0. Introduction.

During the 1980s, both the relative and absolute conditions facing the poor appear to have worsened in a number of low-income countries, especially in Africa. [FN 1] Many of the poor, of course, began the decade in circumstances where the resources to which they had access were, at best, barely sufficient to maintain even an adequate level of health. Given this, it is not surprising that the poor economic performance in many countries, and the austerity programs their governments have undertaken, have led to severely deteriorating health conditions in large population groups. This has come about both because the private real incomes of the poor have shrunk, and because there has been a reduction in the amount of publicly provided resources in sectors that are especially important determinants of the welfare of the poor, such as health care and education.

Understandably, this trend has provoked strong reactions, and many proposals for things that should be done to reverse it. Although there is widespread agreement that in the long run, significant and sustained improvements in the living standards of the poor will require an improved economic performance and rising economy-wide productivity, it is also clear that this remedy will take a very long time to work. In the short and medium term, improvements in the health status and living conditions of the
poor will have to be brought about by an increased emphasis on policies specifically designed to benefit them, not by policies to promote growth in general.

The purpose of the present paper is to offer some reflections on ways in which social science research can contribute to this process. I should stress at the outset that my paper represents an outsider's perspective. Although I am somewhat familiar with the economic problems facing some countries elsewhere in Africa, and with the issues that arise in the economic analysis of health care policy, I have not until now had an opportunity to learn about the specific situation in southern Africa. I am grateful to the organizers of this conference for giving me a chance to do so by inviting me to participate.

The paper is organized as follows. Section 1 provides an overview of the links between economic performance, the debt problem, government policies of restraint (including those pursued under Structural Adjustment Programs), and the health status of the poorer segments of the population. In section 2, I turn to a general discussion of different kinds of studies through which social science research can help in the process of formulating effective policies to improve the health status of the poor; in section 3, a list of possible specific program case studies is presented, as a basis for further discussion.

In section 4, I then briefly consider an issue that has become increasingly prominent in the economic development field,
namely the relation between "policy-oriented" research and the political process. In recent years, there has been growing dissatisfaction with the conventional approach which rested on the tacit assumption that the government of the day could be relied upon to make decisions that were in the interests of "the nation as a whole" (including the poor). Under this approach, the role of research was seen as a technical one, that of contributing to the information base necessary to formulate policies that were in the national interest. This underlying assumption is now being challenged, and there is increasing concern that the interests of the poor are inadequately represented in the policy formation process in many low-income countries. The conclusion drawn by many is that research should therefore also seek to contribute to the objective of giving the poor more influence in the policy process. This has led to calls for more involvement of people "at the grass roots" of social programs, in the research process. Section 4 discusses some advantages, but also some potential problems, with this kind of strategy. Section 5, finally, gives a brief summary and some concluding comments.

1. Structural Adjustment Policy and the Economic Crisis

The origins of the crisis that has forced many African countries into pursuing different kinds of adjustment policies during the past decade or so, have been extensively discussed. [FN 2] As world oil prices rose dramatically in the mid-1970s,
the external resource constraints facing oil importers became tighter. For a time, many countries were able to postpone retrenchment through greatly increased rates of international borrowing. (This process was, of course, encouraged by the aggressive lending policies pursued by many international financial institutions during the 1970s and early 1980s.) However, as mounting debt and higher world interest rates combined to create very large debt servicing requirements, the net flow of resources to many borrowing countries dried up. For countries which had previously been able to meet at least part of their debt service obligations through additional international borrowing, this created a very difficult situation: To continue meeting their obligations, they would have to pursue highly restrictive policies, in an attempt to create a trade surplus large enough to cover their debt service.

For many countries, it soon became clear that the external resource constraint created by this situation was simply too tight. There followed a number of debt reschedulings, coupled with negotiations for assistance from the World Bank and the International Monetary Fund. Such assistance, however, could often be obtained only after commitments by the borrowing country to pursue particular types of restrictive policies favoured by the Fund and the Bank. Often, these policies were very unpopular, to put it mildly, and some governments were placed in an almost impossible position as they were caught between the firm demands of the Bank and the Fund, on the one side, and the domestic
critics of their structural adjustment policies, on the other. However, no matter how bitter the domestic opposition to SAPs, many governments had little choice other than to try to pursue them as best they could, since the prospective assistance from the Bank and the Fund was desperately needed in order to retain some import capacity and avoid an even more severe disruption of their highly import-dependent economies.

In a general sense, it is not difficult to find explanations for the unpopularity of the Bank and Fund-inspired SAPs that many governments are trying to pursue. The basis for these programs is the conventional notion that in order to limit the need for external resources, there has to be a reduction in domestic consumption (private and public), and an improvement in the domestic savings-investment balance. These changes, in turn, can only be brought about through restrictive fiscal and monetary policies; that is, there has to be a reduction in the government deficit, requiring cuts in government spending and an increase in taxes. [FN 3] Typically, SAP packages also include a commitment to avoid an overvaluation of the domestic currency, which often means that governments are initially forced to devalue the domestic currency by a substantial amount. All of these policies will generate opposition: government spending cuts will be unpopular among those who have been benefitting from various kinds of public expenditures; tax increases and subsidy cuts are resisted by those on whom they are imposed; and increased prices of imported goods as a result of devaluations are opposed by
those who have been benefitting from access to low-priced foreign goods. The result is likely to be intense political controversy, as different groups or social classes try to protect the kinds of government spending in which they have a particular interest, and to avoid an increase in their share of the burden of taxation.

The strong emphasis in much of the recent literature on the relation between SAPs and equity can be seen as a manifestation of this kind of controversy. Observers have argued that there has been a tendency for SAPs to increase the degree of income inequality in many countries, because the poorer classes in society have been forced to bear a disproportionate share of the burden of reduced government spending and increased taxation.

From a political-economy point of view, this suggestion certainly appears plausible. If one believes that domestic elites, drawn from high-income groups, have a dominant position in the political systems in many countries, one would not be surprised to see these elites utilize their influence to shift the burden of adjustment onto lower-income groups. At the same time, there is a wide-spread impression that the policy strategies favoured by the Bank and the Fund tend to reinforce this tendency, focussing on spending cuts in programs (such as food subsidies) that are of special importance to the poor.

However, the view that SAPs have tended to worsen inequality is not universally shared. Some observers argue that, in political systems dominated by high-income elites, many government spending programs have had a tendency to benefit high-
income groups disproportionately to begin with, so that a net reduction in the scope of government programs may well reduce the real income of these groups by at least as much as that of lower-income groups. Moreover, the international lending agencies themselves have strongly argued that various special provisions in their policy recommendations are intended to protect the poorest groups in society. The most that can be confidently said at a general level, therefore, is that the relation between SAPs and equality is a controversial issue, and that more empirical work is needed if there is to be any hope of reaching a reasonable degree of consensus. [FN 4]

The preceding comments relate to the question of the relations between SAPs and equity in general. The focus in the present context is somewhat more specific, concentrating on the impact of SAPs on equity through their impact on health. Although the issues that arise with this specific focus are similar in many ways to those already discussed, the health-equity relation also raises a set of important questions of its own.

First, there is a the factual question to what extent government restraints under SAPs have in fact led to significant retrenchment in programs that are intended to improve the population's health, such as subsidized provision of staple foods, provision of water and sewage facilities, public health programs, and provision of conventional curative health services such as hospital beds and the services of physicians and nurses. There is also the question of the extent to which the impact of
reductions in public spending on some of these services have been offset by improved "targeting", or in some cases by increased private provision, and the equity implications of such changes. [FN 5]

Second, although there is little doubt that there is a strong positive correlation between income and health status, it is much less clear exactly what the nature of this link is. For example, is it the case that the poor are less healthy than the rich because they cannot afford to buy a nutritionally adequate diet? What role does education play in this nexus (if knowledge of principles of nutrition, as well as an adequate income, is needed in order to ensure that families have nutritionally adequate diets)? How cost-effective are programs of food subsidies in alleviating nutritional problems? [FN 6] Does the correlation between health and income arise principally because the poor, on average, have less access to clean drinking water and proper sanitary facilities than the rich? Or because public health programs, such as spraying against malaria, immunization of children, or knowledge of oral re-hydration techniques, reach the poor to a lesser extent than the rich? What role does access to conventional curative health services, such as hospital beds and physicians, play in this regard? (Some observers have argued that in some countries, tax-financed provision of curative health services has, in practice, tended to increase inequality, since these services have principally been accessible to upper- and middle-income individuals and families.)
Another aspect of health care that is especially important in poor countries relates to the cost and availability of drugs. This raises the issue of how significant access to drugs is as a determinant of health, and the extent to which the system of drug pricing and distribution contributes to the relatively poorer health of low-income groups. Another important question, finally, is: Does the nature of the health-income link differ between urban and rural areas? If so, how?

Answers to these questions are likely to differ from country to country, and existing knowledge does not appear to provide much of a basis for answers to most of them. Yet, an assessment of the extent to which retrenchment of health-related programs has increased inequality requires some idea of what the answers are.

2. Research Questions and Strategies

In this section, I turn to a discussion of what kinds of research strategies could be pursued, if research is to provide a better basis for policies to reduce the impact of SAPs on the health of the poor.

Improved knowledge can contribute to better decision-making in this area in two fundamental ways. First, it may provide a basis for a better allocation of a given amount of resources among different programs designed to improve the health of the poor. For an economist, a natural policy question to ask is: Given a particular amount of funds available to improve the
health status of the poor, how should these funds be allocated if they are to yield the maximum contribution to this objective? Using conventional economic logic, an answer requires an attempt to measure the contribution that an incremental amount of funding would make to this objective, for each type of program to which the funds could be allocated. [FN 7]

The second way in which more knowledge can contribute to better policy is by providing a basis for more efficient use of resources within a given program. For example, whether or not the total amount of resources devoted to modern hospitals is the appropriate one, it is clear that the efficiency of society's resource use will be improved if the costs of producing any given bundle of services can be reduced, or the quality of service provided with a given amount of resources can be increased. This may be accomplished, for example, through better management, or better "intra-program" allocation, of given resources. Through research, opportunities for such improvements may be identified.

Given these basic questions, it is now possible to identify examples of specific research projects that could be helpful in answering them.

Determinants of health status in population subgroups In order to consider the question what kinds of programs or expenditures are most effective in enhancing the health of the poor, one must have information about the relative importance of various factors in determining individuals' health status. Thus, survey research to measure health status of individuals in
particular population groups, and to attempt to relate observed differences to potential determining factors, could be very helpful.

If the research projects are to be kept small, it would be appropriate to concentrate on particular sub-groups among the poor. In urban areas, surveys could be taken among formal-sector workers in one or more establishments, or among a sample of informal-sector workers, residents of one or a few particular urban neighbourhoods, etc. Surveys could be family-based, or focus on special categories of individuals such as women, school-age children, or women around the time of child-birth. Similar categories could be surveyed in rural areas: farmworkers, women, children.

If the object is to try to measure the impact of particular types of government programs, care must be taken in designing the samples in such a way that they include significant number of individuals that do have access to these programs, as well as individuals who do not. More generally, to allow identification of the effects of any particular variable or factor on health, samples have to be designed in such a way that there is significant variation among observations in the value of this variable.

Measuring effectiveness of particular programs A variant of the type of study discussed above is when research is specifically focussed on measuring the impact or effectiveness of a particular program to improve health. [FN 8] In this case, the
appropriate strategy would be to choose samples in which the individual observations are as similar as possible, except with respect to access to this particular program. Thus, to evaluate the effectiveness of rural health posts, one may select two villages that are as similar as possible in other respects, but which differ in that one does, while the other does not, have a health post nearby. Or, surveys could be made of the health of mothers and newborn children in two groups consisting of users and non-users of well-baby clinics. While the multi-factor approach discussed in the previous section is more commonly used by economists, the technique discussed here (in which inferences are drawn by studying the differences between a "study group" and a "control group") is more common in health care research.

Case studies on design and administration of government programs While the research discussed above relates most closely to the question of the relative cost-effectiveness of different policies to help the poor, case studies on the way particular expenditure programs actually operate is more geared to the question how the internal effectiveness of individual programs could be improved. Although a number of case studies of this kind exist in the literature, since programs differ from country to country there is certainly room for many more. Moreover, an incidental benefit of undertaking similar studies in a number of countries is that it might make possible systematic international comparisons, from which useful policy conclusions may sometimes be drawn.
Another advantage of individual program case studies is that it is possible to go into considerable detail concerning issues such as financing, program design and coverage, and methods of administration. Much can be learned about these things from official program descriptions, and from interviews with senior officials. However, the gap between program principles and plans and their implementation in practice, is sometimes distressingly large. Thus there may be great value in a "grass-roots approach" in which careful attempts are made to observe the way programs are implemented in practice, as a complement to analysis of their formal design. This process may of course sometimes be very sensitive if program administration is plagued by irregularities and small-scale corruption, as often happens. However, knowledge of the extent to which programs are affected by such problems is evidently vital if attempts are to be made to improve them.

The list of programs that could be studied using this type of approach is obviously very long. What follows is intended to provide a few possible examples only.

3. Specific Program Case

Food subsidies and price controls Many countries maintain price controls on various kinds of foodstuffs classified as "essential", or have programs under which food is distributed at subsidized prices, or directly to particular consumer groups. [FN 9] As such programs differ from country to country, case studies may yield helpful comparative information. Issues of interest
include not only the scope and coverage of the programs, but also questions of financing and administration (in the case of food distribution programs) and methods of enforcement (for price controls). In most countries, price control programs give rise to black markets to some extent (when the supply of price controlled commodities exceed the demand at the controlled price, as is often the case), and various kinds of irregularities and petty corruption often plague the administration of food subsidy programs. Even though it is likely to be very difficult to get information on the extent to which these problems are present, such information is important, and comparative studies on ways in which they can be counteracted may be very helpful.

Considerable interest also attaches to the problem of measuring the precise impact that these programs have on the distribution of real income. As some studies have noted, even though they are intended to help the poor and reduce economic inequality, they are often effective in the cities only. Thus, even though they may have the effect reducing inequality between rich and poor in urban areas, since most of the poverty in many countries is in the countryside, their overall effect on income distribution is less clear. However, in considering this problem, it should also be taken into account that to some extent, the rural poor may also benefit if food subsidies lead to higher producer prices of food, and increased rural incomes.

Another interesting comparison, finally, is between programs such as price controls or food subsidies, on the one hand, and
programs intended to improve agricultural productivity, on the other. When successful, the latter kinds of programs (which may involve agricultural extension, distribution of credit, fertilizer, and improved seeds, or the construction of networks of rural feeder roads) have the effect of raising incomes among the rural poor, as well as lowering the prices of foodstuffs in urban areas. [FN 10] Thus, indirectly, they may have the effect of improving nutritional standards, and thus health status, among the poor. Information that would make it possible to compare the relative impact of such programs with policies such as price controls or distribution of subsidized food, could be particularly helpful for policy-making.

Water and sewage The importance of access to piped drinking water and proper sanitation for good health is well established. Having an effective, low-cost system for the provision and maintenance of water and sewage facilities is one important way in which society can contribute to good health among the poor.

Obviously, studies relating to the technical aspects of cost-effective system design, in rural and different-sized urban areas, can be useful. Another important issue relates to financing. To the extent that improved public water and sewage facilities have a disproportionate impact on the health of the poor (as is likely to be the case when it is possible for better-off families to provide adequate facilities out of their own funds), the central government may become involved in financing
them. However, the burden on the central government budget can be reduced by transferring part of the financial responsibility for construction and maintenance to local authorities. Put differently, water and sewage provision is likely to be an area where the payoff to programs of "community mobilization" and "community financing" may offer substantial payoffs. [FN 11]

**Public-health services** Although the terminology in this context varies, the term "public health" is often used to refer to a collection of health services with one or both of two kinds of characteristics: being preventative (rather than purely curative), and having substantial "external benefit" elements (because they involve prevention of contagious disease, or consist of services, such as spraying against malarial mosquitoes, that jointly benefit all individuals in a community). [FN 12] Typical services included here may be immunization clinics, maternal-child health programs (or "well-baby clinics"), information programs aimed at AIDS and venereal disease prevention, and eradication of disease-carrying insects. A case may also be made for including programs for providing information and services relating to family planning in this category.

In developed countries, expenditures on these kinds of programs typically represent only a small proportion of the total health budget. Although spending on these services may have very high initial returns, the returns rapidly diminish and incremental spending tends to be directed toward curative services. In low-income countries, however, it is not clear if,
or in what particular activities, the stage of diminishing returns has been reached. [FN 13] For example, in many countries, services may be available in some areas but not in others.

Public-health services of this kind (like water and sewage) are likely to be particularly important in protecting the health of low-income families. Thus case studies relating to the scope and extent of such services, and attempts at measuring their distributional impact, are potentially important. Similarly, studies aimed at studying the efficiency of resource use in public-health programs, and possible ways of improving their internal administration, could be very useful.

Curative health services The services of doctors, nurses, and hospitals represent the largest portion of total health-related expenditures in all countries. Even though there are some kinds of public spending on health care that clearly contribute to equity, there is, as noted above, some controversy over the issue whether the net impact of total government spending on these kinds of "curative" services actually favours equity in many countries. Even though, on average, poor people are less healthy than the non-poor, the pattern of spending, and the criteria according to which access to these services is determined, may well combine to yield a net increase in the relative real income of the better-off groups. Therefore, reduced spending on curative services, as a result of SAPs, may not imply a relative worsening of the position of poorer groups: The impact on equity depends very much on what kinds of services are cut.
Thus, studies of the relative importance of different curative services for the poor may be needed to provide a basis for deciding what kinds of spending cuts would have the least impact on their welfare.

(i) Institutional services. Apart from the services provided in the offices of privately practicing physicians or in private clinics, most curative health services are rendered in some type of publicly financed facility, such as a hospital, urban polyclinic, or rural health post. Descriptive, comparative studies of the organization and administration of the system of health facilities in different countries would provide useful knowledge. Especially important issues in this context include the geographical distribution of different types of facilities, including the distribution within urban areas, and also the substitutability between publicly financed and privately owned facilities. For example, closing a polyclinic in an affluent urban area may often result in the opening up of privately operated clinics instead, although this would not be likely to happen in a low-income district, or in the countryside if a rural health post were closed. Another issue of interest is the division of responsibility for financing of health facilities among different levels of government. For example, since it is reasonably easy to determine which towns and villages are the main beneficiaries of rural health posts, it may be possible to reduce the burden on the central government by transferring more of the financial responsibility to local governments. [FN 14]
(ii) Technology choices. A set of questions closely related to the above concerns the relative amounts spent in a country to treat different kinds of diseases. With the progress of technology, new medical therapies are constantly being invented. Sometimes these therapies are very expensive, are used to treat relatively rare diseases, or result in short increases in patient life expectancy.

If resources were unlimited, every country would obviously want to give its citizens access to the newest and best technology. However, not even in the rich industrialized countries does every sick person receive the best and most sophisticated medical treatment. In poor countries, where resource limitations often mean that there aren't enough funds to provide even basic care to many citizens with serious but easily treated health problems, the question how many resources to spend on sophisticated, expensive technology, becomes an even more important one. In many countries, the problem is presenting itself in an especially acute form with the recent spread of AIDS, for which a range of expensive therapies are available; however, none so far appears to offer more than a relatively modest increase in patients' life expectancy.

Answers to these kinds of questions are now increasingly sought through systematic "technology evaluation". These evaluations are typically carried out by teams consisting of health professionals, health administrators, and health economists, and may involve use of concepts such as "incremental
quality-adjusted life years" as an outcome measure. [FN 15)
Because new technologies may require expensive specialized facilities and personnel, the decisions which ones to use (or not to use) may have very important implications for total health care spending, and the distribution of existing spending among different facilities and personnel training programs.

To my knowledge, formal technology evaluation of this kind has so far not been used to any substantial extent in low-income countries. Part of the reason for this undoubtedly is that the relevant data from clinical experiments, etc., are often not readily available. However, even if data limitations would mean that the results could only be taken as suggestive, pilot studies involving evaluation of selected technologies would nevertheless seem to me potentially worthwhile. To some extent, the value of such studies may lie not so much in the actual results, as in training decision-makers to appreciate the nature of the questions being asked and the criteria that may be used to answer them.

(iii) Health manpower policies. Most health services are provided by different kinds of specialized, highly trained personnel, and the design of health manpower policies is one of the most challenging tasks of the decision-makers in any health services system. Relevant issues here include the balance among different kinds of personnel (doctors in different specialties, para-medics, nurses, pharmacists) in a well-functioning system, as well as the appropriate length and content of the professional
training programs. [FN 16] In all these areas, descriptive comparative studies would yield helpful information.

An effective manpower policy requires not only the right number of professionals with the appropriate training, but also that this manpower is efficiently used. In the case of physician manpower, this leads to consideration of the question of "how to pay the doctor": through some form of salary, fee-for-service, or capitation? It also raises the issue of organizational and administrative arrangements that can be used to provide incentives leading to more efficient use of manpower in the public sector.

The budgetary cost to the government of providing health personnel depends on several factors: the extent to which the training is subsidized; on the salaries paid to health care personnel; and on the share of their income paid by others, such as patients or local governments. Thus, studies on government policies with respect to determination of the incomes of health services personnel, and on the extent to which different kinds of professionals (doctors in private practice?) should be required to pay for the cost of their training, are all questions on which comparative studies might be helpful.

(iv) Drugs. In comparison with high-income countries, the cost of drugs is likely to make up a larger share of the total cost of health care in low-income countries. Although I am not aware of precise statistical information, I would suspect that this is especially true when one considers the cost of the health
care received by the poor; investigation of this through some type of survey study would seem to me an important task. If the conjecture is true, background studies on things such as the overall cost of drugs, as well as on the system of production, imports, and distribution, could potentially be very useful for health policy. With respect to distribution channels, an important issue concerns the roles of drug distribution through hospitals and clinics, on the one hand, and through pharmacies, on the other. [FN 17] Pharmacies may, in practice, be a particularly important part of the health care system serving the low-income population; existence of an efficient network of pharmacies selling drugs at reasonable prices may thus be an important factor raising this group's welfare. By the same token, one suspects that pharmacists in many countries often go beyond their traditional (by Western standards) role, and effectively engage in some amount of diagnosis and prescription. Information about this, and analysis of the possibility of providing pharmacists with additional training so as to enable them to carry out these functions more effectively (that is, to substitute, to some extent, for the services of doctors and nurses), would seem to me important topics for research.

Many drugs sold in low-income countries have been developed and/or produced by multinational drug companies who control their distribution through patent legislation. Thus, issues of drug provision are closely linked to foreign exchange availability and international trade licensing systems in many countries, as well
as to their obligations under international patent (or, more generally, "intellectual property") agreements, and policy-making in this area tends to be influenced in part by pressure exerted by representatives for these companies. However, although international agreements impose some restrictions on how a country's government can change its own patent laws, individuals countries do have considerable freedom to make its own laws. Research on alternative forms of patent legislation, to make possible improvements with respect to the cost and availability of drugs, might therefore yield useful information.

4. Some Comments on the Political Economy of Research on Health and Equity

In this section, I turn to some comments on certain issues that are particularly difficult in the area of research on economic policy affecting equity and the poor: The relation between research and the political process; and the role of special interest groups.

With respect to the interdependence among research, policy, and the political process, the traditional approach in mainstream economic development research was essentially to disregard the political process. The role of the "policy-oriented" economist was typically seen as that of providing technical advice that would help policy-makers achieve the objectives of economic policy, whether these were aimed at accelerating the rate of economic growth, improving the efficiency of resource use, or
achieving a more equitable distribution of real income. The question whether these were, in fact, the objectives of actual governments, was usually ignored, on the implicit assumption that there was, in the background, some sort of political process that could be relied upon to make the policy-makers represent the interests "of the nation as a whole".

In the recent literature, however, this assumption has increasingly been questioned, and more attention has been paid to the "political-economy" issue of the interaction among the economic self-interest of particular groups in the economy, the political process, and the formulation of the goals and instruments of economic policy. (This trend in economic research is not limited to analysis relating to developing countries: Research on political-economy questions, such as whether there is a "political business cycles" in the United States, or why governments continue to maintain barriers against international trade, has become an important area in economics in general in recent years.)

In low-income countries, critics who have studied the impact of economic policies on the distribution of income have charged that governments often do not seem to be very concerned with the poorest classes. Instead, political systems in many countries tend to be dominated by "elite" groups (often the "educated elite"), and policy decisions tend to reflect the interests of these groups. In some countries, the critics charge, this tendency is exacerbated by the fact that the educated domestic
elite has close international contacts, and may sometimes be unduly influenced by foreign organizations and interests.

These claims, if true, may clearly create a dilemma for the policy-oriented analyst. For example, if one is interested in the question of how to design effective policies to help the poor, what is the point in studying this question if one does not believe that the political decision-makers are truly interested in pursuing this objective (although, for various reasons, they may say that they are)? For someone concerned with the conditions of the poor, would it not be better, in the circumstances, to devote himself to political agitation on their behalf instead?

Although this dilemma may be a real one in some cases, its significance should not be overstated. In part, the political willingness to help the poor may depend in part on whether or not there exist effective instruments for doing so, at a reasonable cost. Thus research into ways of designing such instruments may, in itself, help bring about changes in politicians' attitudes, favouring the poor. Equivalently, it may contribute to the political effectiveness of groups who already favour such change. By the same token, if careful empirical work can demonstrate that the burden of existing policies is born disproportionately by the poor, popular pressure to change these policies will increase in the long run, even if helping the poor is not a high priority for the government of the day.

Occasionally, people working in this field respond to the "political-economy dilemma" by trying to combine more
conventional analytical and empirical work on specific issues, with general discussions of what they perceive as inadequate government priority being given to support of the poor, and of international actions or attitudes that have partially caused or aggravated the economic situation in low-income countries. There are, however, problems with trying simultaneously to provide, through research, a better knowledge base for policy decisions, and to engage in political advocacy on behalf of the poor, or particular groups among the poor. For those reading such discussions, it may be difficult to distinguish between statements or recommendations that represent "objective" conclusions from the scientific research, from those that express the researcher's value judgments and personal opinions with respect to the policies of governments and international organizations. [FN 18] This problem is especially likely to arise when the researcher represents a group that is directly involved in a particular program being discussed, either directly as beneficiaries, or as administrators or providers of services.

Clearly, this observation has a bearing on the question of the role of such groups as participants in research on health and equity. As noted in the introduction, many people have argued that the quality and relevance of research in this area could be considerably improved if there were more participation by "grass-roots" groups, such as peasants' associations, trade unions, women's organizations, health workers' organizations, and so on.

In one sense, it is hard to disagree with such suggestions.
The perspective of those who have been directly involved with existing program and policies, as clients, service providers, or administrators, is obviously critical for realistic case studies and evaluations, and as sources for proposals regarding how to improve them. Giving such people a role in the research underlying policy and program changes may also contribute to easier acceptance of proposed changes among the groups they represent.

At the same time, it must of course also be recognized that groups of this kind typically have a direct self-interest in the findings and recommendations coming out of the research. In such circumstances, there is a potential conflict between their role as participants in research projects requiring reasonably strict standards of detached scientific "objectivity", and their special interest in the outcomes. However, even though this conflict often cannot be avoided, as long as it is openly recognized, and care is taken to establish in advance the groundrules under which such "grass-roots" representatives participate, it may be possible to have the advantages of their involvement without impairing the integrity of the research process.

5. Concluding Comments

Roughly speaking, the two basic questions addressed in this paper are: (1) What kinds of policies can be used to reduce the impact of economic retrenchment on the health and welfare of the poor classes in low-income countries? (2) How can research by
social scientists contribute to the design of effective policies that may help accomplish this?

As in other works that have considered the issue, the conclusion with respect to the first question is that there usually is considerable scope for measures to protect the poorest population groups, even when aggregate resources are being reduced. On the one hand, in most countries there are opportunities for more effective use of a given aggregate amount of resources through a reallocation among different programs. On the other hand, there may also be opportunities for improving the effectiveness of the resources used within given programs, for example, through better targeting of benefits on the most vulnerable groups, or by rationalizing methods of service delivery and administration.

Research can contribute to accomplishing these aims, in a number of ways: through empirical work giving better measures of the relative impact of various programs on different income classes; through case studies (possibly involving international comparisons) of the design and administration of existing programs; and by providing "blue-prints" of more effective policies and programs.

Although some care must be taken to avoid potential conflicts of interest, the quality and relevance of such research can undoubtedly be improved by increased involvement of individuals and groups at the "grass roots": clients, administrators, and service deliverers. That this be done is
especially important in those areas where an improved policy or program performance is expected from giving greater administrative and financial responsibility to local governments and community agencies, a strategy that has been advocated by many analysts. While the suggestion for a more "grass roots oriented" strategy certainly is not new, it does not appear to have been extensively tried out in practice, and the design of research projects in which this is effectively done could be a major contribution.

Some of the possible research projects discussed above would, of course, be similar to other studies that have already been carried out elsewhere. Although work of this kind may not seem as exciting from a scientific point of view as work on "new" questions, it nevertheless has several important functions. First, whether or not an empirical result derived in one society is true in others as well, is of interest in itself. Second, the likelihood that a particular finding will have an impact on public opinion and policy in a given country is much greater if it has been confirmed in a study in the country itself. Thus, research projects modelled on ones that have already been carried out elsewhere should probably be encouraged, and carrying out similar studies in several countries at once may be a good strategy as well.
FOOTNOTES.

1. For a review of the evidence, see the first two chapters in Cornia et al. (1987).

2. For a careful review, see Edwards and van Wijnbergen (1989), and the reference cited there.

3. In developing countries without a highly developed bond market, monetary policy can only be effectively used if the government budget deficit is brought under control. In such countries, the only way to finance a large government deficit typically is through "the printing press", that is, through incremental money creation.

4. See the comments by the editors on pp. 6-9, 21, in the introduction to Bird and Horton (1989), with regard to the discussion of the paper by Helleiner (1989) on this issue. See also the discussion in Behrman and Deolalikar (1988), especially pp. 697-698.

5. As Mosley and Jolly (1987) implicitly note, if countries respond constructively to the need for adjustment in the health care sector, the result may be an improvement in equity: "The challenge .. is how to turn the constraints of adjustment into an opportunity for restructuring the health sector to make more rapid progress toward .. basic health goals" (p. 220).

6. For a thorough review of these issues, see Behrman and Deolalikar (1988).

7. For countries where the pursuit of economic stabilization has forced a reduction in the amount of funding available for such programs, the relevant question is: how should the funding reductions be distributed if the impact on the health of the poor is to be minimized? Although the questions appear somewhat different, the information required to answer them is, in fact, the same.

8. For a very thorough survey of a number of studies of this kind, see Pinstrup-Andersen (1987).

9. For examples, see again Pinstrup-Andersen (1987), or the Tanzanian case study by Horton (1989).

10. An interesting analysis of the relative impact on rural and urban groups of a particular food subsidy system (Zimbabwe in the early 1980s) can be found in Davies and Sanders (1988). See also Berry (1989) for a general review.

12. The term "primary health care" (PHC) is sometimes used to refer to some of these services.

13. The possibility of improving health status by reallocating funds from high-cost interventions with potential benefits to only a small group of people, toward low-cost programs benefitting large numbers, is emphasized in Mosley and Jolly (1987). For a particularly interesting case study (Zimbabwe 1980-85), again see Davies and Sanders (1988).


15. For a careful review of methods of technology evaluation in industrialized countries, see Feeny, Guyatt, and Tugwell (1986). Methods of measuring and using the concept of "quality-adjusted life years" are discussed in Torrance (1986).

16. For brief discussions, see Cornia (1987), pp. 176-77, and Mosley and Jolly (1987), pp. 222-224, as well as references cited there.

17. For a brief discussion of issues in drug policy, see Mosley and Jolly (1987), pp. 228-230, where they also refer to an interesting drug policy initiative in Tanzania. For more background, see also WHO (1985).

18. An illustration of this difficulty is provided by the "Ukunda Declaration on Economic Policy and Health".
REFERENCES.


