4.1 Health services
This section looks at information in PRSPs on health services, such as quality, access and cost of care.

Information and analysis
- Analysis of health systems constraints is most commonly concerned with geographical access to care. Niger’s PRSP provides the greatest detail on this issue, including a map showing the location of health centres across the country.
- Financial barriers, such as paying for treatment, are discussed in six out of 10 PRSPs, though detail is typically limited to statements such as “certain services are not affordable to the poorest groups”.
- A few PRSPs include a good analysis of other types of barriers, such as dissatisfaction with health staff, and unofficial fees. Uganda’s PRSP notes that “40% of the users of public services had to pay bribes” and that “Poor people experience frustration that they see no effective mechanism to hold service deliverers accountable”.
- A few PRSPs also look in detail at management constraints to the delivery of care, and patterns of health spending. For example, Honduras’ PRSP notes: “The urban bias of the public health services, and the serious problems of efficiency and quality in small cities and rural areas … continue to restrict the redistributive impact of expenditure among the poorest population groups.”

Strategy and monitoring
- The essential actions needed to strengthen primary health care services are addressed in almost all PRSPs, for example through expanding infrastructure, improving drug supplies, extending coverage of basic services, and tackling human resource problems in rural areas.
- Few PRSPs mention specific poor regions, or poor groups, in their strategies to expand primary coverage, though many implicitly target the poorest areas in their intention to extend services to “all regions” or “100% of territory”. Many PRSPs also mention the need to improve services in “rural areas” or “neglected communities” without naming them. Decentralization is commonly suggested as the strategy for achieving this.
- Two important exceptions to this trend are Bolivia, which focuses on improving the health of indigenous people, who are identified in its poverty analysis as among the poorest, and Mozambique, which targets service improvements on regions identified as having the worst access to care (see box below).
- Suggested strategies on financial barriers to care tend to be limited in detail, mirroring the brief analysis. Many PRSPs contain reference to “cost recovery strategies”, usually qualified with a statement about ensuring access for the poor, e.g. “public services (will be set) at a level that can be affordable to the poor”. Further
detail is limited. Latin American PRSPs typically mention the need to expand health insurance schemes to include the poor.

- PRSPs rarely mention the need to improve the poor’s access to hospital care – this is surprising considering the impoverishing effects of catastrophic illness and accidents. A notable exception is Mauritania, where primary, secondary and tertiary level health care is addressed along with a referral system to ensure that ‘underprivileged rural and urban groups’ have access to higher level care.

- Another important gap is the lack of information on the role of the private sector (profit and non-profit) in the delivery of services. Several PRSPs state an intention to promote, or further regulate, the involvement of non-state actors in service delivery. But there is typically no examination of how this will be achieved, or the potential impact – positive or negative – on the poorest regions.

- Nine out of 10 PRSPs give a distinct health budget but in most cases it is not clear whether the projected budgets are distinct from or part of the overall national health plans. Seven PRSPs break down the budget into clear project components.

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**Selected strategies from Mozambique’s PRSP\(^1\) on improving access to health services**

- At the primary level, build 65 new health centres, and rehabilitate and extend at least 16.
- Rehabilitate and expand 6 rural hospitals in the provinces of Sofala, Zambezia and Cabo Delgado and transform eight health centres into rural hospitals in Zambezia, Tete, Manica and Sofala.
- Equip all health units at primary and secondary level.
- Increase annually the provincial funds from recurrent budgets, taking into account regional inequalities in requirements of the health network, activities developed, levels of poverty, and local conditions.

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**Selected strategies from Bolivia’s PRSP\(^2\) on improving the health of indigenous and native peoples**

- Seek greater participation on the part of small farmer, indigenous and native communities in [...] health and differentiated basic services.
- Improve diagnostic assessments and the information needed for decision making; a database and situation map will be developed on the small farmer communities, indigenous and native peoples in the areas of health, education, and basic services.

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Summary points

1. The majority of PRSPs outline strategies to improve coverage of primary health care, through extending a basic package or services, and improving the quality and availability of services in remote areas. This is likely to be pro-poor in its impact.

2. Financial barriers to care are addressed in six out of 10 PRSPs, though they are rarely dealt with in any detail. The problems associated with fee exemption schemes, and the impoverishing costs of catastrophic illness – both issues extremely pertinent to improving the health of the poor – are rarely mentioned.

3. There is typically very little detail about non-financial barrier to care, or strategies to target the poorest group or regions; however there are some important exceptions to this trend, suggesting that it is not an unreasonable expectation of PRSPs.

4. The analysis is concerned predominantly with the public sector, with little examination of the role of the private sector in the delivery of health services.