



# **Report of Consultation on Equity and Health in South-East Asia: Trends, Challenges and Future Strategies**

Thimphu, Bhutan, 23-27 November 1998



World Health Organization

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## Table of Contents

|  |           |
|--|-----------|
| <b>List of Abbreviations</b> .....   | <b>vi</b> |
| <b>Executive Summary</b> .....   | <b>v</b>  |
| <b>Conclusions and Recommendations</b> .....   | <b>iv</b> |
| <b>1. Introduction</b> .....   | <b>1</b>  |
| <b>2. Sessions</b> .....   | <b>2</b>  |
| 2.1 Globalization, the Current Crisis and Impact on Equity .....                                   | 2         |
| 2.2 Defining and Mapping Inequities .....  | 4         |
| 2.3 Community Participation .....  | 5         |
| 2.4 Intersectoral Action .....   | 7         |
| 2.5 Health Sector Reform .....   | 8         |
| 2.6 Public/Private Mix .....   | 9         |
| 2.7 Resource Allocation .....  | 11        |
| <b>3. Group Reports</b> .....  | <b>13</b> |
| <b>3.1 Group 1: Mapping and Monitoring Inequities</b> .....  | <b>13</b> |
| <b>3.2 Group II: Influencing Equity Related Policy</b> .....                                       | <b>15</b> |
| <b>3.3 Group III: Resource Allocation and Utilization with an<br/>    Emphasis on Equity</b> ..... | <b>16</b> |
| <b>3.4 Group IV:</b> .....   | <b>17</b> |
| <b>4. Concluding Session</b> .....   | <b>19</b> |
| <b>Annexes</b>   |           |
| <b>Annex 1 Agenda</b> .....  | <b>20</b> |
| <b>Annex 2 Field Visit to Punakha District</b> .....   | <b>22</b> |
| <b>Annex 3 List of Participants and Observers</b> .....  | <b>23</b> |

## **List of Abbreviations**

|        |  |
|--------|--|
| ANC    | Antenatal care   |
| BRWS   | Bengal Rural Welfare Society                                       |
| CMR    | Childhood mortality rate   |
| GATT   | General Agreement on Tariffs and Trade                             |
| GK     | Gonoshasthaya Kendra   |
| HFA    | Health for All   |
| IMR    | Infant mortality rate  |
| MCH    | Maternal and child health  |
| NC     | Natal care   |
| NGO    | Nongovernmental organization                                       |
| OR     | Operational research   |
| ORS    | Oral rehydration solution  |
| PHC    | Primary health care  |
| PMC    | Perinatal care   |
| PPM    | Public/private mix   |
| SEAR   | South-East Asia Region   |
| SEARO  | South-East Asia Regional Office                                    |
| SIDA   | Swedish International Development Authority                        |
| TRIPS  | Agreement on Trade-Related Aspects of Intellectual Property Rights |
| UNICEF | United Nations Children's Fund                                     |
| WHO    | World Health Organization  |

## Executive Summary

A Consultation was held in Thimphu, Bhutan, on **Equity in Health in South-East Asia: Trends, Challenges and Strategies**, from 23 to 27 November 1998. The consultation was jointly organized by WHO/Headquarters and South-East Asia Regional Office. The consultation was attended by forty participants coming from countries of the South-East Asian Region and some from the Western Pacific Region. The purpose of the consultation was to share the experiences of countries in identifying and mapping inequities, and in designing policy changes to promote equity. The consultation was structured around six themes:

- Globalization and its impact on equity
- Mapping and monitoring inequities
- Inter-sectoral actions to reduce inequities
- Health sector reform
- Public/private mix in health care, and
- Resource allocation.

Each of the themes formed the forum for the presentation of papers by participants and discussions. As a result of these discussions four working groups were formed on:

- Mapping and monitoring inequities
- Influencing policy
- Resource allocation for equity, and
- Good governance for reducing inequities.

The consultation discussed the current economic crisis confronting many of the countries of the Asian region and concluded that while the crisis had its root in the banking sector, the banks themselves were seldom paying the price of their profligate lending while the poor who did not benefit from these lendings were now bearing the burden of the crisis. In addition the poor paid more of their income for health care than the rich. It is important to recognize issues related to equity in health as a human rights issue and health sector reform must be oriented towards an understanding of the causes that lead to systematic patterns of discrimination and devising ways to protect the vulnerable and the poor. The roots of inequities in health lay principally in socio-economic disparities and hence called for holistic approaches which involved other sectors. The recent rapid growth of the private sector has led to questioning the efficiency and effectiveness of the public sector and an insistent call for privatization by development agencies. However, the lack of regulation of the private sector and the absence of adequate social security measures for protecting the poor have led to increasing inequities. The role of governments, and that of the public sector, should be reassessed and strengthened.

The consultation felt that civil society, including appropriate NGOs and community groups, have a key role to play in highlighting growing inequities in health and in promoting policies to reduce them. Equity data banks could provide the necessary impetus towards action and academic institutions could provide the foci for collecting and synthesizing information that uncover disparities in health status and access to health care. WHO has a key role to play and the consultation recommended a set of actions for WHO to undertake. These recommendations are contained in the next section. Primary health care still remains the most useful approach to provide universal health care to all peoples through a sustainable and equitable framework.

## **Conclusions and Recommendations**

WE, the participants in the Consultation on Equity in South and East Asia, having gathered in Thimphu, Bhutan, 23-27 November 1998,

WISH to express our gratitude to the Government of Bhutan and WHO for hosting the consultation and the extensive preparatory work performed,

CONCERNED at the growing poverty in the world and the consequent rise in inequities in health and socioeconomic conditions, and the negative influences of globalization on the plight of the poor,

EXHORT the countries represented in the consultation to pursue their goals of achieving equitable and sustainable health systems,

BELIEVE that WHO must assume a key role in promoting and coordinating social action against inequities in health,

CONCERNED that WHO's role in addressing inequities in health could have been more effective, we are convinced that its leadership and capacity in this area must be significantly strengthened, and it must exert renewed efforts to promote PHC as a key approach to achieve equity in health,

CONVINCED that its leadership in health matters among international agencies associated with socioeconomic development must be renewed and it must establish the necessary partnership with people and communities whose empowerment is essential to achieve equity and social justice,

WE strongly support the new Director-General's initiatives in reforming WHO into an efficient, transparent and influential leading international agency, and urge WHO to take the following actions toward reducing inequity in health:

1. To establish a cabinet project to address problems of inequity in health in all clusters of programmes,
2. To ensure that primary health care is fully supported through a holistic sustainable approach in keeping with local values and resources,
3. To pursue vigorously its collaboration with civil societies in countries as is being done by other international agencies and, to this effect, make significant allocation of its budget to support such organizations at international and country level,
4. To establish partnerships with other relevant international organizations involved with socio-economic development in order to intensify national efforts for health development.

WE further recommend that NGOs and other members of civil society in countries form networks to fulfil the function of health watch in countries. Such networks should also monitor the efforts of WHO in supporting civil societies in their efforts to reduce inequities in health.

## 1. Introduction

The Consultation on Equity and Health in South-East Asia was jointly organized by WHO Headquarters, Geneva, the South-East Asia Regional Office, New Delhi, and the Country Office in Bhutan. The objectives of the consultation were identified as follows:

1. To share regional and country experiences related to the effects of recent economic and social trends on equity in health, including experiences of equity-oriented actions;
2. To clarify concepts of equity and governance in health, including their central role in health sector development;
3. To identify indicators mapping efforts towards equity in health;
4. To determine policy interventions to reduce inequities in health and identify the role of the health sector in such interventions;
5. To recommend processes to ensure the implementation of policies in this direction and to monitor their effects on equity.

The informal consultation drew upon the professional expertise and experiences of a range of individuals from the region, from different disciplines, engaged in areas of health and health policy in varying capacities. These included academics, health policy framers, and representatives from NGOs and health activists. The names and professional affiliations of the invitees are included in Annex 3.

At the inaugural session, Dr U Kan Tun, WHO Representative to Bhutan, outlined the broad contours of the consultation, drawing attention to the idea that fairness and justice lay at the heart of the oath of Hippocrates that all doctors undertook while embarking on their professional lives. This was in fact also reflected in WHO's call for Health for All (HFA). In this context, there were valuable lessons to be drawn from the experiences of Bhutan which, although poor, devotes a significant proportion of its national income on health, underlining issues of both equity and access. Similarly, the drug policy of Bhutan was extraordinary in its commitment to equity in access. At a juncture when resources were being diverted from social services, serious issues arose out of the utilization of public resources that the consultation could reflect upon.

Dr Dev Ray, WHO Headquarters, recalled the efforts of the WHO in setting the agenda for equity in health, leading to the historic call for **Health for All** through **Primary Health Care**. However, since the economic crises of the early eighties, efforts towards the consolidation of HFA had not been entirely successful. This was partly due to the fact that the efforts towards meeting the economic crisis took the form of the rolling back of the state as Keynesian economics came under increasing pressure. Over this period, the gaps between the rich and the poor in the world had increased, as also the sheer size of the population of the poor. This gap at the international level was also reflected at the national level in various countries. These differences, which are both avoidable and unfair, undermine the efforts towards equity in health. Further, they contribute in diverse manners to the increase of social unrest. Thus, even for primarily pragmatic considerations such as the need to avoid social turbulence, there is an urgent need to address issues of equity.

The message from Dr Uton M. Rafei, WHO Regional Director for South-East Asia, similarly emphasized the concerns of WHO with issues of equity. *The World Health Report, 1995*, for instance, exemplified this concern. Health sector reforms, currently underway globally, will have to address issues related to the poor and marginal. The consultation is an effort in this direction, both to review the effects of recent economic reforms and to study the steps that were being initiated to meet the consequences.

The Chief Guest at the Inauguration of the consultation, His Excellency Lyonpo Yeshey Zimba, Chairman of the Planning Commission and Finance Minister, Royal Government of Bhutan, highlighted once again the importance of issues of equity in health care, drawing attention to the efforts made by Bhutan in this direction. For instance, health care in Bhutan was still provided free of charge, even as PHC coverage now included 90 per cent of the population of the country. This had been made possible by the commitment of the Royal Government of Bhutan to the provision of universal and comprehensive PHC towards which 15 per cent of the national budget was allocated. The issue that the government was concerned with is thus not so much that of equity but of sustainability. This was a serious issue on which more reflection and thought would be required.

The consultation was spread over four days of intense discussion following presentations made by the participants and group discussions. Included in the programme of the consultation was a field trip to a Primary Health Unit and a District Health Centre in Bhutan to help ground the discussions that took place. Following a plenary when recommendations of the various groups were presented and discussed, the participants issued a statement highlighting the concerns of the participants at the consultation. The following report provides an overview of the presentations and the issues that arose during the course of the ensuing discussions.

## **2. Sessions**

### **2.1 Globalization, the Current Crisis and Impact on Equity**

The first session of the consultation was entitled “Globalization, the Current Crisis and Impact on Equity”. As an introduction to the themes for discussion, Dr Dev Ray provided an overview of WHO’s efforts in the equity initiative with the support of the SIDA. These included efforts towards generating interest in issues of equity, commencing with three Country Reports, namely those of Lithuania, Sri Lanka and Zimbabwe. There were also efforts towards advocacy of the equity issue in a Rockefeller supported global health initiative commencing with twelve research projects. Over and above these initiatives, a cluster of programmes within WHO is also involved in efforts to propagate and implement policies of equity and to monitor them. Dr Palitha Abeykoon noted the declaration of the Health Ministers of SEAR, drawing attention to issues of equity in health. Indeed this had led to the focus on equity which was evident in the Regional Health Report: Focus on Women, Health and Development, 1998. There was also serious concern about the health implications of the ongoing economic crises in South-East Asia. Above all, he drew attention to the need to evolve partnerships to meet the growing health challenges emerging from these crises. The objectives thus stemmed from a wide area of concerns and were not exclusive in nature.

In his presentation, Dr Aris Ananta, Indonesia, drew historical links between the present crisis engulfing the South-East Asian countries in general and Indonesia in particular, with the Great Depression which brought forth “a modern Malthusian nightmare”. The sufferings that ensued were arguably responsible not only for the toppling of governments, but also the growth of fascism and ultimately the World War, which encompassed vast areas of the globe. There were striking similarities in some of the social consequences today in Indonesia, including widespread fear of a war and the attacks on minorities. The economic scenario is grim with widespread bankruptcy, unemployment, and economic decline with the population at large suffering massive loss of wages and incomes. Nevertheless it should be possible to utilize this conjuncture as an opportunity for outlining an alternative pattern of development with equity at the heart of its concerns. These would include, as a minimum, an overall development strategy which was people-centred, emphasized people’s entitlements to education and health and thus promised “freedom

from fear". The package of economic policies would emphasize domestic markets rather than external ones to provide the impetus for growth, improve the agricultural sector with an emphasis on food production while balancing regional inequities in growth and development. These would require the support of consistent international economic policies which would be "not just growth oriented but people oriented". Essential to such a process was people's access to information and good governance. Outlining a series of economic scenarios for the future, Ananta emphasized that there was no question of recourse to closed, inward-looking models of development.

In a paper entitled "Equity and the Financial Crisis: Malaysia's Experience", Dr Sondi Sararaks, Ministry of Health, Malaysia, outlined Malaysia's experience with health sector development and the efforts towards sustaining and strengthening it in the context of the financial crisis. The government of Malaysia is aware that equity in health is intricately linked with equity in the determinants of health. Towards this end, health has been an integral part of socioeconomic development planning and indeed at the centre of the National Development Policy 1991-2000 which is explicitly committed to "promoting and strengthening national integration by reducing the wide disparities in economic development between states and between urban and rural areas in the country". Since attaining independence Malaysia has achieved widespread improvement in the health scenario in the country with significant declines in the infant mortality rate, the maternal mortality rate and increase in life expectancy at birth. Over the same period, there have also been significant improvements in the outreach of health services and in the humanpower in various categories of staff. However, while the government is a large provider of health care, the private sector is also large and, more importantly, private sector spending in health is very large. There are still marked rural-urban differences in health accessibility and in health indices between regions and between ethnic groups. The economic turmoil in the region engulfed Malaysia in July 1997 with a collapse of the stock market and asset prices. As a consequence, there has been a sharp increase in the prices of imported goods and in domestic prices with a concomitant decline in real household income and real wages. Inflation, wage cuts, loss of jobs and declining purchasing power, with food prices showing a rise, have meant not only adverse consequences for health but also reduced health expenditures. Indeed, the incidence of poverty has risen.

The National Economic Recovery Plan of 22nd July 1998, which focuses on economic recovery, nevertheless explicitly continues the commitment to equity. Policy measures towards this end include increasing budgetary allocations for health, employment generation, poverty alleviation, rural development and infrastructure growth. The direction of health sector development remains to ensure equity in health, with the government stating that "in the realm of public health, PHC will continue to be the thrust, while medical care, essential care and quality of care will not be compromised". A suitable mix of private and public health care service packages is to be evolved to minimize wastage and optimize resource use in the public sector. An important area that needs to be explicitly addressed is the monitoring of the private sector through strengthening the Private Facilities Act.

The discussions drew attention to the fact that there was a need to address the larger macroeconomic roots of the crisis. While the crisis had its roots in the banking sector, the banks themselves were not paying the price for their profligate lending; while the poor who did not benefit from these lending policies were now asked to do so. What is equally clear is that monitoring the health consequences of the crisis is rendered difficult by the lack of systems of sensitive health information. Indeed many countries are perhaps not conscious of the need to establish such systems. This issue then fed into the theme of the second session, "Defining and Mapping Inequities".

## 2.2 Defining and Mapping Inequities

Dr Abbas Bhuiya, in the course of his presentation entitled “Gender and Socio-Economic Inequality in Mortality in Rural Bangladesh”, drew attention to the fact the IMR and other mortality indicators in Bangladesh had shown improvement. Nevertheless there are significant class and gender differentials which are not always evident from national data. While there have been several significant health and poverty alleviation programmes, unless special efforts are made towards targeting these programmes, the differentials will not necessarily be addressed explicitly. He presented the findings of a study on the effects of health and socioeconomic interventions in Matlab District of Bangladesh, which drew attention, in the first instance to establishing sensitive and sustained systems of health information. The findings from the study reveal that while the male/female mortality gap has reduced in the one to four year age group since 1984, there is a persistent differential between the poor and the rich. In the MCH intervention area, the intervention has not been entirely successful in reducing the gender-based mortality differentials. Further, the mortality decline for the poor had been similar in the intervention area and in the control. Similarly, in the poverty alleviation programme area, while the probability of survival improves in the poor households, males have better survival chances than females. Bhuiya concluded that health and poverty alleviation programmes in Bangladesh had not removed gender inequities, although they had indeed been reduced. The presentation thus also drew attention the issue of sensitivity to differentials in health indices and above all the need to map them.

Ms Myrtle Perera also highlighted this issue in her paper entitled “Equity in Health: The Case of Sri Lanka”. The paper emerged from the WHO sponsored study, referred to earlier, and had profound lessons to proffer to health policy planners. Given the remarkable achievements in health in Sri Lanka, despite low levels of per capita income, it had been assumed that issues of equity in health were no longer relevant in the Sri Lankan case. However, this was not necessarily true.

Sri Lanka’s achievements in the health sector stem from two over-riding factors: a historical tradition of welfare and distribution and, two, the distribution of political power so that governments had to be sensitive to people’s demands in the form of macroeconomic policies towards the social sector. The excellent national averages in health indices however hid inequities and disparities, which become particularly marked in the context of the epidemiological transition Sri Lanka is undergoing and the strains the emerging pattern of diseases imposes on the health care system.

Three sets of indicators, viz. health status indicators such as mortality and morbidity data, health care indicators such as humanpower distribution, etc., and health capability indicators such as proportion of persons below the poverty line, proportion literate, etc. were utilized in the study. The results indicate that there are still considerable province-wise variations, reflecting inequities by region. Further mortality indicators tend to be higher among vulnerable groups such as plantation labour and the poor. The data on morbidity especially suffered from severe limitations since they were primarily hospital based. Nevertheless, they reveal the “double burden” of both communicable and noncommunicable diseases among the poorer provinces. These are also reflected in the prevalence of under-nutrition in the provinces. In this scenario, the distribution of health care facilities shows not only the existence of differentials in access to curative services between and within provinces but indeed their widening over the period 1981-1994. In addition to highlighting the continued need for equity in health, the study also drew attention to the need for adequate data to monitor inequities at disaggregated levels, including age, gender and income categories. Finally, the study drew attention to the need for provision of services which contribute

to health capability, i.e., water supply, housing, sanitation, etc., which had been neglected and which can only contribute to health improvement synergistically when provided simultaneously.

Dr Mahmudur Rahman, in a paper entitled “Equity in Health in Bangladesh: Trends, Challenges and Future Strategies”, presented the findings of a study carried out in two rural and two urban settings in Bangladesh. Covering populations in remote and non-remote rural areas and in slum and non-slum urban settings, the study sought to delineate some aspects of inequity in health. The main disadvantages of households in slums and rural areas were reflected in a higher prevalence of morbidity, higher under-five mortality and low access to qualified health care. These reflected differentials in income, housing, literacy and sanitation. Economic hardship was stated to be the reason for lack of access to health care in a significant proportion of households. While the government of Bangladesh recognizes the role of public spending in addressing equity issues, through raising the capacity of the poor, by both increasing social sector allocations and by initiating schemes to mitigate the severity of poverty, efforts will also have to be directed to monitoring the equity effects of such programmes.

A common theme during the ensuing discussion was the repeated observation that the poor proportionately paid more for health services than the rich did. This has been borne out by studies in several countries including India. While this could be interpreted as an ability on the part of the poor to pay for medical costs, this would be an unacceptable way of interpreting these findings. What needs also to be highlighted, at the same time, is that this arises due to the lack of access of public provisioning of health care facilities to the poor. In this context, the National Sample Survey data in India, for instance, indicated that for in-patient services, the poor were almost completely dependent on public services. While issues of the efficiency of these services were no doubt important and had to be addressed, it was equally important to strengthen such services to increase their access to the poor. In this context, Dr A.R. Mendoza, UNICEF Representative at Thimphu, noted that the fiftieth anniversary of both the WHO and the Declaration of Human Rights was an appropriate occasion to recognize issues related to equity in health as a human rights issue. Analysis from a human rights perspective should lead to an understanding of the different levels, and combinations of causes that lead to systematic patterns of discrimination and call for special protection measures for vulnerable groups. The general principle of human rights includes equity and poverty alleviation, one of the goals of health sector reform.

### **2.3 Community Participation**

The third session of the consultation focused on issues of community participation and comprised two presentations from representatives of the NGO sector in Bangladesh and India. Dr Zafrullah Chowdhury shared the experiences from the project of Gonoshasthaya Kendra (GK), one of the leading NGOs in Bangladesh, working in an area of high illiteracy and poverty to provide innovative programmes, marked by efforts at community mobilization. An important driving philosophy guiding community mobilization was the need to de-medicalize health programmes both to reduce costs and to instill self-reliance and pride in local communities. Efforts in this direction also created sorely necessary employment at the grass roots level. The GK project, therefore, relied largely on a cadre of local women trained for six months to a year as community workers. They were thus equipped to deal with the bulk of common health problems and in addition carried out both minor surgeries and tubectomies. They also provided ANC, NC and PNC, in addition to family planning and immunization. In addition the project was involved with imparting skills for income generation including bookbinding, bakery, printing and boiler operation. In a conservative Muslim society, the fact that women were providing public services served as a model for women’s empowerment. The results of the project are evident not only in terms of health

indicators but also the fact that the project is by and large self-sustained as a result of local health insurance, which was pro-poor in orientation. Equity in health could not be achieved without conscious efforts being made in this direction.

Dr Santanu Bhattacharjee shared the experience of the Bengal Rural Welfare Society (BRWS) which emerged out of the commitment of a group of young activists following their involvement in flood relief work in 1978. What started as a charitable clinic soon extended to activities such as non-formal education for women and children with the assistance of local volunteers and the training of village health workers. Although there was initially some local resistance from vested interests, the initiative of the community, in particular the women who were unwilling to forego their classes, led to strengthening of the BRWS but with a new focus involving the empowerment of women to participate in Panchayati Raj elections. Over the years the activities of the BRWS have expanded to include primary health care in the area and the running of a hospital which not only provides curative services at a low cost but also acts as a link in the referral chain. The hospital provides quality medical care at the local market price to urban middle classes and thus earns a surplus which is used to subsidize the medical expenses of the poor. What is significant in this experience is that community participation and the innovative financing mechanisms have meant that the dependence of the NGO on foreign funds has ceased, while at the same time bank loans have been utilized to create assets.

Dr Somsak Chunharas pointed out that it is important to be aware of why community mobilization is not the necessary avenue to equity in health, even as he underlined the importance of being clear about what we mean by a community. Community mobilization is not necessarily for mobilization of resources for self-help, nor is it for assisting health personnel or disseminating health messages. Different actors have different perspectives and all too often the community itself is forgotten. Community involvement is however essential in health programmes in order to establish priorities, identify the needy and in monitoring and feed back. It is crucial to involve the "right community" in order to create enabling institutions or processes for capacity building and continuous support. In order to achieve this, state financial support is essential.

During the ensuing discussion, a number of issues were highlighted including the role of NGOs and professionals in the health sector. While the dangers of medicalization were appreciated, there was equal concern with bureaucratization of health services. There was concern too about the roles of the private and NGO sector vis-a-vis the public. While a great deal of discussion ensued, there was ultimately consensus that the NGO sector could only complement and not supplant the public sector in health care. Indeed there was concern that the relatively easy flow of funds into the NGO sector without sufficient accountability may introduce distortions. Another issue, which merited further discussion, was the role and sustainability of health insurance schemes. A question that was raised but was not adequately addressed was related to the equity effects of health insurance in low-income countries.

## **2.4 Intersectoral Action**

In the session devoted to intersectoral action for equity with a particular reference to education, Dr Arie Rotem pointed out that there was a need to adopt a holistic systems approach to health, visualizing health as an outcome of the complex interaction between a number of systems. This should obviously include a clear understanding of what development means and how it is meant to be achieved, keeping in mind the limitations of an approach which focuses on economic growth alone believing that the "trickle down" of economic growth would automatically solve problems of poverty and lack of access to resources. This is particularly the case in the current

context of economic reforms. While it is important for communities to benefit from globalization, it is equally important that the processes unleashed do not overwhelm them. A society must arrive at a consensus on the minimum standard of life to be available to all her citizens and this must include minimum levels of health and education. Education is a valuable tool for social enhancement of communities but suffers from the same problems of neglect and inequities as health, including inequities of region, gender and social class. The potential benefits of providing universal access to health and education will by far outweigh the current costs of investment in these sectors. In this context, Rotem drew attention to the crucial need to provide affirmative action for disadvantaged groups as in Australia, which offers a fee waiver even as students acquire tax liabilities for the future.

In a presentation entitled "Inter-Sectoral Approach: The Case of Sri Lanka", Dr Saroj Jayasinghe developed upon some of the issues highlighted earlier by Perera. In drawing attention to the macro-policies pursued in Sri Lanka, which led to the health situation it boasts of today, Jayasinghe drew attention to poverty alleviation programmes, food security, education, housing, water and sanitation noting the persistence of inequities in all these areas across provinces that underlay the health differentials. Further inequities in the distribution and access to these determinants of health appear to be increasing. He particularly drew attention to the role of the private sector in health care, which increases inequities in access. Above all, attention was drawn to the possible role of WHO, which must be reflected upon. These include initiatives toward reduction of national debts of developing countries, and rethinking the package of reforms under the structural adjustment programme. WHO also needs to give greater attention than it has hitherto to the inequity effects of continuing economic sanctions against some countries.

Mrs Mardiati Najib, in a paper entitled "Equity in Health: Trends, Challenges and Future Strategies - The Indonesian Experience", noted that although Indonesia had made significant advances in health over the last three decades, there were persistent differentials in health indicators across regions and between rural and urban areas within these. What was more significant is that resource allocation had also been iniquitous with richer provinces obtaining a higher share of central grants than the poorer ones. These had perhaps been accentuated by differentials in access to both education and insurance coverage. Even before the crisis, there were 22 million poor in urban areas and 56 million in rural areas, but there had been a dramatic increase since the economic crisis. This had increased differentials in access since less than 10 per cent of the poor were covered by health insurance. As a consequence there had been an increase in self-treatment and reduced use of health services among the poor. The government had responded with a range of measures such as free health cards to guarantee basic health services to pregnant women, infants, children and the old, efforts to improve primary health care infrastructure, etc., as part of a health social safety net programme. The outcome of these efforts are thus to be studied.

Dr Mohan Rao discussed the links between education and health, drawing attention to the need to approach complexities in health more holistically. Education is usually looked at instrumentally and not in its own right, as a means to improve health or reduce fertility. Thus, Kerala seemed to offer a model emphasizing literacy in general and female literacy in particular as critical to achieving these goals. However, Tamil Nadu, which is now undergoing a demographic transition, is doing so despite relatively low levels of female literacy. Does this imply then that literacy is no more important? What this indicated is to look beyond this or that particular factor to the structures, which determined health outcomes, drawing attention to such factors as employment, conditions of work and food security. During the discussions that ensued several factors came to the fore which called for further discussion such as externalities associated with different models of

development, the relevance of extant models of education, the role of the private sector in both education and in health care, and above all the question of political will. There appeared to be consensus that more research data is called for on the role of the private sector in both increasing costs in health care and in reducing equity in access. While these issues were no doubt important, Mukhopadhyay felt they still did not address fundamental issues of the structures of poverty such as land reforms and minimum wages, if sustained improvements in health are the desired outcome. In the absence of these fundamental changes, health sector reforms face structural barriers beyond a certain point when they cease paying dividends.

## **2.5 Health Sector Reform**

In the session on “Health Sector Reform”, Dr Samir Guha Roy in a paper entitled “Health Sector Reforms in India: The Issue of Equity”, noted that the economic reforms initiated in India had increased poverty levels in the country even as there were real cutbacks in health sector spending. This apparent decline in public sector provision is accompanied by demands for high technology based health care stemming from privileged urban groups. Data however indicate the continued reliance on publicly funded health services among the lower socioeconomic groups, who have also been hit by the reduction in food subsidies. In this context, efforts towards increasing privatization of health services, as is implied by the World Bank recommendations for health, equally implies a lack of concern for the vast numbers of poor in the country heavily dependent on publicly provided curative services. Indeed preliminary data indicate that a fast expanding private sector has negative consequences for access and utilization of health services among vulnerable groups although this needs further substantiation.

In a paper entitled “The Case for State Intervention in Health Care: A Note”, Dr Mohan Rao analyzed the historical literature on the decline of mortality in both the developed and developing countries. While the case for state intervention which led to structural changes in the determinants of health in the former were appreciated, in the case of the latter, however, the decline of the death rate had been attributed incorrectly to advances in public health technology. It was in view of the limitations of such an approach to public health that the WHO-UNICEF Initiative of Health for All through Primary Health Care had been arrived at. Briefly tracing the shifts in emphasis that had led to the relative neglect of this approach, Rao emphasized that historical data even from the developing countries showed the critical importance of the state in both creating the conditions for health and in health systems that responded to these in a comprehensive manner. There could be no magic-bullet approach to public health that could have sustained positive health outcomes.

Dr Amardeep Thind, in a paper entitled “Managed Care in Developing Countries: What are the Equity Considerations?”, noted that the lessons and experiences of managed care came from the private market, and primarily from the developed countries. Indeed managed care and managed competition had risen in these countries in an attempt to ameliorate market failures in these countries. The experience of managed care and managed competition in Latin American and Caribbean countries indicated that the poor in these regions were systematically excluded from these sectors and are thus forced to rely on out-of-pocket payments when they need care, or indeed receive care from public sector providers. Thus, unless special efforts are made to facilitate the entry of poor into the system, managed care per se will remain inherently non-equitable with regard to access. Its implementation in developing countries would therefore require careful thought and analyses; bearing in mind that managed care is not a panacea.

During the discussions, it was pointed out that it is precisely because health constitutes a good to which monetary value cannot be attached and because of the issues of market failure and externalities, that solutions from the medical care sector cannot be generalized to public health care problems. The market does not offer solutions to the problems of preventive and promotive health care, which lies at the heart of the problems of disease, deprivation and death in poor countries. Moreover, there was a relative dearth of data on the private sector in health care in developing countries. In view of this, it is not always legitimate to make the assertion that the public sector was inefficient and that the private was axiomatically efficient. Reforms that were based on this assumption were thus questionable. Many of the issues identified during the course of the discussion in this session thus ran into the themes of the following discussion areas:

## **2.6 Public/Private Mix**

The sixth working session of the consultation was devoted to the theme, "Public/Private Mix" (PPM). The first presentation in this session related to issues of equity in the health sector in Nepal. In his presentation, Dr B.G. Vaidya provided an overview of health and socioeconomic development in Nepal, drawing attention to regional and rural-urban differentials in both. The western and the mountainous districts are worse off in all aspects of development: health, literacy, income, etc. The Government of Nepal has attempted to deal with these problems by increasing infrastructure, providing more resources for health and social services and by encouraging NGOs and the private sector. At the same time efforts have also been directed towards the integration of health with non-health inputs such as poverty alleviation programmes. However, the experience of Nepal indicates that a more rational allocation in terms of a PPM is not feasible for the rural areas of Nepal since the private sector is largely concentrated in urban areas and is profit oriented. The large mass of rural populations does not permit of a market for the private sector in health care. What is now being thought of is a PPM for urban areas with a reallocation of funds from the public sector in urban areas to the rural along with increasing the scope for community based organizations and NGOs.

Dr Yong-Ik Kim, in his presentation: "Public/Private Mix: The Case of Korea", highlighted the importance of political structures which determined the direction and content of the health services structure. He argued that under protracted military rule, state driven capitalism in Korea had sacrificed social welfare and health even as the national economy had grown by leaps and bounds. Inequities were not studied while the private sector in health had been growing untrammelled. Thus, today 85 per cent of beds are in the private sector which is profit maximizing rather than output maximizing. The economic crisis currently enveloping the Korean economy, along with a return to civilian rule, have now brought issues of equity into focus. Korea has plural medical insurance societies: at public expense insurance was extended to big private companies while the majority of the population were uncovered. Although rural areas also came under the ambit of insurance, the benefits are still incomplete and many services are not included in the umbrella of insurance benefits. Thus out-of-pocket payment still constitutes 60 per cent of the total expenditure for inpatient care. As a result of the domination of the unregulated private sector, medical costs are high and for-profit, high technology based hospitals have grown. Health reforms since 1998 have initiated moves for restructuring health insurance benefits while establishing a new national body for insurance claims review. These moves are long called for but the economic crisis has also worsened inequities in health, which need to be addressed.

Dr Shambu Acharya, in his presentation, briefly traced the evolution of the concept of PPM. He observed that while the private sector of a vast array, and thus internally much differentiated had a long historical presence, it was only in the Keynesian post-Second World War phase that the state

stepped in to play an active role in health care provision. Towards the eighties, with costs of medical care increasing and states increasingly under financial strain, there was a spurt in the growth of the private sector as it was increasingly felt that the public sector was inefficient. Although WHO advised caution, international development agencies were increasingly in favour of privatization. However, these agencies soon realized that privatization carried out without putting into place instruments for the social security of the poor and for regulation of the private sector, had led to increasing inequities. It was at this point in the early nineties that the World Bank conceptualized the idea of an optimum private/public mix with the public sector providing basic health care services along with public goods such as water supply and sanitation, basic nutrition and basic education while the private sector provided secondary and tertiary care. There are still certain unresolved issues such as appropriate regulatory and monitoring mechanisms and the balance governments must strike between provision, monitoring and regulation.

In his intervention, Dr Shin pointed out that on balance the experience of various countries were not conclusive. On the one hand, Nepal has apparently realized the need to strengthen the private sector while Korea, on the other hand, has revealed the need for the opposite. The lesson appeared to be that weak governments in the region had hastened with privatization following the advice of the World Bank while not setting into process mechanisms to cope with the fall-out. Thus, commercial, high technology, health care was introduced into these countries, worsening pre-existing inequities in health. Globalization had the consequence of introducing an American model of health care into developing countries. The crisis in health care was compounded by the lack of leadership on the part of WHO at this critical juncture.

A number of issues came in for scrutiny during the course of the discussion including what was perceived as WHO's role in relinquishing its leadership in health to institutions not technically capacitated to deal with the entire complexities of health issues during the period of the eighties and nineties. There was disquiet too about the onslaught of privatization in this period with the State abdicating its commitments to the provision of comprehensive health care. There was unanimity both for scrutinizing the performance of the private sector and for instituting mechanisms to both monitor and regulate the private sector while the governments must be urged to shoulder commitments to PHC. It was pointed out that while the public sector no doubt suffered inefficiencies, there was no evidence that the private sector did not; in the absence of operational research (OR) studies, it was difficult to optimize resources while considering an optimum mix of these sectors. Indeed, undue haste in policy formulation was equally socially wasteful, especially when not contextualized in the disease and mortality profiles of countries.

## **2.7 Resource Allocation**

In the session on "Resource Allocation", Dr Shin, tracing the evolution and growth of the health care system in Korea, noted that there was a lag between economic and health development which could be explained by the relatively low priority placed on health both within and without the government. While economic development had been given utmost importance and highest priority in resource allocation, till recently the importance of health and other aspects of quality of life were neglected. As in other developing countries, Korea faces shortages of all three components of medical resources and the lack of planning to maximize the productivity of the available resources. Although the government has initiated a number of programmes to reorient health care resource use, it has been neither easy nor effective, partly because of the complexity of problems and more importantly because of the absolute dominance of the private sector. The reorientation of the national health systems infrastructure has to progress in three ways: development of appropriate human resources and their relevant distribution; development of health facilities, focused on quality

and distribution; and, finally, new health programmes to encompass comprehensive needs of promotive, preventive and rehabilitative care. Ultimately the responsibility lies on the government to provide a high priority to health in order to build a more equitable, more efficient and better quality health care system.

Dr Tennakoon in his presentation, "Resource Allocation in Sri Lanka", drew attention to the maldistribution of both human resources and medical supplies in Sri Lanka. These are manifested in the differentials in the availability of specialized care by province and by rural-urban areas, which are widening. There is also the related issue of overutilization of tertiary care accompanied by an underutilization of primary care services, along with a culture of medicalization. Both human resources and medical technology are thus unequally distributed, calling for effective policies to overcome these trends. The government's efforts in this direction must be supplemented with policies to study and monitor the private sector, which has contributed to the skewed distribution of resources.

In his presentation "Inequities in Resource Allocation in Myanmar", Mr U Aung Kyaing provided an overview of health care provision in Myanmar, drawing attention to differentials in health and in some of its determinants. Thus, there are significant differentials in life expectancy, IMR, CMR, education, water supply, availability of health facilities and their utilization by region and by rural-urban areas and gender. Further data on both outpatient and in-patient care point to their high costs, necessitating very high out-of-pocket expenditure. The government has initiated steps towards strategies to reduce these inequities by modifying resource allocation to focus on border areas and areas hitherto marginalized while making special arrangements for the needs of the poorest of the poor in terms of exemption from expense mechanisms and special efforts although there is still a long way to go in this regard.

Mr Faruque Ahmed, The World Bank, Dhaka, in his presentation entitled "Health Sector Reforms in Bangladesh", drew attention to the achievements in the health sector in Bangladesh which included the establishment of a health infrastructure and reductions in IMR and in fertility. A particular feature of Bangladesh had been the tremendous partnership between the government and the NGO sector. Although health sector allocations had increased, the nutritional situation was alarming and there is still the issue of high levels of maternal mortality and child mortality to be addressed. There is a profound need to improve both efficiency and effectiveness in the health sector. The main elements of the health structure reforms currently underway include the essential service package towards strengthening the infrastructure and sector-wide reforms to improve public sector efficiency. Emphasis was also being placed on behaviour change communication strategies.

During the ensuing discussion, it was noted that health sector reform currently underway in all countries in the region had attracted increasing health expenditures in many countries including Bangladesh, Korea, Malaysia and Thailand. India, on the other hand, stood out as a country where health expenditures had not increased. While the increase in health expenditures were welcome they were still not commensurate with the tasks at hand. Nor was the utilization of these resources based on epidemiological considerations. In all countries in the region there was thus a profound mismatch between health needs and health resources, which took varying forms and needed to be addressed. Attention was repeatedly drawn to the need to increase the effectiveness of current resource use. In this context, equally, attention was drawn to the distortions in resource utilization introduced by the private sector in health care while increasing health care costs and inequities.

### **3. Group Reports**

Following the working sessions above which outlined the areas of concern and provided a forum for exchange of ideas, the participants at the consultation broke up into groups for discussion. It was envisaged that these group discussions would provide an opportunity for more focused discussions on specific themes with the foregoing discussions having formed a backdrop. The following themes were identified for group discussion:

1. Group I: Mapping and monitoring inequities
2. Group II: Influencing equity related policies
3. Group III: Resource allocation and utilization with an emphasis on equity
4. Group IV: Good governance and reducing inequities in health.

What follows is a summary of the presentations made of the group discussions.

#### **3.1 Group I: Mapping and Monitoring Inequities**

After intensive discussion, the group agreed that in order to map and monitor equity in health, it is essential to identify appropriate sets of indicators. Since it is not desirable to have a single indicator, the following clusters of indicators were considered critical:

1. Health status indicators such as mortality, morbidity, nutritional status and, indeed, indicators of the quality of life.
2. Indicators related to health determinants such as the availability of water supply, sanitation, elementary education, public distribution systems, etc.
3. Indicators pertaining to issues of availability of health care including the distribution of financial and human power resources.
4. Indicators pertaining to issues of access to health care and utilization.

It is necessary but not sufficient to obtain these indicators at a national level in order to map inequities. It is thus essential to disaggregate the data at various levels by

- a) Region;
- b) Population characteristics such as age, sex, caste or ethnic groups, education, household income, with a special focus on minority groups;
- c) Since the purpose is to map not only inequities in health but also in their determinants, it is necessary to map the data on the proximate determinants of health. These include: food, sanitation, drinking water, living conditions and health resources.

These data requirements thus indicate the need to involve all actors, the government, institutions of civil society and the community. In addition to population based quantitative data, it is also essential to obtain qualitative data. In all cases, available data should first be mobilized and reviewed for accuracy, reliability and validity. Following the review, special studies may be undertaken including community surveys, rapid assessment methods, etc. In the case of utilization data, it is essential to complement facility based data with community based studies. Above all, there is an urgent need to build a data base on equity.

Towards the above aims, it is essential to involve and sensitize all institutions, public, private, NGOs and activist or advocacy groups. Having created awareness of the need for data on equity, individuals and institutions must undertake the responsibility of monitoring both the method and the process of data collection. A well-informed community is a *sine qua non* to this process.

The resources required would not be prohibitive since substantial amounts of both financial and human resources are already being invested towards obtaining a vast body of data in most countries. It would indeed call for some additional resources of trained workforce and finances and equipment towards building data banks at appropriate levels, but these are unlikely to be forbidding. The group strongly felt that leadership and support towards this end be provided by WHO which could also assist these aims by creating a web site on equity.

In addition to creating the equity data bank, efforts should also be made towards the dissemination of relevant information pertaining to equity in health and its determinants. This information should include the tools used, the methods of measurements, and the results of mapping. This information should be shared not only with different levels within the health sector, but also with other sectors in the country at all levels. The data should also be shared with other countries both within the region and outside. Above all, it is essential that there is two-way communication between the organization or institution collating the data and the community.

The process of mapping and monitoring inequities in health commences with identifying persons and institutions within countries to undertake the responsibility. The necessary resource support will have to be sourced and guaranteed. The team of institutions/persons then commences the process including the review of literature, the selection of appropriate indicators, the initiation of training, the collection of necessary data, their scrutiny for reliability and validity, their mapping and their dissemination. The entire process should be continuously reviewed and refined. The system, thus established, should be integrated with the health system to generate a continuous flow of relevant and sensitive data which should be freely available and accessible at various levels, both to professionals and policy makers and to lay persons.

WHO has a critical role to play in this respect. The support that WHO must provide is in the following areas:

1. Coordination of equity efforts for mapping and monitoring between countries;
2. Networking and linking of efforts between countries and across regions through the website and by facilitating sharing of experiences;
3. Providing resource support, including financial resources, technical and logistical support;
4. Ensuring continuous monitoring of country efforts at equity mapping and monitoring;
5. Support research on mapping and monitoring of equity in health within countries and between countries.

The discussions threw up certain critical issues for further consideration. The first was whether or not to have an independent group at the national level for mapping and monitoring inequities in health; it was felt by some that perhaps it would be desirable to have this group within the health systems of countries rather than as an independent group. It was also felt that the intersectoral nature of health may present some problems in both constituting this group and in obtaining the necessary data as sectors outside that of health may not appreciate these efforts being made by the health sector thus compromising on the extent of cooperation proffered towards these efforts.

The third issue that merits further discussion is whether it is necessary to have country specific indicators or whether common generic indicators would be sufficient. Finally, the issue of cross-country capabilities for generating reliable and valid data needs to be addressed.

### **3.2 Group II: Influencing Equity Related Policy**

This group, recognizing variabilities in human populations, nevertheless felt that there is a need to define and strive for equity in health. The overarching goal is, in the first instance, to reduce the growing gaps in health status associated with major discrepancies in access to resources in order to ensure equality of opportunity. Equity in health is a basic human right and an essential component of social development. Thus, both as an ideal in itself and for pragmatic considerations such as the evident links between well-being, productivity and social well-being, equity is a desirable goal.

This message and goal needs to be explicitly restated with evidence concerning the magnitude of the problem and its consequences, including the sustainability of social and economic development. These need to be backed with explicit commitment and disseminated widely focusing on public policy and action towards reducing gaps in health and in relevant sectors.

Towards this end, it is essential to recognize who policy makers are and what information they respond to. It is equally important to recognize the limitations under which policy is made, including competing priorities, powerful interest groups, conflicting community pressures and so on. Thus, the message of equity must be phrased in a language that is accessible to policy makers, bureaucracies and to lay people.

In order to set the agenda for equity, it is essential to gather and disseminate data on inequities and their consequences to as wide an audience as possible, utilizing all available channels of communication. This should highlight the links between economic development and health, mapping gaps which it is necessary to fill. The purpose of this exercise is to promote discussion and debate to arrive at a consensus by strengthening democratic processes. It is on the basis of this consensus that progress can be made in this endeavour.

In order to make the agenda for equity in health workable, it is necessary to strengthen health institutions and systems within countries to set priorities, targets and operational guidelines. All developmental projects and programmes must carry with them statements on their impact on equity along with an assessment of their contribution to reduction of equity gaps.

Towards this end, it is essential to evolve partnerships within countries and internationally to ensure equity issues gain the highest priority on all developmental agendas. It is thus essential to mobilize communities to generate and sustain pressure towards equity.

The current economic crisis may be utilized as an opportunity for restating and influencing policies towards the urgency of addressing the need for reducing growing inequities. It is thus necessary to mobilize additional resources for the vulnerable, focusing on comprehensive and essential health care, food security, universal literacy, etc. Efforts should be made towards achieving these goals by mandating equity through legislation.

Recognizing that WHO is undergoing major reform, it is imperative that the new structures that are evolved will reflect the growing concern with issues of equity as a priority in its agenda. It is thus essential for WHO to restore its leadership role in advocating and coordinating necessary strategies to reduce health inequities.

The PHC approach remains, in our view, the most appropriate conceptual and operational framework to address inequity and to ensure that essential services and support are provided through a holistic and sustainable framework, in keeping with local values and resources. It is imperative that the PHC approach must not be eclipsed in the agenda of health.

The group endorsed the following message: WHO should draw urgent attention to the deterioration of health status, and indeed health emergencies, associated with growing gaps in the health status of populations and in access to health institutions, as a consequence of the current global economic crisis. This crisis was accentuated by weak leadership and poor governance. WHO should call for and propose steps to provide universal and comprehensive health care and safety nets, seeking partnerships with governments, international agencies and civil society for urgent and coordinated action.

### **3.3 Group III: Resource Allocation and Utilization with an Emphasis on Equity**

The discussions in this group were structured along the following themes:

1. Mapping equity in resource allocation;
2. Studying current resource allocation mechanisms;
3. Formulating an “ideal” targeting mechanism;
4. Role of governments;
5. Role of institutions of civil society;
6. Role of WHO.

Equity in resource allocation is based on the principle of equalizing the needs of different groups within the population. This can be studied at various levels: the allocation of national or central resources to health and other sectors of the economy; the distribution of allocations within the sector of health; and finally, the resources that ultimately reach the targeted groups in the population.

It was noted that there are widely varying patterns of resource allocation among the countries. In Thailand, for instance, equity in resource allocation has not been explicitly addressed except for rural versus urban allocations. Within the rural sector, there is no distinction made between the differential needs of the poor. There is currently a move towards devolution to lower levels with a shift to a province as the unit of allocation.

In India, there are two levels of resource allocation: at the Centre and at the State level. There is an explicit concern for certain disadvantaged areas such as hilly and tribal areas but nevertheless there is an urban bias to resource allocation. The current moves towards decentralization offer a rich opportunity towards devolution of resources and power of decision making in this regard. Again, in Myanmar, there are different levels of allocation: central and

divisional with a focus on marginal areas hitherto underserved. In Korea, resource allocation was largely left to market forces with the role of the government restricted to providing subsidies for hospitals in selected areas and for subsidized insurance premiums for the self-employed and unemployed. In Bhutan, on the other hand, the government is entirely responsible for health resource allocation with the district as the unit for assessment of needs. There is an explicit commitment to equitable distribution which is population based.

In targeting resources for equity, it is desirable that the units, either geographic or administrative, be country specific. It is nevertheless necessary to identify the needs of vulnerable groups identified on the basis of demographic and socioeconomic characteristics, in addition to health status. This should be followed by systematic assessment of the actual coverage of such populations to determine the match between felt needs and assessed needs. In this context, concern was expressed regarding the availability of sensitive, reliable and usable data. Questions also arose regarding the mechanisms for translation of research into policy and the role of communities in assessing needs.

There are various options of resource allocation for governments: public finance for public delivery, public finance for private delivery, private finance for public delivery and private finance for private delivery. In choosing the system for equity, it is essential to focus, in addition to efficiency and quality, on issues of access to the poor. Further, bearing in mind externalities, it is necessary to find a balance in the price. An area of concern relates to the assumption that markets are necessarily more efficient in resource allocation in health than governments. The exact mix of various services at different levels may vary between sectors but there is nevertheless a need to monitor quality, efficacy and outreach of services.

The institutions of civil society have a role in mapping and monitoring inequities in health and in mobilizing public opinion both at the grassroots and at policy making levels. Further, institutions of civil society have a significant role to play in continuous monitoring and feed back of information on inequities to policy makers. In this context, NGOs have a significant role to play although it needs to be explicitly recognized that they can complement and strengthen, but not supplant public efforts towards equity.

WHO has a singular leadership role to play in this context, both for explicitly enunciating and supporting policies towards equity. Further, WHO must take the leadership role in research, monitoring and evaluation. It must identify and mobilize resources towards these efforts. WHO's role in mobilizing public opinion and in influencing the equity policies of other international agencies is often underestimated. In this context, it must examine the health equity implications of new international treaties such as GATT and TRIPS. A question that was left unresolved was the role of WHO in working with agencies of civil society.

### **3.4 Group IV: Good Governance and Reducing Inequities in Health**

The group was of the opinion that good governance was a necessary but not sufficient condition for sustainable reductions in inequities in health. Good governance is characterized by accountability, transparency, security for citizens, lack of corruption and nepotism, far-sighted leadership and targets marginalized groups for support. It is also people-centred, participatory and pro-women. It is, above all, a system that moves towards reducing inequity in health and health care.

There were some positive experiences from the region, which should be taken note of. These include, in Bhutan, the participation of districts and villages in developing health facilities and, in Nepal, a successful community forestry programme. Bangladesh could take credit for the innovative use of ORS and Sri Lanka for successful community participation in immunization programmes. In India, steps towards decentralization by strengthening Panchayat Raj institutions were equally significant while Thailand had a successful scheme for rural doctors. It was indeed the failure of the leadership to nurture such programmes that has contributed to the current crisis in Indonesia. These were examples of initiatives that could strengthen good governance if systematized.

The mechanisms to improve good governance in the health sector include setting norms for good governance and disseminating them to all levels. Simultaneously, instruments to monitor and evaluate them need to be established within the institutions of civil society. Towards this end, institutions and professional groups should disseminate information about policies and targets and thus establish channels for continuous feedback of information. It may be desirable for organizations of civil society to formulate charters of health audits.

It is thus necessary to empower people at the lowest level so that civic groups perform a watch dog function. This will also ensure that they influence the political leadership at all levels to ensure good governance. The civic organizations may be supported with finance and technical advice in order to perform social audit of the health institutions.

WHO may create cabinet-level projects to focus on civic organizations with the requisite financial support. In addition to providing leadership, WHO has a critical role to play in research and advocacy.

#### **4. Concluding Session**

A brief closing ceremony followed the presentation of the group reports and the adoption of the resolution. Dr Kan Tun, WHO Representative, Thimphu, expressed his happiness with the outcome of the consultation and his gratitude to the Government of Bhutan for all the support and hospitality provided. The tasks outlined for the consultation, he noted, were forbidding and if it had succeeded in even some of the goals, it would have been far more than could have been hoped for. WHO is involved in a partnership for a better future for all the citizens of the world and towards that end, health and equity were fundamental issues. He was confident that WHO would fulfil the expectations of all the participants of the consultations and indeed the people of the world who looked upon WHO to provide leadership in marching towards a better world of health for all.

Dr Dev Ray, WHO Headquarters, expressed his thanks to WHO, Bhutan, WHO SEARO, and above all, to the People and Government of Bhutan for making the consultation a success. He outlined a series of action outcomes, including research, advocacy and partnerships that WHO may envisage towards working on issues of equity in health. Towards this end, the consultation had been a first step and it had importantly indicated a widespread sharing of WHO's concern for equity in health.

In his concluding remarks, Dr Sangay Thinley, Director, Health Services Division, Royal Government of Bhutan, characterized the consultation as a milestone in the history of addressing the issue of equity in health. He was deeply gratified that in this era of privatization, marketization and globalization, ideas such as equity, of central concern to the Royal Government of Bhutan, should find space on the agenda for discussion. The statement of concern emanating from the consultation would cement commitments towards working for equity in health and would thus be extremely significant for all the people of the world who looked towards WHO to provide the leadership to attain Health for All through Primary Health Care.

**Consultation on Equity in Health in South-East Asia: Trends, Challenges and Strategies,  
Bhutan, 23-27 November 1998**

**Agenda**

Day 1, Monday, 23 November 1998

Morning

**Opening**

09:30 AM

- Arrival of Chief Guest
- Traditional (Marchang) Opening Ceremony
- Opening remarks by Dr Kan Tun,  
WHO Representative to Bhutan
- Message from WHO Headquarters by  
Dr Dev Ray from WHO Headquarters
- Message from  
Dr Uton Muchtar Rafei  
WHO Regional Director for South-East Asia  
Read by Dr Kan Tun, WHO Representative
- Address by the Chief Guest, His Excellency  
Lyonpo Yeshey Zimba, Chairman of  
Planning Commission & Minister of Finance

Coffee/tea break

Overview of the equity initiative & related  
SEARO activities  
Method of Work and Expected Results

Palitha Abeykoon, Dev Ray

Theme: Globalization, the current crisis  
and impact on equity

Moderator: Prof. Arie Rotem  
Presenters: A. Ananta, S. Sararak  
Discussant: Yong-Ik Kim

Afternoon

Theme: Defining and mapping inequities

Moderator: Dr Pem Namgayal  
Presenters: A. Bhuiya, M. Perera  
F.M. Rahman, S. Guha Roy, Mendoza  
Discussant: Dr Suwit Wibulpolpraserti

Theme: Community mobilization

Moderator:  
Presenter: Zafrullah Chowdhury,  
Santanu Bhattacharjee  
Discussant: Dr Somsak Chunharas

Day 2, Tuesday, 24 November 1998

Morning

Theme: Inter-sectoral action; involving  
educational institutions, etc

Moderator: Prof. Saroj Jayasinghe  
Presenters: A. Rotem, S. Jayasinghe,  
M. Najib, Mardiati  
Discussant: Prof Mohan Rao

Theme: Health sector reform

Moderator: Dr Myrtle Perrera  
Presenters: S.G. Roy, M. Rao, A. Thind  
SEARO invitees  
Discussant: Dr H.S.B Tennakoon

Afternoon

Theme: Public/private mix

Moderator: Dr Somsak Chunharas  
Presenters: B.G. Vaidya, Y. Ik-Kim,  
S. Acharya  
Discussant: Dr Youngsoo Shin

Theme: Resource allocation

Moderator: Dr Mathai  
Presenters: Y. Shin, H.S.B. Tennakoon  
A. Kyaing, F. Ahmed  
Discussant: Dr Prakash Aryal

Day 3, Wednesday, 25 November 1998

Group Work

4 groups working independently for 1 day

Group themes:

- Mapping and monitoring inequities
- Influencing policy
- Resource allocation for equity
- Good governance for reducing inequities

Day 4, Thursday, 26 November 1998

**Field trip**

Field trip to Punakha District  
– Thin lay gang  
Basic Health Unit and Punakha District  
Hospital (see Annex 2)

Day 5, Friday, 27 November 1998

Morning

Presentation of group reports

Closing Session:

Dr Kan Tun  
Dr Dev Ray  
Dr Sanjay, Director-General of Health, Bhutan

Afternoon

Visit to Institute of Traditional Medicine Hospital and the Dzong.

**Field Visit to Punakha District on Thursday, 26 November 1998**

**Objectives:**

1. To observe the organization of health services in a district at the basic health unit and district hospital levels.
2. To study the health-related equity issues and some of the strategies that have been adopted at the district level.

**Programme:**

|          |   |   |
|----------|---|---|
| 07:30 AM | - | Departure from the Hotels   |
| 08:30 AM | - | Arrival at Dochula Pass (refreshment)   |
| 09:00 AM | - | Start from Dochula Pass   |
| 10:30 AM | - | Arrival at Thinlaygang Basic Health Unit (BHU)<br>- presentation of BHU activities by Health Assistant (HA)<br>- light refreshment<br>- BHU visit |
| 11:30 AM | - | Start from Thinlaygang  |
| 12:30 PM | - | Arrival at Hotel Zangthapelri for lunch   |
| 02:00 PM | - | Visit Punakha Dzong   |
| 03:00 PM | - | Visit Punakha District Hospital<br>- presentation of hospital activities by DMO<br>- light refreshment<br>- hospital visit                        |
| 04:00 PM | - | Return journey to Thimphu   |

**Consultation on Equity in Health in South-East Asia: Trends, Challenges and Strategies,  
Bhutan, 23-27 November 1998**

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Ms **Mendoza**, UNICEF Representative, Thimphu, Bhutan

\* \* \* \* \*

Dear Mr. [Name],

I have received your letter of the 15th and am sorry that I cannot give you a more definite answer at this time.

The matter is being reviewed and I will be in touch with you again as soon as a final decision has been reached.

I am sure that you will understand the need for a thorough review of all the details involved.

Thank you very much for your patience and understanding.

Sincerely,  
[Name]

Enclosed for you are the documents mentioned in your letter.

If you have any further questions, please do not hesitate to contact me.

Very truly yours,  
[Name]

cc: [Name]

[Name]



11/11