CI-ROAF REGION RESEARCH ON:

THE IMPACT OF ECONOMIC LIBERALIZATION ON HEALTH SECTOR REFORM IN *BENIN, KENYA, MALAWI, MOZAMBIQUE, SENEGAL AND ZAMBIA* AND CONSUMER ACCESS TO ESSENTIAL HEALTH CARE SERVICES.

REPORT PREPARED BY

Norman Z. Nyazema
University of Zimbabwe, Department of Clinical Pharmacology and Institute of Continuing Health Education, P.O.Box A178, Avondale. HARARE. Zimbabwe.

E-mail – nznyazema@yahoo.com/ normann@unorth.ac.za

BACKGROUND

Africa is facing several serious health challenges. Many health indicators are among the worst in the world and diseases such as HIV/AIDS, tuberculosis, diarrhoeal diseases, malaria, measles, to name but a few, continue to be dominant causes of morbidity and mortality. HIV/AIDS epidemic whatever its cause and origin, has emerged as one of the most serious in Africa and its impact is expected to worsen the health status of the region significantly. The epidemic will have major impacts on the African society and prospects for development for several generations to come.

There are clear indications of growing inequities in health and health care, both within and among countries in Africa. These indicators often seem to be ignored and are persistently downplayed as countries on the African continent implement policy changes, for example economic and trade policies that affect health. Today and every day, the lives of the African people, to a large extent, lie in the hands of health systems inherited from their colonial masters, be they British, French or Portuguese. At the time of evolution of these health systems, the health care was implemented primarily to cater for colonial administrators and expatriates, with separate or second-class provision made-if at all-for Africans. The systems so evolved, however, now have a vital and continuing responsibility to people throughout the life span and, are crucial to the healthy development of individuals, families and societies in Africa. This inevitably makes health care a practical as well as a political issue.

This is clearly illustrated by the report of the OAU secretary general to the 6th Conference of the African Ministries of Health (CAMH 6) held in Cairo in 1999. It stated that access to basic health care is fundamental human right and a foundation for socioeconomic development. In his address to the meeting the secretary also asked the following questions about globalization;

- Is globalization an answer to the African Health dilemma? OR, is it just one more challenge facing African Health?

In the report, it is stated that obligations and commitments for implementation of the agreements under the World Trade Organization Global Agreement will definitely have a negative impact on the health sector in Africa. The cost of health services in general will be increased beyond the capacity of most African countries and the gap between the developing and developed countries will widen more and more.

However, the report goes on to say that Africa can make use of the wave of globalization and the information revolution by establishing well-articulated Information Exchange System and by implementing Tele-health and Tele-medicine programmes. This, it must be pointed out from the outset, certainly is not an alternative or priority over the real causes of ill health such as poverty, malnutrition, poor access to essential medicines and lack of clean water and basic sanitation.

The report also pointed out that the critical challenges that African health systems should face up included:

- The implementation of an effective public health care programme
- The access to medicines based on the essential drug concept.
- The achievement of strong national, regional and continental partnership in the field of health development.
- The building up of an efficient human resources and an infrastructure of the health sector.

The recent World Health Report 2000 shared the same sentiment. As a brief illustration of the contemporary role of health systems, one particular birth has received attention in the World Health Report 2000. In 1999, United Nations experts calculated that the global population would reach six billion on 13 October 1999. On that day, in a maternity clinic in Sarajevo, a baby boy was designated as the sixth billion person on the planet. He entered the world with a life expectancy of 73 years, the current Bosnian average.

The boy was born in a big city hospital, staffed by well-trained midwives, nurses, doctors and technicians. High-technology equipment, drugs and medicines supported them. The hospital part of a sophisticated health service, connected in turn to a wide network of people and actions that in one way or another are concerned with monitoring, measuring, maintaining and improving his health for the rest of his life-as for the rest of the population. Together, all these interested parties, whether they provide services, finance them or set policies to administer them, make up what is described as a health sector/system.

Health systems

In today's complex world, it can be difficult to say exactly what a health system is, what it consists of, and where it begins and ends. Health systems include *all the activities whose primary purpose is to promote, restore or maintain health* and are defined as comprising all the;

- Organizations
- Institutions and
- Resources that are devoted to producing health actions.

Health action is defined as any effect, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health. This, however, is not the only main objective of a health system. The objective of good health itself is really two fold:

- The best attainable average level-GOODNESS. This means a health system responding well to what people expect of it.
- The smallest feasible differences among individuals and groups-FAIRNESS. This means that the system responds equally well to everyone, without discrimination.

The system can respond by:

- Allocating equal resources or expenditure for equal need/demand (i.e. allocating resources to a particular group or geographical area in proportion to its health needs/demand);
- Making sure that there is equal access for equal need/ demand (i.e. ensuring that for all individuals with the same need/demand, they will have the same opportunity to use health services);
- Promotion of equal utilization for equal need/demand (which would involve devising a system whereby use of health services would be allocated *pro rata* with need/demand);
- Adjusting in certain ways and standardization at least for age and sex to ensure equality in health.

Demand is normally seen as involving the preferences (through willingness and ability to pay) of the patient and perhaps his family. Need, on the other hand, is based on the value judgments of health care professionals on behalf of the patient and his family and/or society at large. A health system will have to adopt either a “demand” or a “need” stance in order to ensure equity in health, at least at a primary health care level. One of the criticisms of primary health care as a route to achieving affordable universal coverage - the goal of health for all- is that it gave little attention to people’s *demand* for health care. It instead concentrated almost exclusively on their perceived *needs.* Systems in Africa have failed because these two concepts did not match and the supply of services offered could not possibly align with both. What we now see happening is that only the simplest and most basic care for the poor rather than all possible care for everyone, means delivery to all of high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability.

Primary Health Care was not seen as elimination of disease by targeting technological means alone but as a complex of strategies that determined people’s livelihood and quality of life. intersectoral development linkages, equity, basic needs and people’s participation were seen as the key instruments of PHC (WHO 1978). An adhoc group of the Executive Board of the WHO on Promotion of National Health Services had earlier warned that the resolution of the health crisis lay not only in the nature of the health care delivery system but also in addressing the wider existing social, economic and political structures which must be faced at once if destructive and costly reactions were to be averted (WHO 1975). Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The specific steps set out in the IECSR to be taken by States to achieve full realization of the right to health include the creation of conditions that would assure to everyone medical services and medical attention in the event of sickness. The Committee on Economic, Social and Cultural Rights has set out the content of the right to health in general comment No.14 (E/C.12/2000/4), noting that the right is not to be understood as a right to be healthy, but rather a set of freedoms and entitlements concerning

health. According to the CESCR, the right to health contains the following essential elements depending on the prevailing conditions in each country.

These elements are:

a. Availability - the State party must make available functioning public health, and heath care facilities, goods and services, including safe drinking water, adequate sanitation facilities, hospitals, clinics, trained health professionals and essential drugs
b. Accessibility – the State must assure access to health facilities, goods and services without discrimination. Accessibility is assessed according to physical accessibility, economic accessibility and information accessibility. In particular, accessibility includes appropriate resource allocation. For example, investments should not disproportionately favour expensive curative health services which are often accessible to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.
c. Acceptability – the State must ensure that health facilities, goods and services are respectable of medical ethics and are culturally appropriate;
d. Quality - the State must ensure that health facilities, goods and services are also scientifically and medically appropriate and of good quality

The State may violate the right to health through either its direct action or by the action of other entities insufficiently regulated by the State. Violations of the right to health, a consumer right, may include

a. The suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any components of the right to health;
b. The failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States;
c. The failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others;
d. The failure to take measures to reduce the inequitable distribution of health facilities goods and services.

States are specifically obliged to take steps to ensure that, in the negotiation and ratification of international agreements, such instruments do not adversely impact upon the right to health. States also have an obligation to ensure that their actions as members of international organization, including international financial institutions, take due account of the right to health. Liberalization of trade in health services is relevant to the enjoyment of the right to health and also to the realization of the right to development. In a general sense, the more efficient supply of health services can promote economic growth and development, and therefore could provide the economic means needed to promote human rights. WTO notes that services liberalization can promote economic performance, provide a means for countries to capitalize on competitive strength, offer lower prices and encourage technology transfer. However, the liberalization of trade in services, such as health services, without adequate governmental regulation and proper assessment of its effects, can also have undesirable effects. Generally, the liberalization of trade in services can impact on human rights in various ways, depending on a range of issues, not least the type of services being supplied, the mode of service delivery, the development level of the country and its internal infrastructure, the regulatory environment and the level of existing services prior to liberalization.

Clearly stated policies and time frames for liberalization are required. There are opportunities and challenges of liberalizing trade in health services according to the "mode' of supply namely;

- *Cross border supply* – access to health services via the internet, for example
- *Consumption abroad* – traveling abroad to seek medical treatment
- *Commercial presence* – presence of foreign suppliers of essential health services NGOs
- *Movement of natural persons* - movement of health workforce

The key question from consumer rights perspective is not whether liberalization does or does not promote health as a human right; rather, it is how determine the right form and pace of liberalization to ensure the protection of consumer rights and how to reverse policies that are found unsuccessful. States are encouraged to open markets through WTO negotiations only on the basis of sound empirical evidence gathered through assessment. Consequently, WTO members should be encouraged to undertake assessments of the impact of the implementation of General Agreement on Trade in Services (GATS). Assessments done should concern both past experience and potential effects of future liberalization commitments.

It was against this background that the Consumers International regional Office for Africa commissioned research into the impact of liberalization of trade in health service on consumer rights to health. This was part of CI-ROAF programme on Building Consumers Capacity and Institution for a Fair and Transparent Marketplace.

PURPOSE OF THE STUDIES

To undertake public, independent and transparent consumer rights assessments of the impact of liberalization policies – both past and future options- on the enjoyment of health as a human right, through participatory and consultative process with concerned individuals and groups, in order to develop and implement the most appropriate regulations.

OBJECTIVES

Broad objective:

To carry out a public, independent and transparent consumer rights assessment of the impact of liberalization in health services i.e. the health sector reforms, using indicator health services, in 6 countries in the Consumers International Africa Region.

Specific objectives:

Benin

Title: AN IVESTIGATION INTO PUBLIC EALTH SERVICES AND NGOs IN THE FACE OF THE PROBLEM OF THE PROLIFERATING SALE OF ILLICIT (COUNTERFEIT) DRUGS

- To investigate availability of drugs (medicines) in Benin

- To identify drugs (medicines) that are sold illicitly and their distribution channels in Benin
- To assess consumer perception on the possible risks of using such drugs (medicines)
- To share the information with stakeholders in drug production and distribution and recommend policy and regulatory options.

Kenya

Title: IMPACT OF WTO TRIPS AGREEMENT ON ACCESS TO ESSENTIAL MEDICINES IN KENYA

- To assess the impact that TRIPS agreement has had on the access to anti-retroviral drugs in Kenya
- To assess the affordability of nevirapine and combivir (AZT&Lamivudine) before and after TRIPS in Kenya
- To assess the availability of these drugs before and after TRIPS

Malawi

Title: PATIETNTS' RIGHTS AND RESPONSIBILITIES IN A LIBERALIZED HEALTH SECTOR IN MALAWI: A CASE FOR A PATIENTS' CHARTER.

- To assess how consumer right to health as human rights issue, can be incorporated in to the Constitution of the Republic of Malawi
- To carry out a study among consumers on the components of the a Patients' Charter
- To draft Patients Charter for Malawi
- To carry out advocacy activities for its adoption by the Malawi government

Mozambique

Title: IMPACT OF THE HEALTH SECTOR REFORM ON MALARIA CARE, CONTROL AND PREVENTION

- To study the impact of liberalization in health services in general and malaria control and prevention services in particular in Mozambique
- To investigate strategies that have been adopted to prevent and control malaria in Mozambique before and after liberalization in the health sector,
- To study the utilization of the malaria services in Mozambique.

Senegal

Title: IMPACT STUDY PHASE OF THE HOSPITAL REFORM PROGRAMME IN SENEGAL

- To measure the quality, cost and effect of the hospital interventions on the income of consumers
- To assess the knowledge, attitudes and behaviour of consumers with regard to hospital reform,

- To determine the focal points of intervention that would make it possible for the rights and interest of consumers to be taken more into consideration, the through the hospital reform programme.

Zambia

Title: A STUDY OF THE IMPACT OF LIBERALIZATION OF THE PHARMACEUTICAL SERVICE ON THE ZAMBIAN CONSUMER.

- To study what has happened the Zambian pharmaceutical services before and after liberalization,
- To investigate how the different components of the Zambian National Drug Policy, namely:
  - Registration of drugs
  - Inspection
  - Drug quality assurance
  - Drug procurement
  - Drug storage and distribution
  - Financial resources
  - Rational use of drugs (prescription, dispensing, promotion, information, clinical trials and research) were being implemented and monitored.

METHODOLOGY

Study setting

The study was carried out in the following countries and the respective urban, rural and or districts,
Benin : Cotonou, Savalou and Dogbo
Kenya: Nairobi, Mombasa
Malawi: Balantyre, Thyolo and Chkwawa
Mozambique: Maputo, Gaza and Inhambane: Sofala and Manica; Nampula and Cabo-Delgado
Senegal:
Zambia: Lusaka

Study population

The study population in all the countries, consisted of consumers, street vendors, patients, health care professionals, health professional bodies, pharmaceutical industry, regulatory bodies, Ministries of Health, Trade and Industry officials, parliamentarians and NGOs (national and international). Convenience sampling was employed to facilitate easy access to representatives of consumers, patients, health care providers, government officials, regulatory bodies and NGOs.

Data collection

A combination of methods was used to explore the research questions to address the different objectives of the studies. These were

- A review of International covenants, national and international policy documents, statutory instruments i.e. consumer protection legislation and any reports of relevant studies done before and after liberalization;
- Participatory Rapid Assessment techniques, namely Focus Group Discussions and Semi-Structured Interviews using interview guides;
- Participant observation;
- Structured interviews with key informants such as NGOs and government officials, parliamentarians, health care professionals and consumers;
- Multi-media techniques i.e. radio programmes, pamphlets
- Review of newspapers relevant articles before and after liberalization;

RESULTS

In general the results obtained from the studies carried out could be summarized and divided into the following sub-headings;

- Access to and use of essential drugs (medicines) in a liberalized economy,
- The role of NGOs in a liberalized (reformed) health care delivery system,
- Consumer protection in a liberalized (reformed) health care delivery system
- Hospital (district, referral or central) management in a reformed health sector

Access to essential drugs

The intensifying struggle around scarce health resources in many African countries requires the recognition that equity (whichever way it is defined) needs to define and build a more active role for important stakeholders in health, including communities, health providers and funders, health professionals and other sectors. Genuine, people-centred initiatives must be strengthened, both to find innovative solutions and to put pressure on decision-makers, governments and the private sector. Grassroots organizations in Africa need to form coalitions dedicated to changing the prevailing health care delivery system.

Ministries of health must therefore, take on a large part of the stewardship of health system because government responsibility for the health of the people shall always be a continuous and permanent national priority. Health policy and strategies will need to cover both the private and public provision of services, as well as state funding and activities. In fact effective public services themselves can be a regulatory tool. Developing effective public provision and financing systems becomes even more important if government's policy seeks to restrict the development of a private health market, or when it lacks the resources to prevent undesirable market failures. The public sector must then respond to the changing needs of consumers, such as comprehensive care of people living with HIV/AIDS, to the introduction of new medical technologies such as rapid HIV tests, and to t reasonable expectations of health professionals. A strong public sector may even be a very good strategy for regulating private provision and for consumer protection, if it helps to keep the private sector more competitive in price and quality of service.

Too often as is seen in many of African countries, it is the public sector, which is, see as uncompetitive in terms of quality and responsiveness, in spite of its free or subsidized services. If the public system deteriorates or does not continually improve, as is the case in many African

countries, an unhealthy amount of resources and attention will be siphoned off trying to catch offenders in the "black market", and growing under-the-table payments will undermine equity goals. Governments in Africa, through their ministries of health, can play their role as stewards if more resources are made available and dialogue is established with the private sector. Private actors must be seen to work on behalf of public good as is now the case in South Africa's Medical Schemes Act and its accompanying Regulations, which came into effect 1 January 2000 (RSA Dept of Health, 1997). The South African Governments must make a continuing commitment to enforce the regulations and rules by investing in the knowledge and skills of regulatory staff to keep pace with market developments

Health system inputs

The principal health system inputs have to be identified first. These normally include: human resources, physical capital, and consumables. As in other industries, investment decisions in health are critical because they are generally irreversible: they commit large amounts of money to places and activities, which are difficult, even impossible, to cancel, close or scale down. For example new investments in human capital has long-term consequences, similar to investments in physical capital. The creation of a cadre of health workers with new skills requires long-term investment and commitment to paying their salaries. Consumers have to appreciate that health systems are labour intensive and require qualified and experienced staff to function well. In addition to a balance between health workers and physical resources, there needs to be a balance between the different types of health promoters and care givers. The system must also balance investments in human capital to cover future needs as well as present demands.

In most African countries because of prevailing political economic conditions motivation is low among health care providers. Inadequate pay and benefits together with poor working conditions ranging from work in conflict zones to inadequate facilities and shortages of essential medicines and consumables – are frequently mentioned by many health care workforce (Berkmans, 1999). Recently Uganda has tried to address the issue by raising public sector pay 900% between 1990 and 1999, which represents a doubling in real terms. It might be important to note that Uganda received as high as 40% of its total expenditure on health from donors in 1993. This is typical of many other African countries, for example Angola, Eritrea, Gambia, Kenya, Mozambique and Tanzania, who depend on donors for a large share of total expenditure on health. What tends to happen ultimately is that national health authorities devote significant amounts of time and effort to dealing with donor's priorities and procedures, rather than concentrating on strategic stewardship and health programme (Cassels and Janovsky, 1998). This disrupts the process that would have helped to make sure that the right services reach people at the right time. People should be the center of health services.

People at the center of health services

At the center of service delivery is the patient, in the case of clinical interventions such TB treatment, or the affected population, in the case of non-personal public health services such as water and sanitation services. People are consumers of the service, because they behave in ways that influence their health, including their choices about seeking and utilizing health care. The consumer in Africa may be the patient, or someone such as a mother acting on his or her behalf, or simply a person making choices about diet, life style and other factors that affect health. Often the

choices consumers make, particularly about seeking care, are influenced by the responsiveness of the system. Utilization does not depend only on the consumer's perception of need or of the likelihood of benefiting from a service. In all African countries the basic tenets of ethical provider-patient relations usually include similar elements of *consent, confidentiality, discretion, veracity and fidelity.* Calling the elements of *dignity, autonomy and confidentiality* that go into responsiveness "respect for persons" underscores the importance of people, and not simply patients, as the recipients of health services.

Consumers also play the role of contributors to financing the health system whether out of pocket when ill or through health insurance contribution. The 1993 World Development Report *Investing in health* made detailed policy recommendations about insurance financing in middle-income countries but this option was barely mentioned in respect of poor countries. The authors of that report, as did other professionals working in international health, dismissed rural health insurance in Africa as unfeasible. This excluded African countries from the policy debate a crucial option-one that would allow rural households to make contribution to the cost of their health care without placing barriers to obtaining care at the time of illness. The conviction that health insurance schemes for rural population in Africa would not be feasible appeared to be based on the assumption that there was no preference or demand for health insurance among these populations ("demand" being used in the economic sense of willingness and ability to pay for goods or services); and that schemes would require management structures similar to those of developed countries health insurance systems (Arhin 1995).

The assumption that demand for insurance cover would be low arose partly from the view that "African consumers prefer not to pay money for a future benefit for the simple reason that they lack confidence that the future benefit will be made available when they need it". To some extent this is true particularly in countries where the nature of governance systems, in general, are poor. However, in a community health project carried out in Gabu region, Guinea Bissau, villagers when given a choice, preferred collective prepayment to fee for service (Chabot and Savage 1984). These villagers subsequently adapted payment system originally used to finance ceremonies to fund inputs for primary health care- and thus began the *Abota health insurance* system, which preceded the *Bamako Initiative* announced in 1987 at the AFRO regional meeting that took place in Mali. Basically this was a proposal that UNICEF provide essential drugs for use in primary level maternal and child health clinics on condition that charges be made for drugs and services (UNICEF 1990 The initiative, nonetheless, accepts that a proportion of the community is too poor to pay and suggests that this group should be exempted. The mechanisms and criteria for exemption are, however, simplistic and fail to reflect the complex power relationships that exist at the local level of health care in Africa. Many countries in Africa who took this initiative on board have implemented some of the components of the initiative having moved from through various stages of assessment, analysis and action. In Benin, for example, the Bamako Initiative was integrated into the National Health Strategy. The initiative also covered about half the health centers in Guinea (Kanji et al 1992).

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