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The impact of health system reform on remote health in Cambodia and the Philippines

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ABSTRACT

Remoteness is commonly conceived of in the Western health context in terms of geographical or social isolation. These features of remoteness also apply to the developing nation context. However, the international context has additional dimensions of remoteness that impact significantly on health outcomes. These are the economic, social and political realities of poverty and insecurity in remote populations. Based on the experiences of implementation of health development projects in Cambodia and The Philippines in the 1990's, this paper describes the character of poverty and insecurity and it's impact on health outcomes. It also describes recent health sector reforms of decentralisation and devolution, and discusses the degree to which these reforms have responded to the health needs of remote populations. Conclusion: Poverty and insecurity are dominant factors in reducing access to essential health services and hence impact negatively on health outcomes, particularly for women and children. Recent health sector reforms have not as yet demonstrated tangible benefits for the health of remote populations.

Introduction

In developed nations, the idea of 'remoteness' is commonly linked to geographical or social factors such as distance from services, cultural barriers, and poor public health infrastructure. These features are of course common with international experience. However, there are characteristics to remoteness in the international context that developed countries, such as Australia and the United States, do not share to the same degree. In the developing country context, poverty and civil conflict are major determinants of remoteness. Based on the experiences of implementation of health development projects in Cambodia and The Philippines in the 1990s, this paper describes the character of remoteness in several developing country settings and

assesses the impact of health system reform on the health of remote populations.

'Remoteness' in the international context

In the developed world, remoteness is commonly defined in terms of geographical or social isolation. The geographical isolation is associated with distance, sparsely distributed population and limited access due to road or climactic conditions. Vast distances of a desert continent such as Australia have been historically summarised in the phrase of 'tyranny of distance'. To a large extent, this tyranny has been overcome by technological innovations in the areas of transport and communications.

However, the persistent intractable health problems of indigenous people in remote Australia are more arguably related to problems of social and economic marginilisation rather than geographic distance.

In its recent analysis of poverty, the World Bank describes the 'multi-dimensional' character of poverty in developing countries. Poverty is determined by income, access to education and health services and exposure to political insecurity[1]. In the dimension of remote health in developing countries, poverty is often experienced as the inability to purchase or access basic health services and public health infrastructure. Persistent low incomes of rural dwellers limit purchasing power, particularly for catastrophic life events such as injury or obstetric emergency. However, poverty is not only a characteristic of the householder or of the ability to purchase health services. Poverty is also a characteristic of the capacity of local and national governments to fund basic health services. Low public sector investment in health exacerbates household poverty. It increases the requirement to purchase health services from unregulated local private providers or to expend social and economic cost on accessing services more distant form local villages in provincial or national capitals. Poverty of both household incomes and public health sector investment are major determinants of limited access to health services and resources in remote areas of the Philippines and Cambodia.

Surveys associated with health development projects in both countries indicated that the rural population's lack of capacity to pay for transport and medicines is the major reason for delayed referral to higher levels of care[2,3]. In the Philippines in 1997, only 3.5% of GNP was allocated to health. This is well below the WHO recommended 5% figure for developing countries. 46% of total health spending is out of pocket expenses[4]. In Cambodia, the government invested US$1 per person in 1998 and foreign donors US$5 per person. In contrast, $20 per person was expended from household payments[5]. A 1998 National health survey in Cambodia established a strong correlation between access to treatment and hospitalization and socioeconomic status[6].

The other feature dominating the remote health perspective in these two countries is the problem of insecurity. The effectiveness of health systems is determined by a multiplicity of complementary layers of services that is commonly referred to as a health referral system[7]. Health referral system functions are characterised by ability to move and communicate between layers of service and hence across geographical regions. Transport and communications are the fundamental enabling technologies of health referral systems. It is the ability to move between layers of services that enables the providers to provide coverage and communities to access appropriate level of service. It is this 'ability to move' that is compromised in insecure regions of remote Cambodia and the Philippines.

Civil conflict creates obvious barriers to movement, particularly in remote areas where insurgents often retreat and law and order is more distant from central police and justice controls. Geographical and climactic features such as dense forest, mountain ranges, heavy wet seasons, sea crossings and typhoons exacerbate these problems. Transport and communication technology that is a given in remote regions of developed nations is absent or very limited in remote areas of Cambodia and the Philippines. Poor roads, un-repaired bridges, unsafe sea transport and absence of telephone systems significantly extend the physical distances

between villages and towns (and hence between levels of health service).

As is often the case in developing counties emerging from civil war, maternal death casualties can often exceed battlefield casualties. For example, with a maternal mortality rate of 900 per 100 000 births per year, Cambodia would have expected to have 3000 deaths from pregnancy related causes in the early 1990s. This most probably would have exceeded the battlefield deaths in the final Khmer Rouge offensives in 1993. (This is consistent with global health assessments which indicate that the highest maternal mortality rates are in counties involved in civil conflict such as Afghanistan and Angola[8]. Field visits to remote provinces in Cambodia between 1993 and 1996 indicated chronic problems of delayed referral and non-treatment due to inability to travel or fear of insecurity. Health providers identified insecurity as the third major reason why remote populations failed to access health services[3].

Health referral systems are not only dependent on functional health facilities, but also on communications, transport and health management systems. The breakdown of these systems in times of civil conflict effectively traps the poor in remote locations and restricts their ability to move to higher levels of specialized health care in times of increased health risk.

Health system reform and remote health care

Both countries have undertaken processes of health system reform in the last 10 years. In the Philippines, the National Government devolved the management of health services from central Department of Health to locally elected government officials at the provincial, municipal and barangay (village) level. Over the period of one year right across the country in 1993, health staff and health infrastructure were signed over to the management of non-health locally elected politicians and their bureaucracies. The reforms were wide sweeping and fundamental in changing relationships between health providers and their managers and funders.

In 1995 in Cambodia, the Government proposed a health policy based on re-organisation and decentralisation of health services known as the 'health coverage plan'. Under this proposal, operational health districts would be established that would comprise the two levels of referral hospital and health centre catchments. Implementation of health programs would be increasingly under the jurisdiction of district and provincial ministry of health officials rather than the vertical management programs of the central Ministry of Health. The reforms also proposed a national charter on health financing and strengthening of inter-sectoral development activities and structures[5].

In the context of this discussion, the key question is this - what has been the impact of health reforms on health and health services access for rural and remote populations in the two countries? Is there sufficient evidence form project experience, observation, health indicators and international literature to support the directions of reform in improving access to health services for rural and remote populations?

Rapid appraisals and health surveys conducted in these countries between 1993 and 1999 paint a picture of empty rural hospitals and under-utilised health centres. The reasons for the under-utilisation are clear - poor quality of care reduces demand. The poor quality is evident in the poorly maintained infrastructure, lack of medical and equipment supplies and low morale of personnel. The ability to access more distant quality services is dependent on capacity to pay. Surveys and national health statistics from both countries indicate strong co relation between socioeconomic status, rurality and low health service utilisation. In the Philippines the infant mortality rate is 30.9 per 1000 live births while in the rural areas it is 40.2. There have been no significant declines in maternal mortality rate between 1970 and 1995[4]. In Cambodia, 90% of births occur in homes mostly in the care of a traditional birth attendant, with only 40% of rural women gaining access to professional antenatal care (as opposed to 81% in the capital city)[6].

Evidence from international literature supports the view that recent market reforms associated with policies of

decentralisation or devolution are either not reducing or exacerbating inequities between rich and poor and the city and the country. A decline in child health in Papua New Guinea has been associated with the 'lost health services' resulting from recent implementation of a policy of devolution[9]. Market reforms in China had not had any effect on reducing the 'urban-rural divide' between infant and maternal mortality rates[10]. Similarly, introduction of market reforms in Vietnam has resulted in a decline in the quality and coverage of commune health services[11]. The World Health Organization states that globally in developing countries, 'poor urban dwellers have better access to effective personal health care than much of the rural population'[12].

Improving access to health services and health resources for rural and remote populations - what are the lessons learned for health development?

Health system reforms have been undertaken in the name of market reform, globalisation, decentralisation, devolution, people power, cost recovery, cost effectiveness, community participation and rationalisation. But experience to date would indicate that for rural and remote populations in the developing world there is more in the rhetoric than the reality. Health reforms are poorly targeted to the needs of at risk populations. The decline in public sector investment has not been adequately compensated by the development of a well-regulated private sector that has the capacity to provide coverage for rural and remote areas. The empty hospitals, run down health centres, unmanned aid posts and persisting high maternal and infant mortality rates in many countries of the Asia Pacific region are indicative of this.

Decentralisation has been criticised on the grounds that lack of trained staff in the periphery and weakness of lower level governments are major characteristics of flawed policy implementation[13,14]. Crucially, implementation of the policy of decentralisation has been associated with no substantial shift in health resources from urban to rural areas. In Cambodia, despite a policy and financial commitment to rural health, government spending on health care has fallen even further during the period of economic transition since 1989. According to this analyst, 'the gap between health care needs and government support is the principle problem of resource allocation for health care in Cambodia' (P Annear, pers. obs., 2001). In both the Philippines and Cambodia, the substantial dependence by rural populations on household payments as opposed to provision of public health service highlights the high level of policy risk associated with the implementation of decentralisation in the context of structural adjustment reform.

Given the multifactorial determinants of major health indices, and the limitations of health reforms in this context, it would be unreasonable to expect significant positive or negative changes to health indicators in the time period specified that could be attributable to policy implementation. Nevertheless, the concordance of these indices with those from other countries that have initiated similar reforms raises concerns about the likelihood of positive outcomes emenating from current approaches in the health sector of combining market reform and decentralisation.

Many of the health problems in remote regions seem intractable, because they are so bound up with economic, social and political problems that are seemingly outside the scope and influence of the health sector. Investments in health sector reforms that are isolated from broader development agendas are not yielding expected results for rural and remote populations.

Poor health is not just a technical health problem. Poor health is systemic in rural and remote regions in so far as its determinants are related to broader development issues of security, poverty and lack of rural infrastructure. The tyranny of distance can be overcome through introduction of health technology and infrastructure. However, poverty and civil conflict are not resolved through introduction of technology. These remoteness factors are deeply embedded within national culture, politics and history. And it is these factors that will either drive or undermine the technical innovations of health development projects.

International health comparisons indicate inequitable distribution of resources between countries. What these international comparisons also demonstrate is the substantial inequities within countries between urban and remote and rich and poor. Inequities cannot be addressed by health technology alone. The international evidence supports the case for all countries to broaden health system reforms towards wider development agendas that address the underlying social and political determinants of poor health in remote areas.

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