Electronic Annex A


Checklist of policy issues for reaching national health targets

*A foundation for building bridges between the ministry of health and its partners*
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AIDS         acquired immunodeficiency syndrome
CARICOM     Caribbean Community and Common Market
CMH         Commission on Macroeconomics and Health
CPIA        country policy and institutional assessment
CSDH        WHO Commission on Social Determinants of Health
CSO         civil society organization
GAVI         Global Alliance for Vaccines and Immunization
GDP         gross domestic product
GNI         gross national income
GNP         gross national product
HIV         human immunodeficiency virus
IFF         international finance facility
IMF         International Monetary Fund
MDGs        Millennium Development Goals
MTEF        medium term expenditure framework
ODA         official development assistance
OECD        Organisation for Economic Co-operation and Development
PFM         public financial management
PIU         project implementation unit
PRS(P)      poverty reduction strategy (paper)
SARS        severe acute respiratory syndrome
SWAp        sector-wide approach
UNDP        United Nations Development Programme
WHO         World Health Organization
Checklist of policy issues
for reaching national health targets
A foundation for building bridges between
the ministry of health and its partners

The following sections introduce the key issues that the ministry of health, which has primary responsibility for the overall performance of the country's health system, is facing in the pursuit of stronger national planning and advocacy for scaling up essential health interventions. The presentation of these challenges will serve as a background to the country work presented in the main report, elucidate the tough choices that countries must make, and draw specific attention to the components of better negotiations between the ministry of health and the ministry of finance, the ministry of planning, and other stakeholders.

After highlighting the importance of governance for health, the challenges are structured around the interactions among the ministries of finance, planning, and health; between the ministry of health and other public health actors; and between the ministry of health with development partners. Thus the emphasis is placed upon describing the broad environment in which national commissions of macroeconomics and health initiatives have worked.

However, the list of issues provided below is not exhaustive. These issues should be considered within existing frameworks, particularly those involving the main functions of a health system – provision, resource generation, health financing, and stewardship – to assess the performance of health systems, which are set forth in The world health report 2000.

Improving governance for health

As attention to health and development intensifies and development assistance for health increases, a lively debate is being carried on about the importance of governance as a factor in determining development outcomes. The World Bank Institute defines governance as:

… the set of traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced, the capacity of the government to effectively formulate and implement sound policies, and the respect of citizens and the state for the institutions that govern economic and social interactions among them.

Good governance is relevant not only for efficiency of government spending but also for equity, since institutions and governance affect people's inclusion and empowerment ($I$).

Figure 1 illustrates how the level of government effectiveness, as one of the World Bank indicators of governance with particular relevance for health-sector management, affects the empirically weak relationship between government health expenditure and
under-five mortality rates.\(^1\) Government effectiveness combines responses on the quality of public service provision, quality of the bureaucracy, the competence of civil servants, the independence of the civil service from political pressures, and credibility of government commitment to policies (2). The comparison of the samples indicates that higher government health spending is more likely to be associated with a reduction in under-five mortality in countries with higher government effectiveness than in the sample with lower government effectiveness. First, health spending explains a greater share of the variation in mortality in the sample of countries with government effectiveness above zero than in the second sample (\(R^2\) of 0.06 vs. 0.28). Second, the slope of the regression line is steeper. The dispersion is higher for countries with a low level of spending which suggests that there are additional factors, such as GDP per capita, which influence health outcomes and are not controlled for here.

Figure 1

**Government health spending and under-five mortality rate in countries with lower and higher government effectiveness**

\(^4\)The indicator government effectiveness for the year 2002 was used and is scaled from -2.5 (low government effectiveness) to 2.5 (high government effectiveness).

\(^5\)Negative government health expenditures in log scale translate to positive absolute values.

**Source:** Prepared in collaboration with the WHO European Office for Investment for Health and Development in Venice, using WHO national health accounts; *The world health report* 2005; and, by permission of the publisher, from Kaufmann, Kray & Mastruzzi reference (2).

Good governance is thus part of the equation linking resources to development outcomes. *The world health report* 2000 states that:

the ultimate responsibility for the overall performance of a country’s health system lies with government, which in turn should involve all sectors of society in its stewardship.\(^6\)


\(^2\) The broad concept of good governance is closely related to the function of stewardship, which has been described as "arguably the most important" of the four health systems functions in *The world health report* 2000: *health systems: improving performance* (Geneva, World Health Organization, 2000).
Country efforts to carry out an effective response to the challenges described in the following will be abetted by good governance. This checklist therefore looks at how to improve governance, specifically through developing a health and development mechanism and a framework for reforms that can lead to improved efficiency of government spending and more accountability.
Ministries of finance, planning, and health: planning for development

Draw up a plan towards achievement of development targets
The first challenge confronting the ministry of finance – and in some countries the ministry of planning – is to draw up an overall plan for the country based on an analysis of the country’s priorities and to incorporate national poverty reduction and development targets at the centre, including the Millennium Development Goals (MDGs) adapted as necessary to the country context. The United Nations Millennium Project recommends that this plan be drawn up by a "MDG strategy group chaired by the national government and including bilateral and multilateral development partners, United Nations specialized agencies, provincial and local authorities, and civil society leaders” (3). In many countries, administration at the central and local government level is compartmentalized, with little room for reaching a consensus among these groups as to the main orientations of the overall long-term macroeconomic plan.

Much work has been undertaken in recent years to further develop overall macroeconomic plans under the impulsion given by the poverty reduction strategy papers (PRSPs). PRSPs were launched in 1999 and now cover more than 40 countries, accompanied in some cases by a World Bank poverty reduction support credit and an International Monetary Fund poverty reduction and growth facility. Although no formal link exists between the PRSPs and the MDGs, “the PRSPs are expected to be framed against the backdrop of the MDGs while taking into account initial conditions and national priorities” (4) and are generally considered as one of the main instruments to define the strategies to reach the MDGs.

In this important exercise of developing an overall macroeconomic plan, the ministry of health has a very important advocacy role. It must contribute all the information pertaining to the health sector – indicating the costs for the economy of the main health problems affecting the country and the economic benefits which would result from increased investments in the health sector, both for the individual and the economy as a whole (5). This evidence is presented with the aim of attaining a more central position for health in the macroeconomic plan and securing increased financial allocations to health in the national budget.

Funding for health in many countries remains very limited. In 2001, the Commission on Macroeconomics and Health (CMH) estimated that the minimum level of health spending needed in low-income countries to cover essential interventions should be US$ 30–40 per person per year. Even if low-income countries on average have come closer to this benchmark in recent years, the analysis in the main report has shown that many of the selected countries spent less than US$ 34 per person per year in 2002 – which may hide that substantially less was benefiting specific groups within the country. Table 1 indicates differences in the average level and composition of health expenditure for countries grouped by income. For instance, it shows that public spending amounted to less than 30% of total spending in low-income countries on average and that the gap was mostly filled by private out-of-pocket expenditure.
Table 1

Health spending by income group in 2002

<table>
<thead>
<tr>
<th>Countries</th>
<th>Total per capita (current US$)</th>
<th>Total (% of GDP)</th>
<th>Public (% of GDP)</th>
<th>Private (% of GDP)</th>
<th>Out-of-pocket (% of private expenditure on health)</th>
<th>External resources (% of total expenditure on health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>29</td>
<td>5.5</td>
<td>1.5</td>
<td>4.0</td>
<td>95.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Lower-middle</td>
<td>84</td>
<td>6.0</td>
<td>2.7</td>
<td>3.2</td>
<td>82.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Upper-middle</td>
<td>310</td>
<td>6.0</td>
<td>3.4</td>
<td>2.6</td>
<td>84.1</td>
<td>0.5</td>
</tr>
<tr>
<td>income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High income</td>
<td>3039</td>
<td>11.1</td>
<td>6.6</td>
<td>4.5</td>
<td>36.6</td>
<td>0.0</td>
</tr>
</tbody>
</table>


Even conservative estimates suggest that health investments are yielding very high rates of return as compared to other public investments. These are often not calculated in the dialogue between the ministry of finance and the ministry of health in the preparation of the country’s development plan or the PRSP. As a result, health components in these documents are often weak and allocations to the health sector very low, not effectively reflecting the contribution of health to the overall development of the country or to fighting poverty (Box 1).

Box 1

Health components in the poverty reduction strategy papers

The main conclusions of the 2004 WHO study on the significance of health in 21 PRSPs are the following.

*Regarding the poverty–health links*
- All PRSPs recognize poverty as multidimensional, and, in most cases, state that ill-health is one characteristic of poverty. However, the analysis of the links between poverty and ill-health is sketchy in all but a few reports.
- The level of detail on the geographical distribution of poverty is fairly comprehensive, although this rarely extends to a geographically disaggregated examination of the health dimension of poverty.
- Few PRSPs provide comprehensive information of data on poor people’s health needs.

*Regarding the analysis of health in PRSPs*
- The information presented in the majority of PRSPs demonstrates an implicit rather than explicit poverty focus.
- Financial barriers to care are highlighted in the majority of PRSPs, although they are rarely dealt with in any detail.
- Information on the links between health and other sectors is sporadic. Information on water tends to be more comprehensive than that on nutrition and sanitation. Beyond these sectors, only education is consistently mentioned as a sector of importance to health.
Regarding health strategies in PRSPs
- All health strategies in PRSPs focus on interventions which should benefit the poor, but few examine the difficulties they have faced in reaching the poor.
- Few PRSPs target health programmes specifically at the poorest group, but some examples do exist, suggesting that there is some ‘good practice’ to learn from.
- It appears that the health components or PRSPs are becoming more detailed over time.

Regarding health budgets
- The health sector is not gaining significantly in priority as a sector and the sharp increases in health spending necessary to reach the MDGs are not likely to be realized through the PRSP process.
- Many PRSP budgets are only loosely related to the broad programming plans listed in the health strategy.

Regarding monitoring the health component
- The majority of PRSPs present a range of indicators to monitor health strategies, but they are not always comprehensive or quantifiable.
- There is little evidence of indicators that explicitly monitor the impact of the health strategy on the poor regions or groups of population.
- There are strong links between the PRSPs and the MDGs in terms of focus, but not in terms of quantifiable targets.

Source: Dodd R et al. (35). Countries covered by the study: Albania, Bolivia, Burkina Faso, Ethiopia, Gambia, Guinea, Guyana, Honduras, Malawi, Mauritania, Mozambique, Nicaragua, Niger, Rwanda, Senegal, Tajikistan, United Republic of Tanzania, Uganda, Viet Nam, Yemen, Zambia.

Strengthen public expenditure management
The ministry of finance is usually responsible for managing public expenditures, and budgets are the "principal mechanisms through which governments' policy intentions are translated into concrete actions and results on the ground" (6). The World Bank states:

The total amount of money a government spends should be closely aligned to what is affordable over the medium term and, in turn, with the annual budget; such spending should be appropriately allocated to match policy priorities; and the spending should produce its intended results at least cost (7).

The ministry of finance is responsible for collecting revenues through a tax system that functions effectively and equitably, and for spending with a view to maintaining the sustainability of the country's financial position, including managing the debt level. Once the national goals and strategies of the macroeconomic plan have been formulated, the ministry of finance needs to ensure that budget allocations to line ministries follow those priorities. In addition, it must release allocated funds in a timely fashion and demonstrate that annual budgets and medium-term expenditure frameworks (MTEFs) are respected, facilitating medium-term planning by the line ministries. The success in meeting these challenges will depend to a large extent on the collaboration between the ministry of finance and the line ministries. These challenges can also be replicated at the state or district levels as illustrated in Box 2.

On a practical level, when subjected to analysis, many PRSPs – and in particular the health components of PRSPs – tend to be poorly prioritized, are not sequenced to ensure sustainability, and are de-linked from national budgets. Ongoing programmes
are kept on the books in spite of the newly-adopted priorities, and managers of lower-priority programmes effectively prevent the new priorities from taking hold in the budget (Foster, unpublished data, 2004). Health investment strategies, developed in an open manner via national health and development mechanisms, have the potential to link short-term imperatives with medium- and longer-term demands on budget resources (for example, by working through medium-term expenditure frameworks). This could lead to more effective policy-making and more suitable service-delivery tactics.

Evidence from Senegal suggests that

the challenge is to adjoin to the PRSP mechanism a more responsive public expenditures model than the MTEF…. Without such a model, even the costing of MDGs achievement, which countries are under pressure for producing, is in serious doubt of credibility, because of constant lack of capacity in public resources management techniques vis à vis sector development and management (8).

Box 2
Country illustrations of budget management problems in India and Mozambique

**India: lack of stability in budgetary processes**
“State governments normally pass the budget between April and June every year. Once the budget is passed, treasuries located at various districts are intimates of the allocation to various sectors, followed by a budget authorization. The amounts authorized vary widely depending on the financial situation of the state and current priorities, which could be influenced by a range of factors – from political compulsions to debt repayment. Often when fiscal situation is bad, budget authorizations are released but formally instructions are issued to treasury officers not to release money, disrupting ongoing activities and processes; for example, finalizing a contract for procurement of drugs or equipment” (9).

**Mozambique: budget management issues**
“Mozambique faces a number of budget management issues. For example, the budget execution process is still fraught with problems, particularly at lower levels of the administration. First, many provinces and districts receive their first budgetary transfer late in the year resulting in temporary liquidity problems and often low levels of execution over the year. Second, delays in the processing of accounts during the year also contribute to periodic liquidity problems and low execution rates” (10).

**Mobilizing health resources**
Considering the low levels of health financing – in particular, low shares of public funding – in many poor countries, it is an important challenge for the ministry of health and the ministry of finance to define strategies of how to sustainably close the gap in health financing while protecting individuals from financial risks.

Increasing domestic allocations for health requires either increasing the overall government budget via tax increases or reallocating resources from other sectors

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which compete with health for a share of the budget. Government expenditure on health as a percentage of general government expenditure reflects the priority given to health within the national budget. The difficult choices that governments must make in the face of limited resources can be seen from Figure 2, which illustrates general government expenditure on health vis-à-vis education, military expenditure, and debt service. For instance, each of the selected countries is spending a larger percentage of their GDP on debt service and education than on health.

Figure 2
Government expenditure as share of GDP in selected countries

Sources:

A larger sample of countries (see Figure 3) reveals that the share of the general government budget earmarked for health varies substantially between countries with similar levels of per capita GDP. These differences may indicate the flexibility for some governments to increase public funding for health by reallocation. Still, the absolute amounts allocated for health depend on the absolute amount of general government revenues (see electronic Annex B for the level of tax revenue as % of GDP in selected countries). Again, since external funds – which can vary widely among countries – are included in the figures for general government expenditure on health used in Figure 3, comparison between countries needs to be done with caution. Furthermore, as Working Group 3 of the Commission on Macroeconomics and Health recognized, macroeconomic budgetary considerations must be taken into account in deciding on the amount and timing of changes to taxation and expenditure. Governments face difficult trade-offs that must be considered in the country context (11).
Figure 3
General government expenditure on health in 192 countries in 2002, as share of general government expenditure versus GDP per capita

Source: Based on national health accounts, World Health Organization, 2005.

Assessing the potential to mobilize more domestic sources for health may confirm the need for additional external aid for a rapid scale-up of health interventions. Considering the sample of 40 countries (see country profiles, electronic Annex B), 12 countries had shares of external assistance for health between 13% and 39% of total health expenditure whereas 10 countries had shares of external funding below 1% of total health expenditure in 2002. In addition, only part of these shares of external funding for health is usually channelled through the government budget, the other part being provided as extrabudgetary support. A closer look at the effectiveness of external funds in improving health outcomes may permit to draw lessons for increasing aid in other countries, particularly on the possible macroeconomic implications of large new external transfers for health in a country.

Debt relief is another form of external support which can free resources for social spending in a country facing a high burden of debt service. Strengthening the health components of poverty reduction strategies can help to ensure that financial resources, including those gained from debt relief, are actually used to promote health care that is accessible to the poor.

Apart from theoretic qualities regarding the pooling of risks, the right balance between the different funding sources depends much on the country context. Whereas social health insurance is possible only for workers in the formal sector, private health insurance is a solution only for individuals who can afford it. For example, targeted insurance schemes such as a community-based prepayment scheme is most feasible for closely-knit rural communities (11).
The world health report 2000 presents a comprehensive discussion of the various funding options for health with regard to their implication on risk sharing and equity (12). It is important to consider the needs of the whole population when developing a financing strategy for health care. For a nation to achieve its health goals, the CMH suggested a strategy in which:

the general budgetary revenue, the most equitable and flexible source of financing, would be used to correct the shortcomings left by other financing methods, would fund public goods and essential health care, and would subsidize the poor (11).
Ministry of health: formulating and implementing a health strategy

The four main functions of the health system defined by The world health report 2000 are service provision, resource generation, financing, and stewardship. The ministry of health may not be entirely responsible for the first three, particularly in the face of decentralization reforms and the trend towards contracting out to private or nongovernmental organization providers.

However, the ministry of health retains a primary role in stewardship, aiming to ensure maximal improvements in health outcomes, reduction in health inequalities, and fair health financing for the country’s population within the limits of its financial and human resources. To do so, the ministry of health has responsibility for formulating and implementing a national health sector strategy.

While it relies upon the ministry of finance for certain inputs affecting its performance, notably for budget allocations and human resource levels, there are a number of challenges which are under its direct control. Funding is a necessary but not a sufficient condition for scaling up health interventions. Additional resources will have little impact unless coupled with effective planning, properly-sequenced health investments, as well as improved systems to supervise implementation, monitor progress, and collect data for decision-making.

Measure the country's main health problems and health determinants

In many countries, there is a lack of information concerning the main health problems and determinants of health, and as to which people are most affected – all of which impede appropriate allocation of health resources. Evidence is needed, concerning the present and future burden of disease by age, region, gender, and socioeconomic status.

As underlined by Working Group 5 of the Commission on Macroeconomics and Health, “… systems for health monitoring are poor to non-existent in many developing countries … with the present poorly known, the future is hard to design”. It further argues that a “… sine qua non of any global programme to improve the health of the poor would be routine, reliable, low-cost, and long-term reliable health surveillance systems” (13). Much effort has been undertaken – particularly at the global level – to develop indicators of burden combining mortality and morbidity, but the level of knowledge at country level remains very partial.

The challenge goes beyond the knowledge of the burden of diseases – extending to the knowledge of the determinants and risk factors – which explains why the incidence of the diseases is so high. Determinants and risk factors include malnutrition, water and sanitation, outdoor and indoor air pollution, tobacco, alcohol, overweight, physical inactivity, and other lifestyle factors. Collecting detailed information on health determinants will permit to define the health strategies with the most promising impact on reducing the incidence of disease and affecting lifestyle choices. Although much work has been undertaken by WHO and its partners in recent years regarding risk factors and determinants at the global level, systematic information at country level remains even more limited than that on the burden of disease.
It is widely accepted that many determinants of health lie outside the health sector. Social factors – including food security, social exclusion and discrimination, human settlements, early childhood development, and employment conditions – underlie a significant portion of the global burden of disease and death. These social factors are a primary factor in the stratification of health status within and between countries.

A major new effort focusing on social determinants of health was launched in March 2005 with the creation of the WHO Commission on Social Determinants of Health (CSDDH). The CSDH emerged to build on existing efforts to work towards better health and greater health equity. A key component of the CSDH process will be to consolidate, disseminate, and promote the use of knowledge that demonstrates both the imperative and the opportunities for action on the social determinants of health.

**Define priority health objectives and interventions in a multisectoral approach**

Once the main health problems and determinants have been established, it is necessary to clearly define health objectives and indicators of performance for the period of the macroeconomic plan. Few countries have specific targets, and indicators of performance often reflect more the local data availability than the result of a priority-setting exercise based on disease burden and risk factors and a realistic assessment of what can be accomplished in a given time period. For example, nutrition is universally mentioned, but few countries have defined specific targets regarding this major health determinant (Foster, unpublished data, 2004). Box 3 illustrates the difficulties of defining long-term health objectives in India, Mexico, and Nepal.

**Box 3**

**Challenge of defining long-term country health objectives and interventions: illustrations in India, Mexico, and Nepal**

**India**

“In India, improvements in population health outcomes are an important goal of health policy, but so is protection from the financial risk associated with illness. Thus, compared to cancers, diarrhoeal diseases impose a much greater disease burden in India at present, but the former obviously imposes a much greater financial risk on affected households. This then justifies the urgency to avoid and prevent the onset of these diseases to the extent possible. Given the absence of research data on the causal connection between intervention and a reduction in morbidity or mortality, we take the position that an ideal health intervention ought to have the following two key properties. First, it is technically effective in substantially ameliorating a major health problem – in other words, has the potential to markedly reduce disease burden; and relative to the outcome gains achieved, it is financially inexpensive (cost-effective). Second, in narrowing down such a list of supportable interventions, we focus on mortality gains likely to be achieved, as mortality accounts for a substantial proportion of the disease burden, while the disability and morbidity effects of a disease are highly correlated with its mortality effect” (9).

**Mexico**

“One way of defining health targets is comparing Mexico with countries (or regions) that have similar characteristics (in particular, income per capita). Another way is adopting the targets agreed upon through international consensus, as is the case of the Millennium Development Goals. However, both approaches have their limitations. For example, in

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4 Foster M, op. cit.
terms of the first method, what should the goal be for countries whose performance is above its comparison group? In terms of the second method, targets might be inappropriate for certain countries since they are formulated in relation to a historic baseline (for example, reducing the maternal mortality rate by 75% from 1990 to 2015). The resulting target might have little to do with a target that can be realistically achieved until 2015 based on current indicators” (14).

**Nepal**

“The Second Long Term Health Plan (1997–2017) describes many interesting policy options, but only a few of these refer specifically to improving access to health-care services for the poor, although the overall objective of the Plan is to improve the health status of the needy. There is, for instance, no mention of the need to expand or upgrade the number of facilities in rural and remote areas. As usual, targets are national averages. In the context of the objectives, it would also be more meaningful to have specific targets and indicators for the vulnerable, women, children, rural populations, and specifically for the poor. To reflect this, the health-management information system would need to be adapted. It would be helpful to disaggregate information on health status and utilization by gender and income quintile for example” (15).

Following the definition of clear objectives, the challenge is to identify the basket of health and health-related interventions that will be delivered. This requires a systematic evaluation of the alternative or combined possible interventions for each of the specific health objectives of the government. Definition of interventions will need to take into account cost-effectiveness of interventions and their impact on reducing inequalities in health. The world health report 2000 explores the issue of prioritization and cost-effectiveness as a component of the complex function of service delivery, which also entails service organization and provider incentives (12).

In this process, it is critical for the ministry of health to link up effectively with other ministries and stimulate actions in non-health sectors that play a crucial role in health promotion and disease prevention. For example, strategic collaboration with the relevant ministries in the fields of education, water and sanitation, agriculture, transportation, air pollution, toxic chemicals, deforestation, and soil erosion could contribute much to improvements in population health. Such efforts in Ghana led to the formulation of a multisectoral health investment plan, as illustrated in Box 4.

**Box 4**

**Non-health sector interventions**

**Ghana: water and sanitation**

Apart from health services, health-related interventions can be identified as critical inputs to the attainment of improved health outcomes in Ghana. One such important input is improvement in access to potable water and sanitation. In Ghana, it is estimated that 70% of all diseases are caused by lack of clean water and sanitation conditions. This is due to the fact that only 41% of Ghanaians have access to water from the pipe. This situation is also compounded by the inadequacy of sanitation systems. Consequently, the Ghana Macroeconomics and Health Initiative has developed a multisectoral health investment plan suggesting substantial investments in access to water and sanitation (16).
In most countries, preventive measures have been very limited in comparison to the benefits which could be expected from such measures. In India, for example, an estimated 2% of total health expenditures, or 6% of the central budget for health, was spent on preventive care aiming at behaviour change. This represents a very small amount in comparison to the huge treatment costs that will be required to cope with the emerging epidemic of noncommunicable diseases (9). It is therefore crucial to include preventive and behaviour change interventions in the national health sector planning. Box 5 describes the challenge of addressing the growing problem of chronic disease.

Box 5

**Chronic disease: choosing interventions**

<table>
<thead>
<tr>
<th>There is no ‘one-size-fits-all’ model to prevent chronic disease. Replication of successful interventions should be encouraged, whether ‘top-down’ government policy or ‘bottom-up’ approaches based in encouraging communities to adopt healthy lifestyles.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government: policy and persuasion</strong> Government's sphere of influence stretches throughout society, to all groups whose ‘buy-in’ is needed for prevention programmes to be a success. Government action on chronic disease is required to provide health care to those suffering from chronic disease, provide information to allow individuals to make better-informed choices, and change the culture and purchasing environment to ensure that easy choices are healthy choices.</td>
</tr>
<tr>
<td>Governments can do this through legislation and taxation. The main economic, political and institutional constraints facing government will only be overcome by strong advocacy backed up with solid research into risk factors and an appreciation of the economic logic behind positive action.</td>
</tr>
<tr>
<td><strong>Community: culture and education</strong> The most successful prevention programmes are tailored to the communities in which they are based. Such ‘population-based’ approaches require the involvement of many levels of society to foster changes in attitude to the unhealthy lifestyles that are implicated in chronic disease – although it is not sufficient to educate individuals to recognize that their choice of lifestyle is unhealthy if alternative, healthier options are unavailable.</td>
</tr>
<tr>
<td>Prevention programmes should address the many risk factors of chronic disease. Increased coordination and monitoring of projects allow for successful projects to be replicated at lower cost and reduced risk.</td>
</tr>
<tr>
<td><strong>Business: opportunity and responsibility</strong> Globalization encourages the expansion of business both between and across borders, providing a wealth of new opportunities – including to the food, pharmaceutical and tobacco industries. Business should be encouraged to recognize that the new opportunities need to be balanced with a responsibility not to exacerbate chronic disease, recognizing the risks of obesity and smoking.</td>
</tr>
<tr>
<td>Further, business leaders are already recognizing their potential role in changing behavioural norms in a way that will encourage sustainable growth in the long term. Voluntary frameworks – such as the United Nations Global Compact – should incorporate chronic disease prevention, to move the issues further up the business agenda.</td>
</tr>
</tbody>
</table>
Both employees and consumers stand to benefit from more responsible action from business on prevention of chronic disease.

International community: awareness and assistance
The potentially devastating impact of chronic disease should be a factor in revising and negotiating trade and investment agreements. However, any alteration to the trade and investment framework is unlikely to be an orderly transition, given the entrenched interests involved.

Source: Adapted from Chronic disease: the call to action, contributed by the Oxford Health Alliance, July 2005, see Annex 2 of main report.

Plan and cost the needed investments
After having identified the curative, promotive and preventive interventions which will enable health objectives to be met, the ministry of health must plan the needed associated investments. Investments will need to be undertaken in an appropriate sequence so as to optimize their efficiency. These investments will include both the costs of interventions and complementary investments in the health system for delivery – particularly to poor or remote areas. One difficulty for the health sector is the identification of appropriate costing methodologies for a basket of diverse interventions, both in nature of target disease and level of care, and effective costing tools that take into account shared health system components, necessary for the delivery of a variety of disease interventions. Further, insufficient technical support to apply the costing tools can be a challenge for the health sector.

A key challenge for the ministry of health is to estimate the improvements in population health which are expected to result from such investments, thus linking resource inputs to health outcomes. In Mauritania for example, the 40% increase in the health budget in 2002 was influenced by the argumentation of the ministry of health that it would permit, within five years, a 30% reduction in child mortality and a 40% reduction in maternal mortality (Foster, unpublished data, 2004). In many countries however, budget proposals presented by the health ministry to the ministry of finance are not very credible as they adopt targets that are more ambitious than recent historical trends, without explaining how the performance will improve to the extent assumed (Foster, unpublished data, 2004). The next two sections look more closely at the inputs necessary for delivery of health services which must be considered in planning and costing health investments.

Optimize the mix of inputs for health
Health workers are essential to the delivery of health services, and they require adequate drugs, medical supplies, and facilities to fully perform their tasks. The ministry of health is confronted with a complex optimization problem requiring high-level management and economic competencies. The world health report 2000 describes “resource generation” as one of four health system functions and differentiates between human resources, physical capital, and consumables as main health system inputs (12).

5 Foster M, op. cit.
6 Ibid.
A key issue health planners must consider is at what level of the health system to deliver an intervention. The CMH Report recommended a close-to-client system, with a functional referral system to higher levels of care. This consideration will have important implications for the health system inputs needed.

In many countries, public health spending is biased towards spending on tertiary centres, which have more revenue-generating opportunities as well as possibly a positive political effect. Figure 4 illustrates that in some countries, hospitals accounted for more than half of expenditures in 1998. Spending on hospitals is more likely to benefit people living in urban areas – who are also richer – and does not represent an efficient allocation of resources when many people could access care at lower levels.

Figure 4
Health expenditures by providers in 1998

<table>
<thead>
<tr>
<th>Country (Code)</th>
<th>Hospital</th>
<th>Outpatient Clinics</th>
<th>Pharmacies</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia (a)</td>
<td>22%</td>
<td>21%</td>
<td>53%</td>
<td>4%</td>
</tr>
<tr>
<td>Guatemala</td>
<td>47%</td>
<td>33%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>27%</td>
<td>22%</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td>Malawi (b)</td>
<td>54%</td>
<td>11%</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Mèxico</td>
<td>30%</td>
<td>48%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>26%</td>
<td>12%</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>South Africa</td>
<td>61%</td>
<td>12%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Tanzania (c)</td>
<td>53%</td>
<td>35%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Yemen (d)</td>
<td>56%</td>
<td>9%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Synthesis of findings from national health accounts (NHA) studies in 26 countries (2004), conducted by Partners for Health Reform plus (Abt Associates Inc., USAID, Contract No. HRN-C-00-95-0002).

a Ethiopia: expenditure on drugs shown under pharmacies; “other” includes administration, research and information, education, and communication.

b Malawi: tertiary and secondary care shown as hospitals. It was necessary to adjust for expenditure on pharmaceuticals from other sections of NHA. This reduced the total expenditures shown against hospitals.

c United Republic of Tanzania: further breakdown not possible.

d Yemen: information on hospital care and pharmacies was available. This was used to estimate expenditure on outpatient facilities.

Financial resources for the health system can further be classified as capital (training of people, investment in buildings and equipment) and recurrent (labour costs, maintenance, consumables) (12). In many countries, public spending has also been directed towards large capital investments while recurrent costs, including salaries and maintenance, are underfunded. In Yemen, on average over the period 1999–2003, approximately 30% of the total health budget was capital spending on new buildings and equipment, while existing facilities are seriously understaffed, undersupplied, and poorly maintained. Since salary recurrent costs are often incompressible, this situation leads to a severe shortage of funds for other recurrent costs and results in
underutilization of facilities due to a shortage of drugs and medical supplies (Foster, unpublished data, 2004).  

**Ensuring the optimal quantity and quality of the health workforce**  
Human resources are a key input into the health system. Their improved management will be critical for building long-term national capacity to expand access to essential health services.

The challenge of establishing and maintaining an adequate health workforce in terms of quantity and quality has become much greater in recent years due to the increasing problems of ‘brain drain’ and the HIV/AIDS pandemic. The problem of brain drain is most serious in sub-Saharan Africa. In South Africa, for example, medical schools estimate that one third to one half of their graduates emigrate to the developed world, and more than 3600 nurses per year are estimated to leave the country (17).

Other regions of the world are affected as well. In the Caribbean Community, there is a 35% vacancy rate for registered nurses, and an estimated loss of revenue of about US$ 17 million annually through migration of nurses whose basic training was paid for by the state (18). In recent years, the problem of health-staff availability has been made more challenging yet because large numbers of health workers have fallen ill or died from HIV/AIDS. Figure 5 shows the dramatically low level of health workers in Africa and the projected further losses over the next ten years due to brain drain and HIV losses, if no new measures are adopted.

**Figure 5**  
**Projection of health workforce in Africa based on current trends**

![Graph showing the projection of health workforce in Africa based on current trends.](image)


The health workers who remain in developing countries often show poor motivation due to low remuneration, lack of training opportunities, and insufficient supplies to perform their work. Health workers are concentrated in urban centres due to lack of incentives to serve in isolated, rural areas. International financial institutions and

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7 Foster M, op. cit.
development partners have neglected long-term investment in human resources in favour of short-term training or foreign technical assistance.

Policies that influence the health workforce of a country originate both from the ministry of health and from other sectors, such as finance and education. The ministry of finance is responsible for setting the conditions for the recruitment and retention of staff for the government ministries, including determining numbers of civil servants and salaries. The problem of human resources thus has to be dealt with at the level of the ministry of finance and planning through a reform of the employment conditions.

Nonetheless, the ministry of health can do much to measure the size of the problem and its consequences for the health situation in the country, identify effective measures towards retaining health workers, and make specific proposals to the ministry of finance and cabinet. At the same time, the ministry of health must consider how to allocate the limited resources available to optimize health outcomes. The responsibility of the ministry of health is to develop the best possible staffing for the health-care delivery system given the resources available to the ministry and the country’s priority health problems.

**Accessibility of health services**

*Targ et poor and vulnerable populations*

Many obstacles prevent poor and vulnerable people from accessing health services. These obstacles could involve limited demand for health services – because of lack of information about health problems and treatment, high costs of care, poor transportation to the point of service, lack of confidence in those providing the service, or fear of stigmatization. The obstacles could also be on the supply side of health services – for example, lack of quality inputs or lack of programme-management capacity. There may also be missing links between supply and demand – for example, the lack of community-based organizations capable of intermediating access of the poor to public health services (19).

Public health expenditures tend to benefit proportionally more the wealthier segments of the population (see Figure 6), and are generally focused on cities as opposed to rural areas. For example, in Ghana and Senegal, more than half the physicians are concentrated in the capital cities, where fewer than 20% of people live (20). In China, urban per capita medical expenditure was more than double that in rural areas, a gap which is growing over time (21). Yemen, too, sees most resources and staff concentrated around urban areas. Unsurprisingly, health indicators tend to be much better in urban areas. In Mexico, where there are great differences in childbirth coverage under medical supervision (14), the infant mortality rate in the poorest municipality of Chiapas is 67 per 1000 live births, as contrasted with the Benito Juarez district of Mexico City at 17 per 1000 live births.
Figure 6
Benefit incidence of public spending on health in the 1990s

Reaching poor, rural populations with essential health services relies on the efficient transfer of funds for health to the service-delivery level. Many countries have embarked upon decentralization reforms towards improving efficiency and quality of services. However, coordination between the centre and the periphery is often weak. Leakages of funds at different levels are common, as well as delays in the release of funds to the periphery. In addition, district-level capacity to manage funds and implement health plans in line with national priorities is lacking.

In Senegal, only 20% of total expenditure in health is utilized at the operational level (22). In Malawi, funds for health at the primary level are channelled through district hospitals, where they are often diverted from their original allocation, thus never reaching primary-level health-care centres (23). It is critical that lower-level management capacity be bolstered and that the flow of funds be streamlined to ensure that poor and rural communities are accessed. See Box 6 for examples of underfunding of health in rural areas and financial accessibility of health care in China, Ghana, and Yemen.

Box 6
Country examples of biases in budget allocations against rural areas and financial accessibility of health care – China, Ghana, and Yemen

China
In China, the problem of inadequate money for public health services in poor localities is due largely to the weaknesses in the existing system of transfers from the central Government to lower levels. With the introduction of fiscal contracts in 1988, the central Government formally ended its responsibility for financing local expenditures and expanded the role of local government from simply providing services to also financing
them. Many local governments are lacking the money to fund health programmes and the central Government’s equalization grants that should help poorer areas pay for their programmes – when made – are not large enough. Recent increases in equalization grants and corrective interventions have helped, but are insufficient to solve the problem. For instance, the Government increased its health investment in the western rural counties substantially in recent years, but "most of government spending had been used at the capitals of the counties, a little on township level, and almost nothing on village level of health providers". At the same time, the 2003 National Health Services Survey shows that more than half of the rural patients used at the village level of medical services.\(^8\)

**Ghana**

The Government estimates that only 45% of the rural population have access to health services. Access in this context is defined as living within one hour of travel time (by any available means) from the health facility. A number of contributing factors have been identified as the probable causes. Under most publicly-financed systems, per capita health expenditure for local populations is determined primarily by health staffing levels rather than health-care need of local populations. This has created a situation whereby “funds follow staff, not needs”. In Ghana, as in most developing countries, staff is assigned to fixed facilities and not according to the need of the facilities. As a result the placement of facilities and the level of staffing of these facilities largely determine the distribution of services and the distribution of health expenditure (16).

**Yemen**

In rural areas, only 24% – and in all areas, about 42% – of the people have access to government facilities. Lack of access due to limited geographic coverage is compounded to some extent by lack of access due to cash needed to receive care: the indirect costs of transportation to facilities are added to the direct costs of paying the fees required to receive care and/or prescription drugs. Access to needed care for women is also limited by social constraints in traditional areas – their need for male escorts to facilities and their need to be seen by women health workers, who are not readily available at health facilities in most of the country (Fairbank, unpublished data, 2005).\(^9\)

**Minimizing out-of-pocket payments**

Financial barriers taken together represent one of the key obstacles to demand which prevent the poor from accessing health services. In low-income countries, private health expenditure constituted 72% of total health expenditure in 2002 (24), a large proportion of which is constituted by out-of-pocket spending. *The world health report 2000* highlights “equity and efficiency” as important dimensions of the health financing function of a health system (12). The magnitude of out-of-pocket health spending versus other forms of health financing is shown in Figure 7 for different regions.

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Figure 7

Composition of health spending in 2002

![Composition of health spending 2002 chart]

AFR: African Region
AMR-USA: American Region excluding the United States of America
EMR: Eastern Mediterranean Region
EUR: European Region
SEAR: South-East Asian Region (SEARO)
WPR: Western Pacific Region (WPRO)
OECD-USA: Members of the Organisation for Economic Co-operation and Development excluding the United States of America
USA: United States of America

Source: National Health Accounts Unit, EIP/HSF/CEP, WHO

Figure 8 illustrates shares of total health expenditures raised out-of-pocket in 2002, highlighting 40 countries. People in poor countries spend a larger proportion of their incomes on out-of-pocket health payments than do people in rich countries, although the absolute amounts of out-of-pocket spending are higher in rich countries. A study of expenditure patterns in 191 WHO Member States found that – in low-income countries – the average out-of-pocket share is high and extremely variable (20–80% of all health spending), whereas the range of variation narrows with increasing income (25).
Figure 8
Private out-of-pocket payments as share of total health expenditure versus GDP per capita in 192 countries in 2002

Source: Based on WHO national health accounts.

In China, despite significant investments in health infrastructure and expanded coverage, many people reduced their use of medical services for financial reasons in recent years. According to the third National Health Services Survey (NHSS) in 2003, 38% of non-visit patients said that they had financial difficulty in visiting doctors. Moreover, the reasons that 70% of those who failed to receive inpatient care were associated with financial difficulty. Financial protection schemes were not entirely effective in overcoming financial barriers to the use of health service.  

In Rwanda, where 33% of health expenditure is paid by households as out-of-pocket fees and prevalence of poverty is 60.3%, the reintroduction of user fees in health facilities by the Government in 1996 led to a sharp drop in medical consultations. In 2004, the Government mandated that all Rwandans join health payment schemes and to date, about 25% of the population is enrolled in Mutuelles de Santé. Surveys conducted in areas covered by health payment schemes have shown a 40% increase in the demand for health service from members of Mutuelles de Santé, although other issues such as quality of care continue to create a barrier to access to care. 

Out-of-pocket health spending is a major factor leading to impoverishment. A World Bank study on India concludes that out-of-pocket health expenses (estimated at more than 80% of total health expenditure) may push 2.2% of the population below the poverty line each year (26). Out-of-pocket expenses do not distinguish between those with greater or lesser ability to pay and there is no element of risk-sharing.

The ministry of health is responsible for developing a financing strategy for its proposed health plan. In most low-income countries, resources for health come

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primarily from the government, development partners, or out-of-pocket spending. Ministries of health need to explore ways to limit out-of-pocket health spending on essential health services, particularly by the poor. In most cases, this will require increased public spending on health. Experiences with user fees in the Caribbean have shown that user fees affect utilization levels by the poor and vulnerable groups, including for preventive care services, and that exemption systems have not worked well and have led to much abuse (18).

Work with civil society organizations and the private sector
One of the key variables impacting the access of poor people to public health services is the presence of organized communities able to ensure information, advocacy, and delivery of services (13). Experiences in the countries described in the main report have indicated that it is at the national level that both the potential and challenges for innovative civil society organizations (CSO) experiences in the area of health and development are greatest. In several developing countries, civil society is in a stronger position today than in previous years, with an increase in the number of civic organizations and associations working on issues such as access to health, gender, human rights, and trade. See Box 7 on the Asian Civil Society Conference on Macroeconomics and Health.

Box 7
The Asian Civil Society Conference on Macroeconomics and Health

<table>
<thead>
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<th>Box 7</th>
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<tbody>
<tr>
<td>The Asian Civil Society Conference on Macroeconomics and Health was</td>
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<tr>
<td>organized on 27 and 28 April 2004 in Colombo, Sri Lanka. It brought</td>
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<td>together some 60 representatives of local and international</td>
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<td>nongovernmental organizations with activities in WHO's South-</td>
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<td>East Asia and the Western Pacific regions, with the governments of</td>
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<tr>
<td>12 countries engaged in carrying forward the recommendations of the</td>
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<tr>
<td>Commission on Macroeconomics and Health.</td>
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<td>The objective was to take stock of ongoing civil society</td>
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<td>organization action at country level and envisage mechanisms for</td>
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<tr>
<td>CSO participation in macroeconomics and health processes. The</td>
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<tr>
<td>Conference recognized the important contribution of CSOs on the</td>
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<tr>
<td>national health scene over the past decades, in particular with</td>
</tr>
<tr>
<td>respect to:</td>
</tr>
<tr>
<td>(a) expanding the scale of primary health care for the underserved</td>
</tr>
<tr>
<td>populations;</td>
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<tr>
<td>(b) mainstreaming poverty reduction in a national political agenda</td>
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<tr>
<td>comprising health, human rights, debt, trade and environment; and</td>
</tr>
<tr>
<td>(c) integrating health in a comprehensive package of services</td>
</tr>
<tr>
<td>including nutrition, education, and micro-credit.</td>
</tr>
<tr>
<td>At the end of the Conference, the participating organizations</td>
</tr>
<tr>
<td>adopted the ‘Colombo Consensus’ in which they committed themselves</td>
</tr>
<tr>
<td>to fully participate in the national mechanisms on macroeconomics</td>
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<tr>
<td>and health in order to meet the health needs of the poor and</td>
</tr>
<tr>
<td>defined the role of CSOs in the following areas.</td>
</tr>
<tr>
<td>• CSOs can play an important advocacy role by speaking on behalf of</td>
</tr>
<tr>
<td>the poor, stressing that health care is a basic human right,</td>
</tr>
<tr>
<td>promoting equity in health care, and lobbying politicians to</td>
</tr>
<tr>
<td>commit increased resources for health.</td>
</tr>
<tr>
<td>• CSOs can provide many examples of innovative ways to reach the</td>
</tr>
<tr>
<td>poor through services, by multisectoral approaches, in difficult</td>
</tr>
<tr>
<td>circumstances, and through relief to households. They can document</td>
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<tr>
<td>these practices and extract lessons learnt, in order to</td>
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facilitate replication on a larger scale.

- CSOs can assist governments by experimenting with alternative health financing schemes, such as equity funds or community-based health insurance. Specifically, CSOs can look into building safety nets for the very poor, because user fees and insurance premiums – however low – have undesirable consequences for health-care-seeking behaviour.

- CSOs can be instrumental in preventing catastrophic health-care costs by advocating for a universal health insurance system, by delivering health care themselves (both regular and emergency care), as well as by organizing disaster preparedness and relief programmes.

- CSOs are in a good position to identify problems, issues, and areas for macroeconomics and health-related research and can also conduct research themselves – in particular operational research and applied research.

Opportunities exist for involving civil society in addressing the challenges associated with governance described above. So far, the potential of citizen participation in budgetary planning and monitoring for improved health outcomes remains underused. This underuse is largely because of the preconceived idea that national budgeting is a highly technical area, beyond the scope of interest and understanding of ordinary citizens. However, experience in various developing countries has shown that organized and informed citizens can influence budgetary allocations and ensure expenditures are targeted better to the needs of the people (27).

Several specific challenges relate to the interaction of civil society organizations with governments – particularly in social policies – and undermine the potential for CSO involvement. These include the following.

- The nongovernmental sector encompasses a wide variety of organizations, with a broad range of performances, strengths, and weaknesses. In the interaction between national government and civil society, there remain issues around assessment of the quality of CSOs' action and their capacity to operate in support of the most vulnerable. A delicate balance has to be drawn between the need for setting standards for accountability and respect of autonomy and freedom of action (28).

- Effective social outcomes arise from the combination of push by the civil society, and pull from the creation of participatory opportunities by the state. This means that CSO action should not be regarded as a substitute for the state's core responsibilities and functions, but as an input towards social goals. CSOs function more effectively within the framework provided by a strong and well-organized state committed to participatory processes. For instance, contracts between government and CSO providers are unlikely to result in satisfactory outcomes when contracting capability is low at government level (29).

- A weak information flow may hinder the interaction between governments and CSOs. There is a need for improved public access to data and information
– as well as public participation in defining the information and indicators that will be collected and measured – so that the welfare of each population segment is monitored and addressed in a fair manner (30). There is an urgent need to inventory and evaluate ‘best practices’ in the promotion, establishment and operation of community-based organizations. Models with proven replicability need to be identified and disseminated (19).

- Interactions between government and CSOs need to be institutionalized through mechanisms that are operational and not merely representational, particularly in local level monitoring systems and local committees (31). The challenge is to make these institutional processes a real means for democratizing and decentralizing policy-making.

- It is important to ensure an adequate and consistent level of resources to local organizations in order to ensure the sustainability of the relation with the government. This would also serve to redress the current imbalance between the relative influence of international, mostly nongovernmental organizations based in the industrialized world, with access to larger financial resources, information technology and mobility, and civil society and nongovernmental organizations in the developing world. The transfer of health budgets and special funds are important experiences in this direction.

**Collaboration with the private commercial sector**

The private commercial health sector – including private physicians and health personnel, private health facilities, and pharmaceuticals – plays a crucial role in promoting people’s health. The challenge for the ministry of health is to collaborate with this sector so that its contribution to solving the country’s main health problems is optimized – through the delivery of services, financing, and the sharing knowledge and data.

In India, the 2005 *Report of the National Commission on Macroeconomics and Health* draws attention – on the one hand – to the important contribution of the private sector in all fields of health (medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services, and provisioning of medical care). Indeed, over 75% of the human resources and advanced medical technology, 68% of an estimated 15 000 hospitals, and 37% of 624 000 total beds in the country are in the private sector.

On the other hand, the India NCMH Report also underlines that state regulation is essential, since the private sector tends to focus on profit maximization and not public-health goals. Yet, more than one third of the private enterprises in the private sector reportedly have no registration of any kind. The Report is concerned that:

. . . in the absence of regulations governing location, standards, pricing, to name a few, private facilities run in marketplaces, residential colonies, pharmacy shops, with freedom to provide any kind of service, of whatever quality and at exorbitant cost, which varies from facility to facility. Of concern is the documentation, though limited, on the abysmally poor quality of services being provided at the rural periphery by the large number of unqualified persons . . . (9).
**Build national research capacity**

The CMH called for at least US$ 3 billion per year to be allocated towards research and development directed at the health priorities of the world's poor – of which half should be used for basic scientific research in health, for example on epidemiology, health economics, health systems, and health policy (32). Financing of these investments by the public sector is justified by the recognition of knowledge as a public good.

As pointed out by the Global Forum for Health Research, public funding for health research in most low-income countries is very limited (see Figure 9). The 1990 Commission on Health Research for Development recommended that governments in low- and middle-income countries allocate at least 2% of national health expenditures for research (33).

Among the low- and middle-income countries for which data was available, only few have met this level (see Figure 9). As a result, decisions about investments in the health sector suffer from a severe lack of information and evidence, resulting in misallocation of resources. As proposed by the Tanzania Essential Health Interventions Project study in Tanzania, there are great benefits to be derived from combining research and development functions into a mutually-reinforcing, integrated system, which permits acting upon important research findings quickly (34). Box 8 provides an illustration of health research needs in China and India.
Figure 9
Public funding of health research as percentage of public health expenditure and GDP in 2001

Box 8
Health research needs in China and India

China
The Macroeconomics and Health China Report concludes that, “following the rapid expansion of the role of Government to fill gaps in the system of public health in the case of SARS, the view has intensified that the Government needs to re-assume greater responsibility for many public health functions and broaden its role to strengthen the provision of public goods such as health surveillance, reporting, regulation and prevention and control of infectious diseases”.12

India
The 2005 Report of the India Commission on Macroeconomics and Health concludes that there is a need for “a National Institute for Health Information and Disease Surveillance … disease burden estimations, national health accounts, cost-effectiveness studies of interventions, independent evaluations of programme implementation – are

Monitoring and evaluation of results

Good management includes an annual process for reviewing sectoral progress based on pre-identified performance indicators. Monitoring uses these indicators to track actual performance or situations against what was planned or expected, while evaluation provides a reliable and useful assessment, so that lessons learnt modify decision-making. The information obtained through this process should be used to increase accountability at all levels and to adjust health priorities and strategies to improve the effectiveness of health policy-making. To establish good governance, the cabinet or ministry of finance should set incentives for line ministries to review their performance as part of the ministry of health’s stewardship role (12).

A review of the poverty-reduction strategy papers (PRSPs) of 21 countries reveals the extent to which indicators were included to monitor health results. In the majority of cases, indicators were provided to monitor the key components of the health strategies presented in the PRSPs. Certain strategies, however, lacked any means of monitoring or did not indicate any baseline. A fairly consistent gap across PRSPs was the failure to provide indicators for reducing financial barriers to health care. Although 15 PRSPs addressed this issue, only three presented indicators that could be monitored. Moreover, few PRSPs explicitly target poverty within their health strategies and therefore few attempt to monitor the impact of their health programmes on the poor. Finally, PRSPs consistently reflect the MDGs, but do not necessarily reflect the associated quantifiable targets (35).

The example of monitoring the health components of PRSPs illustrates that strategic investments in health require a set of indicators – not only to advocate for more resources, but also to technically support the mobilization and allocation of funds. A timely and disaggregated assessment of the flow of funds for health is an essential basis for the prioritization of scarce resources and the monitoring of health reforms.

Studies on Cambodia, Indonesia, and Sri Lanka have shown that the data available to track external funds at the country level were quite limited and inappropriate to fully document the flow of funds within recipient countries. The major information gap pertained to the flow of funds to the numerous providers of activities, particularly the provision of health services by local and international nongovernmental organizations at different levels of the health system and varying collaboration with – and support to – the provision of care in the public sector (36).

Since detailed data on the flow of health expenditure is not available on a sufficiently recent and detailed basis in many countries, technical and financial support in this area is indispensable. Countries should be enabled to develop their own indicators, set targets, and monitor their achievements based on recent data sources. The national health accounts methodology is used in some countries to fill this information gap, providing a comprehensive framework for "tracing all the resources that flow through
the health system over time and across countries” (37). Another recent attempt to systemize evidence is the Health Metrics Network, a global partnership – including developing countries, multilateral and bilateral agencies – with the aim of building capacity and expertise "to increase the availability and use of timely and accurate health information in countries and globally through shared agreement on goals and coordinated investments in core health information systems" (38).
Development partners: improving the quantity and quality of assistance

While external assistance plays an important role in supporting the health sector in low-income countries, evidence suggests that there is much room for improvement in its quantity and quality. In addition to inadequate levels of development assistance, foreign aid should place more emphasis on strengthening national capacity to enable improvements in health outcomes over the long term.

Increasing funding towards reaching the MDGs in low-income countries

While development assistance for health has increased in recent years – from US$ 7 billion to US$ 10.7 billion between 2000 and 2003 (Michaud, unpublished data, 2005) – it remains far short of the needed US$ 27 billion by 2007 and US$ 38 billion by 2015 recommended in the 2001 Report of the Commission on Macroeconomics and Health. This shortage of funding will impede efforts of many low-income countries to reach the MDGs and other national targets by 2015.

Correcting for exchange rates and inflation leaves the real increase in official development assistance (ODA) between 2001 and 2003 at only 13%. Even this real increase is not leading to wide-reaching new ‘net cash inflows’ since strategic motives, technical cooperation, and debt relief account for the majority of it. In 2002, US$ 2.9 billion of the US$ 5.9 billion nominal increase in ODA was due to debt relief, and another US$ 1 billion was for just two countries, Afghanistan and Pakistan (39).

The Organisation for Economic Co-operation and Development estimated that if all donor countries were to meet their pledges to provide more development assistance – including those at the March 2002 International Conference on Financing for Development in Monterrey, Mexico and the August/September 2002 World Summit on Sustainable Development in Johannesburg, South Africa – the ratio of ODA to gross national income would increase to 0.29% by 2006. This would be a return to 1994 levels but still be substantially below those during the Cold War (39).

There are some encouraging signs. A number of innovative financing mechanisms are proposed, with the aim to ensure a rapid and significant scale-up of development assistance to enable accelerated progress towards the MDGs. The International Finance Facility – a proposal launched by the United Kingdom Treasury and the United Kingdom Department for International Development – is based on the assumption that donor countries that have committed to regularly increase their contribution to ODA at the Monterrey Conference on Financing for Development will sooner or later concretize their pledges, and that a mechanism can therefore be established to advance resources to developing countries through bonds issued in the financial market. By frontloading aid, an additional US$ 50 billion a year in development assistance between now and 2015 would be made available. Also under consideration is a proposal to promote new forms of international financial contributions to development aid based on international taxation mechanisms.

Recently, the European Union agreed to double its development aid to poorer countries by the year 2010, to US$ 80 billion, with a special focus on Africa. A number of global partnerships for health have been set up, such as the Global Alliance
for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, with the aim of mobilizing increased resources for priority health problems. There is concern, however, that large commitments to vertical programmes may be absorbing staff and resources from the horizontal health system (Foster, unpublished data, 2004). 13

In summary, although recent commitments to increase aid are encouraging, they fall far short of what will be needed to reach the MDGs. The Millennium Project recommends that developed countries fulfil their longstanding pledge to provide 0.7% of GNP by 2015 (3). Wolfensohn and Bourguignon roughly estimated the ratio of ODA to GDP necessary to reach the MDGs of more than 0.40% in donor country GDP (39) (see Table 2 for estimates of external funding required to meet the MDGs).

Table 2
Recent estimates of external funding required to meet the MDGs

<table>
<thead>
<tr>
<th>Type of estimate</th>
<th>Domestic</th>
<th>External</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission on Macroeconomics and Health (2001)</td>
<td>All low-income countries: health only</td>
<td>Additional 1% of GNP by 2007 and 2% by 2015</td>
<td>Development Assistance for Health should increase to US$ 27 billion per year by 2007 and US$ 38 billion by 2015a</td>
</tr>
<tr>
<td>United Nations Millennium Project (2005)</td>
<td>Global: all MDGs</td>
<td>Will rise by 4% of GDP between 2005 and 2015, in addition to the increase in domestic resources available due to GDP growthb</td>
<td>Overall ODA required for the MDGs over the coming decade will be US$ 73 billion in 2006, rising to US$ 135 billion in 2015</td>
</tr>
<tr>
<td>Commission for Africa (2005)</td>
<td>Africa: all MDGs</td>
<td>One third to be mobilized domestically</td>
<td>Aid should be doubled, translating into an additional US$ 25 billion per year over the next three to five years, and a further US$ 25 billion per year at the end of this period. Of this, for health, an additional US$ 10 billion should be provided immediately, rising to US$ 20 billion annually by 2015.</td>
</tr>
</tbody>
</table>

Sources:
- a World Health Organization (32).
- b United Nations Millennium Project (40).

13 Foster M. op.cit.
Aligning development assistance on national plans and budgets
Development partners need to do more to support the preparation and execution of the long-term macroeconomic plan and to integrate their projects and programmes into national strategies and budgets. A 2005 study found that while development partners do seem to be aligning on health sector strategies in many cases, it is less common to find development partners’ funds integrated in the medium-term expenditure framework (41).

Distortion of country priorities
While development partner programmes are likely to have greater impact in the short term, they may draw human and financial resources away from broader health systems. Because of their narrow targets, disease-specific approaches may fail to consider solutions that would increase the efficiency of the overall health system. Projects of development partners can also distort country priorities when large increases in external funding for disease-specific programmes are not matched by similar increases for other components of the health sector.

Continuity and predictability
In addition, ODA is subject to important fluctuations over time – due to budgetary procedures, changes in priorities, decision-making and administrative delays, and conditionalities attached to aid. This volatility has a serious impact on developing countries, an impact even greater than the fluctuation of developing countries’ GDPs (42). The unpredictability of external aid may deter countries from making investments in health systems which cannot be maintained if development partner preferences change. Increased predictability of aid is therefore a key precondition for the global increase of aid effectiveness.

Parallel arrangements and delivery structures
The majority of development partner support is provided ‘off budget’ and country financial-management and procurement systems are rarely used (Foster, unpublished data, 2004). In Cambodia, the estimated share of external funds disbursed through the Treasury was a mere 20.5%, whereas this share was 80% in Indonesia and 50% in Sri Lanka. By bypassing governments, development partners hope to circumvent weak systems and institutions and better reach recipients of aid. Though ‘off budget’ channelling aims to ensure better accountability for the use of resources and facilitates budget execution, it can be a major constraint to the development of a comprehensive integrated strategy in line with the national medium-term expenditure framework (36).

Financing recurrent costs
There is a pressing need for long-term financing of recurrent costs of the social sector and basic health services. If aid has to have a sustainable impact on the development of health systems, nurses and doctors need to be paid, and health premises and equipment maintained in working condition and updated. These recurrent costs often go beyond the budgetary capacity of poor countries, constrained by a weak fiscal basis and the external debt burden. It is increasingly accepted that strong health systems are necessary to help disease-specific programmes succeed. There is scope for action by development partners in providing sustainable budget support and funding for recurrent costs – including human resources – in order to build national institutional capacity to supply public goods for health.
Strengthening sector-wide approaches

A concrete product of the increased engagement by development partners in aligning behind country strategies has often been identified in the sector-wide approaches (SWAs). SWAs evolved in part from the 1980s sector investment programmes of the World Bank. They seek a government-led process to unite all relevant policies and expenditures of a particular sector – such as health – in a comprehensive and coordinated manner. There is no one type of SWA, as each country develops one within its unique environment. The idea behind the SWAs is that sectoral goals can be better achieved if development assistance is used to support nationally defined sectoral policies and strategies, rather than specific projects.

The SWA mechanism has not overcome all problems associated with the relationship between development partner and recipient. While focused on the health sector, SWA planning is not automatically linked to the budgeting process of the finance ministry, nor does it generate much of a local evidence base useful in making resource allocation decisions across various health investment options. Further, SWAs do not address the long-term sustainability and predictability of financing schemes. Studies have indicated, for example, flaws such as insufficient resources and excessive presence of development partners in the management process (Interagency Group on Sector-Wide Approaches and Development Cooperation, 2000). Nevertheless, SWAs have represented an important change in the scenario of aid planning and management.

Harmonizing development partner procedures

Multiple and uncoordinated activities impede the ability of governments to manage development assistance, creating high transaction, negotiation, and administration costs. Recent findings emerging from country studies find that “countries continue to face the problem of coordinating large numbers of development partners providing their assistance via multiple routes” (Foster, unpublished data, 2004). There is little evidence that development partners are streamlining conditionality at the sector level, including in health (41). Such fragmentation and duplication of efforts further strains limited national capacity.

Clear linkages to the need for harmonization, predictability, and sustainability can be found in the recent proposals to accelerate resource mobilization for development – such as the International Finance Facility and proposals for international taxation mechanisms. Also, ongoing discussions related to the OECD High Level Forum on Aid Effectiveness and to the third High Level Forum on the Health MDGs, have the potential to contribute greatly to productive processes in that direction. The Paris Declaration on Aid Effectiveness, adopted at the 2nd High-Level Forum in March 2005, defines for the first time measurable targets for 2010 for increased aid effectiveness (see Table 3).
<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>TARGETS FOR 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Partners have operational development strategies</td>
<td>At least 75% of partner countries have operational development strategies.</td>
</tr>
<tr>
<td>2a Reliable public financial management (PFM) systems</td>
<td>Half of partner countries move up at least one measure (i.e. 0.5 points) on the PFM/ CPIA (Country Policy and Institutional Assessment) scale of performance.</td>
</tr>
<tr>
<td>2b Reliable procurement systems</td>
<td>One third of partner countries move up at least one measure (i.e. from D to C, C to B or B to A) on the four-point scale used to assess performance for this indicator.</td>
</tr>
<tr>
<td>3  Aid flows are aligned on national priorities</td>
<td>Halve the gap – halve the proportion of aid flows to government sector not reported on government’s budget(s) (with at least 85% reported on budget).</td>
</tr>
<tr>
<td>4  Strengthen capacity by coordinated support</td>
<td>50% of technical cooperation flows are implemented through coordinated programmes consistent with national development strategies.</td>
</tr>
<tr>
<td>5a Use of country public financial management systems</td>
<td>For partner countries with a score of 5 or above on the PFM/CPIA scale of performance (see Indicator 2a).</td>
</tr>
<tr>
<td></td>
<td>90% of donors use partner countries’ PFM systems; and reduce the gap by one third – a one third reduction in the % of aid to the public sector not using partner countries’ PFM systems.</td>
</tr>
<tr>
<td>5b Use of country procurement systems</td>
<td>For partner countries with a score of ‘A’ on the procurement scale of performance (see Indicator 2b).</td>
</tr>
<tr>
<td></td>
<td>90% of donors use partner countries’ procurement systems; and Reduce the gap by one third – a one third reduction in the % of aid to the public sector not using partner countries’ procurement systems.</td>
</tr>
<tr>
<td>6  Avoiding parallel PIUs</td>
<td>Reduce by two thirds the stock of parallel project implementation units (PIUs).</td>
</tr>
<tr>
<td>7  Aid is more predictable</td>
<td>Halve the gap – halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.</td>
</tr>
<tr>
<td>8  Aid is untied</td>
<td>Continued progress over time.</td>
</tr>
<tr>
<td>9  Use of common arrangements or procedures</td>
<td>66% of aid flows are provided in the context of programme-based approaches.</td>
</tr>
<tr>
<td>10a Missions to the field</td>
<td>40% of donor missions to the field are joint.</td>
</tr>
<tr>
<td></td>
<td>Country analytic work</td>
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<tr>
<td>11</td>
<td>Results-oriented frameworks</td>
</tr>
<tr>
<td>12</td>
<td>Mutual accountability</td>
</tr>
</tbody>
</table>

*On March 2, 2005, the participants at the Paris High-Level Forum issued the "Paris Declaration on Aid Effectiveness," in which they committed their institutions and countries to continuing and increasing efforts in harmonization, alignment, and managing for results, and listed a set of monitorable actions and indicators to accelerate progress in these areas. The document can be accessed at www.aidharmonization.org.

**Source:** The Paris Declaration on Aid Effectiveness, 2005.
http://www1.worldbank.org/harmonization/Paris/FINALPARISDECLARATION.pdf*
References


