

# Pushing the boundaries: health and the next round of PRSPs



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## Preface

This report attempts to assess whether health has benefited from the Poverty Reduction Strategy Paper (PRSP) process launched 5 years ago by the international community. Focusing on two crucial areas in health and development policy – macro-economic constraints on health care financing and the issue of ‘pro-poor’ health policy - we conclude that, in health at least, the PRSP process has not lived up to the expectations it has generated. Progress has been particularly hamstrung by the continuing financial conservatism of the IMF and World Bank, institutions which have failed to make the radical changes needed to make development work for the poor and their health and well-being.

Health cannot be secured by the health sector alone. Health advocates should look beyond the boundaries of their sector and join others calling for policies that reduce social and economic inequities. This paper shows how the PRSP process can offer opportunities to address issues traditionally beyond the control of the health sector.

The issues addressed in this paper – especially those related to social inclusion - are not only relevant to PRSP processes. They are equally important to address in health sector policy formulation and review processes. Moreover, these processes should not be seen in isolation, nor can they be isolated from the way donors are doing business. Health and poverty need a higher profile and require a strong political commitment from all actors involved.

We hope this paper gives rise to debate and action, whether in the context of official consultations, or outside the official circuits, as part of broader efforts to mobilise public pressure and hold governments and international actors accountable. Please share your comments with us.

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## Introduction

The Poverty Reduction Strategy Paper (PRSP) has, since 1999, become a central feature of the international aid and development agenda. Initially introduced at the annual World Bank and IMF meeting of that year to encourage the donor community and governments to ensure that debt relief was focussed on the needs of the poor, the PRSP has become increasingly important in the disbursement of aid from the World Bank, International Monetary Fund and bilateral donors.<sup>1</sup>

The PRSP also seemed to represent a break with the past in that it recognised key problems in the field of international development assistance. These included the apparent failure of many past efforts at poverty reduction and the increasing “aid dependence” of poor countries, especially in sub-Saharan Africa. In response, PRSPs emphasised the following five key objectives. Policy-making should be:<sup>2</sup>

- Country driven – involving broad-based participation by civil society and the private sector in all operational steps;
- Results oriented – focusing on outcomes that would benefit the poor;
- Comprehensive in recognizing the multidimensional nature of poverty;
- Partnership oriented – involving coordinated participation of development partners (bilateral, multilateral, and nongovernmental);
- Based on a long-term perspective for poverty reduction.

This shift in perspective is as relevant for those interested in improving health in the poorest countries as it is for other parts of the development community. Aid to the health sector has been characterised by many of the problems PRSPs are supposed to deal with, due in part to the popularity of focusing resources on a key human development outcome. The PRSPs themselves assign health a high priority, and so it has been no surprise that their advent has kicked off or re-invigorated useful debates in several areas of health policy. These include the level of funding for health in poorer countries; the ‘poverty-content’ of health sector reform policies; and the role of civil society organisations (and the private sector) in improving health policies. International agencies are becoming increasingly active in debating policy content and monitoring the outcomes of PRSP processes.<sup>3</sup>

NGOs are also exploiting the promise of participation at the heart of the PRSP model. In 2003, Wemos commissioned a series of country studies on the subject of health in PRSPs (see box). These studies raised a number of interesting issues about the ways in which health policies and actors were being influenced by the PRSP processes occurring at country-level. They provide a rich variety of testimonies from Africa, Asia and Latin America on experiences so far. More importantly, the process of producing these studies has in itself enabled greater dialogue in the different countries between civil society and policy-makers on key health policy issues.

<sup>1</sup> Booth (2004)

<sup>2</sup> Bretton Woods Project (2003)

<sup>3</sup> See, for example, WHO (2004). WHO/OECD (2003).



**Monitoring Health in PRSPs**

In 2003, together with partners in **Bangladesh, Bolivia and Kenya**, Wemos initiated a joint monitoring project on PRSPs and health. The monitoring project had 3 overarching purposes:

- to analyse the process, content, implementation and impact of the PRSP;
- to strengthen civil society action; and
- to facilitate capacity building of participating organisations

During the initial phase Wemos commissioned a country study from each of the partner organisations on PRSPs and health. These papers explored common themes, especially around the content of PRSPs and issues concerning funding for the sector. The papers were complemented by case studies from a further four countries, where Wemos had the possibility of commissioning work from other partners. These countries were: **Ethiopia, Ghana, Nicaragua and Uganda**. Summaries and full reports can be obtained from: [www.wemos.nl/prs](http://www.wemos.nl/prs).

## Where this paper fits in

This paper – which has also been commissioned by Wemos – uses the seven country studies as a springboard to open up discussions on the added-value of the PRSP. We look at two main areas: whether the PRSP has led to increased funding for poor country health services; and at some of the principles that underlie a ‘pro-poor’ health system. We call for ‘expansionary public policy’ and greater efforts to increase funding for health services; better co-ordination of resources for health; government action to strengthen the grip of poor people on health services; and attention to issues of redistribution and cross-subsidy.

### Funding for the health sector: expansion and co-ordination

Given the origins of the PRSP process in the political imperative to cancel developing country debt, and the much-touted ‘high priority’ given to social sectors such as health and education in policy fora, we have tried to assess whether the PRSP process has, in our study countries, created more resources for health. We also look at the barriers to increased investment – such as continuing high levels of debt and inadequate aid – and argue for ‘expansionary public policy’ which tries to deliver greater resources in a more sensible and planned way to the health sector. Delivering more resources for health – especially through the public sector – is vital if poverty targets are to be met, and economic growth rates raised.

This argument creates dilemmas of its own. If, as we suggest, there needs to be a greater reliance on aid in the long-term for most of the poorest countries, how can we avoid the fragmentation of health systems and political dependency which often follows in its wake? Some commentators<sup>4</sup> note that a positive effect of the PRSP process – and its emphasis on government control of resources – has been renewed engagement with this problem. We argue that further steps need to be taken to solve it, including encouraging the development of indicators of health system sustainability within the PRSP process.

<sup>4</sup> Booth op.cit.

The issue of the negative effects of aid to the health sector has been given greater urgency by the establishment of new funding mechanisms to support specific disease-control interventions. These initiatives have brought new resources with them, but they have not necessarily been used to support the strengthening of overall health systems, and there have been occasions (as in the case of Uganda) where they appear to challenge both economic and health sector planning. We suggest there is a need for a 'code of practice' to ensure that new money available from these initiatives is used to support the renewal of collapsing health systems.

### **'Pro-poor' health systems: strengthening health claims and redistribution**

The second set of issues raised by both the country studies and by governments and international agencies has been around the impact of the manner in which access to health services is financed – whether by individuals, social or private insurance funds or from government revenues – and about who provides them (the public or private sectors). These issues are however, only addressed partially in current PRSPs, and often at a very general level.

To think about these topics we need to get to grips with the problems generated by the disorganised health care markets in low-income countries. Levels of private provision are high, service from all types of providers is often poor, regulation is lacking and rates of financial exclusion are significant. The public sector itself is increasingly 'marketised': health professionals moonlighting in the private sector is one example; the levying of both formal and informal charges another.

How should decision-makers try to help the poor and vulnerable in such a situation? Can health policy, instead of allowing health care to be shaped by the market, attempt to shape the market back? One way of thinking about this is to focus on strengthening people's "health claims". Here, we take a claim to mean the 'duty owed to an individual that they should have a good or service'.<sup>5</sup> Claims may arise either from the prior existence of stated commitments – entitlements to services enshrined in law for example – or from advocacy or other public action to strengthen entitlements. There may be a number of means through which governments can act to strengthen poor people's claims on health systems: for example, making sure that exemptions from user charges work; or through the creation of campaigning groups that can defend the interests of vulnerable sections of the population.

This process of strengthening health claims can be seen as complementary to an overall strategy which attempts to enhance mechanisms of cross-subsidy and redistribution in favour of the poor within health systems. Marketisation tends to drive out these vital elements of health care services. We argue that we need to think creatively about how they can be put back in, involving not just pooling of financial resources, but also redistributive actions on the part of both public and private providers. Government's role in using its legal and political muscle, in addition to its financial muscle, to encourage cross-subsidy and redistribution across the whole sector, is thus very important.

<sup>5</sup> Mackintosh (2001); p.185-6

In this context, it is particularly heartening to see that, partly because of the new emphasis generated by PRSP processes, the poverty-inducing effects of user charges for health care are receiving renewed attention. The picture is not a completely rosy one however, as many of our study countries show a continued reliance on user fees and, in one case – that of Ethiopia – renewed attempts to levy even higher burdens of co-payments on individuals as part of the PRSP. Yet Uganda has shown how user charges can be abolished, and Ghana is about to follow suit. The results so far have been promising and we summarise experiences and lessons learned, especially relating to the quality of health services after abolition. Where user charges are widespread, or where they remain at higher levels of the health system, there is a continued need to emphasise the importance of strengthening exemptions for the poor and vulnerable.

We suggest that there needs to be much more explicit lesson-learning in policy discourse about the ways in which poor countries can progress towards equitably financed universal health services. This reflects once more the spirit of a key PRSP objective – in this case long-term planning for poverty reduction. It is widely acknowledged that fairly financed health services perform a key social protection function for lower-income groups, by shielding them from catastrophic health expenditures. Bolivia and Kenya amongst our study countries are planning an expansion of social insurance as part of the PRSP process. Making sure that the poor get a good deal during this expansion – that their claim on health care is strengthened – is crucial, and policy-makers could use the PRSP process to urge greater focus on the poor during reforms. Conversely, there needs to be a clear-eyed assessment of the dangers of moving towards a system of private insurance in low-income countries (as the World Bank appears to be suggesting in Bangladesh), a shift which could make universalisation much more difficult in the future.

On the provider side the international policy discourse around PRSPs has been focussed on encouraging competition and greater levels of contracting with the private sector. The emphasis on targeting public resources on a narrow range of services for the poor has also implied privatisation of health services for better-off groups. We question these emphases, and make some arguments for a strong public sector role in both financing and provision. That said, we need to acknowledge the diversity of providers (public, for-profit and not-for-profit, as well as traditional healers) in the health systems of low- and middle-income countries. Public contracting with private providers is often crucial in order to expand services for hard-to-reach population groups. Similarly, ensuring that providers (of whatever kind) are committed to serving the health needs of the poor is also important. Yet, there is a danger that the focus in the donor discourse on competition between providers actually undermines the type of collaborative effort – or ‘joint venture’<sup>6</sup> – between public and private (and particularly not-for-profit) sectors which is needed to protect the poor and encourage the development of universal services.

After five years of PRSPs we suggest that health sector policies have been positively influenced by the higher profile of poverty, but that much more needs to be done both through the formulation of PRSPs and in health sector reform processes more generally to serve the health needs of the poor. We notice that health tends to be treated in a limited way in most PRSPs processes. Overall, there is little analysis of the poverty-health links, the

<sup>6</sup> The phrase is from Mackintosh (1999)

proposed strategies do not tackle fundamental problems of, for example, increasing fragmentation and competition in health financing and service delivery, and there is a blind spot for the health impact of other policy areas like economic policies. Opportunities for intersectoral action, offered by the integral nature of the PRSP, are not taken. We are concerned by the limited involvement in PRSP processes of health sector actors, due to limited capacity, exclusion from decision making, and little interest (for example, Ministries of Health thinking poverty is not their business and assigning low-ranked officials without any support, to provide health input). There is a therefore a need to both strengthen the voice of health sector actors (including WHO) and to stretch the content of the debate. This paper aims to fuel further discussion on issues that we think are crucial, in order to strengthen PRSP processes that help realise the right to health.

# Health spending and PRSPs

## Have PRSPs led to increased spending on health?

The advent of PRSPs has generated a sense of optimism in the development community and now also in the field of health. Rhetorical commitments to the poor have increased – an important outcome, as public discourse has a key role to play in any strategy for national development. As a result of the widely acknowledged importance of health in the lives of the poor spending on key poverty related sectors such as health and education has been widely expected to increase as PRSPs are rolled out and funded by donors and governments. The World Bank predicted that social expenditure in decision point countries would increase from an average of 6% of GDP in 1999 to 9% in 2002, equivalent to an average increase of \$830 million per year.<sup>7</sup> The IMF too has predicted that “real public spending on health and education is expected to rise sharply on a per capita basis” under PRGF-supported programmes.<sup>8</sup> These increases would be mainly funded by debt relief available through the enhanced Highly Indebted Poor Countries Initiative combined with higher aid flows and re-allocation of budgets.

Our country studies find a more mixed picture. In many respects – given the delays in approving debt relief for many countries – it is too early to say whether increased health expenditure has resulted. As WHO points out, it is also possible that where health expenditure has increased, this is more in line with the commitment of donors and governments to achieving the Millennium Development Goals rather than a reflection of their support for priorities outlined in the PRSP.<sup>9</sup> Furthermore, in all of our study countries – even those that have received debt relief under enhanced HIPC – the debt burden remains high, crowding out public expenditures on health, education and other important sectors, and slowing economic growth.

**Table 1: Annual per capita government health expenditures in study countries (2001)**

Country	Per capita govt health exp.
Bangladesh	\$5
Bolivia	\$33
Ethiopia	\$1
Ghana	\$7
Kenya	\$6
Nicaragua	\$29
Uganda	\$8

Source: WHO. [www.who.int/whosis](http://www.who.int/whosis) accessed 12/04/04

<sup>7</sup> Cited in WHO (2002); p.7

<sup>8</sup> IMF (2002); p.14

<sup>9</sup> WHO (2002)

In our study countries, per capita government health expenditures are generally at abysmally low levels (see table 1). All of the countries are spending far less than the US\$60 per capita set out by WHO as the level of spending which guarantees a minimally functional health system.<sup>10</sup> It is actually very difficult to say definitively whether the PRSP process has increased total government health expenditures – but summarising information gleaned from the country studies we suggest the following trends:

- In Bangladesh the period after the development of the I-PRSP has seen slightly increased expenditure on health but per capita health expenditure was down in the proposed budget for 2003/4;<sup>11</sup>
- In Bolivia HIPC debt relief funds have certainly been used to fund health sector activities, but we are unable to obtain data showing whether this has resulted in an increase in total spending on health;
- In Ethiopia donors and government have been projecting an increase under the parallel Health Sector Development Plan, but funding commitments have not materialised and what has been made available has been underspent;
- In Ghana it is not possible to tell whether health expenditures have increased as a result of HIPC or PRSP, but the signs are promising;
- Nicaragua saw a projected increase in HIPC relief for health, but total resources available to the health sector are in fact down;<sup>12</sup>
- In Uganda government support to the health sector has shown an upwards trend since 2001, but donor support appears to have been quite volatile.<sup>13</sup>

Judging from the trends reported here the PRSP-signal to increased health spending does not appear to be so strong.<sup>14</sup> Declines in total and/or per capita expenditure have occurred in Bangladesh and Nicaragua, although there seems to be more promise in the cases of Ghana and Uganda. The lack of available, up-to-date data presents clear problems for any proper assessment of the impact of PRSPs on levels of health financing. Increased transparency is vital to see whether national and international commitments on increasing health expenditure are being met.

## Potential sources for increased expenditure on health

Given the very low levels of per capita government spending in most of these countries, it is essential to think through ways in which they can be increased over time. To do this we have identified a cluster of issues that deserve further exploration as a source of funds. These include:

- Enhanced debt reduction;
- Flexibility on fiscal deficits;
- The potential for increased aid.

<sup>10</sup> WHO (2000)

<sup>11</sup> Health expenditure figures are as follows: 222.80Tk per capita (2002/03); 220.45Tk per capita (2003/04 predicted). Source: country study

<sup>12</sup> Health expenditure figures are as follows: US\$125.8 million (2002); US\$ 121.0million (2003). Source: country study

<sup>13</sup> See Uganda country study for more detail

<sup>14</sup> For a similar assessment see WHO (2004); pp.12-13

Further issues worth discussing but not dealt with here include: the scope for reallocation of resources within the government budget; higher levels of economic growth; and higher levels of direct taxation. Of these the lack (or in some cases, volatility) of economic growth has been a major barrier to increasing health expenditure in poorer countries. In view of the widespread failure of adjustment measures promoted by the World Bank and the International Monetary Fund to stimulate economic growth in low-income countries, there is a clear need for health actors to involve themselves in further discussion around macro-economic policy.

Considering all these issues together would enable greater discussion of the potential for 'expansionary public policy' – in other words, trying to move in a co-ordinated fashion towards higher levels of funding for health, and other key sectors. We believe it would be helpful for donors and governments to more explicitly discuss these possibilities in the context of the PRSP, and try to address the blockages in a systematic manner. Work being conducted by the UN on costing the Millennium Development Goals on a country-by-country basis is a helpful example of this type of process.

## Need for greater debt relief

The burden of external debt that has rested on all of the countries in our studies for much of the last two decades has had immense effects on health and health services. Firstly, debt servicing has diverted scarce government resources, creating large opportunity costs for health and other public services. Secondly, it has undermined both public and private investment and hence the economic growth needed to increase health expenditure and relieve poverty.

**Table 2: Annual government health spending versus annual external debt servicing in study countries**

Country	Estimated government expenditure on health (US\$ millions)	Government expenditure on external debt servicing (US\$ millions)
Bangladesh	492	1084
Bolivia	285	244
Ethiopia	132	104
Ghana	143	129
Kenya	189	580
Nicaragua	125	194
Uganda	190	80

Sources: Health expenditure figures are estimates extrapolated from data at [www.who.int/whosis](http://www.who.int/whosis). Most figures for 2001. Debt servicing estimates are from Jubilee Research 2003. Figures are for 2002. Except: Bangladesh (source: country study); Nicaragua health expenditure (source: country study); Ethiopia health expenditure (source: IMF 2001); Uganda health expenditure (source: country study)

Table 2 shows the current picture for our study countries. The health expenditure figures in particular should be treated with caution, but the point is to reveal an opportunity cost – many of the study countries are still making high levels of debt repayments which could be better spent on health or other priority sectors. Bangladesh and Kenya fare the worst – neither are eligible for debt relief, according to the World Bank and IMF's rather narrow criteria for "debt sustainability". A comparison with the amounts spent on health in these countries, both in

absolute and per capita terms, is not a flattering one for international creditors. In Kenya's case there is an additional "unseen" problem of an internal debt of US\$3.1 billion – bringing the total level of debt to US\$7.97 billion, or almost 70% of the country's GDP.<sup>15</sup> There is surely a case for these countries being considered for debt relief along with other HIPC.

Of the remaining countries, Bolivia and Uganda have progressed farthest along the path to debt relief – both have passed the "completion point" in the enhanced-HIPC initiative and have had substantial amounts of debt relief committed by international creditors: some of which, as our country studies show, has been used in the health sector. Yet in both cases the remaining debt burden has now been judged "unsustainable" due to over-optimistic initial projections of economic growth – in the case of Bolivia – and a collapse in the price of coffee in the case of Uganda. Debt repayments are set to increase again in both countries over the coming years.

At the time our country studies were undertaken, Ghana, Ethiopia and Nicaragua had all passed the "decision point" in the enhanced-HIPC initiative and were receiving some interim debt relief (Ethiopia and Nicaragua have now passed the completion point). In all these countries, debt spending remains high relative to health spending. The case of Nicaragua is particularly concerning. The country has a huge domestic debt totalling US\$4.1 billion. During 2003, of every one Cordoba paid in taxes, 85 cents will be used to service the external and internal debt. The situation is due to worsen in 2004 when it is estimated that servicing these debts will cost up to 90 cents of every tax Cordoba.<sup>16</sup> Our country study reports that nearly sixty percent of HIPC relief will be used for balance of payments support (presumably to facilitate debt repayments).

The narrowness of the "debt sustainability" criteria of the World Bank and IMF clearly needs to be replaced by a more positive focus which asks what extra resources are needed to meet international targets such as the Millennium Development Goals, and given this, what level of debt servicing is really sustainable for poor countries? This principle has been accepted at the UN's International Conference on Finance for Development, and in many countries is also being costed in UN supported, country MDG reports.

## **Flexibility on fiscal deficits**

Under structural adjustment programmes, the international financial institutions have been widely criticised for forcing governments to keep a tight leash on public sector spending in order to limit inflation and the accumulation of public sector debt. The IMF and World Bank have argued that it is vital to keep inflation under control in order to protect both economic growth and the incomes of the poor who often bear the brunt of rising prices, but are less able to shield the value of their incomes and assets. There may also be other strong reasons – for example where domestic debt is at a very high level (as in Nicaragua) – to be cautious about allowing a widening deficit.

In terms of inflation, the reality at the present time is that rates are at quite low levels for many developing countries. In 1995, more than half of the countries in the developing world had inflation rates of less than 15% per year<sup>17</sup>. Even in sub-Saharan Africa, where

<sup>15</sup> Jubilee Research (2003)

<sup>16</sup> Jubilee Research (2003)

<sup>17</sup> Stiglitz (1998)



stabilisation of economies has remained a priority, many countries are now entering a 'post-stabilisation' phase with inflation at tolerably low levels. Targeted inflation rates for our own study countries are also very low (see table 3). Several commentators have argued that at these levels any negative effect of inflation on growth prospects is likely to be quite weak.<sup>18 19</sup>

**Table 3 Medium term and projected rates of inflation in study countries with data available**

Country	Target inflation rate
Bolivia	3.75%
Ethiopia	3%
Ghana	5%
Nicaragua	4%
Uganda	3%

Source: Eurodad (2004)

Yet in four out of five of the study countries for which we have data available, governments are being asked to reduce their fiscal deficit still further (see table 4 – a positive figure in the 2nd column from the right shows a reduction in the fiscal deficit). An Oxfam study notes a similar emphasis on lowering fiscal deficits in 15 out of 20 low-income countries.<sup>20</sup> This is despite promises by the IMF of a shift away from the accent on tight fiscal policy evident in past structural adjustment programmes. The consequences of this are grave in countries where public investment is already at low levels and where extra resources to assist public services and stimulate private sector growth are urgently needed. The new Poverty Reduction and Growth Facility (PRGF) of the IMF was supposed to support the implementation of PRSPs, by incorporating 'an emphasis on allowing greater flexibility in accommodating **rising** budget deficits, financed on suitably concessional terms for countries with sustainable macroeconomic and debt positions and scope for productive public spending' [our emphasis].<sup>21</sup>

The figures in the shaded column of Table 4 illustrate the opportunity cost of the proposed deficit reduction (over three years) in relation to one year's health spending as a proportion of GDP. In the case of Ghana, Ethiopia and Nicaragua, the comparison shows that targeted deficit reduction amounts to a significant proportion of these countries health expenditures. From a health perspective there are two further 'hidden' problems associated with tight fiscal policy:<sup>22</sup> Firstly, an inability of governments to meet the recurrent costs of capital investment; and secondly, the way in which it encourages governments – and donors – to keep expenditures off-budget, undermining better budgetary management. For these reasons, and because the fiscal deficit projection is a key variable often used to determine the limits of the Medium Term Expenditure Framework, and thus the ceilings on spending in each sector, it is vital that health actors keep a watchful eye on this issue.

<sup>18</sup> Sen (1998)

<sup>19</sup> Adams and Bevan (2001)

<sup>20</sup> Oxfam (2003)

<sup>21</sup> IMF cited in Oxfam (2003); p.8

<sup>22</sup> Addison and Ndikumana (2001) note these problems from a developmental perspective

**Table 4 Fiscal balance projections**

Country	'Current' fiscal balance (% of GDP)		Average of projections (after grants) over next three years (% of GDP)	Difference (increase/decrease in the after grants balance over 3 years)	Government spending on health (as % of GDP)
	Before grants	After grants			
Bolivia	-6.1	-3.8	-3.2	+0.6	4.6
Ethiopia	-9.9	-5.9	-5.2	+0.7	1.8
Ghana	-10.5	-6	-2.2	+3.8	2.2
Nicaragua	-8.8	-2.5	-0.3	+2.2	2.3
Uganda	-10.4	-3.3	-3.3	+0	1.4

Sources: Eurodad (2004); Shaded (right hand) column: World Bank. <http://devdata.worldbank.org/hnpstats/> (accessed 08 April 2004)

Wider analysis of the IMF's role in low-income countries shows a distinct lack of flexibility and debate in target setting.<sup>23</sup> This is despite the promise that all major reforms would be subject to analysis of their expected impact on poverty, one of the supposed key features of the PRGF. In none of the countries in which our studies were conducted has there been explicit public debate over the possible trade-offs of tight fiscal policy for spending in the social (and other) sectors, nor are line ministries or parliaments involved in these decisions that usually take place between Ministries of Finance and the IMF. In any case, trade-offs between different policy options are not discussed in PRGF documents. Ghana is one exception, where the issue has been raised with the IMF by government in relation to spending on human resources.<sup>24</sup> NGOs can helpfully call for a discussion of trade-offs, and for an informed debate in the PRSP-context, for instance on the basis of a poverty and social impact analysis.

## Increased aid

This paper starts from the premise that given the extremely low health expenditures in many poor countries, the international community will have to make a significant contribution to funding health sector costs into the foreseeable future. Yet aid has been fraught with problems in the past. Firstly, there are basic questions about whether it undermines macro-economic stability. Secondly, the manner in which aid is given is important from a health perspective: often, aid has financed mainly capital expenditures, leaving governments with running costs which they are unable to afford. It has also been channelled through projects or vertical programmes which are difficult for governments to co-ordinate and which may fragment health systems further. Thirdly, high volumes of aid can also act to create political dependency and a weakening of government ownership.

Given that there needs to be an increasing volume of aid channelled to poor countries, how can these problems be mitigated? Concepts of donor-government co-ordination, planning for long-term support, and a shift to government ownership are at the heart of PRSP process. In this section we suggest that increasing aid to the health sector needs to focus on these objectives and the long-term sustainability of health system functioning. PRSPs, by

<sup>23</sup> Eurodad (2004)

<sup>24</sup> See Ghana case study

promoting planning and co-ordination, could assist in this process, alongside other instruments such as Sector Wide Approaches (SWAs).

### ***Aid and macro-economic instability***

Amongst our study countries, arguments about the effects of aid flows on macro-economic instability have been most pronounced in the Ugandan context. Here, the Ministry of Finance raised objections to the disbursement of a grant from the Global Fund for AIDS, TB and Malaria arguing it would cause macro-economic destabilisation. There was a fear that substantial new inflows of aid could overvalue the Ugandan currency, leading to a fall in the competitiveness of Ugandan tradeable goods on world markets and a collapse in growth. The Ministry also feared that it would need to sterilise new inflows leading to a rise in interest rates and a decline in private sector investment.

There is widening consensus that short-term fluctuations in the level of aid can have negative effects on economies by increasing instability and uncertainty. However, if donor flows are sustained and predictable then the economic benefits outweigh the costs, because of medium- and long-term positive effects on growth.<sup>25</sup> This is an important conclusion from a health perspective as long-term, predictably-delivered aid is also an important pre-requisite for health systems development.

### ***Getting aid to the health sector right***

The inflow of new AIDS money into Uganda (through the GFATM and more recently the President's Emergency Plan for AIDS Relief – PEPFAR) has also raised a number of serious planning issues for the Ministry of Health. Firstly, and most publicly, there have been major budgeting problems. The Medium Term Expenditure Framework – which has itself been determined with reference to a number of economic variables such as the fiscal deficit and inflation rate – puts a strict ceiling on government expenditures in each sector. If new aid money is offered, it must be absorbed within the ceiling. If it is, a question arises about what other activities will be dropped in order to accommodate the new project. The strictness of the budget ceilings thus raised public concern about the flexibility of the MTEF in a situation where new resources were urgently needed.

Less noticed however, have been deeper effects of the new money for disease control programmes on health system planning. Reports suggest a number of problems. Preparing proposals has taken up a considerable amount of time and human resources. Attractive salaries for the donor-supported programmes are causing disruption in the labour market for health personnel, leaving gaps in provision elsewhere. Overall, there are fears that the shift to the Sector Wide Approach initiated in Uganda a few years ago will be undermined by the new aid climate.<sup>26</sup>

From the experience of Uganda it does not appear that the PRSP is leading to a culture change amongst donors – co-ordination of health sector aid appears to be getting more difficult at the moment. Whilst most commentators would argue that linking Medium Term Expenditure Frameworks with PRSPs has been helpful in enabling greater planning of expenditures, the increasing proliferation of donor initiatives is undermining this. A closer linkage between major donor projects and the PRSP/MTEF is clearly necessary.

<sup>25</sup> Department for International Development (2002)

<sup>26</sup> Anon. personal communication with the authors, May 2004

At the same time, planners must carefully consider the health system effects of any new aid money coming in. More money is not the only issue in the health sector – co-ordinating it better and ensuring that it meets overall health system objectives is also crucial from the perspective of planning and sustainability. How could this be done in the case of new initiatives such as the global funds? One possibility is the development of a ‘code of practice’ which would outline ways in which disease control programmes can be integrated with the broader health system.<sup>27</sup>

This code might include the following measures:

- ensuring that disease control programmes are integrated in public and not-for-profit facilities;
- ensuring that disease control programmes are compatible with primary care priorities, even if this came at the expense of faster coverage build up;
- enable funding to be used flexibly to support functional improvements in the rest of the system; and
- ensuring that administrative integration goes hand in hand with operational integration to avoid the emergence of parallel command structures.

A further issue which requires attention is the long history of donor attachment to funding capital rather than re-current costs. Donors are under pressure from domestic constituencies to show results, and providing aid for operational costs which may only show results in the longer-term is not such an attractive proposition. The danger is that governments will not be able to afford the running costs of donor-financed capital investments.<sup>28</sup> Indeed, governments have also shown a tendency to focus available resources on capital investments, again often as a result of domestic political pressure.

This issue arises strongly in Ethiopia where 88% of the Birr 156.4 million (approximately US\$18million) that has been provided through HIPC relief to the health sector is being used for capital costs and just 12% for recurrent expenditures. This is despite one of the main objectives of the PRSP being a slow down in the construction of new health facilities and an improvement in the quality of care,<sup>29</sup> as well as other reports which have suggested that the inability of recurrent spending to keep pace with capital expenditures has already resulted in a serious shortage of drugs at the facility level and therefore little increase in utilisation.<sup>30</sup> Increased attention to this issue in PRSPs is necessary. Whilst, over the past decade, donors have in fact been supporting more and more of the recurrent costs in health systems in poor countries, there needs to be a more explicit acknowledgement that this will be necessary over the long term. Donors should avoid creating bureaucratic problems for

<sup>27</sup> Unger et al. (2003)

<sup>28</sup> There may also be a macro-economic aspect to this problem. In line with the attempts to keep recurrent costs such as salaries relatively stable, the IMF, in its review of whether the PRGF is working, appears to be focussing its resources on capital costs. “programs... envisage higher outlays for capital investment which include the provision of critical infrastructure. These outlays will rise, on average, by three-fourths of a percentage point of GDP in PRGF-supported programmes, and will also climb as a share of total government outlays. In combination with the containment of current expenditures, the improved composition of public expenditure envisaged in PRGF-supported programs constitutes an important ingredient in countries’ poverty-reduction strategies.” IMF (2002); p.16

<sup>29</sup> WHO/Ethiopia summary: <http://www.who.int/hdp/database/country.aspx?iso=ETH>

<sup>30</sup> Russell and Abdella (2002); p.12.

country officials trying to juggle scarce resources; negotiate accountability frameworks with their domestic constituencies so that long-term support is politically and legally acceptable; and finally debate with international institutions the need to relax the macro-economic

#### **Improved national capacity – process indicators**

- The extent of collaboration between donors, governments and consumers in the design of the intervention
- The extent to which local level health officials gain control over resource management and use that control effectively
- The extent of attention paid to the continuity of health activities in design, implementation and monitoring once the initial investment phase is complete.

constraints to increased recurrent funding. There also needs to be informed public debate within recipient countries about how health sector resources can be used to create health systems that are sustainable.

#### ***Ensuring government ownership***

Health sector investment has generally favoured the production of output goods over capacity building or process goods.<sup>31</sup> Yet the PRSP takes as a central aim a very important ‘process good’ – increasing government control over investment. Whether this is happening in the health sector is difficult to say. There has been some debate at the more general level of relationships between government and donors (rather than Ministry of Health and donors), but the evidence is contradictory. In one sense, given the firm links being established between PRSPs and MTEFs, some commentators are relatively optimistic that government’s control over planning is being increased.<sup>32</sup> However, others have noted how many of the prescriptions for economic reform favoured by the donor community have been uncritically reproduced in supposedly government-owned PRSPs.<sup>33</sup> Our judgement is that this problem also afflicts the health components of PRSPs, but we also accept that the process may be helping to re-install a sense of government control over investment after two decades of donors calling the shots. Further steps are needed to push this process further. LaFond’s important work on health system sustainability makes two key recommendations in this area.<sup>34</sup>

- ***Investment needs to focus on strengthening government capacity to negotiate with funding sources; and***
- ***All investments should aim to enhance government control over decision-making and resource management at every level.***

There is a danger that these recommendations – and others which conform to the spirit of the PRSP – may be undermined by a donor agenda which has again returned to focussing on outputs, most notably in the form of the Millennium Development Goals and in campaigns

<sup>31</sup> LaFond (1995)

<sup>32</sup> Booth (2004)

<sup>33</sup> Stewart and Wang (2003)

<sup>34</sup> LaFond (1995)

against specific diseases. It may be useful to draw up measurable indicators of improved national capacity to set against goals emphasising health outcomes (see box for LaFond's suggestions<sup>35</sup>).

## Conclusions and Recommendations for this section

- More timely information disclosure is needed on health spending in order to enable public discussion and to facilitate the process of costing the amounts of funding needed to improve health systems.
- Our review does not show the widely predicted increases in expenditure that were expected under the PRSP framework. There is a need to encourage policy-makers to think about expansionary public policy that mobilises greater debt relief and aid needed to meet international commitments such as the MDGs.
- Debt sustainability criteria should take into account the need for increased public spending to achieve the MDGs and finance PRSPs. More cancellation is required. Debt relief is the most efficient and effective way to finance development.
- Higher levels of predictably-delivered aid are supportive of growth in the long-term and better for health system development. Donors should explicitly accept the need for provision of recurrent costs for many years into the future in low-income countries.
- There needs to be much more debate and discussion about fiscal policy and ceiling setting. The health sector should challenge economic targets which determine the Medium Term Expenditure Framework and ask for evidence of why these targets have been set. PRSPs should contain a discussion of the trade-offs involved in further reduction of the fiscal deficit, assisted by a Poverty and Social Impact Analysis; PRSPs should also strongly advocate for increased investment in health from the point of view of its contribution both to the fulfilment of human rights and to economic growth.
- PRSPs should promote greater co-ordination of donor resources to the health sector and also promote discussion of how aid can support long-term health system functioning. PRSPs should be used as a mechanism to help shape resources available from disease control programmes to achieve this end.
- Increasing country ownership is a vital part of the PRS process. We need constant attention and monitoring of whether this is happening – it is vital to focus on process as well as outcome indicators during PRSP reviews. Donors need to commit themselves to supporting inherently complex processes, rather than expecting quick fixes and instant outcomes that undermine the functioning of the rest of the system. Accompanying these increases there needs to more effort to increase spending capacity and accountability. The example of Bolivia's National Mechanism of Social Control which monitors spending of debt relief resources is a useful model in this area.<sup>36</sup>

<sup>35</sup> LaFond (1995)

<sup>36</sup> See Bolivia country case study

## **‘Pro-poor’ health systems**

This section critically examines some of the major themes emerging in discussion of PRSPs and health at the international level, interweaving the discussion with examples from our country case studies. PRSPs are not the place to spell out sectoral policies, but they should strategically identify areas for making existing policies pro-poor. WHO points to two key gaps in the health components of PRSPs – neglect of the poverty implications of catastrophic health expenditures and what can be done about them; and the lack of discussion of the role of the private sector.<sup>37</sup> Here we emphasise, firstly, government’s key role in the health sector – in contrast to the current emphasis on a residual role for the state in financing public goods for the poor. We then move on to discuss ways in which the poverty-inducing effects of health expenditure can be avoided and suggest ways in which poor people’s grip on disorganised health care markets – their health claims – can be strengthened through government action to shape health systems, including the private sector. Whilst the health components of PRSPs (where they are explicit on linkages between poverty and health) tend to place their emphasis on the necessity of tackling diseases that disproportionately affect the poor, we argue that greater attention needs to be paid to people’s relationship to the health system, and especially to the standards of care that they receive when they manage to access it.

## **The vital role of government action in the health sector**

Despite the hugely important role government plays in the health sector in the developed world, some donors have consistently argued for a more limited role for the public sector in developing countries. Governments have been encouraged to focus their scarce resources on financing and providing public goods – such as immunisation – or a limited version of primary health care for poorer groups. This type of argument is now prominent in health sector discourse – and in discussions on PRSPs. For instance, the recent draft of Uganda’s Poverty Eradication Action Plan 2004 states that:

...Government should focus its interventions on preventive care and on making sure that the poor, who would not otherwise be able to pay for good private care, have effective access to the public health system.<sup>38</sup>

Whilst this strategy appears to promote equity, there is a danger that, in the long-term, it promotes segmentation in the provision of health services, leading to the creation of a poor public service for poor people, as the political voice and the resources of higher-income groups detach themselves from the public sector. An important objective for government, in systems where high levels of private provision prevail, may be to ensure that boundaries are blurred between the providers that different income groups use, in a way that strengthens rather than diminishes, the power and efficacy of the public sector.

<sup>37</sup> WHO (2004); p.9

<sup>38</sup> PEAP draft (2004); p.158

An expanding role for government is important for other reasons:

- Government's ability – when measured cross-nationally – to produce better health outcomes than the private sector. Cross-national evidence shows that higher government spending is often associated with better health outcomes; conversely, recent evidence looking at the relationship between levels of private spending and health achievements shows a weakly negative relationship.<sup>39</sup>
- The critical role of governments in strengthening the social protection function of health services, notably through risk-pooling and cross-subsidy. Payments at the point of use are most prevalent in low-income countries, and most injurious to household well-being there as well. There is a danger that increasing marketisation will further drive out risk-pooling and cross-subsidy in health systems in poorer countries, leading to increased financial burdens on poorer people.
- There are fundamental concerns that in systems with high levels of private finance and provision – and hence fragmentation – it will be harder to achieve important public policy objectives, such as cost control, regulation, responses to public health emergencies and planning. Different elements of the system produce 'joint products' which are necessary for the functioning of other parts.<sup>40</sup> Hospitals train health workers, are sites of specialised personnel and equipment and help skills development; primary care providers act as a gatekeeper to the system and make referral to higher levels effective. These joint products can easily be lost if the components of the system are allowed – or encouraged, as in those health reforms which aim to focus government resources on discrete services – to spin apart.
- Finally, the introduction of market mechanisms within health services, leading government services to compete with a diversity of providers, may also reduce the amount of collaboration and information sharing in the system. Health policy analysts have expressed concern about the focus in the reforms on a 'culture of individualism and market relations'<sup>41</sup> and emphasise the need to sustain a 'public service ethos', based on professional ethics. The rewards for this are many: where government services work well – and market mechanisms are kept tightly under control – the sense of trust and security engendered by health systems can even have spillover effects into the wider society, promoting greater social cohesion.<sup>42</sup> It will be harder to realise these types of effect in a highly-privatised health system.

Rarely are these broader types of argument for a strong government role put forward in PRSPs, although they are vital from the point of view of equitable health system development and increasing the access of the poor and vulnerable to health services. More frequently, the current failures of government performance in health services are brought to the fore. Whilst acknowledging the huge difficulties with state provision of health care in developing countries as extremely important, we continue to emphasise government obligations to protect, promote and respect the right to health for all citizens, and call for more debate about how governments can shape messy health care markets so that they work better for poorer people.

<sup>39</sup> Mackintosh and Koivusalo (forthcoming)

<sup>40</sup> Mackintosh (2003)

<sup>41</sup> Green and Collins (2003); p. s73

<sup>42</sup> Gilson (2003)



This process will involve governments in strengthening health claims and encouraging greater cross-subsidy and redistribution in health care systems over time. As discussed earlier, a health claim means a 'duty owed to an individual that they should have a good or service'.<sup>43</sup> Claims may arise either from the prior existence of stated commitments – entitlements to services enshrined in legislation for example – or from advocacy or other public action to strengthen entitlements. A claim may be usefully seen as a staging post on the way to the fulfilment of a right – part of an incremental strategy to increase access to quality health care. In what follows we address both strengthening health claims and encouraging cross-subsidy and redistribution as parallel strategies for governments to follow when thinking about the financing and provision of health care in the context of PRSPs.

## User charges

User charges are a widespread fact of life in low income countries. However, there is deep concern over their effects. As Bennett and Gilson note "in virtually all cases where user fees were increased or introduced there has been a concurrent decrease in service utilisation. The magnitude of this drop in utilisation was frequently larger, and the effect of a longer duration, amongst the poor part of the population".<sup>44</sup> The long-term impoverishing effects of paying for health care at the point of use are now emerging from different countries.<sup>45</sup> There is also concern over the impact of charges on irrational use of drugs and gender equity.<sup>46</sup> Yet, the charges do not raise significant amounts of revenue for poor country health services (estimates range from 5% to 20%), and the cost of administering charging systems frequently soaks up a sizeable proportion of funds.

As a result, after nearly two decades of policy advice which has often promoted increased user charges for health services, there appears to be a "new consensus" emerging that they are bad for the poor. There is no doubt that concern with poverty, expressed in the context of PRSPs, is a factor which is helping this process along. International bodies are also highlighting the need for increased risk-pooling of resources in poor country health systems.<sup>47</sup>

Our country studies also reflect the problems caused by user charges for poor people, although there is some divergence on how financing issues are being dealt with in individual PRSPs. In Ethiopia, for instance, the PRSP contained a commitment to raising the amount of user charges collected by public health facilities from a level of 12.8% (2001/2002) to 20% of total public expenditure on health by 2004/5. There was no discussion of the impact that this policy might have on the poor.<sup>48</sup> The implications look dire. A report by Save the Children UK on cost-sharing in Ethiopia reveals their significant negative consequences already, in terms of both financial and time costs as well as the longer-term impoverishing effects.<sup>49</sup> In Bangladesh, focus group discussions frequently raised the issue of charges and their effects on the poor. It should also be remembered that in most of our study countries the majority of the population are living under or not too far away from the absolute poverty line, indicating

<sup>43</sup> Mackintosh (2001); p.185-6

<sup>44</sup> Bennett and Gilson (2001); p.11

<sup>45</sup> See for example Liu et al. (2003)

<sup>46</sup> Whitehead et al. (2001)

<sup>47</sup> See, for example, OECD (2003)

<sup>48</sup> WHO/Ethiopia summary: <http://www.who.int/hdp/database/country.aspx?iso=ETH>

<sup>49</sup> Russell and Abdella (2002)

intense vulnerability to health care charges, especially ones associated with catastrophic and chronic illness which require expensive and/or long-term treatment.

Part of the problem in many instances is the fact that user charge initiatives are poorly designed and implemented.<sup>50</sup> Exemption schemes for the poor often do not work and benefits are often captured by wealthier or other well-connected groups in the community. Exemption schemes can certainly be made to work better. Two of the most important failures are a lack of clear central guidelines which localities are required to follow and the conflict-of-interest problems generated by the tying of health professionals salaries, or institutional funding, directly to revenue from charges, leading to a perverse incentive to health facilities and workers to charge more.<sup>51</sup> Exemption schemes should therefore be given high priority by politicians and bureaucrats and they should communicate the content of the schemes clearly to health workers and the general population. They should be easy and clear to implement, and although there should be some degree of flexibility in implementation at the local level – to enable adaptation in response to local circumstances – this should only be within limits set by clear central guidance.<sup>52</sup> Avoiding the capture of exemptions by non-poor groups must sometimes tread a difficult balance, as quality improvement at the institutional level may be an important by-product of user charges, and research shows that some capture of exemptions by more wealthy groups, particularly within local communities, may help maintain support for the exemption mechanism.<sup>53</sup>

Some countries have gone further, abolishing user charges in parts of their health services. Uganda has achieved this in the wake of a 2001 election commitment by President Museveni. Ghana is soon likely to follow suit. We regard these as positive developments. Unfortunately, there is not a wide literature to draw on on the effects of abolition, but studies from South Africa<sup>54</sup> where fees were withdrawn for under fives and pregnant mothers in 1994 and for all primary health services in 1997 and from Uganda,<sup>55</sup> where primary health care services became free in April 2001, enable some lessons to be drawn.

- Abolition can lead to positive and large impacts on utilisation of curative services, especially by the poor. In Uganda, follow-up visits for children under five also increased. There may be a positive impact on utilisation of preventive services if abolition leads to greater within-facility referrals or greater awareness.
- Abolition may result in clinic congestion and reduced consultation times. Health services need extra spending to cope with increased utilisation. In Uganda the government introduced a supplemental buffer of US\$5.5 million from the World Bank-supported district health services project. Drug supplies also need to be kept up: a dramatic decrease in utilisation in Uganda in October 2001 was attributed to widespread drug stock-outs.
- Health workers have been supportive of the policy change and responsive to new demands (and potential loss of revenue from cost-sharing) in both Uganda and South Africa, but morale is easily undermined, especially if working conditions worsen and salaries are not paid on time. There may be a danger that health workers will devote more time to their activities in the private sector, although there is no data available to see whether this

<sup>50</sup> Bennett and Gilson (2001)

<sup>51</sup> Mackintosh and Gilson (2002)

<sup>52</sup> Bennett and Gilson (2001)

<sup>53</sup> Bennett and Gilson (2001)

<sup>54</sup> HST (1996); Wilkinson et al. (2001)

<sup>55</sup> Burnham et al. (2004)

response occurred in either country. It is important to monitor the morale of health workers. Attention to the wider conditions of the health system is essential.

- The apparent decline of the community committees which previously managed user charge funds in Uganda could lead to a decline in the accountability of services. Policy-makers should try to avoid such an accountability-access trade-off.
- Barriers to accessing care faced by patients – other than charges – such as transport costs, lack of trust and intra-household decision-making processes around access which may affect women, children and men differently should also be noted.
- There is a need for consultation both before the policy change and after it to ensure that as many of these problems as possible are dealt with in an open and transparent manner.

The key message from these studies is that abolition can have very positive effects, especially on the uptake of services by poorer groups. This is important as the evolution of any health system towards greater equity must involve a movement away from the widespread levying of user charges. However, the possibility of a diminution in quality of health services and health worker morale needs to be kept in mind: abolition must be accompanied by measures which strengthen the responsiveness of the system otherwise there is a danger that even though a financial barrier has been removed, the poor will still be faced with sub-standard services. Ensuring that exemptions work is important if patients still face fees at higher levels of the system – where especially high charges may be encountered.

## Social insurance

Slightly better-off developing countries are also struggling to deal with fragmented health systems. This is the case in Bolivia. A social security health system (paid for by formal sector employers and employees but also heavily subsidised by the state) covers 22% of the Bolivian population. The remaining – poorer – 78% of the population must rely on the private sector (and cover the cost themselves) or on an under resourced public system. As the Bolivian case study notes, this is unacceptable:

'Health in Bolivia is therefore discriminatory. It discriminates against the poor for being poor. In a country described as democratic, health and health care ought to be democratised rather than being the birthright only of those who can pay for it, thanks to their purchasing power. **Bringing about universal access to health and health care is therefore an indicator of the impact of the "strategies to combat poverty" and respect for fundamental human rights.**' (Bolivia case study; p.16; our emphasis)

Interestingly, the government appears to be using the development of the PRSP to push forward universalisation. At the end of 2002, the government enacted the Universal Mother and Child Health Insurance Law to try and address some of the problems of lack of insurance for poorer people. It covers pregnant women through to six months after giving birth and children up to the age of 5. The Bolivia case study notes that the law has provoked strong resistance from the municipalities (from whose budgets money for the scheme will come) and from associations of health professionals – including the Bolivian Medical Association – who question whether it can really be universal when remote areas lack health

infrastructure. The debates are continuing in a commission comprised of the government, the Bolivian Medical Association, municipalities and representatives of the social security system. A health insurance scheme for older people has also been enacted, and the poverty reduction strategy paper seeks to extend coverage in health until a “universal health insurance” is reached in the future, by enacting a “Health Law” that becomes the means for integrating the public health system with the social security health system.

The current debates over health insurance in Bolivia highlight the fact that financing health care systems is never simply a technical issue. Those who stand to lose or gain will attempt to shape the future of the health system in their own interest. It is important in such a fragmented situation that the poor and uninsured are represented in the debates about universalising coverage, and government can play a clear role in facilitating this. There are lessons from Latin America<sup>56</sup> which show that tiering problems that result from fragmented health insurance schemes need to be addressed – a coherent financing approach is required that promotes integration across mechanisms rather than further fragmentation. Other ways of strengthening health claims in this area include:<sup>57</sup>

- Opening up health sector financing reforms to public discussion, and trying to institutionalise the presence and voice of the poor in all the financing mechanisms;<sup>58</sup>
- Communicating new policies clearly to the general public to build a political constituency for reform. This has a feedback effect – discussion that results can inform future development of government policy;
- Ensuring the technical and financial management skills are available to implement the new schemes in the most efficient and fair way possible. Monitoring the effects of the reforms, and especially the effects on equity, is also critical;
- Ensuring that any new provider schemes (such as accreditation schemes) which accompany the financing reform also assist the poor. Such schemes can offer incentives for providers to deliver the same level of care to both insured and uninsured patients, and if the poor use the same institutions as the insured this could provide an upward pressure on the quality of care they receive.

The international community can also play a key role in supporting these processes in the context of the PRSP. Yet in Bangladesh interviews by the case study authors found that the World Bank was promoting private health insurance as a means of keeping wealthier patients in the country. However, there are dangers that the development of private health insurance schemes may make protection of the poor – as well as other objectives such as cost control – much harder in the future. From the perspective of the poor, systems based on private insurance are highly regressive. Furthermore, systems characterised by a combination of private health insurance, high medical incomes and high technology costs are very hard to universalise due to the vested interests (from insurance companies, medical professionals and so on) which begin to operate in its defence. The “path-dependency” of health services should be noted – initial conditions matter for the future shape of the system.<sup>59</sup>

<sup>56</sup> Bennett and Gilson (2001)

<sup>57</sup> Bennett and Gilson (2001)

<sup>58</sup> Bloom (2001)

<sup>59</sup> Mackintosh (2003)

## Health care provision

WHO also identified the lack of attention to the private sector in the health component of PRSPs as a problem. Our country studies did not set out to examine individual health systems and the role of private provision in detail. Somewhat inevitably however, the issue of how to deal with the messy health care markets which exist in many poor countries was raised. Partly this was due to the negative effects of marketisation on the government sector, for example in Bangladesh, where problems with the “commercial attitude” of public sector providers were identified.<sup>60</sup> Partly it was simply due to the expansion of private sector activities in health in low-income countries. The question is, how can government action, within a mixed health care system with numerous providers, promote social inclusion and greater levels of redistribution over time? The answer must involve both public and private providers, given the high levels of usage of private providers in many developing countries. It must also acknowledge and support a clear leading role for government in giving a pro-poor orientation to the whole health sector.

The international community appears to be enthusiastic about using public funds to allow greater contracting with the private sector, although some of the lessons from the failures of contracting are increasingly being taken into account.<sup>61</sup> The focus on ‘hard’ outputs leads to perverse incentives to misreport achievements; it is difficult to evaluate what providers have achieved when health outcomes are determined by many different factors; and there are also incentives to inflate costs. Beyond this, there is a real concern that as a result of competitive contracting financial incentives come to dominate health system relationships; and that this is to the detriment of ‘softer’ types of relationships – such as collaboration – which are actually more important for health system functioning.

Mackintosh argues that current models which place the emphasis on hard contracts and financial transactions between governments and different providers block a more collaborative approach by giving the wrong signals to market participants. She asks,

‘...to what extent are these relationships ‘transactions’ at all? In other words, do we understand – do we wish the participants to understand – these relations as exchange? It is in the nature of the meanings of exchange in the twentieth century’s economy that we tend to understand exchange relationships as something-for-something swaps: in this case, cash or operating licenses for evidence of ‘performance’. We also invest ‘exchange’ with meanings about the ethics of strategic and arm’s length behaviour: it is generally felt to be acceptable to behave self-interestedly in exchange, but not in relation to – whom? Parents? Children? Vulnerable patients? Those funding vulnerable patients?... Alternative discursive constructions, such as professional partnerships, longer-term ‘gift’ relationships where the something-for-something relationship is softened and not all the returns are material, or collaborative joint ventures, have different real effects. The gift relationship framework can alert us to the danger of assuming self-interested behaviour in a collaborative culture, and thereby creating a self-fulfilling prophecy.’<sup>62</sup>

<sup>60</sup> See, for example, Bangladesh case study

<sup>61</sup> See for example World Bank (2003)

<sup>62</sup> Mackintosh (1999); pp.165-166

In place of the dominant model of contracting and a residual role for the government, Mackintosh proposes the model of a 'joint venture'<sup>63</sup> where the government uses its political and legal leverage (in addition to its financial leverage) to influence other market participants towards better behaviour towards the poor: this would include attention to quality of care, attitudes of staff towards the poor and vulnerable, as well as to the problem of pricing and exemptions. Providers whose staff behaved well towards the poor would be rewarded and publicly compared with those who did not. Norms could be agreed for charging and treatment and the results widely publicised to influence the standard of care in other parts of the sector. Similarly, redistributive relationships would be valued by emphasising good practice in exempting the poor from charges. And closer collaborative relationships between private and public providers could mean greater potential for risk-pooling. In other words, boundaries between providers should be deliberately blurred with the objective of reducing polarisation in the system as a whole and intensifying collaborative relationships.

The joint venture model – with its twin objectives of preventing polarisation and creating social inclusion – avoids the perverse incentives of the contractual model and keeps us more focussed on the end objective which is to make health systems more socially inclusive over time. Mackintosh and Tibandebage – looking specifically at the case of Tanzania – point to a number of policy options.<sup>64</sup>

#### ***Increase voice, strengthen referral***

There is a need to strengthen collective representation between groups of users and particular institutions. It is very difficult for poor people – or any patient or their family – to face the system alone. Government should try to encourage involvement in facility management and collaboration between local people and primary providers to create a strong medical constituency which can represent people's interests at higher levels of the system. The lack of adequate referral mechanisms is a critical problem in disorganised health care markets.

#### ***Negotiate explicit returns for government support***

Better off parts of the system, such as government referral hospitals and non-government hospitals that charge high fees and which may have been given government subsidies or tax breaks, should be asked to contribute to the capacity of the health care system as a whole through:

- contributions to training;
- allowing other institutions access to scarce equipment at low cost;
- exchanging staff to update clinical and managerial skills
- providing services to patients referred from the government sector at free or low-cost
- negotiating cross-boundary contracts for their staff which lay out explicit and monitored commitments for work in government sector institutions

The goal should be to strengthen the public sector, and elements of the system that serve the poor well, through utilising the strengths and resources of other parts of the system.

<sup>63</sup> Mackintosh (1999)

<sup>64</sup> Mackintosh and Tibandebage (2002)

***Differentiate providers and benchmark***

Where private providers are helping the poor, help them to undercut competitors of a lower standard by publicising bad practices and accrediting good ones. This process can also act as upward pressure on standards in the public sector. Good providers can help develop and publicise 'benchmark' fees and standards of accessibility and care. Publicity can raise activity levels at good clinics and help undercut those providing poor services. Membership of a 'high quality' association can act as a signal for increased subsidy from donors and government. Furthermore, benchmarking would involve the public in identifying success, adding further upward pressure on standards.

***Blur boundaries***

Make sure that the better-off do not separate themselves out institutionally – this makes it easier to extract cross-subsidy: firstly, it allows institutions to use resources from richer patients to subsidise poorer ones; secondly, it stops the better-off distancing themselves from problems in the system and the poor.

## **Conclusions and Recommendations for this section**

PRSPs have commonly focussed on defining a package of disease-based interventions which will benefit the poor most. We suggest that this approach needs to be supplemented by a focus on people's relationship with the health system, and the claims they are entitled to make on it. A process of strengthening health claims could be achieved in many ways. We have highlighted a few examples, including:

- Strengthening exemption mechanisms
- Promoting quality standards based not just on clinical outcomes, but also the way vulnerable people are treated when they access health care
- Encouraging forms of collective representation, such as patients' groups or closer collaboration with primary providers who can act as advocates for patients at higher levels of the health system
- Ensuring that the voice of the poor is represented in national policy decisions related to the financing and provision of health care

In parallel, PRSPs should promote the strengthening of redistributive relationships within the health system, in order to lessen the financial burden of access for the poor, and to help those health care institutions that are serving the poor. Measures might include:

- Abolishing user charges;
- Promoting social insurance and intentionally setting out to include poor groups in schemes in the long-run;
- Ensuring that community insurance schemes include some element of cross-subsidisation between poorer and richer members of the scheme;
- Negotiating explicit returns for government investment in richer parts of the system – returns that benefit parts of the system serving poorer groups.

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# Annex 1. Case study summaries\*

(\* full studies available from <http://www.wemos.nl/prs> or from [elle.verheul@wemos.nl](mailto:elle.verheul@wemos.nl))

## The Bolivian PRSP, the HIPC initiative and the impact on the health sector

Case study by AIS-CODEDCO, La Paz, December 2003

Summary by Wemos

AIS-CODEDCO conducted a case study about the impact of the EBRP (*Estrategia Boliviana de Reducción de la Pobreza*, the Bolivian PRSP) and the HIPC initiative on the health sector in Bolivia. The objective of the study is to monitor implementation of the current PRSP and the allocation of HIPC funds in the health sector, with a view to influencing the development of the next PRSP.

As stipulated in the “National Dialogue 2000 Law”, Bolivia has to organise a National Dialogue periodically as an ongoing mechanism for social participation in the design, monitoring and adjustment of policies that aim to reduce poverty. The next national dialogue will take place in July 2004 (with preparations at the municipal level starting in April) and the results of the case study will serve as an input for the discussions. On the basis of the same law, Bolivia has established a National Mechanism for Social Oversight (in Spanish: Mecanismo Nacional de Control Social – MNCS). Through the MNCS, civil society organisations can exercise the right to access information, to supervise decision-making processes and evaluate the results of public policies. As an affiliate and board member of the MNCS (until February 2004, when there will be elections for a new MNCS board), AIS-CODEDCO has coordinated MNCS work in the field of health.

### Poverty, the Health Situation and the National Health System

The Bolivian strategy for poverty reduction faces an enormous challenge, with a large proportion of the population living in poverty. Almost sixty percent of the population has unsatisfied basic needs, and the differences between socioeconomic groups and geographical areas are large. In rural areas, 90% of the population lives in poverty, in urban areas 39%. Infant and maternal mortality rates are still very high, again with large variations between regions and population groups. Seven major health problems are mentioned: child malnutrition, Chagas disease, malaria, tuberculosis, acute diarrhoeal diseases, acute respiratory diseases and vaccine-preventable diseases.

The national health system consists of the public health system, the social security health system and private health services (including for-profit and not-for-profit private providers). In the '80's and '90's, health sector reforms and government changes have resulted in at least seven health policy and strategy documents. There is a lack of continuity and an urgent need for a single integrated health system that guarantees good quality and accessible health

services for the entire population. Health indicators give a mixed picture; between 1988 and 1998 the infant mortality rate has decreased from 89 to 67 per 1000 live births. On the other hand, over the last ten years infant mortality has increased in 55 out of the total 315 municipalities in the country.

## **EBRP, HIPC and Health**

The objective of the EBRP in the health sector is to “reduce maternal and infant mortality rates and achieve control over the main endemic diseases”. The EBRP recognizes, at least on paper, the importance of investing in the health of the poor, but does not provide clear and quantifiable objectives and indicators to monitor these objectives.

While the EBRP provides policy guidelines, the allocation of resources from debt relief (HIPC resources) is guided by the outcome of the National Dialogue 2000. Although the Dialogue is a participatory process, in practise the influence of civil society organisations on allocation of resources in the health sector has been limited. In general, the level of knowledge about the EBRP is low among health professionals and especially among rural people.

The report indicates that HIPC has not actually released government resources; the net balance of external debt has hardly changed since debt cancellation started. The Bolivian government is obtaining new loans and creditors are charging new obligations to the total amount due. For example, in the year 2002 an amount of USD 227.9 million was added to the debt balance because of “currency exchange differences”, which superseded the amount of debt cancelled in that year! Debt servicing has changed very little between 1999 and 2002 and it is expected that in 2003, the amount of Bolivia’s external debt will exceed the amount owed to creditors before debt cancellation. A large proportion of Bolivia’s external debt is so-called illegitimate debt, because it was contracted under dictatorial governments without approval from congress.

In total, an amount of USD 1.573 million of external debt was cancelled and destined for poverty reduction, over a period of 15 years starting in 2001. This amounts to an average of approximately USD 105 million per year. Of this 105 million, allocations to health sector (related) investments are as follows<sup>65</sup>:

- USD 27 million goes to the Municipal Solidarity Fund, to fill accumulated vacancies in the education and health sectors (USD 18.5 million and USD 8.5 respectively),
- the remainder goes to the Account of the National Dialogue, allocated as follows:
  - ten percent (approx. USD 7.8 million) to improve public health services,
  - twenty percent for improvement of education services,
  - 70 percent for municipal public works programmes; a part of this goes to health related expenditures, but how much is not prescribed.

The report’s criticises the way in which these funds have been spent (too much emphasis on curative and not enough on preventive activities, allocation of a relatively large share to sophisticated urban health care centres) or not spent: there are significant balances from HIPC funds for the years 2001 and 2002 at both national and municipal level.

<sup>65</sup> See table 16 on page 29 of the report (the English version, or page 44 of the Spanish version) for an overview of the allocation of HIPC resources.

The reports main conclusions are that:

- the HIPC initiative did not constitute genuine relief for Bolivia, and has only increased the state's obligations (thus increasing the fiscal deficit or drawing on funds from other planned investments)
- taken the share of illegitimate debts and the amount already serviced by Bolivia, it is unjust and immoral to continue debt service payments
- the allocation of HIPC resources disproportionately benefits middle classes and does not address the roots of the health problems of the poor
- the capacity for planning health interventions and spending needs to be improved
- the economic growth model in the EBRP is exclusionary and overoptimistic
- although the country has taken important steps towards a more participatory democracy, there is insufficient support for social oversight instruments
- international donors should pay more respect to conditions on transparency that they themselves impose, and actively support instruments such as the MNCS.

## Nicaragua – Health in the Poverty Reduction Strategy

Case study by Ana Quirós Viquez (Cisas, October 2003)

Summary by Wemos

The PRSP of Nicaragua (ERCERP, the Spanish acronym for Reinforced Strategy for Economic Growth and Poverty Reduction) was approved in August 2001 and has been implemented for over two years. This case study analyses the goals of the ERCERP in the areas of health, nutrition and population, in how far they were met, and the allocation of HIPC resources to this area.

### ERCERP in Nicaragua

The ERCERP has four pillars (economic growth, human capital, vulnerable groups and governance) and three cross-cutting themes (environment, decentralisation and equity). Health aspects are included in pillar II and III.

Civil society groups have criticised the drafting process of ERCERP for its limited consultation with the population. Other points of criticism include the narrow definition of poverty, which leads to inadequate prioritisation, the failure to secure sufficient financing, and the fact that most projects and programmes already existed and were merely renamed without being evaluated for their poverty impact. An important omission, in the eyes of civil society, is that there has been no debate on the role of international cooperation and lending institutions. With regard to its health content, Civil Society Organisations criticised ERCERP's narrow vision of health and its exclusive focus on reproduction and children under age five.

### Expenditures on Health and HIPC relief

The amount of spending on pillar II (Investment in Human Capital) is insufficient by far to cover the needs in this area. Of the total ERCERP budget, 12.4% is allocated to health, nutrition and population. Per capita spending on health was USD 23.20 in the year 2002 and

USD 22.08 in 2003. While considered important by the government, it is not enough and the amount spent is the smallest in all of Central America.

The percentage of HIPC funds allocated to health was 8.31% in 2003 (USD 20.1 million, on a total health budget of USD 121.0 million). The intention of HIPC relief was that it be considered as an additional fund and be designated for poverty reduction. According to the case study, neither condition is fulfilled, and a relatively large share of HIPC funds goes to covering balance of payment deficits.

## **Fulfilment of ERCERP goals in the area of health**

An evaluation of the intermediary indicators shows that, of the 17 health-related indicators, only three are expected to be met, nine are below what was expected and for five there is no data. One of the Millennium Development Goals farthest from being reached (ERCERP appropriated most of the Millennium Development Goals, or MDGs) is the reduction of maternal mortality. Evaluation is complicated because different sources give different values for the indicator and the government has changed its definition. According to the government, satisfactory progress has been made in providing access to reproductive health services, but the evaluation by World Bank and UNDP deems it unlikely that the goals in this area will be met.

Regarding nutrition there is mention of bringing about behaviour change, but the main policy to address child malnutrition consisted of adding micronutrients to certain foodstuffs, showing a focus on the manifestations rather than the causes of malnutrition. Nicaragua has formulated "National Politics of Population", but these were not referred to in the ERCERP and no major commitment regarding its implementation have been established. Plans for sexual education programmes were halted due to pressure from the Catholic Church.

## **Conclusions**

For the past twelve years, the focus of health policies has been on modernising the health sector and improving coverage and quality of services, but the improvement in health has been minimal. The ERCERP has not provided the promised results, and demonstrates a narrow concept of health care. In addition, its proposed policy measures focus on manifestations rather than on causes of ill-health.

The definition of a National Health Plan and revision of the Politics of Health 1997 – 2001 are expected to be launched in the coming months. The National Council of Health, reactivated in 2002, is participating in this process and has created a sector-wide health board with participation of the international aid community. Representatives of the international community consider these discussions on a sector-wide approach for cooperation as important advances. This process offers an opportunity to incorporate the necessary changes into the ERCERP, the main challenges being:

- consider the health sector in an integrated fashion
- to designate the required funds
- review the allocation of these funds within the sector
- that international cooperation be flexible in modifying agreements so that they truly respond to needs, and
- measuring the real impact of agreements with the IMF (PRGF) on the PRSP, because currently they appear to be moving in opposite directions.

# Uganda's Poverty Eradication Action Plan (PEAP) and Resource Allocation to the Health Sector

Case study by Uganda Debt Network, Uganda, November 2003

Summary by Wemos

## Introduction

In 1999, the PRSP approach was introduced by the World Bank and IMF to strengthen low-income countries' efforts to fight poverty, by encouraging pro-poor budgeting, implementation of poverty focused policies and aligning donor support. This provided a window of opportunities to improve the heavily under financed health systems in these countries. In 2003, the Uganda Debt Network (UDN) took a closer look at whether the PRSP process in Uganda<sup>66</sup> delivers on these expectations and contributes to increasing investments in the health sector. The case study is based on a desk review and interviews with government representatives, civil society organisations and donors.

## Health indicators: progress and stagnation

Health indicators in Uganda are showing a mixed picture. Successes are booked in reducing the HIV prevalence rate from 6.8% in 1999 to 6.2% in 2000 and reversing the decline in immunisation rates in the 1990s. The coverage of health facilities has increased considerably. Progress is made in malaria, TB, guinea worm and measles reduction campaigns. The abolition of user fees in 2001 contributed to a remarkable increase in service utilisation (OPD attendance) from 41% in 1999 to 84% in 2002. On the other hand, infant, child and maternal mortality rates are stagnating, with infant mortality among the poor being 80% higher than among the non poor. The number of assisted deliveries is declining from 25% in 1999 to 20% in 2002. Service quality is poor, due to lack of (qualified) staff and shortage of drugs especially in the remote areas. Only 53% of approved posts are filled with trained health staff.

The poor are proportionately more likely than the non-poor to use the public sector. In 2002, for instance, of household in the poorest quintile who consulted a health facility, 44% used a public facility, whereas only 19% did so in the top quintile. Poor women are less able to access care for the problems associated with child birth.

## Health expenditure trends

Uganda's health budget shows an increasing trend since 2001. Currently, 3% of its GDP and 9.5% of the government budget is allocated to health. Total per capita expenditure is around 15 USD, of which 9 USD is public spending. The Ministry of Health estimates that around 28 USD per capita is needed to cover a basic package of health services through government and NGO units, as indicated in the Health Sector Strategic Plan (HSSP) covering the years 2000/1-2004/5. The HSSP initiated a shift in budget allocation from secondary and tertiary services to primary health care. Allocations to district health services<sup>67</sup> have increased from 32% of the government health budget<sup>68</sup> in 1999/00 to 54% in 2003/04 while the share of

<sup>66</sup> Uganda calls its PRSP the Poverty Eradication Action Plan (PEAP)

<sup>67</sup> including district lower level health units, district health management, district hospitals and Private not-for-Profit hospitals and lower level units

<sup>68</sup> including development partner budget support, but not project support

hospital services declined from 22 to 12%. The share of the sector's expenditures financed by donor projects (as opposed to Government revenue and budget support) has fallen from 59% of the 1999/2000 budget to 31% in 2003/4.

The overall financial requirements for HSSP implementation are far from met. This translates into significant under-funding of HSSP priorities including reproductive health services, human resources and health infrastructure.

## **The PEAP and Health: the strategies**

Uganda prepared its first PRSP or Poverty Eradication Action Plan (PEAP) in 1997, which was revised in 2000 and under revision now. The PEAP is widely praised as a comprehensive yet realistic poverty reduction strategy grounded in a Medium-Term Expenditure Framework (MTEF). Spending on key poverty-reducing activities, such as Primary Health Care, is protected through the Poverty Action Fund (PAF), ensuring that policy promises are backed up with financial resources. However, concerns about its implementation are beginning to emerge. Recent figures show that growth targets have not been met, the public deficit is rising, and that the gap between rich and poor is increasing. For Uganda to reach its poverty targets, the economy will need to grow by 7% per annum; at present, the growth rate is 4.5%.

The PEAP recognises health as key to poverty reduction and focuses on the development of basic health services and disease control programmes. But neither the analysis nor the strategies presented in the health component of the PEAP is consistently poverty focussed. There is a lack of disaggregated data, limited discussion on the causes of health inequality and financial barriers for the poor, and issues like non-communal diseases and disabilities remain unaddressed. The PEAP lacks indicators to monitor short-term progress in implementation, nor does it mention indicators for the health impact of reforms in other policy areas, like employment. There are no details on financial requirements and options for resource mobilisation for the implementation of the HSSP.

## **Budget formulation and macroeconomic concerns**

The health sector comprises the Ministry of Health and various partners. It exists to promote better health outcomes through the monitoring and provision of preventive and curative health services. Its responsibility stretches not only to the public provision of services but also to supervision of the private sector, which provides a significant proportion of health care in Uganda.

The allocation of the health sector budget is a participatory process, based on discussions with stakeholders in the health sector and based on principles and strategies derived from the PEAP and the Sector Wide Approaches (SWAPs) through Sector Working Groups and the MTEF. The determination of the overall health budget however, is noted as non-participatory. Sectoral budget ceilings are set in the MTEF which is developed by the Ministry of Finance Planning and Economic Development (MoFPED) with little or no participation of line-ministries and other stakeholders.

The MTEF ceilings reflect the fiscal targets for maintaining macro-economic stability as a condition for accessing IMF loans<sup>69</sup>. The IMF is requesting Uganda to control inflation at 5%

<sup>69</sup> IMF provides 'soft' loans for low-income countries under the Poverty Reduction and Growth Facility (PRGF)



and reduce the fiscal deficit to 6.5% of GDP by 2009/10. These targets require a limit on total government spending. This policy has led to a ceiling<sup>70</sup> on expenditures in 'non-productive' sectors, including health, based on the argument that both increases from donor inflows and limited absorptive capacity in these sectors would disturb the already vulnerable macroeconomic fundamentals.

The opportunity offered by the application to the 60m USD grant from the Global Fund grant for combating HIV/AIDS, TB and Malaria,<sup>71</sup> which is delivered outside the MTEF, to raise additional resources for health, has led to resistance by MoFPED. The Ministry argues that the influx of additional funds into Uganda's economy would lead to excess liquidity, 'Dutch disease' and macro-economic instability<sup>72</sup>. A number of policy analysts and macro-economists have contested this argument. They feel that macro-economic and security concerns are being given priority over human development in PEAP implementation. They point out that spending restrictions are a key limitation on the ability of social sectors such as health to achieve their PEAP objectives.

## Conclusions and recommendations

The resource gap as indicated in the 2001 HSSP was not solved, despite recent increases in the health budget. Health ceilings are based on macroeconomic assumptions rather than health needs. This means that Uganda will not be able to meet the Millennium Development Goals (MDGs) health targets and human rights obligations.

The macroeconomic concerns used to restrict further increases in health spending (by accessing additional donor funds) are over-exaggerated. MoFPED and donors should realise that meeting ambitious economic growth targets requires a healthy population and therefore adequate investments in health. Health must not be regarded as an outcome of economic growth, but as a prerequisite.

The trade-offs between macroeconomic targets and investments in health and poverty reduction should be assessed and made subject to public debate, part of the PEAP review process.

The PRGF, Country Assistance Strategy (CAS) and other PRSC programmes that support PEAP implementation should be developed with full involvement of line ministries, parliament, civil society, and be subject to public scrutiny.

The revised PEAP (and MTEF) should reflect the budgetary requirements for the health sector plan. The government should increase domestic resource mobilisation (through progressive taxes). But with a GDP of 300 USD per capita, Uganda's domestic resources are too limited to cover the financing gap for health. Donors should support the ministry of health to increase its spending capacity and make sufficient funding available. Civil society should monitor implementation of the budget and service delivery at (local) level.

It is important to appreciate health and its rightful place as 'productive' investment. Keeping with the specific focus of PEAP, health sector policy should not lose sight of the pro-poor focus in planning. It is necessary to involve all stakeholders to ensure ownership of the entire process of resource allocation starting with planning.

<sup>70</sup> Ceiling refers to 'caps' on health expenditures for each financial year based on a macro economic estimate of a 'non-inflationary' limit.

<sup>71</sup> Funding is for a 5 year period.

<sup>72</sup> The government contests that Uganda will turn down all future offers of donor aid because of the impact on macro-economic stability. Instead, it will focus on the quality rather than the quantity of its donor support.

## Health in the Poverty Reduction Strategy – Bangladesh Perspective

Case study by Development Organisation of the Rural Poor (DORP), December 2003

Summary by Wemos

This report is the result of the first year of monitoring the impact of the PRSP (process) on the health sector by the Development Organisation of the Rural Poor (DORP) in Bangladesh. The report addresses (a) the level of involvement of the poor and their perception of the I-PRSP and (b) the health content of the I-PRSP and its impact on the health budget.

In Bangladesh, 60 percent of the population lives below the poverty line and although the poverty situation has slightly improved, the rich-poor gap has widened over the years. There is a heavy dependence on donor support and donors have a large influence on government policies. On the other hand donor support is at risk due to governance problems, such as widespread corruption, a gap between policies and practise and sudden mid-stream policy changes. The government embarked upon the PRSP process in the year 2000, prepared an interim PRSP (I-PRSP) by 2002 and will draft the final PRSP this year (2004).

DORP, on the basis of their extensive experience with poverty reducing programmes in rural areas, emphasizes the importance of a bottom-up approach for poverty reduction and the linkages between poverty and health. Through focus group discussions (FGDs) in twelve sub-districts (Upazila's), they have gathered the perceptions of a range of local people about the I-PRSP and the PRSP process. The main messages emerging from these discussions are that:

- there is widespread ignorance about the I-PRSP among the population at local level
- people at grassroots level are more concerned with service delivery than policies, as a consequence of the wide gap between policy and practise in Bangladesh
- foreign donors are seen to have more influence on policies than the local population, which undermines willingness to contribute financially
- there is widespread discrimination against the poor in delivery of health services
- community clinics, established as the main vehicle for grassroots level services, are reportedly closed in many places
- many people, especially the poor, depend on traditional health service providers
- outdated administrative rules inhibit service delivery and cause apathy among health workers

The constitution of Bangladesh recognizes the right to health, but the country's health sector still has a long way to go toward improving the accessibility, availability and acceptability of health services. The government's health expenditure is not strictly pro-poor; participation in and decentralisation of decision making are limited. Although the number of hospitals and hospital beds doubled between 1980 and 2000, it remains insufficient by far. Besides, most of the increase consisted of private hospitals/clinics, which are unaffordable for the poor. They depend on public health services, in which physicians increasingly neglect their official duties to tend to their private practices.

A National Health Policy was formulated in the year 2000, which identified the limited expansion of the number of health care institutions (relative to population growth) and low

public spending (less than USD 4 per capita) as key factors for the fragility of the national health system. The budgeting system in Bangladesh does not apply clear policy guidelines or estimates of future financial resources; allocations are made on the basis of the historical budget. In the health sector, the allocation of resources is based largely on the size of beds and bed-days and number of staff in the facilities (not considering out-patient treatment). This leads to wide differences in district per capita allocations, which are not explained by differences in health needs.

The I-PRSP identified increasing resources as one of the first challenges for the health sector, including through a higher allocation from the national budget, more donor assistance and increased household spending on health (according to the ability to pay). In addition to spending more on health, the I-PRSP emphasizes spending better and spending on the right groups (reducing inequalities in health).

Critics state that the I-PRSP gives a sound diagnosis of development and poverty in the country, but lacks a vision for the future and does not present a plan to combat the widespread problem of corruption. Consultations have taken place, but of limited nature. With regard to health, also few remedies are offered, there is no estimate of the amount of resources needed and the paper does not mention the absence of proper monitoring or systems for accountability.

No impact of the I-PRSP on resources for health has been noted yet. The paper mentioned an option for micro-insurance but failed to clarify how this insurance could be materialised and the idea is not taken up in the Mid-term Plan 2003/4 – 2005/6. Despite the importance that the I-PRSP gives to investing in health, the country's investment budget shows a decline in the per capita allocation on health, population and family welfare. The allocations to other sectors, including education but also debt repayment and defence, have increased in both absolute and proportional terms. In addition, the health and education budgets both show under-spending, while over-spending occurred in the case of debt repayment and defence.

The full PRSP is expected to be finalised before the end of 2004, offering an opportunity for government, civil society and international donors to address current deficiencies and to take steps towards realising the right to health for all. The case study report includes a number of recommendations for different actors.

The government is requested to indicate what would be the ideal budget (necessary to achieve the Millennium Development Goals) and how much it can provide (clarifying its position), introduce health insurance and increase the health budget to at least 2% of GDP, adopt an all-out strategy for combating corruption and decentralise the health system. Participation of people at grassroots level needs to be institutionalised in decision making and in the implementation and monitoring of policies. Strong directives and example setting from the top are necessary to halt preferential treatment for elites in health services. For many years to come, local people will depend on traditional health service providers, and therefore these should be recognised and trained.

NGOs are called upon to provide health credit to the poor and vulnerable, establish independent monitoring mechanisms, and raise awareness among ordinary citizens about the right to health and their entitlements.

International donors can assist the government in decentralising the health sector, request that the government allocates an optimum amount of resources to the health sector, introduces participatory budgeting and cooperates with NGOs that provide health services to the poor. Donors should beware that their interventions are pro-poor and, for example don't push the government towards commercialisation of the health sector that will mostly benefit the higher income groups.

## **Do PRSPs deliver? Ghana Case Study**

Case study by Gilbert Buckle, National Catholic Secretariat, Department of Health, March 2004

Summary by Wemos

This case study, commissioned by Wemos, seeks to assess whether the Ghana PRSP 'delivers for health' by looking at the health content of the PRSP, its link with resources for health and their allocation and the role of international development partners in decision making on these issues.

The case study finds that the health content of Ghana's PRSP is duly related to existing health policies and has increased the focus on inequities in the country's current health situation. On assessing health gaps, the PRSP looks beyond the income dimension of poverty and also addresses other factors that limit access to (health) services, such as gender and social structures. The health targets in the PRSP are linked to the Millennium Development Goals (MDGs) and focus on reducing child and maternal mortality and increasing access to health services in the poorest regions.

Whether these objectives suitably address the existing inequities and their underlying causes may be subject for debate. The case study mentions that there is broad stakeholder support for the health sector component of the PRSP and its planned interventions. The implementation capacity of the Ministry of Health appears to be the main concern. However, the case study also states that there is no properly organised consumer group with a focus on health specifically, and that civil society participation could have been better secured and done much earlier in the process.

The percentage of the national budget allocated to health was increased substantially over the last years (to 12% of the national budget in 2003). Although not credited with this increase (as it was initiated before) the PRSP is recognized as having strongly supported the government's commitment to keep increasing the health budget. Budgeting guidelines from the Ministry of Finance requested that all sector budgets be linked to the PRSP. The PRSPs health budget aims to increase the overall allocation to health, increase recurrent expenditure at district and sub-district level, increase capital expenditure at sub-district level, and new allocation criteria for the poorest regions.

Not all the funds required for implementation of the health interventions planned in the PRSP are available yet. About 50% has been pledged and it is uncertain how much will be actually received. The Ministry of Health has adopted a 'wait and see' attitude and focuses on prioritisation and commencing implementation with funds available so far.

The budget formulation process is perceived to be transparent and decentralised, with evident inputs from different stakeholders. These included a focus on human resource development, staff accommodation and expansion of exemption programmes. Bilateral donors (Danida in particular) have supported the government's decision to increase staff remuneration in the health sector. In the light of the acute loss of health workers, the increase of staff emoluments was considered a strategic intervention by the Ghanaian government. The government managed to overcome resistance from the WB/IMF team in this regard, who argued that increasing salaries would lead to inflation and erode macroeconomic gains.

In the last 3 to 5 years, a substantial share of donor funds for the health sector has not been accessed. This has not only to do with the lack of human capacity in health. There are restrictions on the use of donor funds (most funds cannot be used for staff motivation, remuneration and at times not for infrastructural development), and the government is not always able to provide the matching funds required for donor fund release.

## **Involvement of Health CSOs in the elaboration and implementation of the Kenya PRSP/ERS**

Case study by the Consumers' Information Network (CIN) of Kenya, May 2004  
Summary by Wemos

CIN conducted a case study about health and the PRSP in Kenya, with a focus on the involvement of health CSOs (Civil Society Organisations) in the elaboration of the Kenyan Poverty Reduction Strategy. The main aim of the study was to gather information to facilitate an informed, transparent and inclusive participatory process.

Kenya is a country marked by large inequalities and this inequality is reflected in highly unequal access to health care services. Moreover, the capacity of health care services has been in constant decline over the years, and the budgetary provision for health (per capita government health expenditure in 2001 USD 6; or 7.8 per cent of GDP) is far insufficient to meet the growing population's health requirements. Budgetary allocations are not pro-poor, and the system is plagued by lack of accountability and transparency, corruption and high levels of bureaucracy. The increase in the number of health institutions, which is recommendable in itself, is not reflected in the budgetary provisions for drugs and other health services.

Revenues from cost sharing in health (introduced in 1989) represent approximately 7% on the non-staff recurrent budget and are expected to rise to 30% of non-staff expenditure over the next five years. The government has recently drafted a national social health insurance bill that is meant to transform the National Hospital Insurance Fund into a National Security Health Insurance Fund covering both outpatients and inpatients.

The Ministry of Health (MoH) remains by far the major employer and provider of health services in Kenya, although traditional and private providers play an important role too. Several CSOs are engaged in the provision of health care services at the primary level, including NGOs, mission/religious organisations and welfare associations. There is very little

consultation between the MoH and the private health sector in formulating policy or even in coordination of response to health problems.

The Institute of Economic Affairs has listed a number of factors that may have contributed to the decline in health indicators that occurred in the late 1990s. These include financial constraints, high population growth, inefficiency and corruption, poverty, the emergence of new diseases (AIDS and Rift Valley Fever) and resurgence of others, and the inconsistent and poor implementation of policies. Many development plans and the health policy put emphasis on preventive health care provision, but this has not translated into practise.

The Kenya Health Policy Framework (1994) aims at transforming the role of the MoH from service provider to regulator and policy maker. Measures include decentralisation of management, provision and financing of health care, encouraging a more active role for individuals and communities and stimulating competition amongst health care providers. The "Kenya Health Policy Framework Implementation and Action Plan" was developed to operationalise the plan and the Health Sector Reform Secretariat established in 1996, followed by a Ministerial Reform Committee in 1997. To implement the reforms, the National Health Strategic Plan (1999 – 2004) translated the policy objectives into programmes and activities.

Implementation of the plans has been slow and hampered by several problems, including institutional weakness, reluctance to delegate responsibilities, inadequate information and "a decentralisation policy that seems to be more concerned with promoting financial sustainability than enhancing access to health care".

CSOs and private health service providers are rarely involved in formulation of health policies in Kenya. The Health Policy Framework of 1994 did not have an input of CSOs and does not indicate how other players will be involved in policy formulation.

Kenya adopted an I-PRSP in June 2000 and then started the process for formulation of a full PRSP. The PRSP is linked to the National Poverty Eradication Plan (NPEP) which was launched in 1999 and has a 15-year timeframe. The PRSP is seen as a short-term strategy which seeks to implement the NPEP in a series of three-year plans. A Medium Term Expenditure Framework is linked to the PRSP.

The development of the full PRSP took approximately eight months. The case study gives a detailed description of the consultation process, which took place at national, district, divisional and community levels. In terms of health content, the Kenyan PRSP did not set forth any new policy on health, but rubberstamped existing policy and emphasized government's commitment to implement the same. No analysis was made of existing policies and whether they reduce inequity in health or of any implementation problems.

The new government launched the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC) in June 2003. It is based primarily on the governing party's (NARC) manifesto and its Post Election Action Plan, but takes into account the previously prepared PRSP. The importance of health for economic development is recognised. No analysis of its health content has (yet) been made.

Over 500 civil society organisations (CSOs) were involved in the PRSP process, but their influence on the process and content of the PRSP have been limited. Therefore, the case states that there has not been 'effective involvement' of (health) CSOs. On the other hand, CSOs seem not to take the PRS process seriously. Otherwise they would have made sure to have an impact on it, as they do with other issues such as the review of the constitution. In the preparation of the ERSWEC some consultations with civil society have taken place but less than in the PRSP process.

The case study recommends that CSOs give the PRSP/ERSWEC the seriousness it deserves and use the budget process as a way of monitoring and influencing policy decisions and their implementation. It emphasizes the need for strong linkages by CSOs both vertically and horizontally, i.e. including people from grassroots to high-level decision makers and strengthening each other through sharing information and experiences.

## Health and the PRSP in Ethiopia

Case study by ETC Crystal, October 2003

Summary by Wemos

In March 2003, ETC Crystal conducted a case study to assess the process and impact of the PRSP process on the health sector in Ethiopia. The study found that so far, the PRSP process shows no impact on the health policies, while the potential health impact of economic policies was not addressed. The PRSP process however did lead to efforts to improve donor coordination. The potential added value of the PRSP process still has to materialise. This requires a much stronger attention for the weaknesses in the current health sector programme and the linkages with other policies.

### Impact on health policies

The PRSP consultation process in Ethiopia took place at the same time as the formulation of the health sector strategy. The latter was basically an extension of its predecessor, while the health component of the PRSP merely summarised the health sector strategy. Thus, the PRSP consultation process failed to inspire the health sector strategy, e.g. by strengthening the pro-poor orientation, providing a framework for inter-sectoral collaboration or addressing capacity problems at local level.

### Impact on the health budget

The PRSP aims to increase the health budget from 5% (2000/1) to 8% of the total government budget in 2004/5. At the time of the study it was too early to judge the impact on the national budget. Public expenditure on health is around 1 USD (!) per capita, while an unknown share of donor contributions to health remains off-budget. The health programme is grossly under-funded, while under-spending is also a big problem. Also, the recurrent budget is insufficient to match the relatively high level of investment in physical infrastructure. In addition, just 2,3% of the interim HIPC debt relief granted to Ethiopia was allocated to the health sector, of which 88% goes to capital expenditure and 12% to recurrent costs. Donors are discussing possibilities to improve the funding base of the PRSP, harmonize procedures and a possible channel support through the ministry of Finance. This could in turn reduce access for NGOs to donor funding.

## **Impact of macroeconomic policies**

The macro-economic chapter of the PRSP lacks concrete analysis and strategies, though it points at fiscal austerity, economic discipline and private sector initiative as the basis for economic growth. There is no mention of the trade-offs for the social sector of the tight fiscal discipline, nor is there any attempt to assess or monitor the social and poverty impact of the proposed policy reforms.

## **Impact on civil society participation**

The World Bank and IMF qualified the 'strong ownership and broad-based participatory process' as one of the strengths in Ethiopia. But the Christian Relief and Development Association (CRDA), an umbrella organisation representing 70% of all NGOs in Ethiopia, felt it had little influence on the PRSP process. CRDA developed recommendations for the contributions that NGOs can make to combat poverty.





## Colophon

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