

Health, Nutrition and Population

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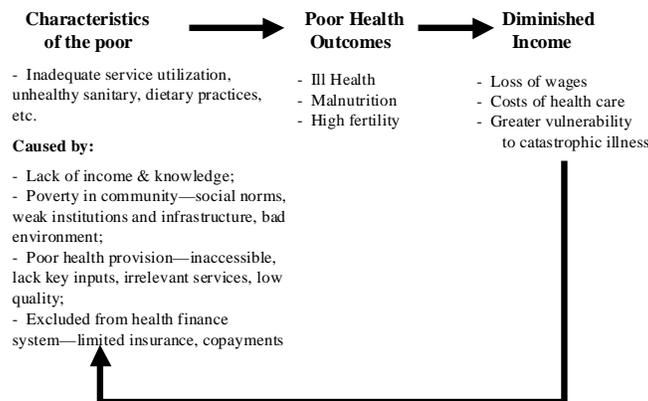
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1. Introduction

1. **Poverty is both a consequence and a cause of ill health.** Ill health, malnutrition and high fertility are often reasons **why** households end up in poverty, or sink further into it if they are already poor. Illness in a breadwinner—and the consequent loss of income—can undermine a poor household’s ability to cope financially. Out-of-pocket payments for health services—especially hospital care—can make the difference between a household being poor or not. And high fertility places an extra financial burden on households—by diluting the resources available to other household members, and by reducing the earning opportunities, especially for women. But poverty is also a **cause** of ill health. Poor countries—and poor people **within** countries—suffer from a multiplicity of deprivations which translate into levels of ill health that far exceed the population average (Box 1). Most obviously, they lack the financial resources to pay for health services, food, clean water, good sanitation, and the other key inputs to “producing” good health. But it is not just lack of income that causes the high levels of ill health amongst poor people. The health facilities serving them are often dilapidated, inaccessible, inadequately stocked with basic medicines, and run by poorly trained and sometimes rude staff. Furthermore, poor people are also disadvantaged by a lack of knowledge about prevention, and when to seek health care. They also tend to live in communities that have weak institutions and have social norms that are not conducive to good health. In short, poor people are caught in a vicious circle—their poverty breeds ill health; and this, in turn, conspires to keep them poor (Figure 1).

Figure 1: Health and Poverty Linkages

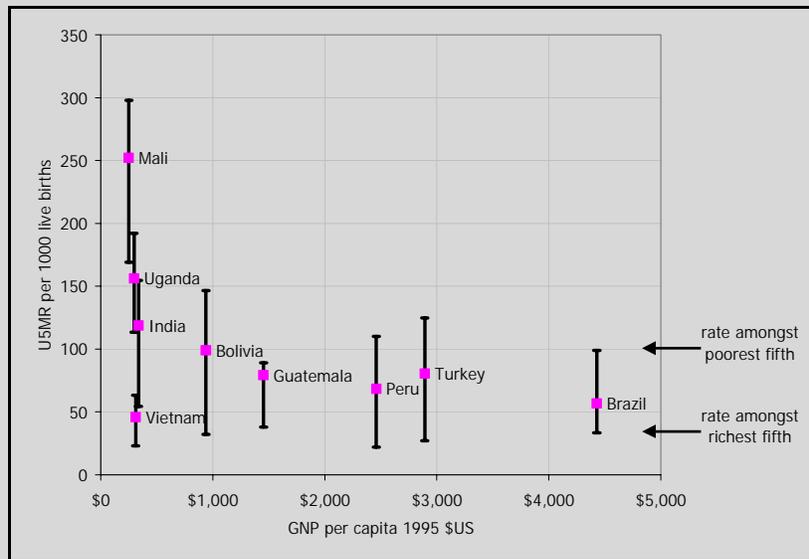
Cycle of Health and Poverty



Box 1—Poor Children Die Early

It is well known that poor countries tend to have worse health outcomes than richer countries. For example, in several sub-Saharan African countries, as many as 200 out of every 1000 children born will die before their fifth birthday; in Sweden, by contrast, the under-five mortality rate is currently only 5 per 1000 live births. This tendency is shown in Figure 2, where the population under-five mortality rate (indicated by the marker) is usually higher in poorer countries. What is less well known, but should come as no surprise, is that **within countries** poor people have worse health than better-off people. The vertical bars in Figure 2 shows that poorer children—however affluent or poor their country—tend to have a **smaller** chance of reaching their fifth birthday than better-off children. The chart shows another important point—the gaps in survival prospects between poor and better-off children vary from one country to the next. Vietnam, for example, despite its low per capita income has not only a low national average child mortality rate but also a small gap between poor children and better-off children.

Figure 2: Under-five mortality: gaps between and within countries



Source: Data from Gwatkin et al. (2000) and World Development Indicators 2000.

2. **Governments can improve the health of poor people.** Health—along with education—is seen as one of the key ultimate goals of development. Indeed, increasingly health is seen as a **dimension** of poverty in its own right. This is reflected in the fact that no less than four of the seven international development goals (IDGs) relate to health broadly defined (Box 2). Governments can do much to improve the health of their populations—especially that of the poor. They can mitigate the effects of low income on health outcomes by reducing reduce the price poor people pay for health and other key goods and services, through, for example, health insurance, fee-waivers, and targeted food subsidies. But governments can also reduce the non-income disadvantages faced by poor people. They can improve poor people’s access to—and knowledge of—health services. They can improve the quality of services that poor people use—both in technical terms and making them more user-friendly for poor people. They can get services more focused on the interventions that are relevant to the health profile of poor people. Improving the health of poor people means contemplating action on several fronts. The main objective of this chapter is to provide guidance on

accomplishing this. ***One point needs emphasizing, however, at the outset, namely that funds linked to PRSPs—whether debt relief or IDA credits—will have a far greater impact on poor countries' health levels if they are accompanied by a thorough review of existing policies, and by a willingness to link new spending with reforms that make health systems work better, especially for the people they tend to serve least well—the poor.***

Box 2— Health and the International Development Goals

The international development goals have been embraced by much of the international development community as a way of ensuring that progress in poverty-reduction can be measured and monitored. Health features prominently in four of the seven goals:

- ***Reducing extreme poverty.*** The proportion of people living in extreme poverty in developing countries should be reduced by at least one-half between 1990 and 2015. Progress is to be measured via income poverty statistics but also via the proportion of children under age five who are underweight. Large health expenditures by households and ill health are widely recognized to be contributory factors to income poverty.
- ***Reducing infant and child mortality.*** The death rates for infants and children under the age of five years should be reduced in each developing country by two-thirds between 1990 and 2015.
- ***Reducing maternal mortality.*** The rate of maternal mortality should be reduced by three-quarters between 1990 and 2015.
- ***Reproductive health.*** Access should be available through the primary healthcare system to reproductive health services for all individuals of appropriate ages, no later than 2015.

Source: <http://www.paris21.org/betterworld/home.htm> .

3. ***Governments can reduce the impoverishing effects of ill health.*** By improving the health of their populations, governments can reduce income poverty. But they can also reduce income poverty indirectly, by reducing the ***impact*** of ill health on household living standards. For example, they can modify health-financing arrangements to ensure that people do not face large out-of-pocket payments when they fall ill. This is sometimes called the ***financial protection*** goal of health systems—clearly a secondary goal to that of improving health, but nonetheless an important one. Other parts of government also have a role to play here—for example, by introducing schemes to provide income support to households where the breadwinner is ill and unable to work. The second objective of this chapter is to provide guidance on ***what health ministries*** can do to reduce the impoverishing effects of ill health. The chapter does ***not*** address what ***other*** parts of government can do on this issue—this issue is covered in the **Social Protection** chapter in this volume.

4. ***The role of government.*** In countries as poor as those preparing PRSPs, funds are extremely limited, and it is vital that these be used wisely to ensure they have the greatest impact. Governments cannot do everything, and in any case in the health sphere they never will. Good health can be produced in many ways, and central to this process are ***people***—as members of households, and as members of communities. Good health is not just about what goes on inside health clinics and hospitals. This is not to belittle the role of governments. Governments have a key role to play, but it is not

just question of pumping money into health services. Services need to be relevant, accessible and affordable to poor people. There has to be coordination between government and the other actors in the health system, such as donors, NGOs, and community organizations. Actors in the system have to be kept well informed, about the costs and benefits of different health interventions, about best practices in their delivery, about the health risks associated with certain activities and products, about the opportunities for obtaining care from different providers, and so on. Good government also means reaching out across ministries. In short, a good government is as much a **steward** of the health sector as it is a financier and provider of health services.

5. **The different levels of government action.** Putting together policies aimed at improving the health of poor people and reducing the impoverishing effects of ill health requires thinking broadly, but it also means thinking across all the relevant levels of policymaking. The first is the **macro** level—the level of the government’s national budget. Here the major concern will be the amount of resources allocated to health, but an important secondary concern will be the possible reallocations of budgets to reach poor people better. The second key level is the health system, where the concern will be to put together reforms and improve incentives to get the system to function better for poor people. The third level is the **micro** or service delivery level, where the focus will be on how to implement specific activities to reach poor people. Work at these three levels is interdependent—those working at the project or service delivery level cannot succeed without the cooperation and assistance of those at the systems and spending levels. The PRSP represents an opportunity for all people working at all three levels to work together.

2. The key stages in policy design

6. **Diagnostics.** What are the health outcomes of the country in question and how do these vary between poor people and less poor people? How far are households currently put at risk of poverty because of payments for health care?

7. **Analysis.** What explains the bad health outcomes of poor people and the impoverishment associated with ill health, and how far do current policies help improve matters? The chapter proposes a framework for organizing this analysis. It views health outcomes and impoverishment as the result of an interaction between households, communities, health services, other sectors, and government.

- **Households.** In effect, it is households who “produce” health, though their consumption of food, their sanitary and sexual practices, their consumption of health-damaging commodities such as a cigarettes, and their use of preventive and curative health services. None of these is fixed. Some households seek and manage to obtain health care when ill, whilst others do not. Some manage to consume the daily-recommended amount of different nutrients while others do not. And so on. Invariably, **because of their poverty**, poor households fall behind better-off households, often dramatically so. Key questions to ask at the household level include: What household actions—broadly interpreted—make for good health outcomes? How does the population—and different sections of it—fare with respect to key household actions and risk factors? What household-level factors prevent poor households from achieving good health outcomes? Examples include: insufficient income, lack of knowledge (e.g. about appropriate preventive services), and gender inequality within the household.

- **Communities.** The values and social norms a community shares can make a big difference to health outcomes—e.g. through the use of antenatal and other reproductive health services by women. Communities can also exert a major influence over the way local health services are run. Involving communities in the running of health services can improve social accountability and empower the poor, which may be seen as a goal in itself. Other community-level influences on health outcomes—the environment (broadly defined) and infrastructure—are also important, but are covered elsewhere in this volume.
- **Health services.** A number of aspects of health service *provision* are important to consider here. Most obviously, there is the question of accessibility—whether services are sufficiently close to the population they serve and whether the infrastructure is sufficiently good to enable access. There is also the issue of whether the facilities have a sufficient supply of key inputs—drugs, vaccines, and so on. Other important dimensions include organizational quality, technical quality, and efficiency. Throughout a key question is how the poor are served. Also important is the *financing* of health care. How much do different groups have to pay out-of-pocket? Who is covered by some form of insurance scheme—whether public or private—and for what risks? How far do people with insurance share risks with the insurer through copayments? How is health insurance financed?
- **Other sectors.** Obvious examples of other sectors to examine are the market for food, the education sector, the transport and infrastructure sectors, energy, and water and sanitation. Other examples include pollution, workplace health hazards, and so on. This chapter does *not* cover the issue of how to assess the role of these sectors in improving health outcomes—this is covered in other chapters of the Sourcebook (see section 4.3 for cross-references).
- **Government.** Governments have at their disposal a number of instruments to influence the provision of health services—in the public sector but also in the private and charitable sectors. They also have ways of influencing the way health services are financed, and can exert a considerable influence over sectors beyond the health sector. They can also influence households (e.g. by improving the education of women) and communities (e.g. by giving communities a degree of control over the planning and management of the health facilities in their area).

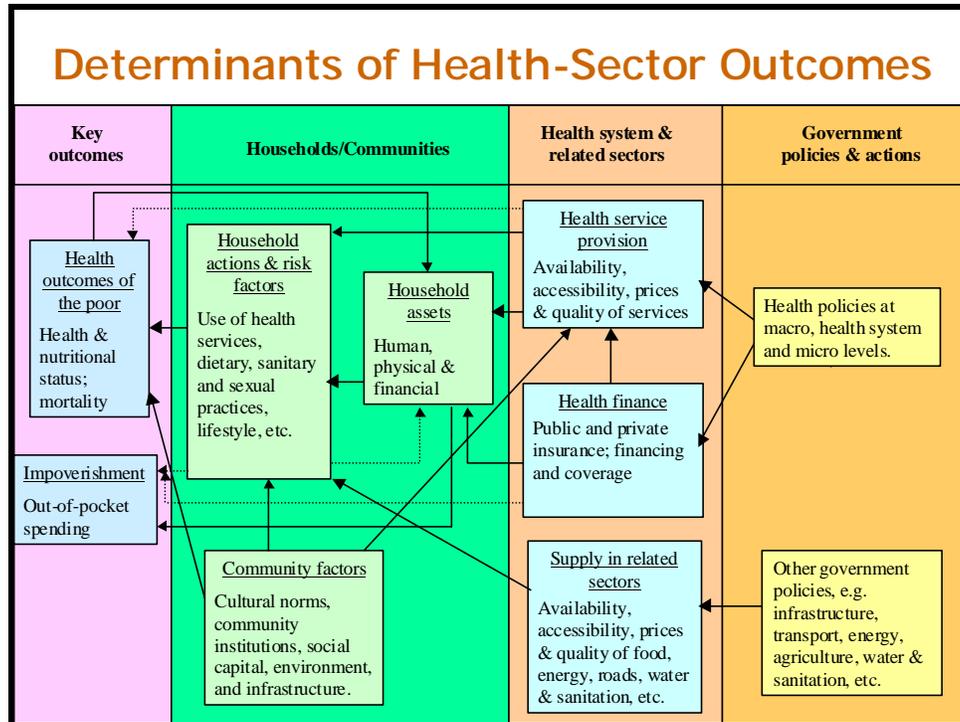
8. **Prioritization.** After analysis comes prioritization. Although putting together policies aimed at improving the health of poor people and reducing the impoverishing effects of ill health means contemplating actions in a variety of areas, this does not mean that countries should try to do everything. Resources—financial and human—are limited, and it is essential to draw up priorities based on assessments of the likely payoffs associated with various policies, their impact on poor people, and the resources required to implement them. This stage is likely to involve learning from the experiences of other countries, and a dialogue within the country between the various stakeholders.

9. **Setting targets, and monitoring and evaluation.** Targets have to be set realistically, and progress towards them needs to be monitored. The success of policies in terms of moving the country towards the targets also needs to be evaluated.

10. **A conceptual framework.** The above can be captured in a chart—see Figure 3. Working from the left to the right involves diagnostics, analysis and prioritization, ending with the policies and actions column on the right-hand side. By contrast, working from right to left involves monitoring and evaluating the effects of these actions—the chart

makes clear the intervening steps between policy action and improved outcomes. Figure 3 can help structure the process of producing the PRSP for health, nutrition, and population, as a means of identifying desired outcomes, actions to achieve those outcomes, and inputs required to produce the actions. The process may be as important as the actual written product in gaining consensus on the key problems and how to address them, what risks will have to be managed to succeed, and what will need to be measured to monitor and evaluate performance.

Figure 3: A Conceptual Framework for Linking Government Policies to Health-Sector Outcomes



3. Health sector outcomes—diagnosis

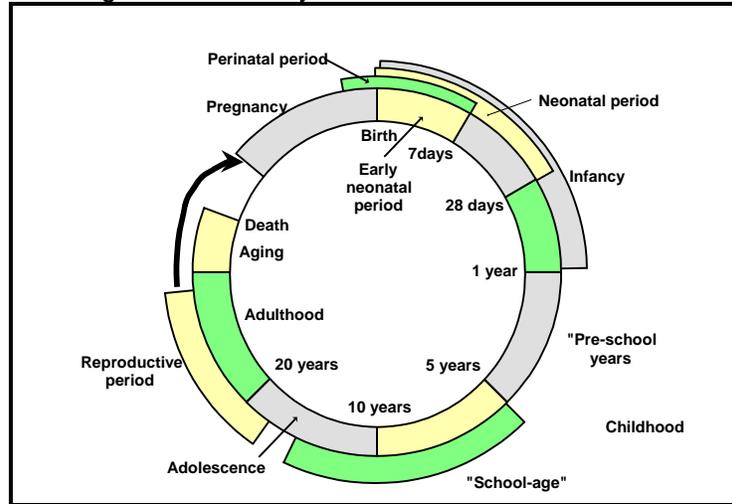
11. **Diagnosics—the first step.** This section shows how the two key outcomes—health and impoverishment—can be measured, and where PRSP teams can look for evidence on them.

3.1 Health outcomes

12. **A health “lifecycle”.** The concept of health is a broad one. It embraces health status, nutritional status, morbidity, fertility management, disability, and mortality. It embraces not just the health of young children but also the health of older children and adults. It also embraces reproductive health—the health of women during and after pregnancy, and **unwanted** pregnancies. A useful way of organizing a health assessment is to focus on the lifecycle (Figure 4), which starts in pregnancy, and moves through birth, infancy, childhood, the school years, adolescence, adulthood, and aging. In the reproductive period, the life cycle comes full circle, with pregnancy and the birth of

a new generation. This framework highlights four principles. First, health interventions have a cumulative impact—the benefit, nature, and cost of interventions at a later age is partially dependent on earlier interventions. Second, prioritizing interventions at several points across the life cycle is needed to sustain improvements in health outcomes. Third, interventions in one generation bring benefits to successive generations. The most obvious of these are good prenatal care and programs that help teenage girls delay pregnancy, both of which give babies a healthier start in life. Finally, the approach also facilitates identification of key risks for families and associated gaps in the health system, where interventions can break the cycle of poverty and ill health.

Figure 4: The Main Stages of the Lifecycle



13. **Risks and outcomes vary over the lifecycle.** At each stage of the life cycle, there are risks to health, and associated with each is a corresponding outcome indicator. For example, during the first year of life (infancy), there are risks of illness, poor nutrition, slow growth, and development, permanent impairment, and even death. The corresponding indicators include the incidence of specific illnesses (such as diarrhea or disabling diseases such as polio and diphtheria), low weight-for-age (underweight), low height-for-age (stunting), and death (infant mortality). Technical Note 3A contains lifecycle risk and indicator sheets for all the various stages of the lifecycle, including adulthood. They outline the major risks at each stage of the life cycle, the corresponding outcome indicators, and their definition and measurement. Some of these are amongst the international development goals (see Box 2).

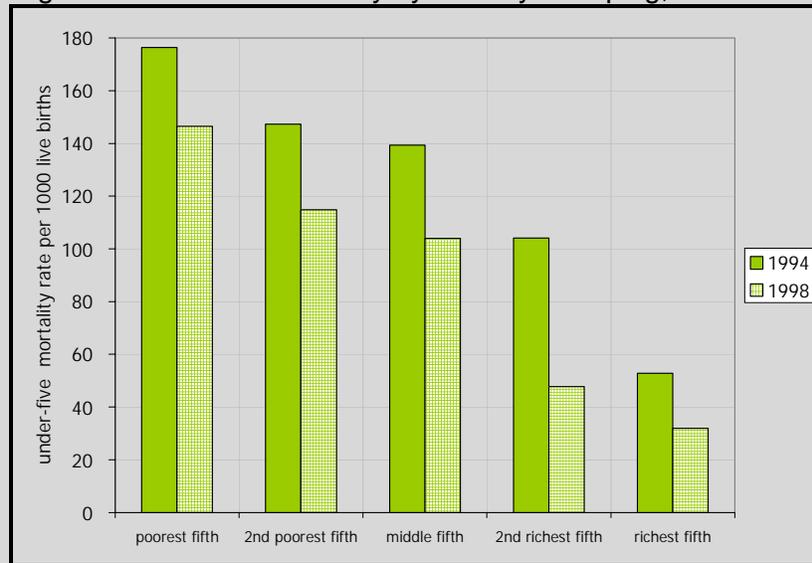
14. **Assembling diagnostics on health outcomes—by poverty grouping.** It is not necessary—and in many countries simply not feasible—to assess all the various health outcomes for all the stages of the lifecycle. What *can* be done is to select, for as many stages of the lifecycle as possible, key health outcome indicators for which data are available. It is vital for the PRSP that data should be assembled not just for the population as a whole, **but also separately for different poverty groups** (Box 3). PRSP targets need to be set not just for national averages (as has been the case in the four PRSPs to date), but also for the poor. (We return to the issue of target-setting in section 6.) Data along the lines of Figure 5 in Box 3 have, in fact, already been produced (for one year only, so far) for 44 countries—including many HIPC and IDA countries. The data cover maternal and child health (MCH) outcomes, and derive from the Demographic and Health Survey (DHS) (see **Technical Note 3B**). The references

in **Technical Note 3B** discuss how countries can generate similar data from other surveys. Also useful are disaggregations by geographic area, especially if these can be linked to poverty maps.

Box 3—Improvements in Population Averages May Mask Widening Inequalities

Box 1 showed how poor children have worse survival prospects than better-off children. When that data are shown for each fifth (or quintile) of the population, it emerges that survival prospects worsen progressively as one moves across the income groups from richest to poorest (Figure 5). Also evident is another important fact—there is no guarantee that the poor will, over time, see the same proportional (or even absolute) improvements in their health as the better off. Figure 5 shows that in the case of Bolivia, over the period 1994-98, the largest *proportional* reductions in under-five mortality were in the second richest and richest quintiles, while the largest *absolute* declines were in the second richest and middle quintiles.

Figure 5: Changes in Under-Five Mortality by Poverty Grouping, Bolivia



Source: Data from Gwatkin et al. (2000).

3.2 Financial protection outcomes

15. **The impact of health spending on household living standards.** Data from household expenditure or multipurpose surveys on health spending by quintiles of living standards can provide a useful indication of the extent to which health spending compromises households' ability to finance other consumption. Expressing the data as a proportion of household income allows one to assess progressivity. However, spending could be progressive (poorer households spend less as a proportion of their income than richer households) and yet households in poverty or close to the poverty line might nonetheless find it hard to cope financially. An alternative, then, would be to examine households' actual living standards relative to the poverty line, and then compare this with where they would have been in the absence of the health "shock" that necessitated the payments. From such calculations, it is possible to compare the change in poverty—as measured by the headcount or the poverty gap—attributable to

health payments. Calculations along these lines suggest that out-of-pocket spending on hospital care might have raised the headcount in India by two percentage points, and that out-of-pocket payments for all health services might have raised the headcount in Vietnam by as much as four percentage points. While somewhat crude, these calculations provide some indication of the degree of impoverishment attributable to the burden of health care payments.

4. Households and communities

16. **What matters and how to get evidence on it.** This section begins with a summary of the evidence on the household actions and risk factors that make for good health. It then shows how countries can assemble evidence on the extent to which the health of its population—and sections of it—is compromised by households getting locked into actions that are not conducive to good health. It then shows how countries can assemble evidence on how far this is due to factors at the household and community levels. Section 5 looks at the role of the health system.

4.1 Health-related household actions and risk factors

17. **The key health-related household actions and risk factors that make for good health.** Extensive scientific evidence is now available on the factors that contribute to good health outcomes in childhood, the reproductive period, and adulthood. For example, much is known about preventive and curative health services that promote good health among small children, sound dietary and sanitary practices, and the importance of stimulation for young children. Corresponding to the various health service interventions is good information about the training and resources required for delivering the respective services. Much is known too about how to alter household choices and actions through behavior change and communication (BCC) programs. The specialized agencies—such as UNDP, UNICEF, the United Nations Program on HIV/AIDS (UNAIDS), and United Nations Population Fund (UNFPA), and the World Health Organization (WHO)—have extensive resources on these issues. The life cycle sheets in **Technical Note 3A** provide summaries of what is known about interventions, household actions, risk factors, service delivery issues, and policy issues at each stage of the life cycle, including the intersectoral issues that are so important for diseases such as AIDS.

18. **Assembling evidence on household actions and risk factors—by poverty grouping.** The key household actions and risk factors vary widely across countries. For example, in Chad only 10 percent of children are immunized, while in the Kyrgyz Republic the figure is nearly 70 percent. In Uganda 70 percent of infants are exclusively breastfed; in Senegal only 9 percent are. The factors directly influencing health outcomes also vary widely within countries, especially between poor and nonpoor households. The preparatory work for the Burkina Faso PRSP, for example, noted that poor children in that country are less than a third as likely as rich children to be delivered by a medically trained person. When they have diarrhea, children in Burkina Faso are only half as likely to be treated with oral rehydration therapy, and they are less than a third as likely to receive a full course of childhood immunizations. The pro-rich bias in public health services in developing countries is not confined to MCH services. In India, for example, as in many other developing countries, the better off make greater use not

only of private hospital services but also of **public** hospital services. **Technical Note 3A** discusses how survey data and other methods can be used to assemble evidence on the key household actions and choices—including health service utilization—and risk factors. For many of those relevant to MCH outcomes, disaggregated data by poverty group are available for 44 countries (see **Technical Note 3B**).

4.2 Household influences on health actions

19. **How household factors influence health actions.** The ability of households—especially poor ones—to obtain appropriate health services, adopt healthy dietary and sanitary practices, etc., depend on a variety of factors, including several at the household level.

20. **The role of household finances.** Poor households have limited resources at their disposal—not just money and in-kind income, but financial assets and physical assets, such as land and animals. Low levels of wealth, but especially of wealth that can easily be converted into cash, are a major constraint for poor households in times of illness and crisis. But it is not just levels that matter. Also important is the variability over time, or the riskiness, of an income stream—whether in cash or in kind. As the World Bank's World Development Report 2000/2001 **Attacking Poverty** emphasized, insecurity—of income, of food, of access to health services—is one of the many deprivations suffered by the poor.

21. **Using household surveys to see how household finances matter.** Household surveys provide one of the best ways of getting evidence on these issues. Many allow estimates of household consumption to be derived—usually considered to be the best measure of a household's living standards, since it takes into account the household's production of food and smoothes out short-term fluctuations. Some surveys contain income data but not data on consumption, and some do not contain even these. In such cases, measures of household resources can be constructed using data on housing characteristics and ownership of assets, such as consumer durables, cars, etc. (see **Technical Note 3B**). One way of determining the impact of income or consumption on health-related actions is to link measures of health-related household actions and choices—e.g. service utilization—to data on income or consumption, and data on other influences, using a multiple regression framework. A large estimated effect of income for specific groups or a large effect (by international standards) for the country as a whole would suggest that low income is a serious barrier to beneficial health actions, such as utilization of health services. An alternative is to use **direct** questions on the impact of income on service utilization. Many Living Standard Measurement Surveys (LSMSs), for example, ask respondents who were ill but did not seek care whether this was because the care was likely to be expensive. Responses to this question were used in the preparation of the PRSPs in Burkina Faso and Mozambique, where 24% and 35% respectively of respondents reporting sickness but not seeking health care said their decision not seek care was based on financial considerations. We return to the issue of household finances in the discussion of health financing in section 6.

22. **The role of knowledge.** Also important are the human assets in the household—knowledge, literacy, and education. Knowledge about health issues is especially important. Lack of knowledge, which is especially common in poor households, often

leaves them unaware of available opportunities. Household surveys typically contain information on household members' educational attainment and literacy. Of special importance here are levels of general education and health-specific knowledge among women and girls. Some surveys also include information on health-specific knowledge. For example, the preparatory work for the Tanzania PRSP noted that poor women were less likely to know the sexual transmission routes of HIV/AIDS than better-off women. Regression analysis may help to shed light on the question of whether lack of knowledge—especially amongst some groups—acts as a barrier to beneficial health actions. But, as with income, some surveys seek to elicit this **directly** from the respondent. The immunization example from India in **Technical Note 4B** provides an example of how such a question can be used effectively—the survey data made it clear that lack of knowledge about the benefits of childhood vaccination was one of the main reasons for poor households not vaccinating their children. In a similar vein, the work underpinning the Mozambique PRSP cited evidence showing that it is not lack of food that is the main cause of malnutrition in that country, but rather lack of knowledge on the part of the caregiver and a consequent lack of diversification of diet. The use of focus groups and other qualitative data are also important here, enabling countries to dig deeper into the “why” questions than is usually possible with quantitative data.

23. **The balance of power within households.** It is not just households' overall level of resources that matters. In many societies, the balance of power within households is unequal between men and women. Women may have little control over household finances and play a minor role in decisions about the use of contraceptives to prevent unwanted pregnancy and condoms to prevent sexually transmitted infections. Mothers may be constrained in the household when seeking health care for themselves or their children. This unequal power, which may be more pronounced in poorer, less educated households, is a major risk factor for poor reproductive health outcomes and the poor diet of many women. Some Demographic and Health Surveys (DHSs) ask about women's control over their earnings and about their involvement in family planning decisions, and these questions can be used to gauge the extent of intra-household inequality.

4.3 Community influences on health actions

24. **Cultural norms.** Poor communities are often traditional communities, so values, norms, and cultural gaps are key factors affecting their health. Traditional social norms often impede women's access to resources such as land, extension services, credit, and education, and in turn these impediments limit their capacity to engage in productive work, to seek health care, and to devote time and energy to childcare. Better reproductive health, along with empowerment of women and their partners to manage fertility, are interventions that work best when they fit into cultural and social norms, but also can help women break through some of the cultural barriers they face. Different ethnic groups have different values, norms, and beliefs. These, too, often have both poverty and gender dimensions. Female genital cutting, for example, is determined largely by the existence of a cultural norm. Health programs, however, do not always respond appropriately to differences in norms and values. Cultural constraints such as social taboos surrounding the issue of disability may constrain individuals from accessing available health and rehabilitation resources. Measuring shared attitudes, norms, and values is not straightforward. However, focus groups, consultation, and other qualitative exercises have been used with great effect to generate insights, from

detailing the intricacy with which networks are constructed and reproduced, to identifying the various means by which marginalized groups are excluded from equal participation in formal institutions such as banks, courts, and health insurance.

25. **Community institutions.** Community institutions, such as community health services, but also civic associations, such as youth clubs and women's groups, matter for health actions. But their impact on health outcomes is felt not only through their influence on actions but also through their impact on health service provision. Community groups often manage to mobilize community action and resources for better health and nutrition outcomes. They can also play an important role in the oversight of health services, improving social accountability and enabling decisions to be better linked to community needs and preferences. This has been the case, for example, in Burkina Faso, and in the work underpinning that country's PRSP was argued to have resulted in improvements in the quality, affordability and stability of local health services. The activities of community groups can include: informing the poor where they can obtain essential services and drugs and at what cost, and how to prevent communicable diseases at household level; organizing the poor to participate in the planning of specific health services, targeting them, monitoring the availability and prices of these services, and the extent to which these services reach the poor; providing a supporting environment for household health practices; and providing institutional support to community co-management, co-financing and co-planning of services and building capacity of these local organizations (local health boards with participation of the poor) so they can become real forces to counterbalance and to support the power of public private providers or contractors.

26. **Social capital.** The term "social capital" is used to describe the norms and networks that facilitate collective action—such as the setting up of a community nutrition program. There is some statistical evidence, mostly from industrialized countries, that high levels of social capital are associated with better health outcomes, but the evidence noted above relating to Burkina Faso is consistent with this. There are three key layers of social capital: ties within the community, or "bonding"; relations between members of different communities, or "bridging"; and connections between communities and formal institutions, or "linking." The poor—as both a cause and consequence of their condition—typically have a lot of the first, a moderate amount of the second, and very little of the third. A challenge for governments is to build on the bonding social capital of poor communities to support and to forge more extensive bridging and linking ties. Schemes like the Burkina Faso one—and others like it in the Bamako initiative—require social capital to work. Several household surveys inquire about trust and other attitudes, or about the nature and extent of people's participation in the civic life of their community. These questions, along with other exercises such as focus groups, may shed light on the extent of social capital and help understand its role in shaping health-related outcomes.

27. **Environment and infrastructure.** Environmental factors—broadly defined—are well known to have an important impact on health, directly and via their impact on actions. Examples include indoor and outdoor pollution, poisoning, water-borne disease, illness associated with poor sanitation, overcrowding in urban slums, and work-related health risks including those faced by young child laborers. Infrastructure also matters, especially roads and transport, since these directly influence the time costs that households incur when using health services (see section 5.1 below), but also electricity and telecommunications. We do not discuss these issues at length here, since they are

covered in some depth in the Rural Poverty, Urban Poverty, Private Sector and Infrastructure, and Environment chapters in this volume. It is, of course, important in assessing the factors that hold poor households back from achieving good health outcomes that these be taken into account. For example, regression studies often find that water and sanitation at the community level influences individual child health outcomes, and that the passability of roads influences households' use of health services. Failure to model such effects might lead to biased estimates of the effects of, say, household income on health outcomes and service utilization. Household surveys—coupled with good community questionnaires—can often shed light on levels and gaps in environmental and infrastructure factors, and may help to establish their effects.

5. The health system

28. **Health systems vary...** The basic function of a health systems is to ensure that providers deliver health services to patients. This is accomplished through a structure of payments and regulations, and this structure varies from one system and sub-system to the next. Sometimes, patients pay providers the full cost directly out-of-pocket. Sometimes, they pay only partially directly out-of-pocket, with the provider being paid the rest by a third-party payer. This could be the government or it could be a private insurer. For example, in a typical Ministry of Health (MoH) scheme, households pay taxes or compulsory contributions to the government. This owns and provides budgets to health facilities, the staff of whom are government employees and are probably paid by salary. Patients either receive services free at the point of delivery, or pay a subsidized fee for them, possibly with the fee varying by income. Another example would be a community health insurance scheme where enrollees pay a premium and in exchange have the right to use facilities operated by the scheme for a nominal fee. In both these examples the provider is paid by the third-party payer through a budget or salary, and the provider is part of the insurance or financing organization. Such organizations are known as **integrated organizations**. An alternative model is where the provider is not part of the organization but instead provides services to enrollees of the insurer on a contractual basis. The MoH might, for example, contract with an NGO to provide certain services instead of getting them delivered by MoH clinics. This is an example of a **contract model**.

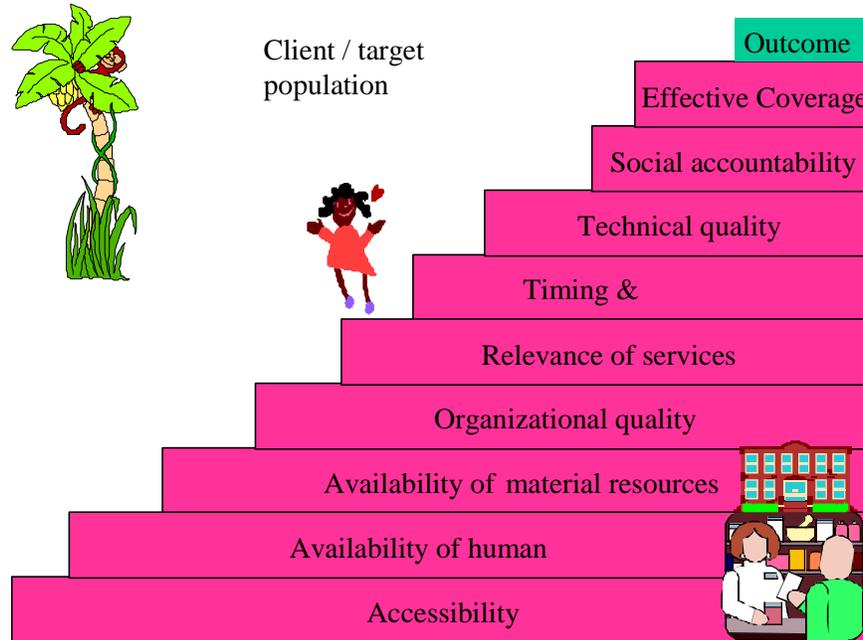
29. **but are judged by the same criteria.** Whatever its organization, a health care system will be judged largely according to two criteria. How well does it get high quality and appropriate services to those who need them most—especially the poor? Do payments for services leave some groups—especially the poor—unable to afford other essential commodities such as housing and food? In this section we identify several key dimensions of performance in service provision that influence the quantity, quality and appropriateness of health service utilization, especially amongst the poor. We also identify several key dimensions of a country's financing system. What cover do people have against different types of health expenses, and how do they pay for it?

5.1 Health care provision

30. **The key steps to quality health services for the poor.** This section outlines the tools that are available to countries to capture the key features of health service

provision, and to assess the performance of health services in terms of their impact on health-related behavior and ultimately health outcomes. The tools presented in this chapter have been used in several interim PRSPs and in some of full PRSPs. To a high degree the exercise is sequential (Figure 6). If services are inaccessible, the issue of whether they are staffed properly is irrelevant. If they are accessible but not properly staffed, the issue of whether they are properly stocked is irrelevant. And so on. There is little point making progress on one step of the ladder if the system fails badly on the previous step.

Figure 6: The Eight Steps to Effective Coverage for the Poor



31. **Are services physically accessible?** The issue is whether health facilities are available and sufficiently accessible to the poor to enable them to make use of them. Distance is clearly one issue, but travel time will also depend on the availability of roads and public transportation. In Africa and many other places, to consider the seasonal variation of physical accessibility may also be important. The physical infrastructure of facilities also matters—stairs (rather than ramps) may impede accessibility to persons with disabilities and other physically impaired people. Surveys can be useful here. The work leading up to the PRSP in Burkina Faso, for example, cited survey evidence that 40% of health center users had to walk more than one hour to reach the center, while the work underpinning the Mozambique PRSP cited survey evidence that 38% of people who had been sick but had not sought care had not done so because their local facility was too far away.

32. **Are human and material resources available?** Services may be geographically accessible, but essential inputs, such as drugs, vaccines, contraceptives, micronutrients, or trained staff, may be unavailable or in short supply part of the time. Are essential resources available for the poor? Again, surveys can be useful. Household survey evidence was cited, for example, in the work underpinning the Mozambique PRSP, showing that although a relatively small proportion of sick people not seeking care cited

lack of drugs as the reason for their not seeking care, those who did were almost all rural residents. Surveys and inspections of health facilities are also useful. The work underlying the Burkina Faso PRSP, for example, reported that, when inspected, nearly 20% of facilities had run out of essential vaccines, and in 24% of centers the refrigerators for storing the vaccines did not function. The Mauritania PRSP reports drug shortages as the most important reason explaining the low level of use of services. The problem of staff shortages in rural areas is fairly widespread in the developing world. The authors of the *Voices of the Poor* report for Somaliland, for example, noted that “rural people said they rarely see health workers in their localities. If some people have been trained for the villages and other main grazing areas by international agencies, they are not now functional.”

33. *Is organizational quality good?* The way health services are organized (hours of operation, waiting time, perceived low quality, gender of providers, lack of courtesy, required under-the-table payments) may deter patients from using services. Is the organization of health activities good and friendly to poor clients? In *Voices of the Poor*, public health facilities were frequently criticized for their long waiting times and rude staff. Household surveys and qualitative consultation exercises are a useful means of shedding light on this issue.

34. *Are services produced relevant?* Does the sector provide services that are relevant to the diseases that affect the population, especially the poor? Although a core package of interventions may be defined, these interventions may not be the ones that are provided in practice. It is therefore critical to examine the case mix of services units and assess whether priority is really given to the most relevant. Health sectors performance in raising or maintaining high utilization of essential interventions can be measured by assessing the quantity of services produced in specific areas and relate it to the income level of the population of this area. Such a mapping of equity of output production is currently conducted routinely in Mozambique. (In Mozambique an index is constructed using services basic information on children immunized, the proportion of women using antenatal services, and number of inpatient and outpatient visits.)

35. *Are services delivered in a timely way? Is there continuity?* Certain key health services—such as emergency obstetric care but also epidemic control measures—must be delivered in a timely manner. For other services, such as the completion of tuberculosis treatment or immunizations, continuity is an essential determinant of efficacy and outcome improvement. Do the poor benefit from timely and continuous services? One indicator of continuity is the proportion of children who are fully immunized. This was used in a study of continuity of care in Benin, where it was found that this measure increased from just over 30% in 1988 to around 80% in 1996 for immunization services, thanks largely to the introduction of financial incentives to health staff provided on the basis of the rate of fully immunized children (DTP3).

36. *Are services of a high technical quality?* Are the services provided to the poor of lower technical quality compared with those provided to the better-off population? Is a basic service of reasonable quality available to all? The term “technical quality” is meant to capture the variations across providers or patients in the impact of a particular service on health status. Health facilities in developing countries—especially those serving the rural poor—are often plagued by low levels of training and competence. Health facility surveys are useful for assessing the extent of this problem. Such surveys undertaken by

WHO in the 1990s found that in Burundi only 2% of children with diarrhea were correctly diagnosed, compared to 78% in Vietnam. Amongst those correctly diagnosed, there were large variations across countries in the proportion correctly rehydrated, ranging from 0% in 6 (out of 34) countries to around 70% in Rwanda and Vietnam. It seems likely that differences in the quality of care are likely to exist within countries too, with—one suspects—lower levels of quality in facilities serving poor people.

37. *Is there social accountability in service delivery?* To what extent are health systems and service providers accountable to their clients and communities, and in particular, to their poor clients? Consultation exercises are an especially useful tool for getting evidence on this. Surveys can also be conducted to measure the extent to which joint management contributes to local decision-making. A survey conducted in Benin in the early 1990s showed for example that about one third of the health management committees were truly triggering genuine accountability to users, while one third was considered somewhat functional and the last third was only a matter of token presence. Revision of the election modes and provision of incentives for women to participate in these committees contributes to improving the situation and health committees have grown into powerful forces in the Benin health system today.

38. *A framework for diagnosis and action.* The health sector's performance can be assessed by looking at measurable factors that affect how it interacts with clients (see column 1 of Table 1). Countries may want to go through this exercise to identify the key obstacles to better performance in providing essential services to the poor, then focus actions on the determinants that are most problematic. Rather than aiming at an exhaustive review, this instrument would be most beneficial if used to identify at which levels the most important problems occur. It can also become a checklist for monitoring improvements in system performance. What should emerge from this analysis is a well prioritized set of feasible, time-bound actions with known costs for which there are adequate financial resources (see Box 4).

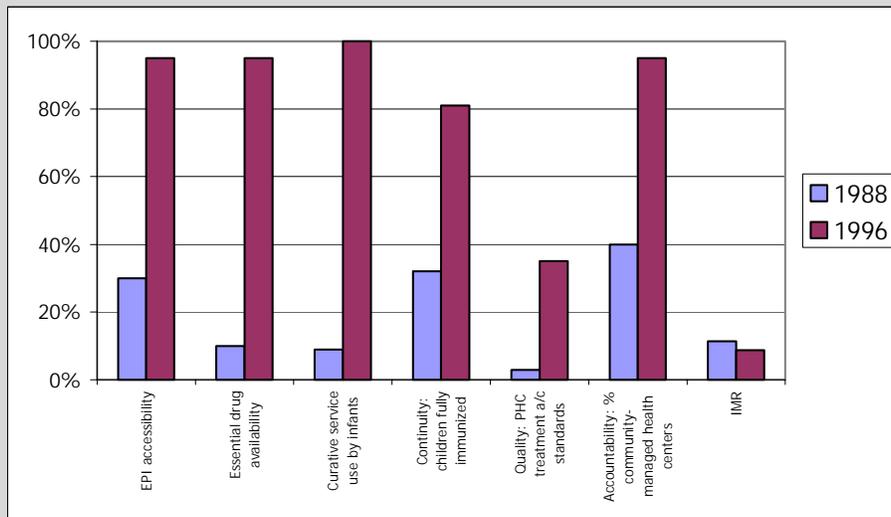
Table 1: Relationship Between Performance and Structural Dimensions of the Health Sector

| 1. Key determinants of the sector's performance | 2. Examples of the nature of the problem identified | 3. Instruments available to change each characteristic (see section 6 for an explanation) |
|--|--|--|
| 1. Physical accessibility | Low access to clinic services, to community based activities | <ul style="list-style-type: none"> • Public, private, non-governmental mix • Core health packages • Human resources |
| 2. Availability of human and material resources | Shortages of drugs, vaccines, trained staff | <ul style="list-style-type: none"> • Pharmaceuticals • Human resources • Stewardship |
| 3. Organizational quality | Inconvenient opening hours, lack of privacy | <ul style="list-style-type: none"> • Human resources • Community/civil society participation |
| 4. Relevance of services | Mix of services does not correspond with basic package | <ul style="list-style-type: none"> • Public, private, non-governmental mix • Core packages • Pharmaceuticals • Contracting and purchasing • Stewardship |
| 5. Timing and continuity | Weak linkages with community structures; poor supervision | <ul style="list-style-type: none"> • Community and civil society participation • Contracting and purchasing |
| 6. Technical Quality | Inefficacious services because of failure to respect treatment standards | <ul style="list-style-type: none"> • Contracting and purchasing • Pharmaceuticals • Human resources • Stewardship |
| 7. Social Accountability | No voice of the poor in delivery of services | <ul style="list-style-type: none"> • Community and civil society participation |

Box 4—The “Steps” Framework in Action in Benin

Some countries have attempted to orient the reform of the health sector towards better serving the poor. They used a matrix of health sector performance, such as Table 1, as a starting point to define priority actions. In Benin, for example, reforms in health systems in 1989 provided the basis for a positive trend in most health indicators. Infant mortality dropped from 114 per thousand in 1987 to 88 per thousand in 1996, exceeding the drop in neighboring countries that were at comparable levels of household consumption. Regular reviews of the sector’s performance in improving key determinants of health outcomes were seen as an essential element of “a virtuous cycle of implementation” in this country (see Figure 7 below). Similar applications of this framework have been undertaken in Guinea and Mali, among other places.

Figure 7: Benin—A Virtuous Cycle of Implementation



5.2 Health financing

39. Reducing the role of user fees and out-of-pocket payments. There are numerous ways governments, employers, private companies and communities can reduce the amount households pay out of pocket when they use health services. Governments can have low user fees or do away with them altogether and instead finance the use of health services through taxation. If they do levy fees, they might try to exempt certain groups—such as the poor—through fee-waiver schemes. These schemes have to be financed, of course—through, for example, tax revenues. The government might instead, or as well, have a social insurance scheme for formal sector workers. Employers might have their own health insurance schemes, arranged in-house or through a private insurer, with workers paying through wage deductions. Private insurers may offer coverage with insurees paying premiums to the insurer. Communities may offer a community-financing scheme whereby those enrolled pay a membership fee or premium to the scheme and in return have lower user charges when they use the services covered by the scheme. What all of these schemes have in common is that people enrolled in—or covered by—the scheme do not pay the full cost to service providers at the point of use, and the shortfall is financed, in the first instance, by the third-party payer, but ultimately by households through, for example, premiums,

contributions or taxes. All of these schemes are, in effect, **insurance schemes** of one type or another, even though they may not usually be thought of as such.

40. **Who is covered by insurance?** Health insurance thus provides a way of both increasing utilization of health services (by reducing the cost at the point of use) and reducing the impact on household incomes of service utilization. The question of “Who is covered?” is important since insurance coverage or lack of it affects the amount of money people pay out of pocket for health care, which affects their usage of health services and the amount they have left for other consumption after they have used them. The first questions to answer here, then, are: What schemes operate? Who is covered by each? And, how does the coverage vary across poverty groups?

41. **What is covered by insurance?** In both the public and private sectors, there will be some element of “risk pooling”, except in the case of the private sector when there is no insurance of any kind. For example, premiums collected by an insurer from all enrollees will be pooled and used to finance claims from those enrollees who fall ill and seek treatment. The size of the pool and its diversity will influence the benefits offered and the level of premiums and copayments. For example, a small-scale community-financing scheme in a poor rural area will not be able to offer very generous benefits per dollar of premium without large copayments, since the probability of illness will be fairly high across the pool. By contrast, a government-run compulsory tax-financed scheme will be able to offer more generous benefits per dollar of tax revenue, since the risk pool will be larger and more heterogeneous, and its average risk will be lower. Against this has to be set the greater complexity associated with a large pool and the lower degree of control exerted by the poor. The next questions to answer, then, are: What do the different schemes cover, and what do they leave uncovered? Are the poor covered against the potentially impoverishing costs of catastrophic illnesses? Of course, in the case of public insurance, what is and is not covered may not be written down. For example, the health background document for the Tanzania PRSP noted that as public funding for public clinics has declined, the range and quality of services offered by rural clinics has declined, thereby reducing **effective** insurance coverage, and forcing people to seek treatment with NGOs or private providers.

42. **How much risk-sharing is there?** In many schemes, coverage will not be complete and the enrollee will be liable for a copayment in the form of a user fee. How large are such fees? Are they affordable for the poor? This can be answered by calculating the average user fee per unit of utilization (e.g. inpatient day, outpatient visit) and expressing it as a proportion of household income. This can be done for different incomes—say, for the average income of the poorest 20%, the next poorest 20%, and so on. For example, in Vietnam in 1998, the average user charge per spell of inpatient care in a public hospital was equivalent to 45% of the poorest quintile’s average annual non-food expenditure. The figure for the richest quintile was just 4%. Even a visit to a polyclinic absorbed 9% of the poorest quintile’s average annual non-food expenditure. Of course, fees may not be the same for everyone in a particular scheme. Are there any fee-waiver schemes in operation? What proportion of the poor and other groups benefit from them? Are there differences between those who are beneficiaries **in principle** and those who are beneficiaries **in practice**? In some cases, there may be a gap between **notional** insurance coverage and **effective** coverage because of informal and/or under-the-table payments. Is there any evidence on how large they are? The preparatory work for Mozambique’s PRSP, for example, suggested that informal payments “play probably the most important role in hampering access of the population to curative

services” but acknowledged that “no valid systematic research has been carried out on the topic”.

43. **How much do people pay for health insurance?** Health insurance—whether public or private—has to be financed somehow. An MoH scheme might be financed principally through taxes. A social insurance scheme might be financed through payroll taxes, though it is not uncommon for general tax revenues to be used to subsidize the scheme. A private insurance scheme will typically be financed through insurance premiums, though here too there may be a tax subsidy. Community-financing schemes are financed through contributions from members, sometimes with co-financing from a donor or government. It is important to know how much different poverty groups pay into these different schemes, and how far the costs of enrollment in voluntary schemes might act as a deterrent to poor people joining them. So, are taxes, social insurance contributions and private insurance premiums a burden to poor households? Do premiums deter the poor from enrolling?

44. **What is the cost of services not covered by insurance?** What do households—especially poor ones—pay for services for which they are not covered? Is there evidence that lack of coverage for these services deters them from using services? Are they affordable for the poor? Again, this can be answered by calculating the average out-of-pocket payment per unit of utilization and expressing it as a proportion of household income, for different incomes.

6. Government policies and actions

45. **The three levels of government action and how they interlink.** In section 1, we emphasized the three key levels of government action—the macro level, the health system, and the micro level. Government decisions and actions at each level influence the amount households pay for their health care, and the quantity, quality and type of services they receive. It is important in preparing the PRSP to cover all three levels. Improvements at the macro-level—by, for example, prioritizing spending decisions—will not by itself make the health system work better. But it can provide an environment in which the system **could** work better. Developing a sector reform program that addresses key system, organizational, institutional, and incentive problems is an important complement to the macro-level program, because it will improve efficiency, efficacy, and impact. But making improvements at the macro and system levels, even when accomplished together, do not accomplish the equally important third activity: to identify and test interventions at the micro level to address specific health problems, and to target the poor with needed inputs. These interventions need to be designed, financed, implemented, evaluated, absorbed as normal business when they are shown to work, and replaced as they succeed and are no longer needed.

46. **How the three levels of government action link with the conceptual framework.** Table 2 shows the key decisions at each of the three levels, and lines them up with the two key components of the health sector in the conceptual framework—the provision of services, and their financing. The cells in the table present in summary form some of the key issues facing **all** countries. The rest of this section focuses on how these issues arise in the countries writing PRSPs.

Table 2: Levels of Government Policies and Action

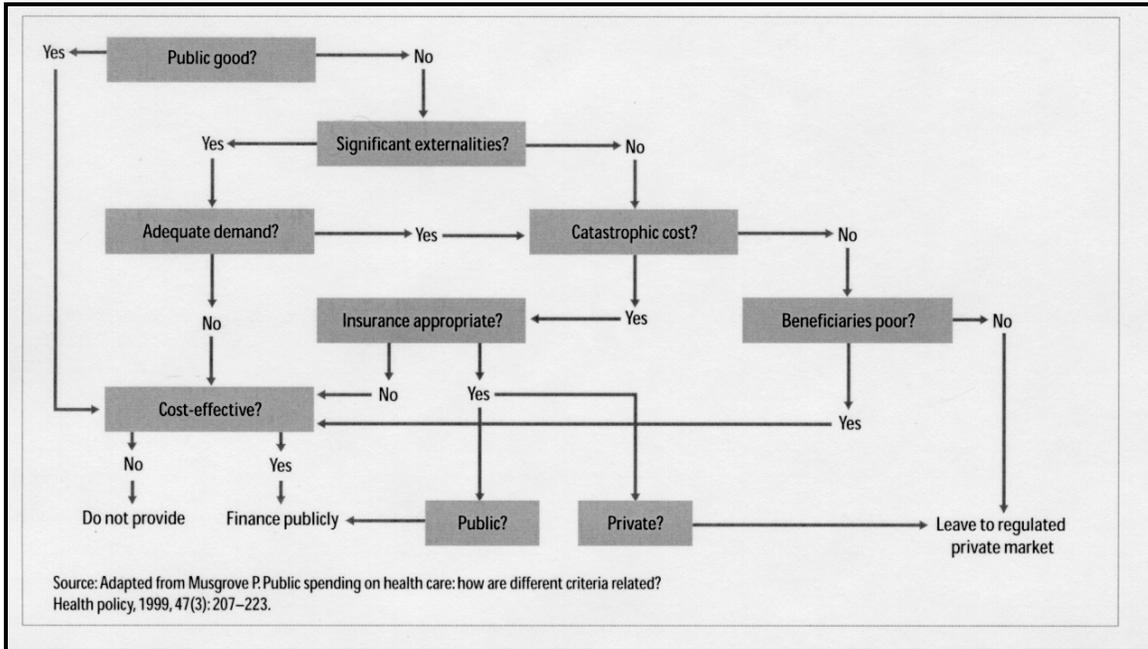
| | Health service provision (Who provides what to whom, and how are they paid?) | Health financing (How is the burden spread across households?) |
|----------------------------|--|--|
| Macro level | <p>Government spending: macro. How much should government spend overall? What should government spending be focused on and what should it leave to the private sector? How can it make its own spending more equitable, e.g. by altering geographic allocations? How can it prioritize its own spending across programs and activities, with a view to having the greatest impact on the poor? How can government ensure spending properly balanced—e.g. between labor vs. equipment and consumables, capital vs. recurrent, and maintenance.</p> <p>Government's role in input markets. For pharmaceuticals, key issues include selection, procurement, distribution, pricing, and quality. For human resources, key issues include training and skills, geographic distribution, retention and continuity, and governance and civil service issues (see chapter ? in this volume).</p> | <p>Government financing: macro. How are revenues to finance government spending to be raised? How much revenue should be raised through user fees? Should the poor be exempt from fees? How much should be raised through earmarked taxes or payroll taxes? Are revenues sustainable? How much public insurance cover should be provided, to whom, how, and at what cost?</p> |
| Health system level | <p>Improving delivery at system level. Who should provide publicly-financed services? Government facilities or others working on a contractual basis? How should these providers be paid to achieve best balance between efficiency and equity?</p> <p>Stewardship. Roles include coordination (within public sector and between public and other sectors), quality assurance, regulation of private providers, dissemination of information to providers <i>and</i> users, and monitoring and evaluation.</p> | <p>Government financing: health system. How should government charge for different services? How can government reduce or eliminate fees for the poor? What services and interventions should governments cover in their public insurance scheme? How far should revenue-raising be decentralized? How can cross-subsidization be introduced between areas where revenue-raising is substantially decentralized?</p> <p>Stewardship. Government can influence and oversee private insurance market, and formal and informal payments levied by private and public providers. Regulation can be used to effect change. Monitoring and evaluation.</p> |
| Micro level | <p>Improving delivery at facility level. How can management quality and accountability be improved? Should local communities be involved in management and/or monitoring?</p> <p>Deciding what should be delivered and how. What services and interventions should government be focusing on? Should there be a core package? What types of facilities should be delivering the services? And what delivery methods should they be using? What types of community-based preventive services should be used? How will referrals be handled?</p> | <p>Government financing: micro. What is the best way for governments to collect revenues and make fee-waiver schemes work?</p> |

6.1 Government policies and health service provision

47. **Government spending: macro. How much?** In the poorest countries, total government resources spent on health are usually no more than \$3 to \$5 per capita, and private spending adds roughly the same amount, to a total of \$6 to \$10 per capita. For the HIPC countries, debt relief can open some space to add possibly another 20 percent to public health spending. In considering whether government health spending should be increased further still, it may be useful to compare the country's level of public spending with the spending levels of countries with a similar GDP per capita, especially neighbors, and to bring into the picture the size of the private sector and the health status of the population.

48. **Government spending: macro. What should government be doing?** It is vital to get the most out of the very limited resources available, and to improve equity by finding mechanisms to target spending on those least able to protect themselves. The PRSP team could usefully begin by reviewing spending on health, nutrition, and population. This should include *all* spending, whether direct or in the form of tax subsidies (e.g. to insurance schemes), and should be geared towards the goals of the health system. **Technical Note 5B** provides a schematic for a health spending review, while **Technical Note 5C** provides a set of spreadsheets designed to convert an administrative budget into a program budget, along with an example of a public spending report from Tanzania. Within the goal of improving health outcomes, the review should be linked to the burden of disease in the country. **Technical Note 5D** provides a spreadsheet-driven framework for burden of disease and cost-effectiveness analysis tied to public spending. Next, the team should consider which activities the government would do best to focus on, and which to leave. Some of the latter may, of course, be done as well by the private sector. Figure 8 is a decision tree that helps this thought process. It starts with the overarching issue of allocative efficiency by asking if the proposed spending is for public goods—generally *population-based* public health activities that protect many people simultaneously. If the answer is yes, the next step is to rank such spending for cost effectiveness—or even better, benefit-cost analysis—to decide which will be funded. If proposed spending does not meet public goods criteria, the decision tree moves through other relevant considerations: whether there are significant “externalities” (e.g. smoking and risky sexual behavior, where the actions of one person affects the health and well-being of others); whether risk of catastrophic costs are involved; and whether the proposed beneficiaries are poor. This is one example of how allocative efficiency, risk, equity, and cost effectiveness should interact to determine public financing decisions in health.

Figure 8: Questions to Ask in Deciding What to Finance Through the Public Budget



49. **Government spending: macro. Making government spending more equitable.** At the macro level, one key issue is how funds are disbursed geographically from the center, and how any locally-raised revenues are shared across localities. Often, central funds are allocated in a highly inequitable way. The preparatory work underlying the Mozambique PRSP, for example, noted that Zambezia received over seven times less government spending on health per capita than Maputo City. Using geographic resource-allocation formulae is a way of approaching this issue, the simplest of which allocates public funds geographically on a per-person basis. More sophisticated formulae would take into account the differing health needs of different areas—some may have a lot of young children and elderly people; some may have a lot of poor people; some may have a lot of sick people. In some cases, additional funds might be allocated to take into account the differences in the quality and age of facilities, or the different costs (e.g. higher allocations to disease-ridden areas, or to rural areas to reflect the greater distances for outreach work and obtaining supplies, and the greater difficulty of retaining staff there).

50. **Government spending: macro. Balancing spending.** Quality of services is partially determined by the overall level of spending, but also by the mix of spending. The quality of labor, capital, equipment, and consumables depend on balanced allocations on: (1) labor versus equipment and consumables; (2) capital versus recurrent spending; and (3) maintenance. Spending on labor, for example, of 45-60% of recurrent spending provides a rough indication that the full complement of inputs would be available at the point of service if the system functions relatively well. Many developing countries have budgets that are over-committed to labor costs. In the preparatory work underlying the Tanzania PRSP, for example, it was noted that 70% of the budget is spent on personnel.

51. **Government's role in input markets.** Governments have a major role to play in the two key markets that support and feed into the health system—the pharmaceutical and labor markets. The availability of drugs affects the clinical quality of health services, costs, and perceptions of clients. Purchasing pharmaceuticals in the private market is also one of the main out-of-pocket expenditure items for the poor. Key aspects to be assessed include selection, procurement, distribution, pricing, and quality. Instruments for improving pharmaceuticals transactions market-wide include: communications campaigns to improve the understanding of drugs among clients and sellers; social marketing to improve the quality and availability of drugs and family planning supplies; and impartial enforcement of regulations to protect consumers. By maintaining and disseminating Essential Drugs Lists and pursuing policies to encourage use of low-cost, high quality generic drugs, governments can improve the functioning of the pharmaceutical system. Procurement in the public sector can be improved through essential lists of drugs, supplies, and equipment; use of competitive bidding; and encouragement of competition in logistics and distribution systems. The labor market too is a key issue. The quality, distribution, and responsiveness of health personnel influence the availability, quality, and access to interventions by the poor. Issues to examine include: the total number and distribution of various types of providers, by geographical location and level of care; retention capacity of the system for trained staff; the quality of education and skills—technical skills as well as responsiveness to the client; and the underlying incentives for provider performance, particularly in relation to poor clients. If civil service regulations represent an important constraint on the availability and quality of health personnel, this finding should inform the PRSP governance objectives.

52. **Improving delivery at system level.** In many countries, publicly-financed services are—or could be—provided by private and non-governmental providers. One issue the PRSP chapter authors may want to explore is the extent to which different types of contracting are currently being used in the health sector, and whether these contracts include explicit provisions for serving the poor, or incentives for improving pro-poor services. Could existing contracting mechanisms be modified or expanded to better serve the poor? Other service providers could be brought into the PRSP process to explore options for more effective use of contracts, secondments of staff, shared logistical systems, and government subsidies (e.g. especially generous contractual terms) to improve service delivery for the poor.

53. **Stewardship issues in health provision.** A core responsibility of government in a mixed system is to exercise effective oversight, or stewardship. Stewardship becomes more important as governments shift from direct service provision to a role dominated by policy; population-based health interventions; financing; regulation of providers and insurers; and guiding the system and behavior through research, provision of information, quality enhancement activities, and careful use of financial subsidies. There are four key areas:

- **Regulation:** This area encompasses establishing and enforcing appropriate laws for governing the public and private sectors. This could include generic drug laws, and the use of minimum service standards as eligibility criteria for providers to benefit from public financing.
- **Coordination:** It is essential for Ministries of Health to coordinate the charitable activities of external donors, to coordinate within government across sectors, and to provide a policy framework and institutions for coordination domestically across different players in the health sector. Coordination requires clear policies,

leadership, and institutional methods. The preparation of the PRSP provides an opportunity to engage donors, program managers, other government ministries, and private/charitable providers in the process of assessment and taking action to improve results.

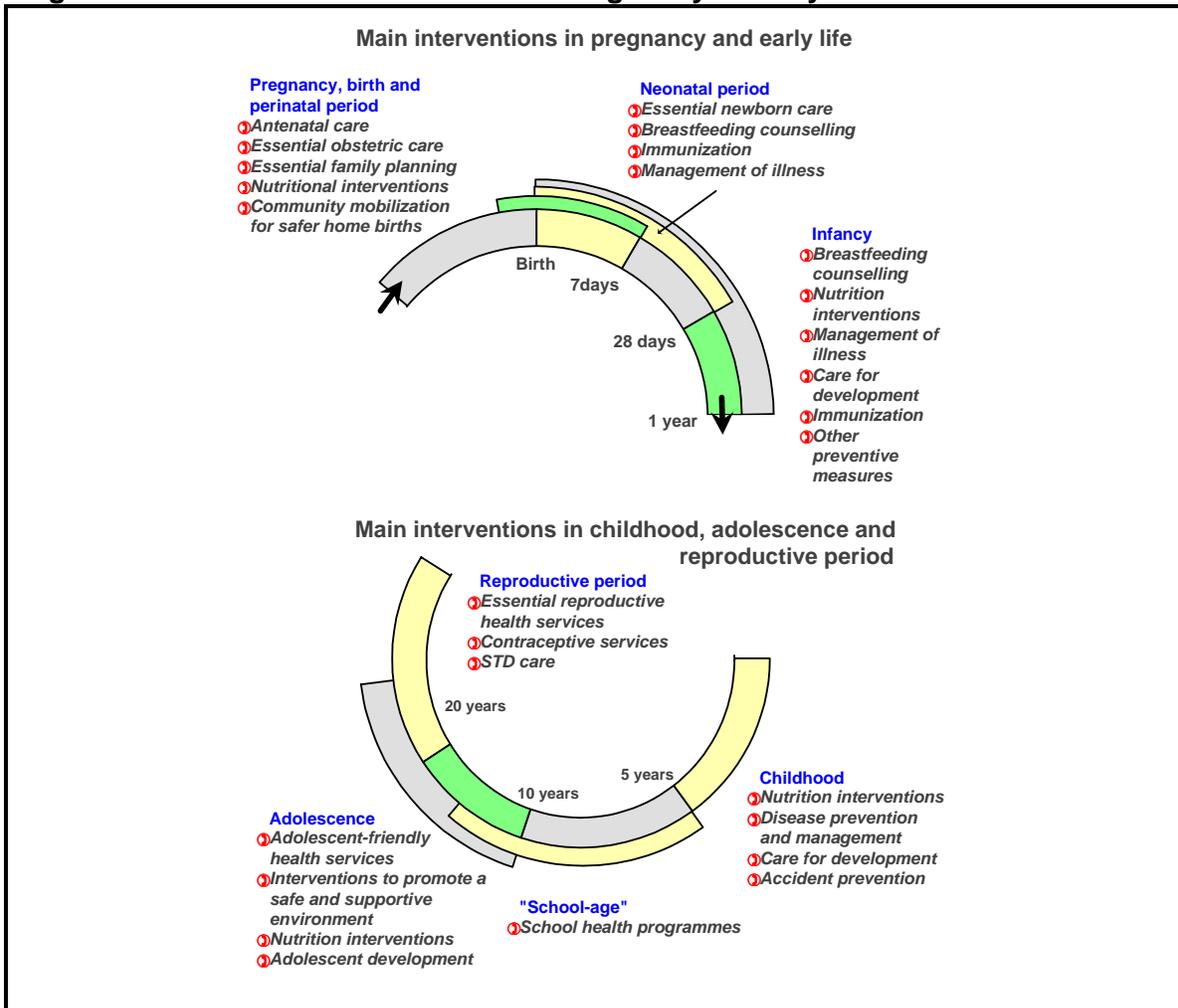
- **Monitoring and Evaluation:** Any result-oriented activity, such as the PRSP, must be concerned with measuring impact. Crucial to this monitoring and evaluation (M&E) exercise is a focus on the poor, but also on other disadvantaged groups. A gender-sensitive M&E strategy that evaluates how well women fare in the system would be especially valuable for women, but also for the poor.
- **Information:** The poor may use private, traditional, or charitable services as much as—or more than—public services. Public information campaigns about effective types of spending can be a useful way of improving the efficacy of out-of-pocket spending by the poor. Knowledge that can improve consumers' ability to choose providers and consume appropriate services is thus a high priority, given the importance of household actions in determining outcomes. Also important is information dissemination to protect consumers, through product labeling, especially for pharmaceuticals and dangerous substances. In countries where labels would be less effective than other methods of dissemination, opportunities to improve awareness of hazardous products and actions could be parts of community health education programs. Finally, dissemination of best practice and new findings is also important. Often providers will change behavior simply when they discover a better way of doing their work, so knowledge can have a strong independent impact on quality.

54. ***Improving delivery at facility level.*** A key issue here for the poor is whether performance can be improved for the poor by increasing their voice in decision-making. There are several ways of doing this. The first is the direct management of local clinical services, through community health centers or revolving drug funds, as in the Bamako Initiative. A second is mobilizing communities for health-promotion activities, from malaria prevention to improved water supply. A third is participating in monitoring the performance of facilities and providers. Assessing these structures is a key task for the PRSP team. Another issue is how to improve accessibility. Physical proximity to poor clients can be improved through investment decisions. But there are also opportunities for consolidation because of improved infrastructure that should be pursued to improve quality and productivity. Accessibility can be improved at lower cost not by duplicating available services in the private and charitable sector, but rather by allowing clients more choice of service delivery outlets through contracts with NGOs and private providers, and by improving technical efficiency and incentives among public service providers. Moreover, NGOs may have greater experience in dealing with certain at-risk groups, such as people with disabilities or youth at risk of sexually-transmitted diseases, than the government. Health care facilities which have shown to be both costly and inefficient at treating their intended beneficiaries, such as residential institutions for the mentally-ill or physically disabled, should be reconsidered in favor of lower-cost, higher-impact services, such as daycare facilities.

55. ***Deciding what should be delivered and how.*** Many developing and middle-income countries have developed “core packages,” which define health interventions to be available at the village (health post), community (health center), and district levels (district hospital). Effective packages respond in a cost-effective way to the needs of the poorest segments of the population, and represent priority activities for public financing. They should include services that respond to the burden of disease afflicting the poor

and should be linked to poverty maps to facilitate geographical targeting. Figure 9 shows these key interventions in the context of the lifecycle of Figure 4, covering the periods before birth, the first year of life, and into the next reproductive cycle. Virtually all of the interventions in Figure 9 are community- and clinic-based, but they also require a supporting infrastructure of population-based services, communication and knowledge dissemination, school health, and environmental health.

Figure 9. The Main Interventions from Pregnancy to Early Adulthood



6.2 Government policies and health financing

56. **Government financing: macro. How are revenues to be raised?** It is desirable that all public health, health education, and preventive services be subsidized to the fullest extent possible, recognizing that there are government budget constraints. If they cannot be fully subsidized, policies can be pursued to encourage charitable activities in these areas. Given the typical resource-constrained public budget, some user fees will be necessary for acute services. Fees can be designed not to create barriers at the point of use for the poor, however, by using waivers, prepayment, credit, or other options.

57. **Government financing: macro. Are revenues sustainable?** The issue here is whether the level of resources available to the sector is sufficient to ensure the provision of essential services to the poor. Have resources been made available to sustain the chosen package of interventions? If not, have priorities been imposed to shrink the package to fit within the constraints? Sustainability does not mean unlimited access to funds, but rather that hard decisions are made so that a functioning system can deliver the highest-priority services over time.

58. **Government financing: macro. What insurance should be provided and how?** Another key issue is whether prepayment and insurance methods, when combined with public subsidies, succeed in creating a pool of poor **and** nonpoor individuals, thereby offsetting the higher health risks of the poor by the lower risks of the better off. Often, risk pools are intentionally segmented to prevent such cross-subsidies, but an important issue for governments seeking universal access to basic services and separation between financing and provision is how these risk-sharing methods can become more inclusive of all income groups. Typically, it takes incentives, subsidies, and compulsion to achieve this goal. What are the existing and potential methods for pooling revenue from various socioeconomic groups? Is there sufficient capacity for managing and regulating these insurance and prepayment schemes? It is never too soon to begin developing this capacity, but creating risk pools that include the poor tends to be part of a long-term strategy of reform that separates financing from provision and gives facilities the autonomy to manage their affairs.

59. **Government financing: health system issues.** One issue here is the decentralization of revenue-raising—where, for example, local governments are able to raise their own revenues for health spending. Whether or not such arrangements lead to improvements in serving the poor may depend on how the decentralization process is designed and implemented. In assessing the impact of decentralization on health services for the poor, PRSP authors may wish to consider the following factors: how local authorities raise revenue; whether national resource allocation takes into account poverty and disease burden in different geographical or political units; methods of cross-subsidization between richer and poorer areas; resource allocation; the extent to which the poor—including poor women—have a voice in local resource allocation decisions; and the skills of district health staff in planning and managing resources for public health.

60. **Financing: stewardship issues.** One key issue here is how governments can help to coordinate, oversee, and—if needs be—regulate non-government risk-sharing schemes, such as private insurance, community insurance, and prepayment schemes. These can be important for the poor population, although insurance markets rarely develop well among poor populations. A number of low-income countries have started to experiment with public sponsorship of risk-sharing programs appropriate to poor populations, either for the employees of some sectors or at the community level, such as mutualities in Francophone Africa. Developing such programs usually requires public action and works best if organized through existing structures, such as rural credit systems, farmers' cooperatives, irrigation associations, mothers' associations, and other cooperative organizations. However, if administrative costs are not kept low, and resources do not go to medical services, they are unlikely to be beneficial.

61. **Government financing: micro issues.** When fees are charged in the public sector, provision can be made for co-management of services by involving the community and users. Studies conducted in Benin, Guinea, Niger and Cameroon have

shown that introducing user contributions can increase the overall equity impact of the services if funds are reinvested in quality improvements of pro-poor activities and are community managed.

7. Pulling it together and moving ahead

62. **From here to there.** This section pulls together the material presented thus far, and puts forward a table that could be used to organize the evidence from the diagnostics and analysis. It then discussed the processes of prioritization, target-setting, and monitoring and evaluation. It also discusses the PRSP process itself and offers some pointers for additional resources.

7.1 Analysis and diagnostics

63. **Recapping.** To recap briefly, Figures 1 and 2 together get across the key points relating to poverty and health. Poor countries have worse health than better-off countries, and within countries poor people have worse health than better-off people. Bad health leads to reduced living standards and often to poverty. But poverty is also a cause of bad health. This is traceable directly to the utilization patterns and actions of the poor. But more fundamentally it stems from the low income and inadequate knowledge of the poor, the poverty in their communities (traditional norms, weak institutions and infrastructure, etc.), and to the poor being badly served by the health delivery system (services inaccessible, poor quality, etc.) and the financing system (inadequate or nonexistent insurance coverage). Figure 3 shows more clearly how these different aspects interrelate, but also how government policies and actions can help break—or at least help dampen—the cycle of poverty and health. Table 2 summarizes how government action at three levels—macro, system and micro—influence the provision and financing components of the health system.

64. **Diagnosis and analysis.** The task of undertaking diagnostics and analysis may also seem daunting. Table 3 therefore pulls together on one page the key issues to be addressed in any diagnosis and analysis underlying the health-related outcomes and health system components of the PRSP. This table may serve as a useful organizing device for the diagnostic and analytical work. Ideally, each issue mentioned in the table should be covered, and evidence assembled. Once this has been done, it might be useful to draw up a version of the table containing bullet points summarizing verbally the evidence assembled—a sort of **Table of Evidence**.

65. **Inter-sectoral linkages.** Central for many health outcomes—e.g. nutrition—will be some cross-cutting and inter-sectoral diagnostics and analysis. This can build on the material in this chapter but also the material in the other chapters of the Sourcebook. A **Table of Evidence** along the lines of Table 2 could be assembled for this inter-sectoral work. Such an analysis should aim to show how action in sectors other than health services might help improve the health of the poor and reduce the impoverishing effects of ill health. Someone—ideally someone in the Ministry of Health—will need to coordinate this cross-cutting work, and it may make sense to set up specialized teams for specific topics. For example, it might be sensible to set up a task team on food security and nutrition to look specifically at activities in health, education, welfare, community development and agriculture, trade and industry that have bearing on the nutritional outcomes of the poor.

Table 3: Overview of Diagnostics and Analysis for Health Service Component of PRSP

| Households and communities | Health system | | Government policies and actions | |
|--|---|---|---|--|
| | Health service provision | Health financing | Health service provision | Health financing |
| <p>Key outcomes. Health outcomes, by poverty grouping. Impact of health spending on household living standards by poverty grouping.</p> <p>Health-related household actions and risk factors. Health actions, including service utilization, by poverty grouping.</p> <p>Household influences on actions. Household incomes and variability, and whether income is a factor in not seeking care. Knowledge, especially health-specific. Balance of power in household,. Are these factors in health choices; e.g. high fertility and low use of reproductive health services by women.</p> <p>Community factors. Cultural norms, and whether they influence health-related household actions. Strength and role of community institutions. Extent of social capital. Environment and infrastructure. How do the poor fare?</p> | <p>Physical accessibility of services. Distance to facilities, and whether is a barrier to use, especially for the poor.</p> <p>Availability of essential inputs. Key medicines and staff, especially in facilities serving the poor.</p> <p>Organizational quality. Opening hours, waiting time, perceptions of quality, staff attitudes, etc. , especially amongst the poor</p> <p>Service relevance. Are the services of the basic package actually delivered? Are they delivered to the poor?</p> <p>Timing and continuity. Especially obstetrics and immunization . Are facilities serving the poor performing worse?</p> <p>Technical quality. Staff sufficiently competent to diagnose and treat correctly? Worse in poor areas?</p> <p>Social accountability. What mechanisms used, and are they effective? Are the poor involved?</p> | <p>Who is covered by insurance? What schemes? Who do they cover? Who covers the poor?</p> <p>What is covered by insurance? What's covered and not covered? Is effective coverage by MoH clear? Is it declining? Is it worse for the poor?</p> <p>Risk-sharing. How large are copayments? Are they affordable for the poor? Do fee-waiver schemes work? Are informal payments a problem?</p> <p>Paying for health insurance. How much do different groups pay? Is it affordable for the poor?</p> <p>How much do people pay for services not covered? Are direct payments affordable for the poor? Are they deterred from using services or buying medicines?</p> | <p>Macro. Is government spending enough? Is spending unequal across areas? Does a mechanism exist to promote geographic equity? What is it spending on? Is it prioritizing well? Is spending properly balanced, or does government overspend on e.g. labor? Is government doing enough and doing the right things in pharmaceutical market, and in health labor market?</p> <p>Health system level. Who provides publicly-financed services? Are incentives likely to promote efficiency and equity? Is government doing the right things in stewardship (regulation, coordination, information, etc.)?</p> <p>Micro. Is quality, management and accountability a problem at facility level? What mechanisms exist to improve matters? Does government have a basic package and a sensible policy on its delivery?</p> | <p>Macro. What mix of revenues is used? Does government rely too heavily on user fees? Are the poor exempt? Are revenues sustainable? Does government have an insurance scheme?</p> <p>Health system level. Is decentralization of financing harming the poor? What role does it play in promoting private and community insurance schemes?</p> <p>Micro. Are fees collected locally retained? Is there local variation in success of fee-waiver schemes?</p> |

7.2 Prioritization and policy design

66. **Identifying potential areas for action.** The **Tables of Evidence** proposed in the previous section ought to give an overall picture of the problems the country faces in improving health outcomes of the poor and reducing the impoverishment associated with ill health. The **Tables** ought also, however, to give an idea about the relative importance of different problems. Most countries will have the opportunity to make improvements everywhere in these **Tables**, but some issues should stand out as being more potentially worthy of attention than others. These areas could be highlighted as **potential areas for action**. Attention can then be focussed on a limited set of potentially high priority areas, accepting it may be decided on the grounds of resource constraints not to pursue all simultaneously.

67. **Logical frameworks: goals, objectives, outputs and inputs.** Once this has been done, it is useful to develop a “logical framework”, or **log frame**. The first step is to decide, for each potential area for action, the ultimate **goal**. Suppose one area identified as being a potential area for action was the shortage of vaccines in clinics in poor areas (see Table 4). Then the ultimate goal—in terms of the final outcome improved—might be the reduction of child mortality. The next step would be to decide on the **objective**, which in the vaccine case might be to increase the immunization rate amongst poor children. The next step is agree on specific program outputs. The program output in the vaccine example would be defined in terms of raising the percentage of properly stocked facilities in poor areas. The next step would be to determine the program inputs required to bring this about. Key steps in the process of deciding what action is required to effect change include:

- assessing what changes at the household and community level would be necessary and sufficient to provide the needed contribution from the health sector;
- assessing what groups of actions the government can take in each of the three areas—macro, systems, interventions—that would be necessary and sufficient to achieve the desired changes at the household and community levels for the poor;
- assessing what specific inputs and costs would be associated with these actions; and
- assessing what indicators will be used to evaluate progress and how these will be collected and used to adjust the program.

The process is **iterative**. It is useful to develop first a “narrative summary”, working backwards from goal to objective to program outputs and thence to program inputs. It can then be reviewed in reverse, asking the question, “Is what we are proposing necessary and sufficient to achieve what is proposed in the preceding stage?” The concept of necessary and sufficient in working from the bottom to the top is key to using this framework successfully.

Table 4: Example of Log Frame

| | Description | Indicator |
|---|--|---|
| Area where action considered necessary. | Shortage of vaccines in clinics in poor areas, considered to be causing low vaccination rates and high child mortality. | |
| Actions required. | Improve distribution system. Ensure refrigerators for storing vaccines properly functioning, and can be repaired quickly when malfunction. | |
| Program's inputs. | Higher stocks of vaccines at clinics in poor areas. | Percentage of properly stocked facilities in poor areas. Intermediate indicator—system input. |
| Program's output. | Higher vaccination rate. | Vaccination rate in poor areas. Intermediate indicator—system output. |
| Program's objective. | Reduce child mortality. | Under-five mortality rate in poor areas. Final or outcome indicator. |

68. **Prioritizing.** Budgets are limited, and it will be necessary to work through the various potential areas for action, and decide on the basis of the log frame analysis which should be chosen as *actual* areas for action and how best to move forward. In Bolivia, for example, as in many other countries, the process of preparing the PRSP has begun. The approach has been similar to that proposed here. As in many other countries, problems had already been diagnosed. Many initiatives were in place; in fact, the diagnostic phase found a total of 65 projects under implementation and \$300 million in external resources committed to the health sector. Following the diagnosis and analysis, four broad areas were agreed upon as potential areas for action: (1) implementing the Seguro Basico—capitation for basic services; (2) implementing the Expanded Program of Immunization; (3) modernizing the social security system-based insurance for health; and (4) decentralization and institutional-strengthening. In each of these areas, a specific individual from the government and a counterpart at a single lead agency from the donor side is responsible for leading the log frame exercise. In March and April 2000, each of these teams developed strategies for breaking through bottlenecks in each of the four areas. After this, the Pan American Health Organization coordinated a team meeting. The four teams sat down with their proposals, consolidated them, ranked priorities, and turned them into concrete actions, with key performance indicators and a framework for monitoring and evaluation.

7.3 Targets, and monitoring and evaluation

69. **Setting targets.** As part of the PRSP process, targets for health outcomes will be set. This has to be done realistically, bearing in mind what can in practice be monitored and evaluated over time. Outcome indicators move slowly, and many are derived from surveys that are conducted only every few years. It is often useful to set

short-term targets for process indicators—proximate or intermediate determinants—that can be measured routinely to assess progress toward the major targets. If possible, the intermediate indicators should be chosen based on evidence of their importance to health outcomes for the poor. It is also important to remember what is achievable, considering the existing situation, the resources available, the general policies being pursued, and the changes to the policy framework decided through the process described above. For example, suppose reduction of the infant mortality rate is a target. The chosen interventions might be specific goals for prenatal care visits, identification of high-risk cases, tetanus toxoid inoculations, and improved nutrition for expectant mothers who are at risk. The infant mortality rate would be too general and slow-moving an indicator for evaluating these efforts. Short-term target setting would have to be done through changes in intermediate variables—such as prenatal visits, tetanus toxoid coverage, delivery of nutrition supplements, and identification of mothers who will have high-risk births—for the poor women being targeted.

70. **Monitoring and evaluation.** For the reasons discussed above, monitoring is also best focused on the interventions. Evaluation would be focused on the relative success of the interventions in achieving the goals, and why they worked or did not work as expected. The chapter on Monitoring and Evaluation in this volume contains a wealth of useful material on these issues. Specific issues relating to the health component of the PRSP include the following.

- Current M&E capacity in the health sector needs assessing, both inside and outside government. This includes the availability and quality of data, and—equally important—the extent to which information is adequately analyzed and used for decision-making. If data are not being used, why not? This assessment should inform the choice and number of indicators.
- An M&E strategy for the health portion of the PRSP needs developing, with particular attention to how both qualitative and quantitative information will be collected and used—at the national, local, and facility level. Experience shows that the quality and use of data are closely linked. Some monitoring functions may be best carried out by government, while others could be done by academics, NGOs, or community organizations.
- M&E needs to be given adequate resources and management attention during implementation. Too often, baseline surveys are delayed or not completed, and critical data not adequately collected and analyzed, making it difficult to assess what interventions are making a difference for the poor and why. Annual review meetings among government and partners can be a useful means to track progress, and ensure that M&E is receiving adequate attention.

7.4 The PRSP process

71. **Capacity-building through joint learning-by-doing.** In African countries, the PRSP process has created significant opportunities for building capacity through joint learning-by-doing. At the country-level, the formation of working groups on health and education is the first step in the government's work of elaborating the PRSP. While their composition vary, these groups typically consist of senior managers of the line ministries

as well as budget and policy analysts from the ministries of planning and finance. They sometimes include observers from donor agencies, and even representatives of NGOs and other civil groups. In Cameroon, for example, NGOs were consulted in the preparation of the AIDS strategy, opening the way for future collaboration between the government and NGOs, including the involvement of NGOs in specific activities under sub-contracting arrangements. The Bank supports the work of these working groups by sharing technical resources, as well as by working collaboratively with members of the group in preparing the CSRs where this has been chosen as the mechanism to consolidate sector knowledge.

72. ***Closer collaboration amongst partners.*** Opportunities also exist for closer collaboration among the Bank's development partners, including bilateral donors and international organizations such as WHO, UNICEF, UNAIDS, UNFPA, AfDB, and so on. This collaboration has meant increased support for the working groups, as well as dialogue on: (a) a common understanding of the underlying analytical frameworks for assessing the link between education and health and poverty reduction; (b) lessons from various efforts to improve service delivery (e.g. efforts to reform and reorganize the health sector in Sub-Saharan African following the Bamako Initiative, and to accelerate public health programs such as EPI, Family Planning and Safe Motherhood, Polio Eradication, etc.); and (c) the design of sound pro-poor strategies in the health and education sectors that take advantage of debt relief to reinforce the donor community's efforts to ensure increased funding for the social sectors in Africa (such as through such initiatives as Roll Back Malaria, Stop TB, GAVI, Massive Attack, Education for All, etc.).

7.5 Further resources

73. ***A guide to the technical notes.*** Table 5 maps the technical notes, and selected additional sources, into the structure of the chapter.

Table 5: Further Resources for Health Service Component of PRSP

| Households and communities | Health system | | Government policies and actions | |
|--|--|--|--|------------------|
| | Health service provision | Health financing | Health service provision | Health financing |
| <p>Key outcomes. TN 3A for risks and outcome indicators by stage of lifecycle. TN 3B for data on key MCH outcomes by wealth quintile for 44 countries.</p> <p>Health-related household actions and risk factors. TN 3A for key household risk factors and behaviors by stage of lifecycle. TN 3B for data on key MCH risk factors, behaviors, and utilization by wealth quintile for 44 countries. TN 5E on differences across income quintiles in health service utilization and subsidies for health care.</p> <p>Household and community influences on actions. TN 3B for data on health-related knowledge by wealth quintile for 44 countries. TN 3C on child deaths in Bolivia. TN 4A-C on impact of household and other factors on household utilization and behavior.</p> | <p>TN 5A assessing health sector performance.</p> <p>World Bank's private sector toolkit for improving role of private sector. Available at: www.worldbank.org/</p> | <p>World Bank's community financing work. Available at: www.worldbank.org/</p> | <p>Macro. TN 5B on how to approach public expenditure analysis. TN 5C on linking expenditures to program objectives. TN 6.2 on benchmarking, and monitoring and evaluation. TN 6.3 on lessons from World Bank's Operations Evaluation Department. TN 6.5 on evaluating public spending options.</p> <p>Health system level. TN 6.4 on stakeholder analysis.</p> <p>Micro. TN 6.1 on behavior change and communication programs. TN 3A on key interventions at different stages of lifecycle.</p> | |

Note: TN=Technical Note to Health, Nutrition and Population PRSP sourcebook chapter