The world health report 2000 – Health systems: improving performance


Here WHO attempts no less than to rank the vastly different health systems of 191 nations on two one-dimensional measures of performance: (a) “level of health,” represented by disability-adjusted life expectancy (DALE) and (b) an “index of overall health system performance”. The latter is calculated as a weighted average of scores on five distinct dimensions: (1) the country’s DALE, (2) the “distribution of health” (based on child mortality distributions within countries), (3) the health system’s “responsiveness” to what people seek from it in terms of “prompt attention, dignity, autonomy, confidentiality,” and so on, (4) an index of the distribution of that “responsiveness” among socioeconomic classes, and (5) the degree of “fairness” with which the health system is financed. The weights for these five measures going into the “overall health system performance index” were culled from a survey of 1006 experts from 125 countries, about half of them on the staff of WHO.

The final rankings of countries on both of the two performance measures are not based on the actual values achieved by the nation, but on the ratios of the achieved values to the values that ought to have been achieved, given the country’s educational attainment and spending on health care. The denominator in this ratio was derived from an empirically estimated mathematical relationship that predicts, for any combination of national health spending and national educational attainment, the level of performance that would have been achieved by an efficiently run health system.

Because the ultimate rankings emerging from this study are the products of a whole series of inherently subjective analytic judgements on the specific measures of systems performance, on the weights to be attached to each measure and on the model used to compare actual with ideal performance, it is fair to query whether, on balance, so precarious an undertaking does more good than harm.

Before addressing that question in regard to the WHO reports, it is well to keep in mind that the decision-makers in the so-called “real world” do prefer to have complex phenomena collapsed into one-dimensional indexes. Even professors at top universities despair of multi-line academic transcripts and prefer to see a student’s entire and often varied academic career collapsed into the single, highly dubious measure of the grade point average. Gross domestic product (GDP) is a similarly crude, flawed, one-dimensional indicator for national economic performance, as is quarterly earnings per share for a giant corporation. All of these simple measures are the products of whole hosts of precarious assumptions. Yet they are widely used, on the assumption that doing so does more good than harm. Can that assumption be made for the WHO report as well?

The chief virtue of the WHO report lies in the challenges it poses for its critics within the health services research community. Could these critics have done better? If so, precisely how? Or can these critics argue that quantitative assessments of this sort are never worth undertaking? In other words, are we stuck in a rut that allows physicians or politicians in every country to proclaim that theirs is “the best health system in the world” without being challenged by data? If that be the verdict of the research community, it would be good to have it flushed out into the open, and on paper.

On the other hand, there is reason to wonder whether more good than harm will have been done by the fanfare with which this report was injected into the public media and thence into the world of policy-making. Two requirements should have been met before the report was ready for a major media campaign.

First, the WHO research team should have been sure that their estimates are robust. Can they, in good conscience, make that claim? An artificially high ranking, for example, could take the wind out of the sails of desirable health-reform efforts. Similarly, an artificially low ranking could assign a bad grade to past reform efforts that were actually commendable. Rumour in the health services research community has it that France’s no.1 rank was driven in part by a flawed measure of national educational attainment. Under the methodology used by WHO, the more the level of educational attainment or of health spending is underestimated for a country, the higher will be the ratio of actual to ideal performance for that country and the higher will be the nation’s ranking.

Second, if the report is addressed to policy-makers, one must judge it poorly written. To be sure, it has a number of fascinating, if chatty, chapters; but these are only loosely connected to the actual work underlying this study. To see what was actually done, one must plough through the cryptic commentary that accompanies the tables in the Annex or dig up and read sundry sources cited in the references. Few policymakers and even fewer journalists will go to that trouble.

To be useful as a policy analysis, the report ought to have started with the crisp executive summary that is now de rigueur among policy analysts, certainly in the United States. That summary would have presented the main conclusions emerging from the study and described, in layman’s terms, the methodology that was used to reach these conclusions. Most important of all, the executive summary should have contained the many caveats that must, in good conscience, accompany ambitious analyses of this sort.

Uwe E. Reinhardt
Professor of Economics and Public Affairs
Woodrow Wilson School
Princeton University
Princeton NJ 08444–1013, USA
(email: reinhard@princeton.edu)

Tsung-mei Cheng
Princeton International Forum
Princeton
USA
Abortion in the developing world


In March 2000, the British Royal College of Obstetricians and Gynaecologists, with the support of the Department of Health in the United Kingdom, produced a guideline for its members on the care of women seeking abortion. It states that abortion should be considered a health care need, and that all British women should have access to a service of a uniformly high quality. In such a context it is easy to forget just how contentious an issue abortion remains in some parts of the world, and how devastating the consequences are for women in societies where it remains illegal, or where need far outstrips the capacity of existing facilities to provide abortion safely.

Abortion in the developing world provides a clear and graphic picture of the problem. In the introduction we are reminded that 70 000 abortions each year result in death. The risk of dying from unsafe abortion in the developing world is 1 in 250 procedures (1 in 3700 in the developed world), with many more abortion procedures resulting in severe complications, including sepsis and uterine perforation. It is against this background that Mundigo and Indriso present a collection of 22 research reports, the aim of which is “...to provide information useful for policymakers...in countries where women’s health advocates are working towards legal reform and normative change in the health codes to depenalize abortion.”

The reports are the result of a research project commissioned in 1989 by the Social Science Research Unit of the Special Programme of Research, Development and Research Training in Human Reproduction at the World Health Organization. They provide data on a range of developing countries, where the availability of safe abortion is restricted because of legal prohibitions, or lack of availability of services. The starting point for the research was the recognition that in this context, induced abortion is an “...important contributor to reproductive ill-health and to maternal deaths”. Researchers aimed to find out why women resort to abortion, including in situations where contraception is available.

The countries covered are Chile, China, Caba, the Dominican Republic, Mauritius, Nepal, Turkey, Brazil, Mexico, Indonesia, the Philippines, Sri Lanka, the Republic of Korea, the United Republic of Tanzania, Colombia and Slovenia. Researchers have considered three main issues: the relationship between abortion and contraception, the quality of abortion care, and adolescent sexuality and abortion. In all cases, the findings make fascinating reading, but perhaps the most novel and striking aspect of the research is the attention paid to the motivations, opinions and needs of women themselves. This focus makes the collection both refreshing and innovative, but most of all challenges the reader to rethink their assumptions, since findings sometimes contradict preconceived ideas.

The challenging aspects of the research are perhaps most apparent where the relationship between abortion and contraception is considered. For example, the studies reveal that abortion is frequently not the result of a lack of knowledge and experience of contraception, or a lack of desire to regulate fertility. Rather, there can be a significant disparity between what policy-makers and others involved in providing contraception might consider effective, and the views of women themselves. The widespread use of withdrawal as the chosen form of fertility regulation is the clearest example of this disparity. For many, it is highly valued as a flexible, free method, which is not considered detrimental to health, and which perhaps most importantly is confidential and does not require contact with clinic or pharmacy.

In this context it would be both impractical and unethical to consider an unplanned pregnancy that may result as a symptom of a lack of knowledge which requires intervention on this basis. A further laudable aspect of the studies which considered the relationship between abortion and contraception was the attention they have drawn to the need for more research into gender (the differences between men and women in their approach to contraception), and emergency contraception.

In the section on abortion care, attention again focuses on the importance of starting with and prioritizing women’s needs. Research reveals that, in order to improve services, providers need to ask questions including what is the level of knowledge about abortion, possible risks and complications amongst women who use it? What does the experience of unwanted pregnancy constitute for the woman concerned? What can be done to minimize levels of pain for women who have abortion? How can a desire for access to medical abortion be better met? How can services address the need for family planning and abortion services to be better linked? Emphasis is placed on the need for better facilities and more compassionate, well-trained staff; in summary, “...where abortion is provided, all who seek abortion should have their concerns and situations as individuals addressed”.

The final section, on adolescent sexuality and abortion, graphically re-emphasizes some themes which are becoming more familiar. Whilst the needs of adolescents are now rightly on the agenda as a key issue for reproductive health services, the needs remain under-researched, and must be a central priority for the future. Research findings in this collection again indicate that there is a lack of access to sex education and family planning services, and that low levels of knowledge about sex and sexuality remains a major issue in adolescent sexual and reproductive health.

Perhaps above all, this volume emphasizes a lesson familiar to those of us in the developed world, that however perfect contraceptive services become, there will always be a need for abortion. Experience indicates that even where efficient and effective methods of contraception are increasingly easily available, and widely used, abortion remains a fact of life. Those involved with the provision of contraceptive services must work hard to ensure their services meet the needs and aspirations of their clients. But part of the alternative to the current scourge of unsafe abortion in the developing world is the provision of an inexpensive procedure, that, as experience in the developed world shows, poses no risk to health when performed under safe conditions.

Ellie Lee
The University of Kent at Canterbury
Canterbury CT2 7NS
England
Founder and co-ordinator of the Pro-Choice Forum (www.prochoiceforum.org.uk).