

Health sector reform in the Middle Eastern region: Potential implications on the implementation of reproductive health programs.

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ABSTRACT

The International Conference on Population and Development (ICPD) and the World Development Report (WDR) share common goals such as equity, quality of care and community involvement in health care. However, the implementation of health sector reform in many developing countries had negative implications on reproductive health. Several of these implications are expected to occur in the Middle East region if similar problems faced in

other developing countries are not taken into consideration. Major components of health sector reforms include financial, organizational and policy reforms. Within the financial reforms, the introduction of user charges and private insurance schemes are expected to decrease reproductive health service utilization among the poor on one hand, while on the other hand, this will lead to overuse of medical procedures and treatments among the richer segments of the population. In both cases quality of care will be seriously affected leading to poorer reproductive health outcomes. Organizational reforms which include decentralization, privatization and integration of services have both positive and negative implications on reproductive health depending on the country's context. If local governments and health care providers are not adequately trained to handle these reforms, reproductive health services will suffer. Moreover, an uncontrolled private sector will increase health care costs and decrease quality of care. It is note worthy to mention that integration of sexually transmitted infection (STI) services into family planning and Maternal and Child Health (MCH) are expected to decrease service utilization in conservative Middle Eastern regions. However, adequate planning and slow implementation of decentralization might have a positive impact on reproductive health. Finally policy changes within the health sector are expected to improve the quality of services and regulate the private sector. However, DALYs which are currently used in allocating resources ignore important reproductive health problems in the region such as infertility, and violence against women. In order for health sector reforms to have positive implications on reproductive health in the Middle East, advocates of health sector reform and reproductive health need to communicate and collaborate with each other.

Introduction

In the early 1990's, two important events took place in the health arena: The International Conference on Population and Development (ICPD) in 1994 and the World Development Report (WDR) in 1993. Both had important recommendations for the health sector, while the ICPD recommended a greater focus on reproductive health services, the WDR called for a reform of health sectors in low and middle-income countries in order to promote a better quality of care and sustain finances. Although theoretically, these two events shared many common goals such as improved equity, quality and patient responsiveness, experience from several developing countries has not revealed that the implementation of health sector reforms is contributing positively to the reproductive health field (Hardee & Smith, 2000). This paper aims to analyze the literature on the implications of health sector reform on the implementation of reproductive health programs. Findings will be applied to the Middle East region. For this purpose, the positive and negative implications of the main components of health sector reform on reproductive health will be reviewed based on other countries' experiences and the applicability of the results in the Middle Easter will be discussed based on the context of each country. First, the paper will discuss the

implications of financial reforms which include the introduction of user fees and insurance schemes on the reproductive health programs. Next, the implications of organizational reforms, which include decentralization, privatization and integration of services, on the implementation of reproductive health programs will be reviewed. Finally, the paper will end up by discussing the implications of policy changes, which include allocation of resources and changes in laws and regulations, on reproductive health programs.

Financial reforms

Two important financial reforms were implemented in many developing countries. These include the introduction of user charges and insurance schemes. The main objective of these reforms is to ensure sustainability of health services and improve quality of health care (Langer et al, 2000). However, several studies revealed a significant negative impact of user charges on the utilization of reproductive health programs and quality improvements has been questionable based on some authors (Dmytraczenko et al, 2003). In Uganda for example, user fees hindered AIDS patients from accessing essential medical care especially female patients as these constitute the poorest segment of the community (Parkhurst et al, 2005). This led to the removal of user fees, leading to an increase in the utilization of services at the expense of a decreased quality of care due to staff demoralization (Neema, 2005). Moreover, user fees can lead to impoverishment of families. In China, one third of households went into debt due to the need to pay for acute illnesses (Krasovec & Shaw, 2000). User fees had a negative impact on maternal health in Niger whereby maternal deaths increased by 56% and hospital deliveries decreased by 46% (Evers & Juarez, 2003). Similar decline in the use of reproductive health services was also

observed in China and Zimbabwe (Kaufman & Jing, 2002; Evers & Juarez, 2003). Moreover, in Burkina Faso, the introduction of user fees dropped health service utilization by 17% which could not be explained by any other factor. In addition, the communities were dissatisfied with the quality of care, high costs and poor staff performance in reproductive health centers (Bodart et al, 2001). Another disadvantage of user fees is that providers will tend to over-utilize services. In Brazil, user fees led to an increased rate of cesarean sections (C/S) and a depletion of other essential reproductive health services (Lubben et al, 2002). In the Middle East region, many countries already use the fee-for service delivery of care such as Lebanon. Experience has shown that this mainly negatively affects the poor and marginalized which include women and are also causing overuse of resources without appropriate indications. As for the countries which free public services, it is expected that similar negative effects will take place in case user fees are implemented. However, the introduction of user fees need not be totally cancelled. Governments can apply exemption of fees for those who cannot afford to pay for essential health care services such as reproductive health. In this case both providers and patients need to be aware of the policy to insure implementation.

Another financial reform has been the introduction of insurance schemes. Insurance schemes can help prevent the vulnerable population from increasing major health expenses as a result of acute illnesses. However, evidence suggests that insurance can have negative implications on women especially in childbirth as many private insurance schemes do not cover delivery and maternal care, and sometimes, women are required to pay a higher premium (Evers & Juarez, 2003). Moreover, in India, private insurance has led to an unjustifiable increase in cesarean section and hysterectomy

rates (Evers & Juarez, 2003). In Lebanon and several other Middle Eastern countries, private insurance is quite expensive and is only affordable to middle to high-social classes, leaving the lower class without appropriate health coverage. In addition, studies have revealed an increase in C/S rates as a result of insurance (Khayat et al, 2000). As for Middle Eastern countries that currently rely on the public sector for reproductive health services, insurance schemes might have positive implications if adequately implemented. For example, in Egypt, insurance schemes were introduced through the contribution of individuals which allowed patients to receive better quality essential health services including reproductive health (Dmytraczenko et al, 2003). In Rwanda, insurance schemes led to an increased use of reproductive health services with an average of 1.5 visits for the insured compared to 0.2 visits for the uninsured. In Mali, funding for transportation to emergency obstetric care was funded by the community (Dmytraczenko et al, 2003). Therefore, insurance schemes will have different implications on reproductive health services, depending on the context and the method of implementation. The financing reforms need to take the context of the country into consideration before being implemented. From the experience of low-income countries, financial reforms have not led to greater funds for reproductive health programs (WHO, 2005) In the Middle East, a good proportion of individuals are uninsured and do not have the means to pay for essential health services. In this case, the government needs to intervene in order to avoid inequity in access to health care including reproductive health care.

Organizational Reforms:

In addition to financial reforms, three major organizational reforms were promoted in developing countries. These included decentralization,

privatization and integration of services. Many of them are linked to financial reforms and some have complementary effects.

The following paragraphs will discuss each reform type separately and its implication on reproductive health.

Decentralization

This is the most widely implemented component of the health sector reform in developing countries and the most politically driven health policy (Lakshminarayanan, 2003). The main aims of decentralization were to improve equity, efficiency, and quality of care. It is also a mean to empower communities and improve accountability at the local level. In fact, the ICPD promoted and encouraged decentralization. Although theoretically decentralization is expected to have positive implications on reproductive health, experience from developing countries has not been very encouraging. Local governments might not prioritize reproductive health and hence, decrease the financial resources for its services. In Ghana, for example, decentralization promoted an increase in HIV/AIDS infections as a result of decreased funding (Mayhew, 2003). Lakshminarayanan (2003) reported that, in the Philippines, local governments were not adequately prepared to deliver family planning services, although contraceptives were provided by the government. In addition, some local governments denied family planning services because of their own catholic religious beliefs. This same study showed that the poorer districts suffered the most from decentralization due to insufficiency of the resources allocated and their limited ability to generate their own

income (Lakshminarayanan, 2003). In fact, data revealed that local governments with the highest proportion of

women in the reproductive age group were given less resources for family planning and health. Another challenge of decentralization is local health workers and administrators in many countries did not have the appropriate training to handle daily activities prior to the implementation of decentralization (Berer, 2002). A review of decentralization in five countries in Asia and Africa revealed that decentralization failed as a result of inadequate training of professionals (Hardy and Smith, 2000). This led to a negative impact on the human and technical skills for reproductive health services (McIntyre & Klugman, 2003).

Although reproductive health programs might face several challenges with decentralization, in many countries, decentralization proved to have positive implications on reproductive health. In fact, decentralization can promote involvement of local communities in decision-making. In Bangladesh, more than 36,000 women were involved in family planning services and in India, women groups were successful in lobbying for reproductive health programs (Aitken, 1998; Evers & Juarez, 2003). Sri Lanka represents a success story in decentralization. In fact the national government took almost 40 years to delegate complete control for the local authorities. This promoted a decrease in maternal mortality and an improvement in the health status of women (McIntyre & Klugman, 2003). Therefore, if adequately planned and studied, decentralization is expected to have positive implications on reproductive health. However, one needs not forget the context as it also plays an important role in implementation.

In the Middle Eastern region, religion plays an important role in daily life

and policy implementation. Therefore, some local authorities might deny family planning and adolescent sexual health services due to religious beliefs and pressures. Moreover, in a male dominated society, women's health issues are rarely given importance (Hardee and Smith, 2000). Another characteristic of the Middle Eastern culture is the fear of the national governments to lose power therefore, this decentralization might not be fully implemented in the region. Currently, reproductive health in the Middle East region is dealt with by both the public and private sector through NGO's. Therefore, immediate delegation of power to local governments and districts might hinder the development of reproductive health programs.

Privatization

Another supported reform strategy by the World Bank is privatization of health services. In the Middle East, health care systems range from complete public to complete private dominance. This implies that privatization will have different impacts in the region based on the context. However, in both cases, privatization is or will be causing negative impacts on reproductive health if not adequately controlled. In Lebanon, for example, the private sector is dominant and this is causing an increased use of services without clinical indications. The rates of caesarean sections for example are almost 20% which is much higher than that recommended by the WHO (Khayat et al, 2000). This is mainly related to the lack of control over the private sector by the government. The health sector reform addresses this issue in the policy changes which will be discussed later in this paper. Furthermore, in countries that rely on free public reproductive health services especially family planning and MCH, the introduction of privatization might cause serious harm specifically for those who cannot afford to pay for essential

services. Experience in China revealed that privatization hindered the poor especially women from accessing health care and it also caused impoverishment of families (Kaufman and Jing, 2002; Jing, 2004). Although privatization might lead to negative consequences on reproductive health, if adequately implemented and supervised, it can prove to be successful. In Columbia, the introduction of the private sector promoted competition among providers which improved the efficiency and quality of services (Dmytraczenko et al., 2003). Similarly in Ghana, public-private partnership has increased the coverage of family planning services in the country (Dmytraczenko et al., 2003).

Based on the above, privatization can have detrimental effects on reproductive health in all countries if not appropriately regulated. Experience from Lebanon as a Middle Eastern country proves this point.

Integration of services

Integration is closely related to decentralization since at the local level, integration is necessary for the provision of safe motherhood programs (Leighton, 1998). In theory, integration of services can improve services and reduce costs which improve efficiency (Dmytraczenko et al., 2003). However, implementation largely depends on the skills of health care professionals and the will of local managers and donors. Among the advantages of integration is that patients will be able to receive several preventive services at lower costs. For example, in Mexico, integration caused a 50% decrease in costs in terms of staff time when three services were provided at a single consultation rather than one service (Krasovec & Shaw, 2000).

On the other hand, integration of Sexually Transmitted Infection (STI's) services with family planning and MCH did not prove to be useful

in some countries (Lubben et al., 2002). This is of particular relevance to the Middle East region where stigma still accompanies STI's, hence integration might hinder women from seeking maternal or family planning services due to the fear of being labelled as an infected person with STI's or HIV. In addition, STI clinics are also visited by men and female sex workers which increase the stigma in the region (Berer, 2003). However, Berer (2004) argues that the integration of STI services with other reproductive health services would enable health care providers to educate and screen patients for STI's especially pregnant women who are infected with HIV in order to prevent perinatal transmission of the virus.

Furthermore, integration might ignore some services because of inadequate staff training. In Tanzania, the health care professionals were not trained to provide STI service. Hence, during the clinical encounter they used to focus on only one area of reproductive health (Oliff et al., 2003). Moreover, the same number of health care providers is required to provide double the services with the same salaries and equipments. This factor leads to decrease in staff morale and poor quality of services (Berer, 2003).

Therefore, integration of services in the Middle East might have different impacts depending on the kind of services integrated. In other words, the integration of family planning and MCH might lead to positive impacts if staff training is provided. However, STI integration with the previous two services might have detrimental effects on utilization of services by women because of the stigma associated with STI's in the Middle Eastern culture.

Policy Changes

Health sector reform calls for a regulating role of the government in the provision of health services. This strategy is largely related to organizational reforms (Dmytraczenko et al., 2003). Setting

priorities for resource allocation and changing laws and regulations are the most common policy changes related to health sector reform (Dmytraczenko et al., 2003). Governments are required to set priorities in allocating resources in order to promote efficiency. For this purpose, the WDR promoted the use of Disability Adjusted Life Years (DALYs) and cost-effectiveness analysis in setting priorities for health. However, DALYs have been shown to have several limitations. DALYs promote inequality as they value more the middle-aged and those with no disabilities (Hardee and Smith, 2000). Moreover, DALYs do not capture disability caused by reproductive health diseases. In the global burden of disease study, reproductive health accounted for 36% of the total burden of disease among women aged 15-44 in developing countries. This burden was mainly due to maternal mortality and morbidity, STI's and HIV/AIDS (Swiss tropical institute, 2000). However, Female genital mutilation, violence against women and infertility, which are common in the Middle East, were not accounted for in DALYs calculations (Swiss tropical institute, 2000).

Therefore relying on DALYs to allocate funds will have negative implication on the implementation of reproductive health programs in the Middle East.

Among the policy changes, implementation of regulation and clinical protocols is expected to cause positive effects on the reproductive health sector in the region. This is particularly related to privatization since regulating the private sector will hinder the overuse and inappropriate use of medical procedures and improve the quality of reproductive health services (Dmytraczenko et al., 2003).

In conclusion, although health sector reform was designed to improve quality of care, reports from developing countries do not always reveal positive results. In the Middle

East, the introduction of user fees is expected to decreased utilization of essential reproductive health services and degradation in health outcomes especially among the poor and women. In addition, organizational reforms proved to be a failure when implemented without prior training of local governments, and health care workers. Hence, slow implementation and prior assessments are needed in the Middle East to implement reproductive health programs. Some reforms might not achieve success in the region such as integration of services. It is evident that health sector reform and reproductive health have common goals which are equity, improving quality of care,

community involvement and decentralization. Hence, recent literature in the reproductive health field is calling for understanding health sector reforms in order to be able to successfully implement reproductive health programs. Moreover, communication and collaboration between reproductive health and reform advocates could have positive effects on reproductive health programs. Therefore, health sector reforms need to be adequately studied prior to implementation in order to reach positive outcomes. Finally, the experience from developing countries needs to be used in the Middle East in order to avoid falling in the same mistakes.

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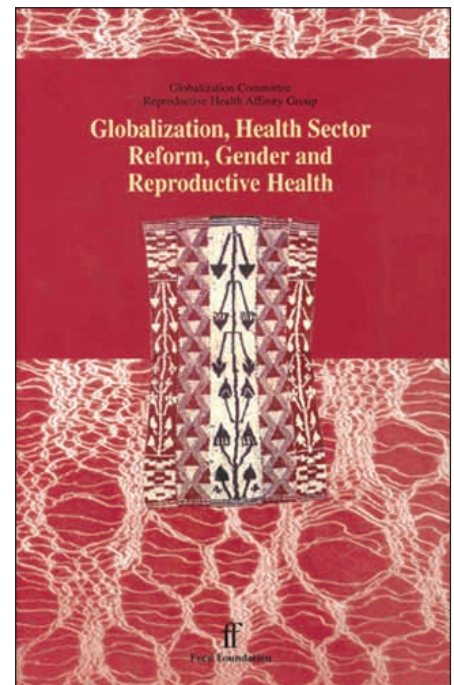
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