POLICY BRIEF

Priority setting in the context of health sector reforms: Implications for sexual and reproductive health services

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Introduction

There are severe challenges confronting developing countries regarding the allocation of public resources in health. It is imperative that governments ensure that resources are allocated according to the actual needs of people, particularly those who are most in need of government protection. It is the duty of government to ensure people's right to health care.

Among these challenges are:

• Governments are faced with shrinking financial resources and competing demands as they try to address the health needs of the population. Payments for foreign debts, fluctuations in prices of commodities in the global market, military spending, economic costs of trade liberalisation and revenue deficits, hinder governments in addressing problems of ill health.

• Health care costs are increasing, compounded by the emergence of new diseases (e.g. HIV/AIDS and SARS) and the re-emergence of old infectious diseases (e.g. TB and cholera), which are mainly afflicting poor populations. Environmental degradation has complicated the health situation as the quality of air and water worsens and traditional water sources dry up.

• Poverty has worsened in magnitude and intensity, as globalisation continues to benefit some and marginalise many, especially women. With the globalisation of western cultures, many traditional societies are unable to provide effective self-treatment as natural resources dwindle and traditional medical knowledge is lost.

• There is a widening in the gap between the rich and the poor within countries, and between developed and developing countries. Many governments in the developing world are caught in a debt trap, increasingly reliant on foreign funding to fund their social sectors.

This has implications for the autonomy of these governments to make independent policy decisions. Taking advantage of the financial crisis faced by poor debtor countries, the World Bank and other international funders use the need for loans to impose conditionalities, including the adoption of various health sector reforms, even when these are not the best options for the particular country context.

Policy makers in developing countries have to recognise the weakness of methods being promoted globally even if these are ostensibly developed by international experts. It is imperative that the priorities they set for allocating resources respond to real needs, not only in curative but also in preventive terms. When the poor and women find it more difficult to access or afford services that they truly need because these are not on the priority list for govern-
ment allocation, or their health conditions are ignored because these do not appear significant, we must examine the method that is being used for setting priorities.

The priority setting approach in health sector reform goes against the principles of equity and access to a comprehensive range of basic health services as an entitlement. This approach is unfair to poor women and their need for universal access to comprehensive sexual and reproductive health services.

This policy brief outlines the problems with priority setting in the context of health sector reforms, with particular reference to sexual and reproductive health. It identifies the impact and implications of this approach to women’s right to sexual and reproductive health services. It concludes with suggestions for possible courses of action for policy makers and sexual and reproductive health and rights advocates to ensure that priority setting is more fair and responsive to the health needs of the most vulnerable sectors of the population.

Brief description of the priority setting approach in health sector reforms

This approach was developed under the auspices of the World Bank and promoted to developing countries, starting in the early 1990s. It has a neo-liberal macro economic cost recovery bias. It tends to limit the scope of responsibility of government in the financing and provision of health care and leaves much responsibility for health care delivery to the private sector.

The description below focuses on the essential elements of this approach, sufficient for understanding its policy implications.

Burden of disease

This approach estimates the health problems of a population in terms of disability adjusted life years (DALYs). ‘Lost DALYs’ refers to years of healthy life lost due to premature death or disability. Health conditions that have the greatest number of DALYs lost (termed also as ‘burden of disease’) are considered priority health needs.

Cost effectiveness

The cost effectiveness of interventions is determined in terms of the number of DALYs averted per unit cost. In other words, cost effectiveness is the cost divided by the net gain in health (expressed in DALYs), meaning that interventions with a high number of DALYs averted per dollar spent, are considered cost effective. An intervention is considered high priority when the burden of disease is large and the cost effectiveness of the intervention is high.

Essential Package of Services

Information on the burden of disease and cost effective interventions are combined to identify the contents of the Essential Package of Services. These are the services that government should pay for. Services outside the package should be paid for on an out-of-pocket basis and are usually left to the private sector to provide. The essential package will vary from country to country, according to the resources that government currently has available to fund health services; where government health care expenditure is very low the package will be restricted.

Problems with the priority setting approach in health sector reforms

The services and health conditions that will be identified through this priority setting approach will not necessarily be those that are the real priority health needs of the poor. This is because the burden of many diseases could have been underestimated, the services prioritised are not really the most appropriate, accessible, or even cost effective. The points below are some of the reasons why this may occur.

- Although the World Bank’s Essential Package of Services approach is advocated as ‘evidence-based’, and therefore an appropriate means of determining priorities, numerous value-based assumptions have been incorporated into their estimates but have not been made transparent to policy-makers. For example, DALYs are weighted differently according to the age of the person who is ill or dies prematurely. The lives of the young and the elderly are valued at a much
lower rate than that of working age adults (e.g. a year lived at age 2 counts for only 20% of a year lived at age 25 according to the World Bank approach). Also, the World Bank uses information on health care costs in a few countries to calculate cost-effectiveness; i.e. it assumes that the costs are the same irrespective of the country. This assumption has been shown to be incorrect and so what may not be cost-effective in one country may be cost-effective in another.

- It has a narrow, biomedical definition of health that tends to ignore interventions that address larger political and social determinants but instead focuses on individualistic solutions. In reality, several interacting factors determine health outcomes and ignoring them would not produce long lasting results. Political and social determinants, such as poverty, create chronic morbidity among the poor and health care expenses can exacerbate poverty.

- It considers cost effectiveness and efficiency over equity considerations. The method does not calculate the additional burden of disease or costs that may be experienced by disadvantaged groups. Nor does it prioritise interventions aimed specifically at these groups. Interventions that are less costly to the health system are prioritised even if these are more costly to patients and their families.

The box below provides one example, illustrating that this method unfairly disadvantages those who should receive the highest priority.

Menstrual disorders such as heavy bleeding exact heavier burden on women living without clean water and who are unable to afford sanitary napkins, than on women who have access to these amenities.

- It under-prioritises high burden diseases which have no known cost effective interventions such as HIV/AIDS. Innovative interventions for which there is no data about DALY gains per dollar expended, may not be encouraged or invested in.

### Problems particular to sexual and reproductive health

This priority setting approach is unfair especially to poor women because many of their health needs are underestimated and excluded from the range of services that government should finance. For example, using this priority setting approach, the WHO (2000) and the World Bank (2000) proposed a very limited list of reproductive health interventions as essential or basic services. These included prenatal and delivery care, family planning, treatment of STIs and AIDS prevention. Priority setting in sexual and reproductive health in most countries is guided by this package. In fact, some countries opt for an even narrower range of services than the package that is proposed. Examples of conditions that are excluded are: uterine prolapse; vesico-vaginal and recto-vaginal fistulae; menstrual disorders; and ovarian and uterine cancers.

The attempts of the WHO and the World Bank to prioritise sexual and reproductive health services beyond the very limited list in the 1997 Health, Nutrition and Population (HNP) strategy paper of the World Bank expanded the range of services to include: post partum care; essential emergency obstetric care; and HIV prevention.

However, the box below (see page 4) illustrates that the actual services offered in the essential package in most countries are very limited and exclude major sexual and reproductive health care needs.
Only 20 of 152 countries assessed included within their HNP projects the following: family planning; prenatal and delivery care; clean and safe delivery by trained attendants; post partum care; and essential emergency obstetric care.

Only 71 of 152 countries had family planning services publicly financed through the HNP project.

Only 44 of 152 projects addressed prevention of HIV/AIDS. The most frequent intervention was condom promotion; Rarely available are safe blood and STI treatment.

Only 51 of 152 projects included STI treatment but as part of an HIV/AIDS programme. STI control was rarely part of antenatal care, family planning and other sexual and reproductive health services.

Other problems with this approach are:

- Failure to consider the impact of social stigma, isolation or gender-based disadvantages in the calculations for the burden of the disease. This results in the underestimation of the actual burden of reproductive health conditions, good examples of which are infertility and urinary incontinence; and

- Failure to consider the benefits from preventive interventions such as safe abortion or contraception, which when not provided could contribute significantly to the disease burden.

The consequence of underestimating the burden of sexual and reproductive health conditions is the lowered priority given to these conditions. Difficulties in obtaining data on the cost effectiveness of interventions further reduce the importance accorded to sexual and reproductive health. This has far reaching consequences as many services become inaccessible, unavailable and unaffordable. The exclusion of delivery services and essential emergency obstetric care from the essential service packages of many countries is worrying, given the high levels of maternal mortality in developing countries.

For example, in three African cities of N’Djamena (Chad), Douala (Cameroon) and Dar es Salaam (Tanzania), delivery care services are absent from the maternal health services package. Sexual and reproductive health services are limited to prenatal and family planning services.

Priority setting using this burden of disease and cost effectiveness approach has reduced the aspiration for universal access to comprehensive sexual and reproductive health services to a publicly financed package consisting of virtually no more than family planning and prenatal services. This constitutes a reversal of gains of the women’s health movement in recent years.

Proposed courses of action for policy and advocacy

Developing countries have to strengthen their capacity for autonomous policy making, especially because they are accountable to their own populations. Governments have to protect the vulnerable and prioritise their needs. There are certain principles that have to be reaffirmed regarding allocation of public resources, among which is the principle that health is a public good to which people are entitled.

There are ways for governments in developing countries to enhance effective priority setting.

- Appropriate values to underlie priority setting

Instead of viewing priority setting as a means of limiting government funding and provision of health services to the bare minimum, it should be viewed as a mechanism to determine a package of relatively comprehensive health services to which all citizens should be entitled, drawing on available data as well as public policy debates. While the package of services that can be immediately guaranteed will depend on existing budget constraints, the agreed priorities form the basis for the gradual realisation of the right to access a comprehensive package of
essential services as more resources are devoted to health care over time.

- **Accountability and autonomy in policy making**
  External experts working for international funders such as the World Bank, involved in pushing for health sector reforms, are not accountable for policy failures. National governments are the ones answerable to the people for policy failures. However difficult, with particular reference to foreign funding, governments of developing countries have to exercise greater autonomy in policy decisions vis a vis external agencies.

  Furthermore, government capacity for independent policy making can be enhanced through greater participation of local and national stakeholders in priority setting and by more transparency in policy matters. Spaces and champions for autonomous and responsive priority setting within government bodies have to be identified and supported.

- **Building capability for priority setting**
  Sound priority setting approaches are required in good governance. Reliable, well organised and adequate data are needed for evidence in determining priority health needs and effects of interventions. In order for governments to have greater self reliance in priority setting exercises, local capacity, including technical capacity, must be built. Investment in research on sexual and reproductive health conditions, and innovative, effective interventions, should be prioritised.

- **Addressing sexual and reproductive health needs could mean greater efficiency**
  It is important to look at health needs from a broader perspective and to redefine efficiency of interventions from this perspective. Studies have shown that better health of women resulted in better health outcomes of children and families. It has also been shown that health interventions that were linked to broader social and political problems have far reaching and more lasting positive health benefits. It is more efficient for society to invest in this type of intervention and not simply on narrow, biomedical interventions.

Finally, priority setting could be a means for government to protect the vulnerable and promote their welfare. As a form of redistributive justice, resources need to be allocated to those who benefit least from the wealth and opportunities of society, yet are the

backbone of food production, the service industry, and in the case of women, are, in addition, the care and welfare providers in the family.

Governments that are guided by principles of human rights consider health and other basic services as entitlements. Obstacles to the enjoyment of these entitlements should be primary concerns in setting priorities.

### References


- Abou Zahr C. Disability adjusted light years (DALYs) and reproductive health: a critical analysis. Reproductive Health Matters. 1999;7(14):118-129.

This policy brief was prepared by Fatima Alvarez-Castillo. It is based on Alvarez-Castillo F, Ravindran STK, de Pinho H. Priority setting. In: Ravindran TKS, 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](http://www.wits.ac.za/whp/rightsandreforms/globalvolume.htm)

Other policy briefs in this series include Health sector reforms in the 1990s: Implications for sexual and reproductive health services; Financial health sector reforms and sexual and reproductive health; Public-private interactions: 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](http://www.wits.ac.za/whp/rightsandreforms/policy.htm)

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