Strategic Options for World Bank support to Africa in Health, Nutrition and Population.

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Health improvements in Africa have been slower than in other regions, and some countries are experiencing reversals. Even where health is improving, poor people are not necessarily benefiting. While the burden of non-communicable disease is growing, treating communicable diseases remains a priority for poor people. The numbers of malnourished children are rising, and population growth and reproductive health will be priorities for at least the next decade. Attacking those priorities will not be easy because Sub-Saharan Africa faces unique constraints in improving health outcomes for poor people, including weak institutional capacity, the heavy influence of external partners, a poor social, political, and geographic environment, and the unprecedented burden of HIV/AIDS.

Today's realities

The significantly lower health gains in Africa over the last 20 years seem to be largely accounted for by a very low level of progress among the poor. The mortality of the poorest income quintile in Africa appears significantly higher—still more than 200 per 1,000—than the level of the same quintile in South Asia, about 140. Africa's health improvements appear to have occurred mainly among the higher income groups, with the poor-rich gap increasing between the 1980s and the 1990s. The largest gap is for under-five mortality, which is much less sensitive than infant mortality to biological and genetic variations. The findings suggest that formulating national health strategies on the basis of aggregate mortality will not improve health, nutrition, and population outcomes for the poor.

AIDS has devastated many African economies. Estimates suggest that annual per capita growth has come down by 0.5 to 1.2 percentage points in half the Sub-Saharan countries. Those hardest hit could lose as much as 8 percent of per capita gross domestic product (GDP) by 2010 and as much as 20 percent by 2020. Public health spending on AIDS alone exceeded 2 percent of GDP in 1997 in 7 of 16 African countries, where health expenditure from public and private sources on all diseases accounted for 3–5 percent of GDP. Zambia lost 1,300 teachers in 1998—about two-thirds of the number of teachers trained each year.

Africa is not one place, and there are exceptions to every generalization, but relative to other regions, Africa faces specific challenges in improving the state of health, nutrition, and population among the poor:

• Geography, environment, culture, and conflict have distinctive effects on the prevalence of disease, and on the supply of and demand for health services.
• Institutional capacity in Africa is limited.
• Donors influence the health sector more than in any other region.
• AIDS puts an unsupportable burden on health systems, in ways both quantitatively and qualitatively different from other regions.

While all other regions in the world are looking at better health services and outcomes over the next 20 years, Sub-Saharan Africa is alone in anticipating further deteriorations in its health services and a stagnation or worsening of its health outcomes, especially among the poor. The few successes in disease control (vitamin A, river blindness, fertility reductions) or health policy (new WTO rules on pharmaceutical patents) are insufficient to meet the unique challenges facing Africa: the severe institutional and human capacity constraints and the adverse geographical, political, and cultural circumstances.

Health, nutrition, and population challenges in Africa have grown so quantitatively different from other regions that they have become qualitatively different. Many indicators relate to challenges outside of the health sector, such as availability of clean water, female education, or access to food and markets. The following sections address what the Bank's response should be to this situation and where Bank might have a comparative advantage in responding to the health, nutrition, and population crisis in Africa.

Why and how the World Bank should be involved

The Bank cannot address all determinants of better health outcomes, and so should focus on its areas of comparative advantage over the many other development assistance agencies working in the region. Client countries, development partners, and staff suggest that the Bank should use its capacity to advocate and influence policymakers. They also say that the Bank should continue to transfer resources to support investments in health, nutrition, and population. They say, in addition, that it should focus its non-lending work on four broad areas: macroeconomic and fiscal policy, multi-sector action, health systems, and health financing.

Because poor health, malnutrition and high fertility perpetuate poverty, and because the Millennium Development Goals incorporate health, nutrition, and

population outcomes, the World Bank has to be involved in improving health, nutrition, and population outcomes among the poor. However, there are many determinants of outcomes, and they interact in ways not yet well understood. There are no simple solutions to improving outcomes, or organizing and financing health systems to best contribute to those improvements. The World Bank can help client countries find locally appropriate solutions that build upon global knowledge and experience.

The Bank needs to make strategic choices in determining where to focus its limited staff and operating budget in addressing the many determinants of health, population, and nutrition outcomes. It is extremely difficult to reach agreement within the Bank on what the institution should not try to do regarding health, nutrition, and population in Sub-Saharan Africa. The immense scale and scope of the needs in the region can compel staff and management to take on a seemingly infinite list of issues: household behavior, community-based interventions, quality of care, medical education, disease control, surveillance, health information systems, and so on. But to have an impact, the Bank should resist the urge to become engaged in areas outside its comparative advantage, however compelling.

The Bank has a comparative advantage over the many development assistance agencies working in Sub-Saharan Africa's health sector and should focus its knowledge transfer, policy advice, analytical, appraisal, monitoring, and evaluation on:

• Influencing macroeconomic and fiscal policy as it relates to health, nutrition, and population.
• Ensuring that policies and investments outside of the health sector have a positive impact upon health outcomes.
• Helping client countries to develop effective service delivery systems.
• Ensuring that resources are effectively mobilized and employed in ways that achieve the greatest impact and protect households from impoverishment due to illness.

Improving HNP outcomes through economic and fiscal policy

There are clear opportunities to improve health, nutrition, and population outcomes among the poor through fiscal and economic policy. Taking advantage of these opportunities at country level will require a sustained dialogue within and among the relevant government, ministries, and agencies—as well as between government and its international development partners. Improved operational and policy dialogue at the country level and stronger linkages between the social sectors and the central ministries (finance, economics, planning, local government, treasury) can change the functioning of the health sector. To ensure added value for client countries, the dialogue must be rooted in solid sector knowledge and understanding.

The share of public spending allocated to health and the way poverty reduction

strategies address health, nutrition, and population suggest that decision makers do not appreciate that better health and nutrition and lower fertility can reduce poverty. Without better policies, resource allocations, and implementation efforts, increasing health expenditures will not improve health outcomes for the poor, and debt relief will not reduce poverty.

The health sector would benefit from working closer with the central ministries on decentralization, civil service reform, taxation and financial management. Sector-specific knowledge and policy advice will be required to develop policy frameworks, inform agendas for reform and monitor implementation—to ensure that economic and fiscal policy, public sector reform, and civil service reform have an impact on the Millennium Development Goals.

Increased spending or economic growth alone will not improve health outcomes

Without better policies, resource allocation and implementation, increased health expenditures will not improve health outcomes for the poor, and debt relief will not reduce poverty. In Sub-Saharan Africa, as in the rest of the world, health outcomes are related to income and to spending, but the relationship is far from linear. Ghana has been performing significantly better than Côte d'Ivoire despite its lower income, and Madagascar better than Malawi. These examples highlight the tenuous link between inputs and outcomes. In the poorly performing countries, there is substantial risk that any additional resources—such as HIPC—would produce inadequate results if they are simply poured into health and education systems as they currently operate. Improving health outcomes among the poor will require significant improvements in allocative and technical efficiency, as well as more effective targeting of services. Policy reforms and strategies to resolve constraints to effective service delivery are required to convert expenditures to outcomes.

Better intra-sector allocations can improve the impact of public expenditure

Each country will require individual support to get the most from new resources and new development approaches. No formulas or simple ratios (salary/non-salary, primary/tertiary, recurrent/investment) will allow the IMF or macroeconomists in the Bank to assess whether health expenditures are allocated and disbursed in a manner that will best reduce morbidity and mortality—or whether such intra-sector allocations are pro-poor. Moreover, reallocating expenditures within the sector is not a simple budget exercise.

Conditionality or triggers on allocations of public expenditure—as incorporated in many Bank structural adjustment and investment loans and more recently in

adaptable program loans—can have the wrong effect. Why? Because of weak budget and accounting systems, a lack of knowledge about public expenditures, and poor appreciation of the real constraints facing many African governments. A budget overrun by the tertiary hospital, a nurses' strike, or a civil service's decision to raise salaries must be financed—there is little political choice, even if that means reallocating away from resources set aside to procure drugs or maintain facilities as agreed.

A large proportion of public expenditure on health, sometimes as much as 60 percent, is still allocated to the national teaching hospital in the capital city, which tends to serve the rich disproportionately and provide less cost-effective services. Reallocating resources away from tertiary care toward primary care has been a common ambition, but it is not straightforward. It generally will not occur unless alternative sources of financing are found. They are always protected politically; reducing their budgets in order to increase those of primary facilities can result in shortages that are very visible because of their location in the capital city, and reducing their size or level of operations is an unlikely option.

Only in the most unlikely circumstances is it politically and socially feasible to close or downsize national referral hospitals or other prominent hospitals or medical institutes (whether in Accra, Dakar, Nairobi, Washington, or Sydney). The unit costs of hospital services are greater than those of primary services. Many hospitals serve as teaching centers or national laboratories, and some deliver primary care (albeit often not efficiently) to local populations. Conditions and triggers may be helpful in holding governments accountable to commitments. But specific experience and knowledge of the situation are required to prevent ignorance and naiveté in the design of such conditionality and to ensure that they have meaning.

There is a need to distinguish between health strategies that will reduce poverty and those that will respond to the needs of the poor(est); these are overlapping—but different—objectives. Most PRSPs promote the former at best. PRSP drafts so far show little focus on either targeted or focused pro-poor services, posing the risk that debt relief will support expenditure patterns that will not benefit the poor. Improving health outcomes in Sub-Saharan Africa will require the development and support of targeted social sector policies to accompany growth in income.

Progress toward the Millennium Development Targets could be achieved through a pattern that primarily benefits the better-off while largely bypassing the poor—or through strategies that focus on gains by the poor, reducing poor-rich differences. There is thus a strong case for modifying the way health and poverty goals

are defined—to focus policies, strategies, and investments on resolving conditions prevalent among the poor. If countries are encouraged to stratify measurements by income and residence, it could help refocus the attention of health and development planners on the needs of the disadvantaged.

There is a great need to develop health sector expertise

Taking full advantage of opportunities to support national health objectives through macroeconomic instruments and dialogue requires a solid understanding of the health sector—its performance, sources of inefficiencies and inequities, and options for improvement. That understanding, to be shared by the World Bank, the International Monetary Fund (IMF), and the government, should extend beyond simply looking at aggregate spending on health. Constructive health sector analysis includes examining how resources are actually used and managed, as well as what is achieved. As a critical first step, analytical work—including public (and private) sector expenditure reviews and benefit-incidence analysis—is necessary to guide investment in health by government and its partners. To ensure success, Bank staff will need to monitor whether the increased resources through debt relief and adjustment lending (in particular, Poverty Reduction Support Credits) are improving health, nutrition and population outcomes, and attaining the Millennium Development Goals.

Health sector expertise is required to ensure that economic and fiscal policy—and government-wide reforms—contribute to efforts to improve health outcomes. The role of the World Bank in health, nutrition, and population cannot be reduced to resource transfers alone (such as PRSCs). Policy advice, knowledge transfer, and monitoring remain critical—and require sector expertise. Early experience with debt relief under the HIPC Initiative shows that government decisions may not always respond to the conclusions of sector analysis—or reflect stated commitments to reduce poverty. Several HIPC countries have used the initial proceeds of debt relief to invest in hospitals or high-tech treatment for higher-income groups. In 2000 Mauritania invested most of its additional allocation in equipment for its tertiary hospital. Senegal allocated HIPC funds to build a secondary hospital—although the Ministry of Health had proposed allocating the funds to meet the recurrent cost requirements to enable the existing primary level infrastructure to deliver services.

Coordinating sudden and large increases in resources with the expansion of capacity is delicate. Health specialists can work with the Bank's country economists to ensure that programs anticipate and deal adequately with such problems. While part of the resources should be used to build public sector capacity over the long term, improved short-term capacity will be required to manage the influx of resources. In many cases, health specialists can work with the ministry of health to outsource central government responsibilities to a variety of local government or non-government parties,

including private sector institutions and contractors. Such approaches are becoming more accepted in Sub-Saharan Africa.

Even if strategies and expenditure programs build on global knowledge and experience—and appear to maximize both public and private sector capacity to improve health outcomes among the poor—implementation will have to be closely monitored. Experience with sector-wide health programs has demonstrated the importance of monitoring activities, processes, expenditures, and impacts—to ensure accountability for stated aims. In many cases, monitoring by the government—working with World Bank health specialists and other partners—can ensure that obstacles are readily addressed, and facilitate dialogue with external financiers when unintended results call for revisions in strategy.

Early PRSP lessons have highlighted areas that would benefit from greater coordination between the IMF and World Bank macroeconomists and World Bank and other agency health specialists:

• Allocating appropriate budgets to the health sector.
• Understanding the impact of slow economic growth, political instability, and cultural factors on human development indicators.
• Reducing disparities in the allocation of public subsidies for health care by region and income groups.
• Analyzing the benefit-incidence of public spending on health.
• Addressing civil service and wage policy constraints that hold back health sector reform.
• Highlighting the effects of taxes, tariffs, and pricing policies on pharmaceuticals, medical equipments, and other health consumables.
• Reforming budgets, including dimensions of decentralization and performance-based budgeting.

Medium-term expenditure frameworks can help in addressing concerns in the distribution of the budget between investment and recurrent costs, and in ensuring that sector specialists and macroeconomists work together. Unsustainable investment continues to be a glaring problem in much of Sub-Saharan Africa's health sector. It has often proceeded without an appreciation of the recurrent cost implications or an appraisal of government's ability to afford such costs in the future. Hospitals may be built without fully appreciating the required personnel, operating and maintenance costs. Analytical efforts often lack economic and fiscal expertise, and the ministry of health's reassuring response that such costs will be accommodated is routinely accepted. For example, Bank-supported investment operations suggest that the responsible Bank staff (task managers/task team leaders) do not critically assess the government's long-term financial, procedural, and human capacity to support statements of commitment to supply staff, drugs, or materials to support newly constructed health facilities.

Nor is all investment accounted for in the national development program. In many countries, the health sector receives donations or supports projects without the central ministries having oversight or even being aware of special agreements between a donor and a district, hospital, or local community. The Bank can better assist client countries to prepare pro-poor, medium-term expenditure frameworks (MTEFs) based on a careful analytical, strategic planning process in which health and finance expertise work hand-in-hand.

Multi-sector action to improve outcomes

Many determinants of health outcomes lie outside the health sector. The World Bank, usually active in many sectors in a country, is considering how to effectively work across sectors, recognizing the potential synergies of multi-sector action. As one of the leading health sector partners in Sub-Saharan Africa, it has a unique opportunity to foster multi-sector action in a way that could improve health, nutrition and population outcomes among the poor.

Actions across multiple sectors can affect health, nutrition, and population outcomes

Despite country variations, almost all government agencies have some responsibilities that have potential health consequences. Occasionally these responsibilities encompass health programs for which the ministry of health does not commonly take the lead, such as school health, water quality, food safety, or road safety. Particularly challenging for the health sector are the (non-health) public programs with large potential negative health consequences—such as hydroelectric water and irrigation schemes that foster the parasites responsible for a number of communicable diseases (malaria, schistosomiasis) or unexploited positive health consequences (electricity provision to rural villages increases healthy behavior). In addition to improving health, multi-sector cooperation can support improvements in the functioning of the health sector. In Uganda cooperation between the Ministry of Health and the Ministry of Energy determined that access to electricity would enable better water pumps, more communication through radio, more effective vaccine storage, and improved sterilization practices.

Multi-sector action for better health outcomes puts a premium on cooperation across ministerial departments, across professions, and across widely varied institutional cultures. Yet cooperation is frequently difficult because of differences in professional training and values and because people working in large bureaucratic institutions tend to be responsive up and down but have few incentives to work collaboratively on a

horizontal basis. The Bank and its partners need to work with African countries to overcome these barriers—and to facilitate the introduction of incentives for multi-sector action. While there is much scope for better interaction across all ministries, selectivity requires focusing on areas promising the greatest impact, including: HIV/AIDS, nutrition, malaria and other vector-borne diseases, water supply and sanitation, school health, road safety, energy provision, and tobacco.

Client countries and development partners expect the Bank, as the only global Multi-sector institution, to address health, nutrition, and population objectives across all the sectors of its operations. If the Millennium Development Goals are to measure success of the World Bank's portfolio, staff have to be concerned with how the various specific investments, strategies, and actions in each sector affect the prevalence of hunger, the incidence of child deaths, the health of mothers, and the impact of disease (HIV/AIDS, malaria, water-borne illness, and others). Sector specialists in the Bank need to build on the insights and knowledge of overall inter-sector correlations—how girls education, electricity generation, rural electrification, water and sanitation, the construction of dams and roads, and the approaches to rice cultivation can affect morbidity and mortality.

Environmental impact assessments provide a platform for considering the health impact *of development initiatives*

The environmental impact assessments required for all Bank-financed investment projects also offer an opportunity to consider the potential impact on health outcomes. Some regional development banks promote health impact assessments separately from environmental assessments. For the World Bank, health specialists would need to work with other sector specialists to devise strategies to mitigate risk or to fully exploit the
potential benefits.

There have been efforts along these lines for HIV/AIDS, whereby all the Bank's projects in Sub-Saharan Africa—across all sectors—have been challenged to identify how they might contribute to reducing HIV/AIDS. Such an approach, applied more broadly, could greatly enhance the extent to which Bank-supported investments contribute to reaching the Millennium Development Goals in Sub-Saharan Africa. Work under way on "universal access" projects for the provision of rural water supply, sanitation, energy, and telecommunications—in Mauritania, for example—offers a possible entry point for multi-sector cooperation to improve health.

Effective systems for delivering health, nutrition, and population interventions

Why should the World Bank focus on health systems? Because they affect health outcomes. Each specific intervention or package of interventions is of course critical to those outcomes, but they need to be well executed in a larger context to be effective. The*World Health Report 2000* asserts that "the differing degrees of efficiency with which health systems organize and finance themselves, and react to the needs of their populations, explain much of the widening gap in death rates between the rich and poor, in countries and between countries, around the world."

Bringing global knowledge and experience to strengthening systems and institutional capacity is the World Bank's contribution to sustainable health system development. The Bank's focus is on building the capacity of client countries to identify and continually re-evaluate priority health concerns, set national health policies, design effective local strategies building on global knowledge and experience, mobilize domestic resources and foreign assistance, implement strategies, and monitor and evaluate their impact.

The Bank needs to address the institutional and organizational frameworks, the critical human and physical inputs, the role of the private sector, and the importance of building effective demand for health services. It needs to recognize the range of actions by African ministries of health as they work to strengthen service delivery, and it highlights challenges they face in improving the effectiveness, efficiency, and coverage of health, nutrition and population interventions:
• Overcoming workforce-related problems.
• Getting the institutional and organizational frameworks right.
• Making pharmaceuticals accessible and affordable.
• Getting the most from health infrastructure (and equipment).
• Strengthening the private sector.
• Increasing household and community demand for effective services.

The effectiveness of interventions to prevent and treat disease and malnutrition and improve reproductive health depend, more than any other factor, on mitigating or even removing systemic weaknesses. The Bank has a comparative advantage to support client countries in identifying strategies that can strengthen the ability of their health systems to deliver. The greatest challenges that face health systems in Sub-Saharan Africa today relate to human resources, organizational frameworks, pharmaceuticals,

infrastructure and equipment, public-private partnerships, and the household and community response.

Neither the World Bank nor the global health community has simple solutions to these many challenges, but African health systems are themselves tying to identify local solutions. The World Bank and other partners can help ensure that those local solutions are informed by global and regional experiences, that they build on a solid analytical base, and that they are closely monitored and evaluated to modify approaches when desired outcomes are not obtained and to share successes across the region.

Sustainable financing of health, nutrition, and population interventions

African client countries and international development partners expect the Bank to contribute global knowledge and advise policy related to financing health, nutrition, and population services—and to influence resource allocation decisions through such analysis as expenditure reviews. The challenges are significant. Most African countries lack adequate financing for health. There is no global or regional consensus on which resource allocation and purchasing strategies best protect households from impoverishment, while improving health outcomes. Nor is the available financing allocated efficiently, effectively, or equitably. Even so, countries in the region are moving to sector-wide approaches, conducting health account and sector expenditure reviews, contracting with large networks of religiously affiliated providers, and forging partnerships with other countries to improve economies of scale.

Spending on health, nutrition, and population is lower in Africa than anywhere else

Total health expenditures in Sub-Saharan Africa average 6.0 percent of GDP and $13 per capita a year (excluding South Africa), compared with 5.6 percent and $71 per capita in other developing countries, and 10.2 percent and $2,735 per capita in developed countries. Health, nutrition, and population goods and services are primarily financed by households, central government revenues, the private sector and external development assistance (grants, loans or "in-kind" goods or technical services) and channeled through the ministry of health, other ministries, local government, as well as formal and informal pooling mechanisms. A large share of spending is by households and not managed by any intermediary—it is spent directly in the formal private sector and the informal sector or for user fees at public sector facilities.

The HIPC Initiative could significantly increase public spending on health. In return for debt relief, beneficiary countries are obligated to adopt sound economic management and poverty reduction policies, with an emphasis on basic social services

(health and education). An explicit expectation is that additional public resources will be allocated to these priority sectors. There is, however, a significant risk that additional resources may not achieve their potential under existing inefficient and inequitable budget allocations and service delivery system. There is an additional risk, supported by early experience, that ministries of health will not be able to quickly absorb the large additional resources made available—and that finance ministries will thus redirect resources elsewhere. The Bank has a responsibility to propose solutions to these problems, track allocations to the sector, and assess the results of HIPC financing in the social sectors.

A lack of financing for key recurrent costs has often undermined the aims of development assistance for health in Africa, as investments in capital or training generate recurrent cost requirements (new clinics and medical equipments will need staff, maintenance and supplies, new or more highly trained staff must be paid and piloted initiatives raise expectations that all will eventually benefit). The high level of investment financing supported by development assistance can generate unsustainable recurrent cost requirements. This is one of the explanations for the trend toward pooled financing and budget support under sector-wide approaches for very poor countries (SWAps).

Strategies to manage financing for health, nutrition, and population services

The Bank has a critical role in supporting African client countries in the development of sustainable and effective health financing strategies. The evidence base for what health financing strategies will best maximize efficiency and effectiveness and respond to the needs of the poor in Africa is limited. There is weak global consensus on best health financing practices for very poor, low-capacity countries. But there are some lessons, and there is consensus on some basic principles. Bank health staff working Sub-Saharan Africa can bring global and regional experience to client countries and ensure that initiatives are closely monitored and evaluated to inform technical and political decision-makers and their constituencies.

For the majority of the rural population in Africa, insurance options are simply not there. Formal and informal risk-pooling and prepayment schemes can provide "consumption smoothing" protecting households who encounter unexpected and insurmountable medical costs. The absence of health insurance or other risk-pooling approaches (especially for catastrophic care) contributes to impoverishment, as poor African households have to draw down their assets, get into debt, or rely on transfers from other households to pay for costly hospitalization. The absence of insurance is the implicit rationale for highly subsidized (or fully subsidized) public hospital services.

The Bank has paid little attention to risk sharing, social insurance, and structured

third-party payment mechanisms in health. Instead, it has been focusing on user fees, which have been accused of being an "illness tax" on the poor. Although the Bank has done much analysis of health financing issues, it has given less attention to the institutional challenges of implementation. And it has generally failed to address the political and cultural dynamics that underlie inequalities in resource allocation to protect the poor.

Most African countries have some form of fee system in government facilities. Although fees are not the preferred option for sharing risk, generating revenues, improving resource allocation, or benefiting the poor, they can ensure the provision of basic health services in settings where financing is uncertain. Even at very low levels, fees can provide a "scarcity signal" to consumers, especially for drugs, improving management of commodities and supplies—as with the Tanzania community health funds and the many cases under the Bamako Initiative. If fees remain where they are collected, they can also generate resources, enhance quality, improve efficiency, and empower communities.

Charging fees for health care in the region generally represent an effort to "capture" household health expenditures and pool them with government financing to finance publicly provided services. They can also be employed to direct care-seeking behavior—using fees to discourage bypassing the first level of care, or removing fees for desirable interventions with less demand, such as immunization. The evidence is clear that fees are not a solution to sustainable financing, because they amount to only a modest fraction of the total recurrent costs of government health services—from less than
1 percent to at most 20 percent.

But they can cover a much larger portion of recurrent expenditures at the local level. In a study of primary health care centers in eight West and Central African countries, fees for the health care given to patients accounted for 50–200 percent of non-salary recurrent costs. Since the expense of operating local health centers is a small fraction of total public health spending, revenue generation may have a significant impact on these centers.

Addressing efficiency and equity

The allocation of public expenditure remains a powerful way to influence household behaviors and expenditures, other sources of domestic and international financing, and the actions of providers (both public and private). The World Bank is in a position to inform and influence decisions on public expenditures for health, to monitor expenditures, and to compare the impact of different expenditure patterns. Many international partners and client countries expect the Bank to contribute from this

perspective. It is important to recognize that there is no consensus on identifying a quality alth sector expenditure program, and, as described in chapter 5, the knowledge base is still weak on how to resolve the systemic constraints to improving outcomes.

Many simple ratios have been used in health sector expenditure reviews: recurrent to investment, hardware to software, salary to non-salary, primary health care to tertiary medical care. But there are few correct formulas for any of these comparisons. Budget analysis is further constrained by the effect of donor financing and nontraditional budgeting. Donor contributions—including those of many new foundations—are not tracked consistently and are often maintained "off budget." That can complicate budget analysis, though most donors can provide financing information when asked. Deriving and disseminating lessons on public and private expenditures for health and employing national health accounts should be a priority for the Africa Region.

Much of the disproportionate expenditure on the non-poor is explained by the location of health infrastructure (particularly hospitals, which consume far more resources than lower level facilities). Infrastructure drives costs, captures recurrent expenditures, and thus restricts how readily budgets can be reallocated to benefit the poor. Skewed expenditures are also explained by the location of staff (the highest proportion of health professionals is in urban areas), the care-seeking behavior of poorer,less educated families, and the revenue-maximizing attitudes of many medical providers.

The non-poor would presumably benefit more from universal public financing of a package of cost-effective medical interventions. Wealthier households are often willing to purchase private health insurance (or community health funds) when the option is available. All this means that much more consideration and better analytical foundations are required to formulate solid health policy frameworks—ones that will maximize allocative efficiency and effectively target public finance to improve the health of the lowest income quintiles.

Investment in infrastructure (capital investments) without the concomitant allocation of trained staff, supervision, behavior change and drugs (recurrent expenditures) will provide tangible outputs and perhaps the illusion of achievements from a political or community perspective—but is unlikely to affect health outcomes. In fact, 30 fully supplied health facilities with trained and well-paid staff will have a greater impact on outcomes than 300 newly constructed health centers with unmotivated staff and no drugs. This message is extremely difficult for governments and communities to accept, undermining targeted investments by many external financiers.

Ensuring the financing of non-salary recurrent expenditure is especially important—because without pharmaceuticals and medical supplies, health care is severely compromised. A large part of Bank financing has traditionally been channeled to capital investment, but the Bank has not been effective in ensuring the provision of concomitant recurrent costs. Recurrent expenditures are subject to fundamentally different risks and institutional constraints than capital expenditures. Continuous, they are driven by economic and demographic factors. Changes in recurrent expenditure are important indicators of the functioning of a health sector but need to be well understood. For example, a decreasing share of the recurrent budget going to salaries may actually indicate an inability to fill staff positions, rather than greater priority being given to non-salary inputs.

The World Bank has a comparative advantage—and opportunity—to support the rational and long-term planning of clinical infrastructure and equipment. Specific investment requests can be conditioned on acceptable plans, and the appraisal of health sector investment strategies can review the rationale for new facilities—the location, population served, referral patterns and demand, as well as the likelihood of medical and nursing staffing, pharmaceutical supply, and maintenance of new clinical infrastructure and medical equipment. Detailed geographical mapping of health facilities (private and public) justifying the construction of new health facilities and firm commitments to the provision of complementary inputs (equipment, electricity, water supply, trained personnel, and maintenance) should be preconditions to any new public sector construction. The procurement of new medical equipment should be tied to establishing or updating inventories, drafting equipment standards, and specifying requirements for long-term maintenance contracts ("life-cycle contracts").

Implications for World Bank operations

The objectives of the HNP staff in the World Bank's Africa Region are to support efforts by our client countries to achieve sustainable improvements in health outcomes, particularly for the poor, and to protect households from impoverishment due to illness. To have a sustainable impact, the institutional and human capacity in Africa's health sector must be able to lead long-term efforts. Bank operations thus aim to:

- Strengthen the capacity of client countries to identify and set priorities for their health concerns.
- Design locally appropriate policies that build on global and regional knowledge and experience.
- Mobilize domestic resources and international development funding.
- Implement effective strategies.
- Monitor and evaluate their impact on health outcomes for the poor.

Lending operations and resource transfers

New ways of doing business—include changes for the way the Bank and others transfer resources to contribute to health outcomes in Africa. The Bank's approaches for resource transfers to Africa are shifting from freestanding projects toward programmatic lending. What the Bank finances at the country level will be a part of the overall health sector budget of that country or even a part of the total public expenditure program. What the Bank will have to appraise, monitor, and evaluate thus expands in scope far beyond the traditional project. Because Bank financing actually supports any and all inputs in the sector or public expenditure program, the entire expenditure program for health becomes more important than the specific inputs the Bank financing may disburse against.

For the health and education sectors in Sub-Saharan Africa, the norm is quickly becoming the sector-wide approach (also known as a "SWAp" or sector program). This approach is consistent with the Comprehensive Development Framework and the Region's commitment to use nationally developed and owned poverty reduction strategies as the framework for development assistance. Although there are many different perspectives on what constitutes a sector-wide approach, key characteristics are: • The government is "in the driver's seat."
• Partnership between development partners and government results in a shared vision and priorities for the sector.
• A comprehensive sector development strategy reflects all development activities in order to identify gaps, overlaps or inconsistencies. The entire sector is considered when conducting sector analysis, appraisal, monitoring, and evaluation.
• Working toward, or from, and an expenditure framework to clarify sector priorities and guide all sector financing and investment.
• Partnering across development assistance agencies to reduce transaction costs for government.

This approach can provide the Bank, and other development partners, with a mechanism for assisting African governments with their overall health development strategies in a way that builds capacity and ownership, recognizes the interactions among development initiatives, and encourages other development partners active in the sector health to work in a coordinated and complementary fashion. The sector-wide approach in Ethiopia, Ghana, Guinea, Lesotho, Mali, Mauritania, Senegal, Tanzania, Uganda and Zambia—despite challenges inherent in transitioning to this new way of operating—has brought a much more comprehensive approach to the sector (reducing the number of fragmented donor projects each with its own agenda, constituency and priorities). It has improved the extent to which key systemic constraints to achieving outcomes are identified and prioritized. It has sharpened the focus on national capacity and strengthened coordination among the multiple agencies concerned.

The use of these tools will focus on where the Bank has a comparative advantage: macroeconomic and fiscal policy, multi-sector action, health systems, and health financing. But to appraise and monitor operations, and provide relevant knowledge and effective policy advice, Bank task teams need to be aware of the leading health concerns in the country and able to tap complementary technical knowledge and expertise (such as that on interventions). If Bank financing is expected to have an impact, staff must ensure that clients are continually receiving the best possible technical support and refer them to other partners as necessary.

Appraising sector national strategies, implementation plans and budgets. In Sector-Wide Approaches appraisals of comprehensive health sector development strategies replace appraisals of projects. They demand a different perspective and broader range of skills. They are not one-off events—indeed, they may be undertaken annually during joint health sector reviews as countries update their strategies based on the previous year's experience.

Today it is recognized that the poorest are not necessarily benefiting as much as they should from public expenditure or from public sector services. Benefit-incidence analysis can reveal to government and its partners how much the poor now benefit from health services at different levels and provoke assessment of existing health strategies and actions to ensure that they do benefit. As described in chapter 4, analysis of behavior, accessibility, and perceptions of quality may also be required to inform and guide national health sector reform strategies so that they respond to the needs of the poor.

Lending for such programs may also suggest different norms and standards from the traditional cross-sector Bank norms in the region. For example, disbursements of financing for health sector programs may be more appropriately "back-loaded." That is, ly small outlays may be needed initially for the required "software" implementation, while large expenditures for the envisaged "hardware" come more toward the end of the reform program. Significant Bank contributions in knowledge transfer and policy dialogue are required not only in advance of implementation, during preparation, and preceding the formal Board approval—but also through the initial years of implementation as countries refine their health sector strategies and learn from early experiences. The Bank's 2003 Assistance Strategy for Africa recognizes that staff time on health reform policy dialogue and implementation support will increase, while staff time on preparation and project management of traditional procurement and disbursement components will decline.

The Bank's support to sector strategies should explicitly complement the

technical and financial support by other international development partners, framed in a way that will strengthen the country's implementation capacity rather than undermine or overwhelm it. This suggests that separate Project Implementation or Management Units would be avoided, and common implementation procedures would be an objective. Promoting the employment of local consultants in preparation, analysis, and specific implementation tasks can help to build domestic capacity, provide opportunities that might dissuade qualified individuals from emigrating, and create links between public and private institutions.

Effective use of lending instruments. The choice of lending instruments, drafting of legal agreements, and development of legal covenants should support streamlined implementation procedures. As implementation strategies will be continually revised or refined on the basis of experience, lending agreements need to be flexible. Onerous legal covenants should be avoided, and disbursement schedules should be simplified. The Adaptable Program Loan/Credit (APL) is a newer instrument intended to support the long-term commitment to Sector Programs. Adjustment lending—as in Poverty Reduction Strategy Credits (PRSCs) or Sector Adjustment Loans/Credits—is preferred if the recipient government has the systems, procedures, and track record to convince its development partners that the prior review of individual expenditures is no longer required and that ex-post accounting and auditing is reliable and effective.

The foundation for a PRSC, which can support several priority sectors, should be a compilation of multiple sector strategies and expenditure programs. This is highlighted in the World Bank's 2003 Assistance Strategy for Africa, which outlines a progression from projects (weak country capacity) to sector wide approaches (better capacity) to budget support (strong capacity). It recognizes that budget support cannot be provided in the absence of country capacity to design and implement sector programs. Disbursements through PRSCs may become the main instrument for resource transfers to the health sector at country level, but generally the PRSC would continue to support the sectorwide program (or SWAp).

In some settings, strengthening the Bank's presence in the sector through more targeted, subsector operations may be required before engaging the country in discussions of a sector-wide approach (for example, in post-conflict situations, as in Burundi, Somalia, Sudan, and the Central African Republic). But the sector dialogue should continually and explicitly work toward this longer-term objective. And some basic tenets of sector-wide approaches should be retained, including donor coordination, analysis of key sector constraints, and consideration of linkages outside the sector.

Addressing health, nutrition, and population outside the sector

Even in countries where the Bank is absent from the health sector, it can contribute to the Millennium Development Goals for health through its work in other sectors. Although all projects are assessed for their potential environmental impact, their potential to affect health is not explicitly considered. Incorporating health impact assessments into the mandated Environmental Assessment process (something already done by the Asian and African Development Banks) could mobilize multi-sector action for health and strengthen the Bank's contribution to reaching the Millennium Development Goals.

Bank-supported public sector reform and civil service reform programs can address organizational frameworks, institutional capacity, public-private partnerships,human resources, and the civil service in the health sector. Given the international demand for health workers, sector specialists should be integrally involved within the Bank's team working on civil service reform programs. They should ensure, in close conjunction with IMF colleagues and their country dialogue, that evolving policies and strategies are appropriately and solidly guided by health sector needs and constraints.

Improving health outcomes through poverty reduction strategies

Health, nutrition, and population staff need to increase their involvement with PRSPs, public expenditure reviews, and medium-term expenditure frameworks to ensure that the synergies among all the various policy interventions are identified and fully exploited. If HNP staff can work closely with Bank and IMF staff engaged in public sector reform and fiscal management, then analysis, policy advice, and conditionalityrelated to PRSCs and HIPC allocations are more likely to serve the health-related Millennium Development Goals and strengthen access of the poor to health services.

The Bank, working with the IMF, has a unique role in the relationship between fiscal and macroeconomic policy and the health sector. Opportunities for coordinated action are exemplified in medium-term expenditure frameworks, privatization and employment policies, taxes and tariffs, financial management and information systems, and the financing of health care, nutrition services and family planning provision.

Strengthening the knowledge and evidence base

Sub-Saharan health systems, and the environment they endeavor to operate in, differ significantly from those of richer countries. Much of the strategic work undertaken inside and outside the Bank on health system organization and finance relates to high-income and middle-income countries. Analysis and evaluation targeted to Sub-Saharan Africa and low-income countries is required to build the knowledge base—and to guide the Bank's health policy advice in Africa. Multi-country analysis of experience, empirical analysis appended to country operations, and sector studies related to the following issues will be priorities for the HNP staff in the Bank's Africa Region:

• Separating the public sector role of health service delivery from its responsibilities for policymaking, planning, financing, purchasing, monitoring, and regulating.
• Defining sustainable financing strategies, including knowledge on user fees, community-based insurance schemes, risk-pooling, national health insurance, and public expenditure.
• Resolving issues of retention, deployment, and performance of the health workforce.
• Strengthening the role of private health providers (regulatory frameworks, accreditation, franchising) and outsourcing to districts, missions, NGOs, and other private organizations or companies.
• Improving the financing and purchasing of pharmaceuticals.

Monitoring and evaluation

Developing systems to rigorously monitor and assess the impact of unproven strategies is a clear opportunity to build the knowledge and evidence base and to ensure that strategies are guided by experience. Some basic standards could make an immediate difference. All investment projects (even PRSCs) should include a list of key indicators with baseline data. No operation should be permitted to proceed to appraisal without baseline data or a process for it. This is a fairly simple requirement that clients can outsource. The potential impact is immense—in knowing whether strategies are having the intended effect and in helping government communicate with stakeholders.

Nutrition information also needs to be used in decision-making. In most African countries the collection, analysis, and use of nutrition indicators in particular, deserves more attention—at all levels—to generate awareness, track the impact of poverty strategies, create demand for services at local level, and command public sector resources. Indicators in the health sector have been refined for many years. Most ministries of health know how to assess the impact of an immunization, malaria, tuberculosis, or child health program. But few African governments have considered

how to measure how changes in financing, institutional arrangements, public-private partnerships, or staffing affect health outcomes. There is a need—not limited to Sub-Saharan Africa—to develop appropriate models for monitoring health reform.

Country level partnerships are essential to complement the Bank's contribution

More than 250 international development assistance agencies are working in the health, nutrition, and population sectors in Africa, including NGOs, bilateral agencies, UN agencies, and three development banks. Mozambique has more than a hundred "development partners" in its health sector, Ethiopia 85, and Senegal and Mali more than 75. Many of these partners provide financial resources and technical advice and push for certain policy reforms. Such assistance is increasingly being coordinated around locally designed and locally owned sector development programs.

In sector-wide approaches and PRSCs, the Bank and its staff rely much more heavily on development partners (WHO, UNICEF, bilaterals, NGOs) to provide support and pursue the biomedical, scientific, and household and community-based dimensions of the country's health goals and objectives. Recognizing the comparative advantages of Bank partners is as important as focusing efforts and contributions around the Bank's institutional comparative advantage.

At a minimum, Bank sector specialists in Africa should operationalize partnerships with regional and national offices of the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Food Program (WFP), and the Food and Agriculture Organization (FAO) and with bilateral agencies working in respective countries. WHO's Regional Office for Africa is a particularly important partner for the Bank. Staff in both institutions require a better understanding of the other's expertise and modes of operating. Consistent efforts to bring the two agencies together would clearly benefit client countries. The Bank's Africa Region confirmed its commitment to the New Partnership for Africa's Development (NEPAD) at the African Development Bank's Annual Meetings (May 2002) and at the 35th Session of the Conference of African Ministers of Finance, Planning and Economic Development (October 2002).

The role and function of each type of partnership needs to be considered ahead of the Region's actual contribution. Some "partnerships" will not involve more than the stated commitment of the Bank to a common objective, approach, or way of operating. Other partnerships will ensure that the Bank remains aware of global knowledge standards and recommendations and allow for specific Bank staff to contribute the Bank's experience, expertise, or perspective toward developing global knowledge or

experience around a specific set of issues.

More demanding are partnerships where the Bank makes an explicit commitment to contribute through its operations and non-lending activities (as with the Global Fund in Lesotho and Swaziland)—or where the Bank's convening power is expected to contribute to certain objectives. The Region must budget for staff time and travel and adjunct non-lending work in these partnerships (as it has done for HIV/AIDS). If it does not, the Bank will be viewed as reneging on its commitments. Last are partnerships, such as the lymphatic filariasis and the onchocerciasis program, where the Bank acts as the trustee or coordinating agency. These partnerships can be productive only if accompanied by significant administrative funds, so they need to be considered in the context of the Region's strategic orientation and priorities.