Improving basic health service delivery in low-income countries: ‘voice’ to the poor

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Abstract

Public social services, such as basic health care, represent the effective option for the poor, especially in the rural areas of low-income countries. The quality of such services are at present extremely deficient, largely due to resource constraints and lack of political will to make them function effectively. The state can no longer provide the comprehensive services it has in the past and which were highly successful in a number of 'high-achieving' developing countries. Yet, the state must turn priority attention to providing public services for the poor, in order to close the widening gap between rich and poor. It needs to do this in partnership with the population it aims to reach, through effective linkage with grass-roots organizations and with the support of non-governmental organizations. Giving ‘voice’ and participation to the population can not only increase the resource base for public services, but can also significantly improve the accountability of providers and lead to a cost-effective option for the poor.

Keywords: Health; Poverty; India; Africa; Social policy; NGO

‘Exit’ and ‘voice’ in the health sector

This paper argues that, at the present stage of development in Africa and South Asia, the accountability of the public system of providers can best be improved through the use of voice by the public. ‘Voice’ essentially means that beneficiaries have a say in how services are run. The context is the poor quality of state-provided health services in rural areas and the relative lack of easily accessible and comparable alternative sources, together with the complexity of using alternative sources as a real option for people seeking health care with meagre resources. Grassroots organizations (GROs) can play an important part in providing this voice, often facilitated by non-governmental organizations (NGOs). At the same time, the role of the state has to change, not only to foster partnerships with GROs, but also to focus more of its scarce resources in a targeted way on the poor. This represents a significant shift from an earlier stage of the development policy and practice of the 1960s and 1970s, when the state’s predominant role was emphasized.

It has been argued that the public’s use of competing services or its participation/protest to induce existing service providers to perform will enhance public accountability in a given situation. In other words, public service accountability will be effective only if normal hierarchical control over service providers is reinforced by the public’s willingness and ability to use alternative services or to influence directly the provision of services.

The services we are concerned within this paper—rural health and rural primary education, but especially the former—are, on the surface, both characterized by low exit and low voice (Paul, 1992). In the case of health, public services are commonly the most extensive in terms of services that are available to the poor, but there are other offers of care, including alternative medicine...
many countries and a marked reduction in the state's indebtedness led to structural adjustment measures in severe international economic recession and financial systems occurred during the 1980s, when a period of recession of services.

People’s response to their health care needs, especially in case of illness, is usually a specific decision to use a particular service available to them, or self-treatment, or no treatment, at least initially until the problem worsens. Often, different choices are made according to the problem faced. People decide what to do for a particular problem, based on a mix of probable effective outcome and value for money. Cultural and social influences play a role in the choice of provider. A certain percentage of the population, across all economic groups, does not use modern medicine at all. Health action also implies an investment, if not in the cost of service although this is often also the case, at least in transport and opportunity costs. Public services often lack drugs and open at times that are inconvenient to the working poor, which implies a cost that the poor cannot bear or do not consider value. Modern care, both private and NGO-run, is an option taken by the rural poor either late and at high cost, or relatively cheap and often ineffectual. Self-treatment is an important choice taken, with drugs sellers then being the main service used, often of partial doses with the associated problems of ineffectiveness and increased susceptibility to resistance. Although different offers of care exist, public and private, modern and traditional, each is seen with a different value and ability to produce different outcomes. As such, they do not compete on an equal footing, but are geared to different demands of the public.

Overall, in the context of improving public health services, we do not see ‘exit’ for the poor in developing countries as a viable option. We would like to see rather the development of significantly improved services in the public sector through the greater use of organized voice by the public, both in the determination of the quality of service as well in the management of resources available to impact effective functioning and outcomes.

The first two decades after independence in sub-Saharan Africa saw marked progress in the health situation, with a steady strengthening of health infrastructure. In rural areas, the extension of health centres and health posts was systematically attempted, largely as action by the public sector. NGOs, important providers of care especially religious missions, were also experiencing resource constraints that were affecting the provision of services.

Serious disruption to the situation of the public health systems occurred during the 1980s, when a period of severe international economic recession and financial indebtedness led to structural adjustment measures in many countries and a marked reduction in the state’s role in the provision of services (Chabot, Harnmeijer, & Streffland, 1995). One approach to this crisis lay in the greater mobilization of community resources in the development of local health services, recognizing that patients seeking care were already beginning to pay considerable sums of money for treatment of various kinds. This was the situation in which the Bamako Initiative (BI) arose in 1987—leading in some countries to a reasonably successful example of voice in ensuring access to affordable essential health services for an increasing proportion of the population (Jarrett & Ofusu-Amaah, 1992).

In South Asia, a similar use of voice still remains to be demonstrated. By the early 1980s, India’s multi-tiered health system was one of the best developed in the developing world. But it emphasized curative, high-technology medicine and urban hospitals, and pursued ‘elitist’ health manpower policies. In rural areas, numerical expansion occurred at the expense of quality, with most recurrent resources spent on salaries, and little left for drugs and other materials. Although the government centre was associated with ‘free treatment’, expenditure for medicines and other ‘unofficial payments’ have been common. Worst of all, doctors or other health staff were often not present.

Meanwhile, the private sector in India has grown tremendously. In comparison with one million qualified doctors mostly found in urban areas, the registered medical practitioners (RMPs) are handling most cases in India’s over half-million villages. Most of the private expenditure in rural areas are on services provided by RMPs—who are usually ill-qualified, ill-equipped, and by definition, charge money (though most charge only a margin on medication, rarely as consultation fee). RMPs are physically, as well as socially and culturally close, to the clientele they serve.

The situation is not much different in the rest of South Asia. In order to ensure an improvement in quality of service by government providers and the RMPs, we argue that ‘voice’ should have an important role to play in South Asia.

**Characteristics of health policies in high-achieving states**

Voice at the macro-level can be very important as well—as shown by the cases of high-achieving countries in terms of social development. Within the last 50 years, most developing countries have made health and educational advances that took nearly two centuries in the industrialized countries. However, 10 developing countries managed to exceed the scope and pace of social development of the majority of other developing countries. Those relevant to this paper are: Sri Lanka and Kerala State (India) from South Asia; Botswana, Mauritius and Zimbabwe from Africa. These
high-achievers have shown that responsive regimes, whether or not liberal political democracies, can deliver high levels of human development early in their development process.

There are a number of policy elements which are common to the high-achieving states (Mehrotra & Jolly, 1997). Public action was central to the achievement of effective health services and high levels of school enrolment at the primary level, through state-supported basic social services for its population with resource allocation to the health and education sectors usually well above the average for developing countries. Policies were marked by a series of specific kinds of health interventions, relevant to about half the existing disease burden from communicable or infectious diseases, poor nutrition, and maternal and peri-natal causes.

What is noticeable about most of the high-achieving countries is that they adopted the principles of primary health long before these had been generally recognized by the world community. They achieved major reductions in the mortality of mothers and children by focusing the attention of the health system on these population groups. Pregnancy management was supported by good health-referral systems, along with household visits by the first-level health worker. Immunization coverage was found to be particularly high in all these countries. Overall, an effective balance was achieved in supporting first-level health workers while maintaining a well-functioning network of hospitals. This was helped by supportive human resources policies, like requiring doctors to work with the government health service for a certain period of time. For the vast majority of the population a universally available and affordable system, financed out of government revenues, functional at the lowest level, made effective by allocating resources at the lower end of the health system pyramid, was key to high health status.

Underlying the action which made improved health status a reality was the ‘agency’ role of women. Relative to other countries in their regions, the selected countries were characterized by a much higher level of education indicators for women at the beginning of the period of analysis. Increasing levels of female education have been associated with better nutritional levels for children and lower mortality rates. Perhaps the mechanism by which the better nutritional levels and lower mortality are attained is the superior control over the allocation of intra-household resources that comes with the mother’s education as well as her effective demand for, and utilization of, health services were available. The use of voice by women, both in the household and in service provision, has been a significant attribute to the success of these 10 countries.

By and large it was the government’s commitment to public action which made health and education development possible. There is limited experience of NGO involvement in the delivery of programmes in these countries (except in Mauritius), either in health or education.

The high-achiever model—still valid?

Are the essential characteristics of these health policies still valid in the countries of South Asia and sub-Saharan Africa where a health transition has not occurred and the disease pattern is still dominated by communicable and infectious disease? The answer is an unequivocal yes, but with a difference. The answer is yes because the state remains, even in these countries, the main provider of public health services, even though private expenditures on health are considerable. The difference arises from the fact that the state’s capacity to service the full complement of needs of a public health package as well as essential clinical services for a rapidly growing population is much more limited now, precisely because these investments were not made early in the development process—unlike in the high-achievers.

In the high-achievers the early investments in public services, which included a public health and essential clinical services package ensured that not only did a health transition occur, the total fertility rate was rapidly brought down to levels close to (or just above) replacement levels. In the rest of the developing world, that has not happened—with birth rates remaining high and death rates falling. These countries now—in the late 1990s—have much larger absolute populations than would have been the case had the health transition occurred earlier, with all the concomitant consequences for the pressure on health budgets. The cost of providing health services has also risen dramatically, exacerbated by a number of factors, among which are the HIV/AIDS pandemic and the alarming increase in resistance to antibiotics and anti-malarial drugs.

While there is a consensus around the need for the state to invest in human capital, the capacity of the state to do so remains in question. There are a number of reasons for linking the problems associated with state capacity to a greater involvement of the people using these services.

First, the State’s capacity to provide services has not been strengthened by macro-economic policies designed to lower public expenditures. In most of sub-Saharan Africa, expenditures for basic social services do not seem to have benefited from adjustment policies. Many countries have opted for short-term disease-related goals without due attention to the long-term strengthening of health systems. Given limited resources, there is a strong logic to public action in health targeting the poor, even if such long-term shifts are politically difficult. Targeting also runs the risk of two kinds of errors: one is that of...
failing to reach the target population (on account of overly narrow targeting), the other is made when the intervention reaches a non-target population. Hence, it might be more politic to aim for universal provision of basic level services, as the high-achievers succeeded in doing, but mobilizing community resources as a new source of investment in public services.

Second, the trend towards, and the need for, ‘voice’ mechanisms to be established has also grown with an increasing role for decentralized means of delivering social services, linked to greater expectation of change through electoral democracy (in Africa especially in the 1980s and early 1990s). Local governments, however, often do not have the institutional capacity to effectively deliver these services. In such circumstances, the role of voice mechanisms acquires particular significance in ensuring the actual delivery of services.

Third, implementation of development policy, broadly defined, is increasingly dogged by growing questions over issues of governance, transparency, and accountability. Falling incomes in Africa during the 1980s have led to more evident corruption. When resources are limited, and health and education system staff often have second jobs to secure higher incomes, service delivery suffers accordingly. In many countries, the distinction between public and private is hazy, with public-sector workers taking advantage of their position to act in parallel as private providers of services. ‘Voice’ mechanisms can play a significant role, in ensuring that services are delivered at least at minimum levels of effectiveness.

The household as investor in health

In looking specifically at health, an important additional reason for re-thinking the health approach for the majority of low-income developing countries is the recognition that the household is the most important producer of health. The household is not only the environment that influences most of the health, nutrition and education of children, but is also the principal financier of services. Half of all health expenditure in developing countries, or an estimated US$85 billion yearly, comes from patients’ pockets (World Bank, 1993). Low-income households in many countries have to use proportionately more of their income for treatment, considering a higher burden of disease and more difficult access to care and essential drugs. In addition, decision-making in the household generally results in girls and women being taken less frequently or later than men and boys for medical treatment, contributing to higher child death rates for girls than boys in many parts of the country.

With the precarious economic situation of poor households, the loss of income due to illness of income earners, together with the costs of treating illness, have a significant impact, leading to or maintaining these households in a permanent state of poverty. The selling of assets is widely stated as a principal recourse of poor households in the face of emergency health care cost.

Quite clearly, households are paying a lot for health care, but often not getting their money’s worth. The question that arises from this is whether consumers or households should largely be left to the vagaries and sometimes dangers of social services run invariably as private businesses, or whether there are means of a more organized approach to service provision in a rapidly transformed world. Such an approach, however, implies consumers can better determine their needs, take appropriate action and be able to negotiate the services that are made available to them. Sustainability leads, therefore, from the centrality of the household to a greater participation by the public and use of voice in the running of health services, which at the same time is seen to be equally applicable to the running of education services.

GROs as health service partners

In seeing how the public can effectively exercise voice in the running of health services, it is important to review their own social structures, particularly GROs. GROs and NGOs are increasingly seen as channels for promoting economic and social development, also contributing to the democratization of the economy and society (Uphoff, 1993). Here it is important to distinguish between NGOs (interested parties coming together to help others) and GROs (interested parties coming together for self-help), as distinct responses of civil society to its better organization for addressing problems.

While the former have tended to set up alternative health services, the latter have not in most cases developed parallel health services but have mobilized a ‘voice’ mechanism where services are of poor quality or providers are under-performing. In this case in particular, their role is to put much greater pressure on the state provider, and thus be much more effective than hierarchical control from within the state system could possibly be. It is argued, therefore, that GROs can have a much more significant impact on the offer of health services by the public sector to the poor, through their active participation, than to consider any significant expansion of parallel services by NGOs, or even a profit-seeking private sector, especially where the latter is unable to be satisfactorily regulated by the State. In this context, the role of the NGO can become critical in giving GROs financial and technical support.

While significant evidence is not readily available on the role and work of GROs, it has been seen that as
partners in the running of public health services they are a response to both increasing government failure as well as severe market imperfections in the provision of health services to the poor. NGOs that have reached success of a significant scale, particularly in South Asia, have provided the leadership and appropriate help to develop the capacity of popular movements to shape national institutions, national policy and development theory. It is surmised that due to the particular stratified social organization of South Asia, NGO-mediated cooperation will more likely stimulate the development of the voice of the poor, as GROs will only be able to represent certain parts of the community.

The Bamako Initiative (BI), implemented to varying degrees in half the countries in sub-Saharan Africa since the late 1980s, has shown that organized communities can help sustain local public health services, not only by contributing financial resources, but by having ‘voice’ in the management of the services. The strategy of the BI is to revitalize public health systems by decentralizing decision-making from the national to the district level, instituting community financing and co-management of a minimum package of essential services at the level of basic health units. The aim is to improve services by generating sufficient income to cover some local operating costs such as the essential drug supply, salaries of some support staff, and incentives for health workers. Funds generated by community financing do not revert to the central treasury but remain in the community and are controlled by it through a locally elected health committee. From mere recipients of health care, consumers become active partners whose voices count.

After 10 years of implementation of the Initiative, community action in most rural health centres in Benin and Guinea has not only enabled nearly half the population to be regular users of the services, but has also raised and sustained immunization levels close to Year 2000 Health for All target levels (Levy-Bruhl et al., 1997). Charging a modest fee to users is seen in some cases to be the most affordable option for the poorest segments of the population who otherwise have to access more expensive alternatives, although it is less clear whether mechanisms exist to protect indigent members of the community. Much of the success has been in ensuring the supply of affordable essential drugs that are readily available in the health centres, under the scrutiny of the committees. Another factor has been the improved attitude of health workers, traditionally one reason for people, especially women, not to use the service.

Recent assessments have shown that community participation in the BI has actually not been as well-defined as originally thought, and that significant community empowerment has not taken place. ‘Induced’ participation, pushed in many cases by donor demand and often based on political decisions or bureaucratic simplicities, tends to accentuate elite groups in communities, marginalizing women and the spontaneous organizations that are already formed to cope collectively with local problems.

Even with a relatively weak voice exercised by households and communities, significant outcomes have been achieved. It would appear that voice needs to be associated with the retention and use locally of generated resources and that these go to improving the health service and achieving sustained outcomes. Greater emphasis, however, needs to be put on working with existing local organizations and in motivating their participation in the running of services.

While in Africa GROs may provide one way of influencing the provision of health services for the poor in an era of downsizing governments and of an often-distant private sector, they are likely to be more fragmented in other regions (e.g. in South Asia), where the government provider (for basic services) is there, but the service is of such poor quality that it is little used. National NGOs that can cut across social and cultural barriers may be the critical ‘missing’ link to the cohesion needed for local GROs to help run and finance local services, in partnership with local government.

The scope for voice has particularly risen in India at the level of local government. The constitutional amendment (1993) which allows for states in India to revive the institutions of local self-government—panchayati raj institutions (PRIs)—has provided an important opportunity for the community to exert its influence on the performance of government health providers. But it is not government providers alone whose performance may be improved by making them accountable to the village council (gram panchayat), but even rural registered private practitioners.

One of the most important developments in the PRI legislation is the requirement in the constitutional amendment that women should constitute at least one-third of the members of all PRI bodies up to the district level. Experience demonstrates that even though women may initially be only token members of the village council, over time they acquire experience and are able to articulate the real concerns of the village.

There are, however, at least three problems which will continue to limit the possibility of voice mechanisms being used, and also their effectiveness. One is illiteracy—which is as much a problem in Africa as in much of South Asia. Where the poor who need voice most are illiterate, they are more likely to be deceived or used or both. Secondly, top-down organization of health committees in the community tends to perpetuate an elitism, and the rest of the population can tend to feel marginalized by this process. The third problem is the fact, that unlike in much of rural Africa, rural India is much more socially stratified, not merely by landholding (and thus income), but also by caste. Under these
circumstances, the scope for organizing them to raise issues of quality of service delivery in the public sector becomes more contentious, especially when health workers may come from one of the upper-castes. This places a greater responsibility on the potential role of NGOs or local organizations to act as an intermediary voice between those socially and culturally margined and public services.

Conclusions

There are a number of conclusions to make, recognizing in particular that GROs are not as yet significant actors in the development of sustainable basic services. High-achievers have emerged where the State has been a provider of universally available and affordable system of health services, financed out of government revenues, functional at the lowest level, made effective by allocating resources at the lower end of the health system pyramid. The same model is still applicable, but with some key differences. While health service coverage has expanded, the over-extended state, with poor institutional capacity and stagnant financial resources due to macro-economic reforms, is unable to deliver in the same way. While the resource constraint has to be eased, institutional capacity improved and staff shortages addressed, the experience from the high-achievers suggests that in the future ‘voice’ mechanisms, especially solidarity groups of women, will be a significant means of improving service delivery.

The household is paying a lot in accessing health and indeed education services, but is not getting value for money. Already experience exists in sub-Saharan Africa of communities organizing themselves to help run and finance basic health services which strengthen the State’s health system. What has happened has been the matching of available public infrastructure to the availability of resources (albeit meagre) in the household, with the proviso that household contributors can have a say over the running of these services. Significant results have been achieved in the BI in terms of sustained health care availability for the poor, even with a relatively weak voice in the community. This voice has been organized from the top-down, but locally generated resources have been used to improve the quality of services, particularly ensuring the supply of essential drugs.

The possibilities of ‘voice’ have to be exploited to a much greater extent than has been done so far—especially but not only in South Asia. The limit of top-down organization has been seen, and a greater understanding of the existence and make-up of GROs is required, recognizing that the prevailing social, cultural and political conditions existing will have an influence over their organization and ability to assume a ‘voice’ responsibility. NGOs could help to train GROs in ensuring that ‘voice’ becomes increasingly an instrument of improving services, while efforts continue to better target the public health system’s resources and improve its institutional capacity. As local governments increasingly take on the financial leadership of basic services, a greater potential for involving GROs will exist, ensuring that locally generated resources are channelled into improving the quality of services to the expectation of service users.

References


