly promote access to sexual and reproductive health services, especially for women, despite many areas of potential synergy.

Key challenges

While in theory promoting improved access to sexual and reproductive health services and gender equity could have been advanced by health sector reforms in the 1990s, in practice only limited improvements have materialised. In some instances there have been significant setbacks. In addition, the HIV/AIDS epidemic has advanced considerably. How can the promotion of women’s sexual and reproductive health and rights be revitalised under these circumstances? The accompanying policy briefs recommend specific policy options for each type of health sector reform. The following section identifies key challenges that need to be confronted across all aspects of health sector reforms.

Acknowledging the profound problem of affordability

In most developing countries, the public sector remains under-funded, under-staffed and poorly managed, especially in the poorest areas. Hence, the imperatives that drove health sector reform in the 1990s have not changed. A new impetus must be brought to bear in mobilising donor aid, but this needs to be balanced with enhanced mechanisms for ensuring that health systems remain accountable to the local populations they serve. There is also a need to advocate for a greater share of government budgets to be allocated towards health services, which will be facilitated by debt relief or debt cancellation. In the medium- to long-term, additional domestic sources of health care financing that are sustainable and equitable must be sought.

Re-affirming the role of the state

There are a number of reasons why government has a responsibility to ensure that sexual and reproductive health services are provided. Such reasons include the fact that sexual and reproductive health services benefit society as a whole, and not just the individuals who receive them, and that progress in sexual and reproductive health and rights is key to sustainable development and the achievement of gender equity. Given the distortions of the market, the implication is that, in many cases, sexual and reproductive health services should be provided directly by the public sector. Hence, the role of the state as a provider needs to be strengthened alongside its role as steward. The state will be most effective in carrying out these roles when it is viewed as legitimate and is trusted by its citizenry. Especially where the state engages in public-private interactions, it needs the capacity to provide appropriate oversight.

Improving the sensitivity of reforms to women’s access to sexual and reproductive health services

There are signs that the designers of the 1990s reforms are seeking to understand the reasons for failures and find solutions that take better cognisance of the complexity of health system contexts. This provides an excellent opportunity for constructive dialogue between the two agendas – health sector reform and women’s sexual and reproductive health and rights – around the objectives of reform, as well as mechanisms to improve policy development and implementation, taking cognisance of the limitations of the ‘one-size-fits-all’ approach. The fundamental issues of equity, quality of care and community participation need to be elevated in this debate.

Making better informed decisions

Improved monitoring and evaluation of health sector reforms, and of sexual and reproductive health interventions, is required to inform the development of policy options. Research must have a strength-
ened focus on equity and the quality of care, take into account the complexities and particularities of interventions, and prioritise the investigation of health problems of women.

References


This policy brief was prepared by Jane Doherty. It is based on Ravindran TKS and de Pinho H (editors). The Right Reforms? Health Sector Reform and Sexual and Reproductive Health. Johannesburg, Women's Health Project, School of Public Health, University of the Witwatersrand, 2005.

The full text of the book can be found at www.wits.ac.za/whp/rightsandreforms/globalvolume.htm

Other policy briefs in this series include Financial health sector reforms and sexual and reproductive health; Public-private interactions: Implications for sexual and reproductive health services; Priority Setting in the context of health sector reforms: Implications for sexual and reproductive health services; Decentralisation and implications for sexual and reproductive health services; Integration, health sector reforms and sexual and reproductive health; Strengthening service accountability and community participation in health sector reforms. They can be found at www.wits.ac.za/whp/rightsandreforms/policy.htm

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