Benchmarks of Fairness for Health Care Reform:
A Policy Tool for Developing Countries

N. Daniels1, J. Bryant2, R.A. Castano3, O.G. Dantes, K.S. Khan, S. Pannarunothai6

1. A New Tool for Policy Analysis:

We report here on progress we have made toward developing the benchmarks of fairness into a policy tool that will be useful in developing countries for analyzing the overall fairness of health care reforms. We shall describe briefly the history of the benchmark approach, the tool itself, and the uses to which it may be put.

Fairness is a multi-dimensional concept, broader than the concept of equity. Fairness includes equity in health outcomes, in access to all forms of care, and in financing. Fairness also includes efficiency in management and allocation, since, when resources are constrained, their inefficient use means that some needs will not be met that could have been. For the public to be empowered to assure that its health is promoted, fairness must also include accountability. Finally, fairness also includes appropriate forms of patient and provider autonomy. The benchmarks facilitate an integrated examination of objectives that often involve trade-offs with each other. It requires looking across disciplinary boundaries in a systematic way.

The benchmarks have relevance because there is rapid reform of health care systems around the world as a result of changes in economic and political systems, economic growth, or

1 Professor, Dept. of Philosophy, Tufts University, Medford MA 02468 (email: ndaniels@emerald.tufts.edu).
2 President, CIOMS, Geneva; Emeritus Professor of Community Health Sciences, Aga Kahan University, Karachi, Pakistan.
3 Ministry of Health, Colombia (though not as a formal representative of the Ministry).
4 National Institute of Public Health, Cuernavaca
5 Associate Professor, Community Health Sciences, Aga Khan University, Karachi
previous failures to meet population needs. External agencies have played a large role in offering incentives to undertake privatizing and decentralizing reforms. In all these contexts, however, reforms are usually debated without a systematic evaluation of their impact on the fairness of the resulting system. Privatizing and decentralizing efforts, for example, may aim at adding new resources and circumventing inefficient bureaucracies. The private sector, however, often competes with and weakens the public one, and it requires strong and efficient regulation if it is not to undermine equity. The benchmarks provide a framework for evaluating comprehensively the effects on fairness of these strategies and others.

2. History of the Benchmarks Approach

The original "benchmarks of fairness" were developed to assess and promote deliberation about comprehensive medical insurance reforms proposed in the United States in the first Clinton administration. These benchmarks focused heavily on desirable features needed in the reform of a technologically advanced but inefficient and inequitable system that lacked universal coverage. Despite this specific focus, the original benchmarks addressed basic questions that must be asked about any reform: does it reduce financial and nonfinancial barriers to access to public health measures and medical services exist? does it promote health care services appropriate to the needs of the population? does it distribute the burdens of paying for health protection fairly? does the reform promote clinical and administrative efficiency, so that health budgets produce value for money? does it make institutions publicly accountable for the decisions they make? how does it affect the choices people can exercise?

The benchmarks connect these quite general questions to specific operational criteria and measures. Reforms are then compared by scoring them against these criteria and by providing rationales for the scores. The rationales provide an objective basis for deliberation. For example,
the original benchmark on financial barriers ranked one reform higher than another if it closed more of the insurance gap or if it better provided for portability of insurance when workers changed jobs. This technique of evaluation is generalizable to reforms in other countries by expanding the criteria to include elements of system design crucial elsewhere.\textsuperscript{7}

To adapt the benchmarks for use in health systems in countries at different levels of development, teams of collaborators from four countries, Colombia, Mexico, Pakistan, and Thailand were formed. During 1999, these teams held two week-long workshops in Cuernivaca (combining the Colombian and Mexican teams), Bangkok, and Karachi, with representation from each Asian site participating in the other Asian workshops. Teams used each country as a “case study” for which appropriate benchmarks were developed. By successively reviewing the work of previous workshops across sites, the teams produced a modifiable schema of benchmarks appropriate to all of them as a final product.

In each workshop, the process included these steps: 1) seminar presentations and discussion about the salient problems facing each system, including a history and critical evaluation of recent reform efforts; 2) a seminar presentation and discussion about the original benchmarks and how they had been applied to U.S. reform efforts; 3) a discussion of whether new benchmarks were needed to address local issues that were not addressed by the original set, or by the provisional set developed by previous workshops; 4) a critical review and revision of each of the original benchmarks, or of the results provided by the preceding workshops; 5) an attempt to link the detailed discussion of system problems and reforms to specific criteria for each benchmark; 6) “testing” (including field testing in Thailand)\textsuperscript{8} of the provisional benchmarks by using them to score actual and proposed reforms in each country; 7) refinement and revision of the criteria in light of these scoring attempts; 8) development of specific plans for
disseminating the benchmarks for actual use in each site. The Asian workshops included field trips to villages and urban slums to examine the delivery system and provide first-hand experience of the problems requiring reform.

3. The Revised Benchmarks

There are nine benchmarks, each of which contains various operational criteria for evaluating specific aspects of the fairness of reform proposals (see Appendix). Benchmark 1 addresses issues of intersectoral public health “upstream” from the point of medical delivery. Benchmarks 2-4 address different aspects of equity of access to medical services, including financial and non-financial barriers and the degree of “tiering,” or unequal benefits, available in to different subpopulations. Benchmark 5 concerns equity in financing, going beyond the issue of financial barriers raised in Benchmark 2. Benchmarks 6 and 7 address how to get value for money in clinical services and the administration of the system. Benchmark 8 takes up the critical issue of accountability of decision-makers, administrators, and providers within the system. Finally, Benchmark 9 concerns issues of patient and provider choice or autonomy. We highlight key features of each benchmark.

**Benchmark 1, Intersectoral Public Health,** has three main purposes: to focus attention on the social determinants and other risk-factors that operate “upstream” from the point of health care delivery; to encourage the development of an information infrastructure to monitor health inequities, and to encourage intersectoral cooperation on reforms. Ideally, the benchmarks should include an explicit measure of the impact of the reforms under consideration on health equity in the population, but we lack a clear understanding of how to estimate this.

The first criterion in Benchmark 1 asks for estimates of the degree to which a demographically differentiated population incurs improvements in exposure to various risk
factors as a result of the reforms under consideration. Obviously, not all reforms will touch on all or even many of these factors, but the comprehensive list is included because reforms would make a system more fair if they did eliminate inequalities in exposure to these factors. Where good information on these exposures does not exist, the criterion encourages gathering it.

The second criterion calls for developing an information infrastructure needed to measure and monitor health inequalities and to carry out research about the most effective ways to reduce them. The third criterion evaluates reforms for their intersectoral focus and their involvement of communities and vulnerable groups in these efforts. Country specific differences in problems and organization mean that intersectoral efforts must vary; use of the benchmarks requires country-specific adjustments. For example, it may be crucial to focus on violence reduction or accident reduction in some countries, and on clean water or other factors in others.

**Benchmark 2, Financial Barriers to Access**, addresses equity in access to needed services regardless of ability to pay in both the formal and informal sectors of a developing economy. The original U.S. benchmark focused on closing a fifteen per cent insurance gap in a “formal” economy in which all workers can be taxed and enrolled in a social security or employer-based insurance scheme. The adapted benchmark recognizes the large “informal,” untaxable employment sector in many developing countries, often including sixty to ninety per cent of the population. Since workers and their families in the informal sector generally include the poorest part of the population, needed services must be provided in full or in large part through general tax revenues. The larger the informal sector, the larger the need for public financing, but the smaller the tax base to meet it. To expand the resources of the informal sector, cash payments are often used, with potentially negative effects on access and equity in financing.
Benchmark 2 encourages a long term, intersectoral strategy aimed at moving as much of
the population as possible into the formal sector, and then into insurance schemes that can be
built on broadly based general tax revenues, social security payments, or employer-based
contributions. Benchmark 2 rewards reforms for various ways of expanding the formal sector,
including decreasing the workforce size that triggers the mandatory registration of employers in
the formal sector.

Benchmark 2 also specifies interim goals in both sectors. Because public resources are so
scarce in the informal sector, a crucial issue is whether the most important services are available
to all. Benchmark 2 encourages reforms to specify a basic package of services that all will
receive by a specific target date, then to improve that package over time. For example, the 1995
Mexican reforms, funded by external loans, aim to provide universal access to a very modest
package of services. By 1999, over 90% of the population has access to them, and when 100% is
reached in the near future, the Mexican government is obliged to finance this universal but
modest package itself. The plan, however, did not specify a next step in expanding the package.
In Colombia, the 1993 reforms aimed at a more comprehensive benefit package for the informal
sector; the new constitution, however, created legal pressure, deriving from a right to life, to
expand those benefits. It has not been possible with existing resources in Colombia to deliver
that package universally. Neither reform, then, would meet fully the criteria specified in the
benchmark.

In Thailand, the debate continues about whether to implement a defined minimum benefit
package proposed in recent reforms, or whether to continue to rely on a type of public insurance
(“Type B”) that allows providers discretion to negotiate what kinds of services will be available
to those without any insurance. As a result of scoring Thai proposals using Benchmark 2, a
specific research question emerged about the levels of unmet need in this population. Research on that issue should inform policy deliberation.

In Pakistan, the informal sector includes ninety per cent of the population. In theory, all people have access to an increasingly robust set of services, depending on the type of facility visited. In reality, many services, including drugs that are officially available, turn out not to be available in practice for various reasons (e.g., the existence of shadow providers, or the drug supply is not well prioritized or adequately funded), driving people to seek private. In scoring reforms, explicit attention is paid to the gap between intention and implementation.

Benchmark 2 concentrates on two goals of reform for the formal sector besides increasing the size of the sector: producing uniform and more adequate benefits across all groups of workers in it, and integrating the various schemes that involve these workers. In Thailand, for example, the long range reform plans call for considerable integration of formal sector insurance plans through district fundholding and regulative controls, and eventual expansion of coverage to all family members, many of whom, except for dependents of civil service workers, are now not covered. In Pakistan, with only ten per cent of workers in the formal sector, the team focused on the need for developing from the start a plan that would lead to a well-integrated formal sector scheme, not a hodge-podge of private plans with little regulation or equity.

**Benchmark 3, Non-financial Barriers to Access**, gives special attention to the geographical maldistribution of resources, and to gender, cultural, and discriminatory barriers to access. The benchmarks provides a comprehensive framework, but different issues will be more important in some countries than others.

The first criterion evaluates reforms for the measures they take to address the maldistribution of drugs, supplies, facilities and personnel common in all four countries. Where
the reform relies on local fund-holding and decentralization, the criteria also examine specific goals and accountability for them (see benchmark 8 as well).

The second criterion addresses gender barriers, which are especially important barriers to primary care in Pakistan, for example in the squatter slums of Karachi, where studies of children at high risk for death from diarrheal disease suggest that maternal autonomy is a key risk factor. The benchmarks emphasize involving community political groups as an essential way to address these barriers, since simply providing services will not overcome them.

Two other criteria address other cultural and discriminatory barriers. The details of these problems will vary from country to country. The benchmarks revealed that too little explicit attention was paid to this issue in recent reforms in Mexico and Pakistan.

**Benchmark 4, Comprehensiveness of Benefits and Tiering**, has, as its underlying rationale, the idea that all people, regardless of class or ethnicity or gender have comparable health needs and there are similar social obligations to meet them. Inequalities in the comprehensiveness and quality of care (“tiering”), especially where these have impacts on health outcomes, violate equity constraints on system design. Some kinds of tiering are worse than others. It is less serious if a small but wealthy group does better than others, provided the others do well (e.g., private sector of insurance in the United Kingdom) than if a poor group is also given worse health benefits than the rest of society (e.g., failing to insure the working poor in the United States, or failing to deliver a reduced benefit package to the whole informal sector while the top 5% has excellent private insurance, as in Colombia). Some tiering is also unavoidable in systems with severe resource constraints and a large informal sector.

All teams focused on extensive differential treatment of people by class within a system, not only between the public and private sectors but within the public sector. Residents of
Sultanabad, a squatter slum of Karachi, remarked that “the tradesman will do better than the laborer in a public hospital,” suggesting a widespread perception of tiering in the system, where the poor commonly wait four to five hours to be seen in a hospital, then to get five minutes with the doctor, whereas well-to-do patients can just walk into private sector services and be seen right away. Tiering exists in the benefit packages available to different subgroups in the formal sector in Thailand, Pakistan, Colombia and Mexico, as well. In Thailand, for example, civil service workers will have better access to hemodialysis than other formal sector workers. In Mexico and Pakistan, some multinational employers provide better coverage than the social security schemes, and the military in Pakistan has the best coverage of any group.

**Benchmark 5, Equitable Financing**, rests on the fundamental idea that financing medical services, as opposed to access to them, should be according to ability to pay. Three main funding streams are involved in most systems: tax-based revenues, premiums for insurance, and out-of-pocket payments. The benchmark divides the problem primarily between tax-based and premium-based parts of the system, noting that in both contexts there is still out-of-pocket payments for care. Tax-based schemes are more equitable if they are more progressive in their structure. Premium-based schemes are more equitable if they are community-rated, rather than risk-rated. Risk-rating shifts the burden to those at higher risk of illness. The same inequity is involved in out-of-pocket contributions in both tax-based and premium-based systems.

The substantial out-of-pocket costs for health care in all four collaborating sites was the main source of regressivity in financing and the main way of shifting burdens to the sick, rather than pooling them across the whole population. There are many pressures on systems to rely on and even increase cash payments for services. Market theory says that some “felt price” for services helps regulate use, but the main reason is to increase resources and “cost recovery” in
underfunded public sectors. The obvious drawback to this way of increasing resources is the burden it places on the ill, and this is true independently of any financial barriers such payments pose to the very poor.

There was considerable agreement on the fundamental issues of equity involved in this benchmark in all workshops. In Thailand, there was support for using the Kakwani index\textsuperscript{11} as an indicator of the progressivity of the overall financing of the health system since it allows comparison across all sources of financing. One study using the Kakwani index showed there has been a considerable improvement in the equity of the financing of the Thai system over the last decade, but this data must be updated to cover the period since the economic crisis. A significant negative factor remains the very large proportion of the health care expenditures that are paid out-of-pocket in a private sector that is of quite varied quality. A single index would have to be adjusted for local features of the tax system, such as the highly regressive tax system in Pakistan, where large land owners control the government and pay little.

**Benchmark 6, Efficacy, Efficiency and Quality of Health Care**, is the first of two benchmarks concerned with efficiency in the system, but it also addresses problems of efficacy and quality.

A key criterion in Benchmark 6 focuses on primary health care for community-based delivery. Reforms aimed at improving primary care must assure appropriate training, incentives, resource allocation, and community participation in the decisions affecting delivery. (The importance of public health measures is already captured in Benchmark 1.) Emphasis was placed on a population focus and on the need for the integration of different parts of the health system, such as referrals, and integration with other sectors. Community participation ideally involves an interactive relationship that goes beyond mere “outreach.”
The second main concern of Benchmark 6 is promoting evidence-based practice in all areas of services, including preventive, curative, and management practices. To advance evidence-based practice, the criteria call for the development of an information infrastructure and data base, as well as for health services research to support such evidence-based practice. The third main criterion concerns measures to improve quality of services in the system, including professional training, continuing education, credentialing and accreditation, and community participation in evaluating the quality of care.

In all systems we examined, there are problems with referral mechanisms and with the role of primary care gatekeepers. Dissatisfaction with primary care services leads many people to jump to higher level hospitals for primary care, leading to considerable inefficiency. Similarly, there is no control of efficacy or quality since people will often abandon the public sector primary care services for completely unregulated private sector services. In addition, in both the Thai and Pakistani primary care systems, there was considerable variation in the degree to which good population-based approaches were adopted. In the better clinics there is good “outreach” through family folders and other good signs of record keeping. Nevertheless, we also know that people avoid primary health care sites in favor of more intensive provincial or district centers, circumventing the need for an efficient referral system. Establishing good referral systems is a critical element in the efficiency of care, but the restrictions such systems involve also conflict with the kinds of choice or autonomy that are captured by Benchmark 9. To justify restrictions on autonomy, there must be high quality practitioners doing the diagnosis and referral, clear, accessible routes to higher levels of care, and education of all about the importance of such a system.
Benchmark 7, Administrative Efficiency, seeks efficiency in the management of the health care system. Each country team emphasized its own examples of inefficient management. Addressing these problems, however, also requires greater accountability, including transparency, in these systems; consequently, Benchmark 8 must work together with Benchmark 7 if real improvement is to result.

The criteria included in Benchmark 7 were constructed out of consideration of many examples for all four collaborating sites of sources of administrative inefficiency. Key areas of common concern, with many examples from Colombia and Mexico, were various sources of administrative overhead (inappropriate technology acquisition, inefficient use of personnel, high transaction costs), cost shifting, and many types of abuse and fraud (shadow providers, drug sales and auto-referrals, inappropriate promotion of drugs and devices).

Some general points emerge that cut across the differences in the countries. In all of them, public sector practitioners receive very low pay, and this fact creates a context for many of the forms of abuse that create efficiency problems noted in this benchmark and accountability problems noted in the next one. The failure to have integrated financing schemes means that there are incentives to shift costs from one part of the system to others. In Thailand, where unions are weak, civil service work rules prevent efficiencies of manpower allocation. In Latin America, stronger unions and their work rules provide the same obstacle to reallocation of personnel.

In the public sector of all the systems, a common set of complaints is articulated: bureaucratic practices and corruption lead to great inefficiencies in the purchase of supplies and equipment, failures to enforce rules about personnel, favoritism and hiring on grounds other than competency, and other highly inefficient practices. In all these contexts, there is talk about
“decentralization” as a solution, but decentralization is not a panacea unless there is careful planning and regulation to make sure decentralized units are aiming at similar goals.

In thinking about scoring reforms, Benchmarks 6 - 8 should play a key role in helping to think through the content of measures, such as the decentralization of public bureaucracies and the establishment of district or other level budgeting of various revenue flows. The integrated Thai reform plan, and decentralization proposals in Pakistan, must be evaluated for the specific ways in which they achieve the goals highlighted in these benchmarks; the benchmarks aim at avoiding being lulled by a fashionable label or idea into ignoring the specifics of reform proposals.

**Benchmark 8, Democratic Accountability and Empowerment**, emerged in all four countries as critically important, since without these forms of accountability, reforms are unlikely to succeed in other areas as well. The rationale for including accountability is that health systems are responsible for the improvement of population health in an equitable manner, and those affected by decisions and policies that affect well-being in such fundamental ways must have an understanding of and ultimate control over that system. Such control is not exercisable without accountability for reasonableness\textsuperscript{12,13} in decision-making about allocation and other matters. Such accountability includes transparency, including that provided by global budgeting, fair appeals processes, and measures to enforce compliance with rules and laws. None of the criteria are ultimately effective without a strengthening of civil society, so that people understand the problems of the health sector and are empowered to seek improvements in it.

One important criterion, originally proposed in the Latin American workshops, evaluates reform for its attempt to stimulate the growth of advocacy groups, clearly an intersectoral matter.
This criterion is important because of the crucial role such groups play, in countries with developed democratic traditions, of compelling public authorities to rectify problems in both public and private sectors. In Pakistan and Thailand, this idea was expanded into the criterion “strengthening civil society” which now has two components, establishing an enabling environment for advocacy groups and stimulating public debate about health policy measures. Many aspects of this benchmark go beyond merely holding institutions in the health sector accountable to the public; they actually increase the power of the public to act to remedy problems.

**Benchmark 9, Patient and Provider Autonomy**, is the benchmark that most directly addresses a culturally variable issue. How important is autonomy or choice? In some market-based approaches, informed choice is necessary if quality is to be improved and true preferences met. But how much choice, and what kinds of choices? Similarly, provider autonomy is much sought by professionals, e.g., Colombian doctors opposed to the 1993 reforms, but it is often seen by many planners as an obstacle to efficient use of services, since professionals and provider institutions are influenced by incentives to utilize what they can supply.

For these reasons, it is important to emphasize how Benchmark 9 may conflict with other benchmarks (and others with each other) and that reasonable people in the same or different cultures may disagree about weightings. Consequently there may be no one fairest system, but many fair designs. Benchmarks allow for cultural and other variation, but encourage maximum deliberation about grounds for designs that value some benchmarks over others.

A clear example of the conflict between Benchmark 9 and other benchmarks involves referral systems and the restrictions on patients they involve. Benchmark 6, for example, may approve of restrictions on autonomy in order to achieve a primary care focus and the efficiency
that results from letting primary care physicians filter access to other levels of care, but Benchmark 9 is driven by the concern for a loss of choice. Similarly, choice of alternative providers will undermine efficiency and quality if there is no adequate credentialing and evidence-based assessment of alternative forms of treatment. Practitioner autonomy may be essential if the practitioner is to address the health care problems of individual patients, but this presupposes high levels of competency and knowledge of appropriate evidence-based, population-oriented practices as a baseline.

4. Scoring and Uses of the Benchmarks

We have adapted the benchmarks for use in evaluating competing reform proposals within a country, and the discussion of scoring focuses on that use. It may be possible to use the benchmarks to make some international comparisons of fairness across systems,1,14 but we have ignored such an application in the work reported on here. If our goal had been to provide inter-country comparisons, it would have been necessary to validate the scale in a way that is not crucial for evaluating reforms. In evaluating reforms, progress is made if people can agree on what they think the current limitation of the system is on a particular dimension and then agree about the degree to which a specific reform would improve or worsen that aspect of the system. Disagreements about these aspects of scoring will make the deliberative process about the merits of reforms better, which is the ultimate goal of the benchmarks anyway. It is crucial to understand this purpose of scoring in order to see why our adaptation has adopted a particular approach to it.

In the original use of the benchmarks to evaluate competing U.S. reforms, a scoring system was adopted that took the status quo as a “0,” assigned a maximal positive outcome a “5,” and maximal regression from the status quo a “-5.” In our adaptation, we experimented both
with this system and with more clearly qualitative symbols, such as the use of “plus” and
“minus” symbols. Numbers prove more convenient, provided it remains clear that these reflect
ordinal rankings on complex dimensions, not cardinal measures of some quantity.

The purpose of actually assigning scores for each criterion is to force deliberation about
the specific, interacting effects of the reforms being compared. Because this is the goal, rather
than simply producing a “report card” with numerical “grades,” it is essential that a rationale be
provided for the score that is assigned to a proposal on each relevant criterion. These rationales
provide the necessary objectivity needed to prompt thoughtful deliberation. Some subjectivity
enters any such scoring process, especially where the criteria do not always refer to a clear
magnitude, such as the proportion of the population receiving some particular service or
comprehensive insurance coverage. By including criteria that may seem to call for subjective
judgments, but by insisting that clear reasons and rationales be offered for the scores assigned,
the benchmarks assure both relevance and a basis for objectivity.

We do not confine ourselves to criteria for which there are straightforward
measurements, simply because they seem objective; rather, we require relevance and salience,
even if that pushes users of the tool to provide reasons for their judgments. Because the tool
maps scores onto rationales, it can serve its purpose of promoting deliberation about fairness.
Since the goal is to facilitate cross-disciplinary evaluation and deliberation, an analytic
framework for thinking about diverse and competing values is more important than the
semblance of rigorous measurement.

The point of this method of scoring is to see how well particular reform proposals, as
compared to alternatives, fare on the many aspects of fairness captured by the benchmarks.
Some proposals will be stronger on some dimensions than others, but weaker on others. Where
these do not represent true tradeoffs, it may be possible to formulate policies that are true improvements overall. Where tradeoffs are being made, the framework stimulates discussion of the competing values underlying the alternatives.

Our scoring exercises showed that the adapted benchmarks could reveal: a) places at which proposed reforms were insufficiently detailed or vague about mechanisms to reveal their effects; b) problematic assumptions about how goals of reform would be achieved; c) empirical issues that would have to be resolved in order to determine the likely success of implementing a reform. As a result, we were able in both Pakistan and Thailand to construct practical lists of such issues to be brought before groups considering the proposals for implementation. We also noted the large gap that often loomed between the intention and underlying a reform and the results of implementation. We were able to highlight this gap by scoring the both the intention and implementation of a proposal, where we had evidence about implementation.

In Thailand, the benchmarks were “field tested” by asking people to use them for evaluation of national reforms under consideration (and partly implemented) as well as for changes at the provincial level over a two year period. This exercise has led to the proposal that the benchmarks be deployed for use in evaluating current national proposals for system reform and for use in evaluating plans made by provincial health officers, who will have more autonomy under proposed reforms. In Pakistan, plans exist to incorporate the benchmarks into training programs for provincial and district health officers, as well as into medical school curricula. Plans also exist to have a public health network of academic centers promote the use of the benchmarks at national and provincial levels. There are more ambitious plans to involve regional WHO organizations in the broader adaptation and dissemination of the tool.
All participants in the four sites agreed that a useful format for presenting the final product will be an interactive computer program that allows policy analysts and broader community groups to draw on a database of similar reforms and their outcomes. Properly designed, such a tool would allow concentration on selected benchmarks with the option of ignoring those less relevant. This flexibility would allow it to be used at different levels within a system -- not just for comprehensive national reforms, but for more specific reforms at the provincial or district level. PAHO has already expressed interest in posting such a tool on its website as one item in a policy “toolbox.”

5. Ethical Foundations and Cultural Differences: A Concluding Remark

The original development and presentation of the benchmarks were provided with an ethical rationale through appeal to a theory of justice and health care. The central idea in that theory is that disease and disability impair the range of opportunities open to individuals, and that a principle governing equality of opportunity provides a basis for regulating a health care system. The same theory can be extended to look “upstream” from the point of delivery of health care to the social determinants of health as well.

The objection might be raised that this liberal democratic, rights-based account is too culturally limited to provide a working framework for the benchmark approach. In our work at the four sites, which differ among themselves quite considerably in political, cultural and religious backgrounds, we found great convergence on the benchmarks themselves without extensive discussion of an underlying ethical framework. Participants were introduced to the equal opportunity theory, but it played no explicit role in producing the agreement on the benchmarks, and there was no discussion of it in any detail. Because of the focus on fairness, we
also avoided some culturally sensitive issues, such as abortion, euthanasia, and the use of human
and fetal tissues or organs that have been highly controversial.

Instead, despite the wide variation in cultural background among the participants,
widespread agreement emerged that fairness included the dimensions that were captured by the
benchmarks. We did discuss the fact that the weight or priority given to different benchmarks in
different countries might vary depending on some cultural beliefs. For example, more or less
weight might be given to accountability or to patient and provider autonomy or even to the
equity considerations underlying Benchmarks 1 and 2. But in our workshops, these variations
were not significant. The overwhelming agreement we reached though deliberation is the
primary feature worth noting.

Acknowledgment: The Rockefeller Foundation and its Global Health Equity Initiative funded
our project; we thank the National Institute of Public Health in Mexico, the National Institute of
Health, in Thailand, and the Community Health Sciences Department of Aga Khan University
for hosting our workshops. We also wish to thank the members of the collaborating country
teams and our hosts at the various site visits we made. Daniels also was supported by a Robert
Wood Johnson Investigator Award.
APPENDIX

Benchmark 1: Intersectoral Public Health

Degree to which reform increases percent of population (demographically differentiated where relevant and possible) receiving the following:

- Basic Nutrition
- Housing
  - crowding
  - homelessness
  - physical adequacy
- Environmental Factors
  - Clean water (and water treatment)
  - Sanitation (vector control)
  - Clean air
  - Reduced exposure to workplace and environmental toxins
- Education and Health Education
  - Literacy
  - Basic education
  - Health Literacy
    - Nutritional education
    - Sex education and promotion
    - Substance abuse education and promotion
    - Anti-smoking
    - Anti-drug and alcohol abuse
- Public Safety and Violence Reduction
  - Vehicular accident reduction
  - Violence reduction (homicide, rape)
  - Domestic abuse (women, children)

Development of information infrastructure for monitoring health status inequalities
  - Provision for regular measurement of health status inequalities, using appropriate indicators
  - Research into interventions most likely to reduce health status inequalities

Degree to which reform has actively engaged intersectoral efforts at local, regional, and/or national level to improve social determinants of health, and the degree to which vulnerable groups have been involved in defining these efforts.

Benchmark 2: Financial Barriers to Equitable Access

I. Nonformal Sector Coverage

Universal access to the most appropriate package of basic services
  - examples of packages of varying scope:
    - Mexican 12 interventions (a minimal package)
    - PAHO’s Primary Care package (a slightly more extensive package)
Colombia’s Basic Benefit Package/Subsidized Regimen or Thai package

Catastrophic coverage
(unclear just where Pakistan package fits, but probably below Colombia through public facilities).
Drug Coverage
Medical Transportation Costs
Portability of coverage (geographical, employment status)

II. Insurance for Formal Sector
Reduction of the following obstacles to enrolling people in the formal sector:
corruption and enforcement-- of tax requirements, mandatory enrollment
worker resistance to enrollment
small employer resistance
Family coverage for enrolled workers
Drug coverage
Medical Transportation Costs

Benchmark 3: Nonfinancial Barriers to Access

Reduction in geographical mal-distribution of:
Facilities and services
Personnel (mix and training)
Supplies
Drugs
Clinic hours (appropriate to village routines, work schedules)
Transportation for medical purposes

Gender
Status in family regarding decision-making
Mobility
Access to resources
Reproductive autonomy
Gender sensitive provision of services

Cultural
Language
Attitude and practices relevant to disease and health
Uninformed reliance on untrained traditional practitioners (such as some healers, midwives, dentists, pharmacists)
Perception of public sector quality
Discrimination by race, religion, class, sexual orientation, disease, including stigmatization of groups receiving public care.

Benchmark 4: Comprehensiveness of Benefits and Tiering

All effective and needed services deemed affordable, by all needed providers
No categorical exclusions
Reform reduces tiering and achieves more uniform quality
Integrates services to the poor and others

Benchmark 5: Equitable Financing

Is financing by ability to pay?
  If tax based-scheme
     How progressive (by population subgroup)?
     How much reliance on cash payments (by subgroup)?
  If premium-based
     Is it community-rated (by subgroup)?
     Reliance on cash payments (by subgroup)?

Benchmark 6: Efficacy, Efficiency and Quality of Health Care

Primary Health Care Focus
  PHC training for community based delivery
     Population-based
     Community participation
     Integration with rest of system (referrals)
     Intersectoral integration (social and environmental determinants)

Incentives
  Appropriate allocation of resources to PHC
  Interactive community participation, including vulnerable subgroups

Implementation of Evidence-based Practice
  Health policies
  Public health and clinical prevention
  Therapeutic interventions
     Incentives for clinical guidelines
     Evidence-based evaluation of methods for managing utilization of services

Information infrastructure and database
  Evidence-based research on clinical and public health measures
  Health services research on patterns of care
  Population health needs and utilization rates, including variation studies (with demographic differentiation)

Measures to improve quality
  Regular assessment of quality, including satisfaction, with surveys or community group involvement as appropriate
  Accreditation of Plans and Hospitals
  Professional Training
     Curriculum focused on fair design of system
     Continuing education

Benchmark 7: Administrative Efficiency

Minimize administrative overhead
Inappropriate technology acquisition
  Purchase
  Maintenance
  Training
Excessive marketing costs (hospitals or plans)
Efficient use of personnel
  Reduction of excess
  Appointments and promotions based on competency
Appropriate economies of scale
  Adequate risk pools for insurers
Reduction of duplicate structures, including integration of vertically organized programs
Minimize transaction costs
  Enrollment and disenrollment costs
  Inappropriate shifting and transfers of personnel or patients
  Minimize loss of needed personnel from system as a whole (brain drain)
Oversupply of some services in some areas
Cost-reducing purchasing
  Reduce price variation
  Drug cost reduction through large scale purchasing
  Reliance on (quality) generics where possible
Minimize cost shifting
  Cost shifting from PC to Tertiary
  Cost shifting to patients
  Cost shifting to public sector or insurance from other types
  Cost shifting between schemes
Minimize abuse and fraud and inappropriate incentives
  Shadow (paid non-shows) providers, partial and total
  Practitioner auto-referral
  Drug sales at profit by rural doctor
  Billing practices (up-coding, un-bundling)
  Un-credentialed practitioners in rural areas (also a problem in urban areas in Karachi)
  Vehicles and other perks
  Inappropriate promotion of drugs and devices
  Appropriation of public resources for private practice

**Benchmark 8: Democratic Accountability and Empowerment**

Explicit, public, detailed procedures for evaluating services with full public reports
  Use reports
  Performance reports
  Compliance reports
  Use of adequately qualified consultants
Explicit deliberative procedures for resource allocation with transparency and rationales for decisions based on reasons all “fair minded people” can agree are relevant

Global budgeting
Fair grievance procedures
  Legal procedures (malpractice)
  Non legal dispute resolution procedures
Adequate privacy protection
Measures for enforcement of compliance with rules and laws
  Strengthening civil society
  Enabling environment for advocacy groups
  Stimulating public debate, including participation of vulnerable groups

**Benchmark 9: Patient and Provider Autonomy**

Degree of consumer choice
  Of primary care providers
  Of specialty care providers
  Of alternative providers
  Of procedures

Degree of practitioner autonomy
References


5. Brock D, and Daniels N. Ethical foundations of the Clinton administration’s proposed health care system. *JAMA*, 1994, **271**: 1189-1196.


7. Daniels N, and Bryant J. Parametros de justicia y monitoreo de la equidad: Apoyo a un programa de los OMS. *Salud y Gerencia*, 1998, **16**(enero-junio):1,7-12.


