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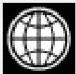

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WC Agenda 97030401.mm
Comments
Minutes

1585805

R1999-034 Other #: 3 Box # 151322B

Health Sector Strategy Paper Project Files, 1996/1997 - Health, Nutrition and Population (HNP) Strategy Paper - White Cover Comments, Minutes,

DECLASSIFIED
WBG Archives

ALL-IN-1 NOTE

DATE: 15-Mar-1997 03:11pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Agenda for WC Review Meeting

A L L - I N - 1 N O T E

DATE:

TO: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Suggested Agenda for SSP White Cover Review Meeting

The following provides a suggested agenda for the review meeting.

1. Brief opening statement by David de Ferranti about objective and audience for document as well as links to the HD network since there will be some people at the meeting from outside the sector and Bank such as IFC and PSD (the Foreword provides the context for this).

2. Brief statement about purpose of meeting and expected outcome by Richard Feachem:

. seek reaction to paper
. guidance on contents and presentation that needs further work; and
. agreement on next steps

3. Comments from Peer Reviews present (five have submitted written comments - two or three will be represented at the meeting).

4. Comments from others present (I suggest asking for comments from IFC and PSD who I expect to attend).

5. General comments from the floor.

6. Discussion around critical issues.

7. Summing up of recommendations and next steps.

CC: DAVID DE FERRANTI (DAVID DE FERRANTI @A1@WBHQB)

ALL-IN-1 NOTE

DATE: 12-Mar-1997 07:45pm EST

TO: Jacques Van Der Gaag (JACQUES VAN DER GAAG @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SSP for HNP

Jacques,

Very useful comments. Also your market up draft has been very useful - please let me have the rest.

I will be writing a briefing note on the comments I have received prior to the review meeting on Friday but I want to flag two issues raised by DEC at this early stage (they have given the paper an unusually thorough read which I really appreciate - there are no real surprises).

One set of issues go over old territory about the Musgrove-Hammer disagreement (i.e., should the state finance high-risk low-frequency events - traditional insurance economics argument; or should the state finance lower-risk more-frequent events but which are not affordable to many of the world's poor - traditional welfare economics argument). This represents two clearly opposing schools of thought. We have a bit of both in the paper right now. I am already meeting individually with people in DEC to try to arrive at an acceptable balance - I personally do not feel comfortable going all the way in either direction. This won't get sorted out by Friday.

Like you, DEC also raises the issue about the Bank's role in research Here, however, I think we need to distinguish between: "pure research", "operational research" and "substantive economic sector work". The paper makes a very strong case for increased substantive economic sector work (ESW). Somehow several people in DEC are taking us to task on research when in fact what they are really referring to is ESW which we also support in the paper. As for the actual contents of the "pure/operational research", I think we will not sort this out before Friday. In fact, I suspect that there is a substantive difference between how this issues is viewed by the by the HNP Sector Board with DEC which needs to be sorted out

before the next draft since it is a major part of the
recommendation in the paper.

CC: Richard Feachem (RICHARD FEACHEM @A1@WBHQB)
CC: David de Ferranti (DAVID DE FERRANTI @A1@WBHQB)

White Cover Review - Minutes

David:

- New product
- Gone beyond what we originally envisioned

R. Feachem:

- Final product may be different from current version

IFC - C. Gross, A. Lander

- Support basic direction
- Get enabling environment right - examples of IFC involvement ?

Peer Reviewers:

Steve Denning
- well written - HNP/Country Focus
- Highlight - what is new and different
- Sector Approach
- Unbinding Bank's services - Flexible responsive mode
- How much does ______ cost
- Knowledge management - what is best practice - w hat work/what does not work

Evans

- Articles of faith rather than fact
- Acknowledge some good successes
- Clearer evidence of what gov. cannot do
- Problems that private sector is alternation
- Does not reflect tension in sector-recognized Political Division
- Gov't not only poor in provision but also in regulation

Chris Walker

- How to reach poorest countries
- Need to justify what you are doing
    - Control Quality at entry
    - Need to move on supervision of current portfolio

PSD

- More policy advice
- Should elaborate more on policy and framework and see how current and future projects would be different
- Do private sector feasibility and studies
- absorption capacity
- Rationale for government involvement should be clearly established
    - policy environment

- study cannot ______
- feasibility studies

Jeff Hammer

- More evidence of how private/public sector does and does not work
- More modesty in _____ on both sides

Barbara Herz

- Public Sector does not work. No good evidence that private sector will be answer
- Under consumption of public and private sector
- Call for more manual presentation of study both public and private capacity and ability to respond to
- More study

Birger Friedrickson

- Realignment of sector rather than radical shift
- Zaire failed state

Susan Stout

- Need to emphasize what we already know.
- Little experience in supporting shift(?)
- Process of learning how to go forward - use specific country example

Chris Lovelace

- Move away from what client wants
- Response to

Ed Elmendorf

- Need to adapt to country specification
- Most reform process - ?
- Dealing with potential economy

Richard

- Know empirically that there is Government Failure
- Both public sector and private
- Recognizing lack of evidence
- Be modest about what can be done

David Peters

- Failure of Aid mechanisms
- Will help guide us
- Not convincing
- User charges have limit
- Insurance does not really work
- Don't really know if all public health works

D. ??

- Resource allocation
- Special processes and procedures

R. Skolnik

- Written at too high level
- Could get things at high level
- Get this
- Do right things
- Do them well
- Effectiveness of treatment
- Little to show on policy from
- Main success may be small project inputs
- Committing Bank to excellence
- Have been

Salim Habayeb

- Misallocation Problem
- Doing too much badly
- Capacity Building
- Shift government involvement but not in the case of financing.

Birger Friedrikson

- Who is audience
- Focus on Policy side for countries to use own resources more effectively
- More emphasis to pop. And demographic transaction
- Africa pop.
- Aim paper on target audience, not MDs
- Staff ratios not right

Ok

- Need to emphasize skills
- We need to have credibility _______ _____ clients.

Sandy Lieberman

- What are real choices facing Bank and countries
- What is current Bank best practice
    - what works
    - what does not work

Julie McLaughlin

- Solo financing problems
- Technical effectiveness
- Intervention token section

- Need to emphasize that sector is dynamic

Sergio

- Paper does not say what we should not do
- SAS should not guide the CAS

Eugene Boostrom

- Have been _______ on resources

Peter

- Ba_____?
- Take time to look
- Need more resources for sector work
- Special ___________ should not see a central fund

Strategy Doc

1. Very Valuable Comments
   with one or two exceptions, no substitution.

2. Dis______ment - Question of four more than contents
   Tone very important
   Sector has been operational under a paradigm that Public Sector

   Complex sector and changing

3. Next step
   Feedback

4.

Next steps: By Fridg

<u>Questions</u>

________(?) What is background - spin off publication.

Evans - Provide evidence of what can be done

Stout - Little experience - ECA, LAC

Chris - Move towards what client wants

Peters

<u>David</u>

Budget

New _____down.

New ways to do this - highlight what is new, what is balanced approach.

Private sector activities - _________ environment, ____ guided environment

N & P

HNP Mission (Not refocussed)

User Charges - sustainable financing
(User charge)
Sensitive Issue

Country specifics - each country needs to be treated in its own light

Decentralization - divestiture of __________
What ____
How _____

We have option. Make better use of them.

Inter ________ Reform

HD
Disconnect between saying and doing
- Not ____ new issues of new solutions

Kees Kostermans

- Make sure that HNP sector is involved in discussions between I.M.F. and Govt.

- Work on civil service reform: employment related to performance

- ~~connectivity → knowledge transfer.~~
  focus on health promotion and prevention.

- Have always a "multi-sectoral" team working on HNP project.

---

(16) lending to NGO's

(17) get real: focus on the end user

(18) improve alternatives analysis

(19) state what you don't know

---

(1) CODD
HDD
Policy R.D. } o

(2) T.A. focussed on capacity building for sector work at local level

(3) always start with sector assessment in the country
connect with macro-econ. assessment

(4) Exchange between Bank staff – Govt staff

(5) assessment of Govt. organization.

(6) Pilots before mainstreaming "
Bank is bad in piloting

(7) Dialogue ~~now at~~ beyond burocratic level, at political and intellectual level.

(8) Communication ↑

(9) Building capacity at carrier of projects

(10) communication within Bank

(11) consultation of stakeholder
+ feed back + participation!

(12) field presence ↑, Empower RM staff ||| training

(13) ~~[illegible]~~ focus on governance

(14) Practice what you preach – Decentralization

(15) work with NGO's as partners

For Further Discussions on HNP Topics: HDD Staff Availability for One-on-One Meetings with Resident Staff on March 20 and 21

If resident staff working in the HNP sector wish to meet with HDD staff on Thursday or Friday (March 20 and 21) to have discussions on particular issues, they can call Hoai Hong at ext. 33611 to set up appointments. The following staff are available to meet with resident mission staff in one-on-one meetings (the date in parenthesis indicates their availability):

Mariam Claeson	Child Health (Friday, March 21) (S9067)
Klaus Imbeck	Pharmaceutical Issues (Friday, March 21) (S9103)
Malayah Harper	Sector Wide Approaches to HNP Lending (Thursday, March 20, Friday, March 21) (S9057)
Prabhat Jha	Burden of Disease Analysis, Noncommunicable Disease Control Strategies (pending)
Tom Merrick	Population and Reproductive Health (Friday, March 21) (S9041)
Merrilyn O'Sullivan	Australia/New Zealand/Singapore Health Systems Study Tour (Friday, March 21) (S9143)
Claudia Rokx	Nutrition (Friday, March 21) (S9070)
Helen Saxenian	Health Finance (Thursday, March 20) (S9051)
George Schieber	Health Finance (Friday, March 21) (S9065)
Anne Tinker	Reproductive Health (Thursday, March 20) (S9031)
Diana Weil	Tuberculosis Control (Friday, March 21) (S9140)
Virginia Yee	HNP Knowledge Management Demonstrations (Thursday, March 20 and Friday March 21) (S9106)

HDD
M:\HEALTH\AGENDA.DOC
March 18, 1997 6:07 PM

SECTION I: SECTOR BACKGROUND AND DEVELOPMENT CHALLENGES

OPC

General Sect I –
– Sect II – case example not bad examples
Sec III – talk about problem
OED – what we have learned
– mapping stuff
– specific examples of what not to do
Sec IV – Reg structure
What Gov need to do to address current problems
knowledge – how Bank can

Document will be used when EDs review CAS or Projects

3/14 Friday 11.0am

Alex - Congratulation's on the meeting. I enjoyed the debate & learned a lot!

I have a 4.0pm meeting with you in my diary for today. This is fine for me but I realise that you may have other demands on your time. If you do need to reschedule I am in and free:

Tues 18 AM

Thurs 20 ⎤ All day
Fri 21 ⎦

I still don't have a computer but do have a tel., ext 36780.

Jane Robinson

Alex from Jane Rotsnuni 6/3/97

The attached table reproduced from SSP for the HNP Sector shows HDI ranks & values & GDI ranks & values from the 1996 UNDP Report.

Although the SSP report states that the analysis in the table has "factored out" the broad socio-economic determinants for the countries in the table, the HDI & GDI rankings suggest possibly otherwise.

Of those countries performing higher than expected [the best performers] in U5 mortality rates, four are in the "high" human development category, and the remaining in the "medium" development category. The two lowest ranking in this table (Honduras & El Salvador) have much higher GDI rankings, although the UNDP report's method of comparing HDI – GDI rankings diminishes the effect.

By contrast, only one country (Mexico) in the poorer performers has an HDI ranking in the "high" development category, two in the "medium" development category (Philippines & Indonesia) and the remaining seven in the "low" development category.

As HDI (& GDI) incorporates life expectancy at birth (so possibly correlation is partially predictable) and adult literacy, primary, secondary & tertiary ed. gross enrolment ratios plus GDP per capita (relative proportions for M:F in GDI), perhaps some socio-economic factors remain unaccounted for ??

Performance in U5 mortality rates for 1990
Deviation in % relative to expected

		HDI Rank	HDI Value	GDI Rank	GDI Value	HDI – GDI Rank (a)
+ 181%	Costa Rica	31	0·884	32	0·813	-5
	Colombia	49	0·840	38	0·797	5
	Chile	33	0·882	44	0·767	-15
	Korea	29	0·886	31	0·816	-6
	Sri Lanka	89	0·698	62	0·679	8
	Algeria	69	0·746	81	0·596	-22
	Honduras	114	0·576	90	0·542	0
	El Salvador	115	0·576	88	0·544	3
	Iran	66	0·754	75	0·618	-18
+ 30%	Tunisia	78	0·727	68	0·647	-5
- 31%	Cameroon	127	0·481	100	0·455	-2
	Mexico	48	0·845	46	0·755	-4
	Bangladesh	143	0·365	116	0·336	-4
	Ghana	129	0·467	99	0·459	1
	Kenya	128	0·473	98	0·469	1
	Philippines	95	0·665	70	0·644	4
	Zambia	136	0·441	104	0·405	1
	Myanmar	133	0·451	102	0·447	0
	Indonesia	102	0·641	76	0·616	4
-72%	Pakistan	134	0·442	107	0·383	-4

High human dev. 57 & above
Med. " " 58 — 126
Low " " 127 — 174

(a) "The HDI Ranks used in this column are those recalculated for the universe of 137 countries. A pos. figure indicates a better GDI rank than HDI, a negative the reverse." UNDP 1996 - page 140.

3/14/97

To Alex Preker
From Jane Robinson

Comments on SSP Board Meeting on Paper on Sector Strategy for HNP Sector (3/1 version)

I found the Board meeting fascinating and the comments made were frank and enlightening. As the meeting is fresh in my mind I am putting on paper some of my impressions. Intriguingly, many of the points seemed to be related to a paper which I did for WHO on Sustainable Development (in press) and rather than repeat them all again I am attaching a copy. In the paper I am arguing that the 1990s are an era of theoretical compromises following the failures of earlier "grand plans" by both WHO and The World Bank. Presumptious, maybe, but a cat may look at a king!!!

At the Board meeting it appeared to me that the issues discussed could be grouped under two broad headings, both of which are highly relevant when addressing health workforce matters:

1. Questions concerning the implicit theoretical underpinnings of the positions adopted in the paper.

It seemed that you (the term is used collectively) were being challenged substantially for failing to make explicit the political science issues inherent in the compromises which, almost inevitably, are made in the paper. Whether this explication is possible in a Strategic Policy paper for The Bank is an open question, but the raising of the issue was probably inevitable given the Bank's reliance in the past on economic theoretical models, and the realisation that they can provide only a partial contribution to the solution of human problems.

It was interesting that the discussion opened with a forceful statement from IFC in support of the development of market initiatives in health care; there appeared to be little further support for this position expressed in the meeting. This statement was followed almost immediately (in impact if not temporal sequence) by Alison Evans' equally powerful challenge that it is not axiomatic that the private sector necessarily provides the best alternative to government failures in the health sector. This, together with her subsequent statements on the need to acknowledge the high politics of private sector developments, and the apparently unquestioned assumption that although governments are frequently categorised as failures in service provision, they will automatically be good in regulation, appeared to have considerable support from the floor.

A significant number of the comments made in the open section which followed supported Alison's challenge, including the need to acknowledge that neither public nor

3/14/97 4.10 pm

ROUTING & REQUEST

Please...

- [x] Read
- [ ] Handle
- [ ] Approve

And...

- [ ] Forward
- [ ] Return
- [ ] Keep or Toss
- [x] Review with Me

To: Alex Preker - I came round - this is as far as I got - I'll be in until about 4.30 Ext. 36780 (Room 0.135)

From: Jane Robinson

Date: 3/14

Post-it ® 7664 © 3M 1994

private sector analyses are well done, and that therefore the knowledge bases for these assertions are poorly developed.

The further important point made later that Primary Health Care has run into all sorts of problems, not least because countries are controlled by elites and that this influences any chance of success, also rang true in the context of the health workforce. The dominance of medical interests has meant that vast swathes of activity on the part of nursing and midwifery personnel in support of the improvement of population and individual health (whether at global, regional, country or local levels) have failed to carry support from that most powerful section of the health workforce, the doctors. Not only have they failed to generate support, but the operation of the elite has frequently ensured that the activities remained completely invisible to a wider audience. This point was brought home forcibly to me when reviewing for Howard Barnum an Indonesian government paper on a proposal to develop the health workforce. There was no recognition in the paper of the considerable work carried out by WHO (including a WHA Resolution in 1992 to which all member states signed up) on the development of nursing and midwifery services in support of health for all. Instead, (it seemed to me) the government had its own agenda related to the development of a nursing workforce which would be competitive in an international health care market and (like the Philippines) a source of external revenue. (See para 72 of attached paper).

2. Questions concerning the adequacy of the Bank's resources in terms of manpower, knowledge and expertise in order to carry out what is demanded.

This discussion went beyond the not inconsiderable question of whether HNP has enough staff to do the job!! Clearly there is a considerable resource issue in the need for a more adequate base of both knowledge and skills in order to carry out the work effectively both at the centre and in the sectors. How this resource base would be obtained and maintained is a major policy issue. But there is also a question of the boundaries to Bank work. Section II of the SSP paper acknowledges the work of other international agencies but, crucially, does not give any indication of how The Bank works, or could begin to work, inter-sectorally with the agencies cited (brief mention is made on page 29). The Indonesian example above demonstrates clear overlap/duplication of effort between two UN agencies which governments, generally, will not admit either for political reasons, or in the hope of getting "two bites of the cherry". This has always been a major problem with AID and substantially reduces the cost-effectiveness of individual interventions.

3. Conclusion: addressing the power issues

It appears to me that the theoretical positions which underpin notions of social justice and equity, and libertarian views on freedom are not, at the end of the day, reconcilable. Choices have to be made, and those choices are political: (See paras 26 - 33 of attached paper.) Perhaps it has to be increasingly The Bank's role to skilfully make these options clear to governments as part of the initial negotiating and later supervision activities.

A crucial issue seems to lie in reconciling the dilemmas highlighted in the section of the SSP paper on "What developing countries say they need" (page 29). As the 4th para states: .."responding directly to such client demand is not straightforward. First it is necessary to reconcile the divergent views of the various interest groups... (client, stakeholders, beneficiaries and partners)".

It is not just their divergent views, but also the considerable imbalance of power between them which is the problem. For example, in the attached paper I argue strongly that nurses and midwives cannot be seen simply as "providers" of formal health care in the waged sector of the economy, but also as (frequently) female "generators" of health and "informal health care providers" in their roles as mothers of families, wives, daughters of elderly relatives, and community members, plus "consumers" of health care themselves in similar capacities. Therefore, it is not quite the same to treat the health labour market like any other market for commodities. I believe that this fact has been obscured by the restriction of the discussion of health labour to members of the medical profession who, as key members of most countries' elites, generate different sorts of problems, and solutions. This situation may change, as medicine becomes more than 50 % female and in some countries is *beginning* to be seen as a less prestigious career option.

Lifetime risk of maternal death,
1 in:

Niger	9
Nepal	10
Papua New Guinea	17
Yemen	8
Nigeria	13
Bolivia	26
Norway	7300
Canada	7700
Tajikistan	120
~~Kyrgyzstan~~	~~120~~
Romania	340

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 12:18pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jacques Van Der Gaag, HDDDR (JACQUES VAN DER GAAG@A1@WBHQB)

EXT.: 31991

SUBJECT: SSP for HNP

Alex,

I now have carefully read all of the SSP paper. First of all, let me congratulate you for having pulled together an enormous amount of very interesting and very relevant information in a relatively short time. It took me a while to read it all just because the paper is so rich in contents.

It was an obvious advantage for me to come in so late in the game. Because of that, I could read it with "fresh eyes". The disadvantage is that in my comments may open up old debates or make suggestions that have previously been rejected. If I do that, just ignore it.

As the paper stands now, it looks more like a "mini-WDR" than a strategy paper. Especially the first two sections (29 pages!) are full of policy analysis, leaving no stone unturned. While the information is very useful, in the end it does not go far beyond what we know from the Health WDR. That is not to say that I don't like it. In particular, the strong and repeated focus on the three central mission objectives (Poverty alleviation, Quality of people's life, and sustainable financing) is very good. I also like the strong link you identify with the 'maco-environment". Nevertheless I do wonder whether you need all this, or rather, whether you need all this here, upfront.

One option would be to move sections one and two into an Annex and start with 3.

I have no major comments on section three. It is informative, reads well and much of it is "new". Not everyone will agree with the WDR recommandations that are repeated on page 32. I do not want to restart the pseudo-ideological debate on this (which I find silly and boring). Still, you may want to clarify that some of these recommandations ("the public sector should finance..") are conditional on the assumption that the overriding objective is an increase in health status. If the objective is, for instance, to provide an issurance function, or to promote "equity" (however defined), or to keep a government in power, other recommendations might follow. (I really think that there is nothing more to the debate than confusion about competing objectives).

You may want to expand a bit on the "Research" section. As was made clear repeatedly at the HCFinancing Conference, many of the important issues are empirical ones. (how do households respond to userfees, how does the private sector respond to public subsidies, etc.). What do we buy with the $43 million? What is DEC doing? What are the key questions our research should focus on?

Section 4 is clearly the most important one. It is also the one that, I believe, needs more work. The central issue seems to be the "paradigm shift" which in turn leads to "New Strategic Policy Directions". You state the paradigm shift as: a substantial re-definition in the role of the state and non-governmental sectors in HNP. No problem with that, indeed a lot of this is already going on. And here is where I believe the paper needs more work: what is going on in this area? Where is this process going well (South Africa?) were are things going wrong (ECA?). What is happening to the role of the central government, the role of local governments, the parts played by NGOs, the for-profit private sector, during the process of decentralization? What should be happening, not just in terms of provision versus financing, but also in the area of regulation, public management reform, accountability, public information, etc. What is the experience to date with decentralization? What with increased private sector involvement? You address this on page 44, but without any further discussion. And the one place where I would have liked to see more "policy analysis (or at least a description of what is happening), is missing from the document.

[indeed, as written now, one could get the impression that the paradigm shift is a "new" idea, rather than something that is going on all over the place - for better or worse; the role of NGOs, current and future, also needs to be discussed more clearly].

Again on the research side (page 45), as it is stated the research agenda appears to be much too narrow (though I admit that the formulation does not really exclude anything). Still, again with reference to the HCFinancing conference, you may want to be a bit more specific and mention the importance of "incentives" on consumers and providers as a key area where more empirical research - trial and error plus evaluation - is needed.

I hope these comments are useful. (I may have more on Friday)

jacques.

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
CC: David de Ferranti (DAVID DE FERRANTI@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 07:45pm

TO: Jacques Van Der Gaag (JACQUES VAN DER GAAG @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SSP for HNP

Jacques,

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One set of issues go over old territory about the Musgrove-Hammer disagreement (i.e., should the state finance high-risk low-frequency events - traditional insurance economics argument; or should the state finance lower-risk more-frequent events but which are not affordable to many of the world's poor - traditional welfare economics argument). This represents two clearly opposing schools of thought. We have a bit of both in the paper right now. I am already meeting individually with people in DEC to try to arrive at an acceptable balance - I personally do not feel comfortable going all the way in either direction. This won't get sorted out by Friday.

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CC: Richard Feachem (RICHARD FEACHEM @A1@WBHQB)

CC: David de Ferranti (DAVID DE FERRANTI @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 11:23am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jacques Van Der Gaag, HDDDR (JACQUES VAN DER GAAG@A1@WBHQB)

EXT.: 31991

SUBJECT: SSP

Alex,

just some thoughts that relate to the discussion this morning.

If you make the drastic change in the paper that we discussed earlier, and put all the policy stuff in an Annex, the reader will directly be confronted with "the new paradigm". As it reads now one can get the impression that the larger role for the private sector is motivated by the failure of the public sector. But that is only because you start with an analysis of the public sector. If you would have started with describing the current failure of much of the private sector, your new paradigm may have been: a larger role for the public sector. What is missing from the paper is a discussion/assesment of the current private role.

The private sector already plays a large role: about half the financing is private; most public doctors run private practices; chances are that most of the pharmaceutical sector is private. Add to that church-based and other NGO involvement, and you find a very large "private sector". I suggest that you make that clear in the paper.

What you should also make clear is that much of the current private sector activities are by default, as a response to government failure. Failure in financing the "free care", failure in delivering to the poor, etc. Most importantly, much of this private sector activity takes place in a hostile environment: sometimes private sector activity is made illegal; sometimes there is no legal status for non-profit organizations; blanked public subsidies undermine private initiatives; the tax structure may discourage private practice, etc.

Presenting it this way, the new paradigm would be: a larger role for the private sector, not by default, but as a STRATEGIC CHOICE.

This would have clear implications for how we do bussiness, for how we approach the government. It would also underscore that we are not talking about the private sector as opposed to the public sector, but rather about the relative roles each of these sectors need to play to take advantage of the relative strenghs of the other. This would lead to a more eloborate discussion of the

various functions of the government, other than "financing" versus "provision". This should include regulations, licensing, information, mandating, quality control, tax incentives, the legal framework, etc. Implications of this strategic choice for how the bank will go about doing its "new" bussiness, and what new skills we need, follow in part from this list; currently we mostly call for "more NGO involvement" because the government fails. Instead, we should discuss with the government what it can do succesfully to facilitate the private sector, to remove obstacles, to provide incentives, and - pardon the jargon - to form a partnership with the private sector. Lessons from the experience with infrastructure are relevant here.

In the end, even this "new" paradigm is not entirely new. It would be useful to go through a handful of projects that pursue this route, and discuss the experience to date (Uruguay comes to mind).

Finally, there is no question that the bank has a comparative advantage in this area. PERs, public sector reforms, strenghthening of the legal system, strengthening the finacial sector, etc. all are relevant. One can also think of (as someone suggested at the meeting) the importance of assessing the country's general "environment" for private sector involvement in the health sector.

I hope this is helpful.

jacques.

CC: David de Ferranti (DAVID DE FERRANTI@A1@WBHQB)
CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 13, 1997 06:25am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Anthony Measham, SA2RS (ANTHONY MEASHAM@A1@DELHI)

EXT.:

SUBJECT: Health, Nutrition and Population sector strategy paper

Alex:

I'm please to comment on the white cover draft.

Overall, it's a good piece, with much to like:

- I support the main messages;
- good analysis, e.g., the methodology for assessing performance of health care delivery systems;
- clear review of where we've been and where we are now;
- lots of good country examples and boxes;
- the main messages resonate in India;
- clearly written and flows well.

Three substantive points need shoring up, in my view:

- risk pooling is overplayed. It's important, sure; neglected, true; but the financial sustainability of the sector depends on many factors, while the report - in places, e.g., p. 43 and the exec. summary - does not convey the number and complexity of factors and oversimplifies, in my view;

- sector work is underplayed. Its importance is clearly shown (pp 32-33) and the recent neglect highlighted. But then the theme is not carried through: the neglect is stated in para. 2 on page 40 but the report fails to: include a strong recommendation for action to increase resources for esw; link this to the knowledge broker role on page 45; and include the need for action in the exec. summary.

- the recommendation of links with IFC, privatization ministries, and the private sector network needs to address the current lack of fit between their predominant interest (bottom line and rightly so) and the key WDR 1993 point that investments in tertiary hospitals (where bottom line potential is highest) yield relatively scant health returns. Why not use this opportunity to interest IFC in HMOs?

Finally, the exec summary is weak. It does scant justice to the paper; doesn't flow well; and, most importantly, does not

convey the analytical rationale for the new strategic directions.

Good luck with the review and regards,

Tony

CC:	INDRA PATHMANATHAN	(INDRA PATHMANATHAN@A1@WBHQB)
CC:	SALIM HABAYEB	(SALIM HABAYEB@A1@WBHQB)
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CC:	Edwin Lim	(EDWIN LIM@A1@DELHI)

A L L - I N - 1   N O T E

DATE: 11-Mar-1997 04:06pm EST

TO: See Distribution Below

FROM: mjimenez, (mjimenez@tgm2.hbs.edu@INTERNET)

EXT.:

SUBJECT: HNP Sector Strategy

Martin and company,

As you know, I spend my 1.5-day weekends at home from "school". But yesterday morning, My flight to Boston took 5 hours longer than it should have due to the weather (I was actually on 3 flights, 2 of which were cancelled). So, I had some time to read this paper, although I was in a pretty sour mood when I did so, having awakened at 5 am to try to be on time for class at 9 am.

I don't have trouble with some of the main messages -- addressing the poor's needs, rebalancing public-private action for example. But I had 2 main comments.

1. The report argues that the Bank will "frame" questions, assess and disseminate results of research, rather than conduct it. This may be the right way to go in HNP, but there is no justification (or even a discussion) of why it might be so. This is the first time i hear of it. Granted, the Bank has not had an extensive HNP research agenda as in the past. But a strategy paper should visit that result and ask whether it is the right way to go. We all know some of the arguments against just being a "broker" of research (or is the right expression, "breaking research"?): pretty soon, the brokers will not be able to tell good research from poor research. Witness USAid. THe report would have the Bank be a data colleection agency. The right way to set strategy in this area has to be in the same way that the report claims to set strategy for operations: assess existing work, ask whether it makes sense to be only a financier versus a provider of research, and if some research is going to be provided set priorities based on needs as well as comparative advantage (I'm not sure data collection in HNP is ours). At the moment, there is NO mention of current RSB-funded work -- it's as if it didn't exist. What about the AIDS work, the work on population in Africa, Harold's nutrition stuff, the past research on the price elasticity of health demand? I would suggest the ff: (a) start a dialogue now with us (we have offered to discuss this with the SEctor Board, right Harold?) on what research in HNP should be and (b) then, discuss what should be"farmed out" versus what makes sense to do in-house. Even if we conclude that ALL analytical work should be done out-house (and the quality may indeed go in that direction) we should go through this exercise. And if some work will be done within the Bank, it is important to set priorities given budget constraints.

2. The paper makes a strong pitch for HNP spending in order to alleviate poverty. This may be an excellent idea and some of the worst consequences

of being poor are reflected in HNP-type outcomes. But the question then is: is this the best way to spend public monies in order to help the poor. There is no discussion of the alternative ways of helping the poor. THere is not even any mention made of who benefits from different types of public spending on HNP -- a growing literature within the Bank on this. This is an area that requires clearer justification and substantiation. I know that this is not a researcj paper so it may not be that important in practical terms to clean this up but...

I leave Jeff and Lant the field to comment on the use of DALYs to motivate the reforms in HNP (althought I think they're careful not to say that they should be used to set policy priorities -- not sure on this)

Other commnets:

p. 2 and the exec summar. This may not have been the intention, but the report seems to imply that the goal of poverty reduction is associated with improved life expectancy, while the quality of life is associated with improved poverty. I think the report should just say that the goals are improving human welfare through reducing poverty and enhancing productivity -- improved life expectancy and "quality of life' are only indicators.

Section 2. this can be shortened a lot by the consolidation of the policy discussions. Policies at the moment are discussed before the subsection on "health care reform strategies." In general, the report should distinguish between diagnosis and reform

p. 8, middle para says that because broad socio-economic determinants have been 'factored out', the rest should be due to interventions. The rest of the subsection concludes the opposite. This is just overstated. In fact, there's no evidence shown on how much of the variiation in performance is due to public interventions.

p. 17. The report argues that it is now possible to "focus" nutrition programs by addrssing undernutrition, micronutrient malnutrition and overnutrition. I don't see how this is focusing.

p. 26 The report argues that if there is a "gap" between the 3 % of GDP target and actuals, there should be aggressive international assistance. I'm no expert on aid effectivenss, but what's the evidence on this. If I were a poor country, there's no way I'd crank up expenses to 3 percent of GDP and then be taxed at a 100% rate. I would stay away from these 'targets" that are mechanical.

p. 30 ARe the numbers on HD lending %'s projects or values of loans?

Martin, thanks for coordinating on this one. BEfore we send the reply, it might be politic to give Alex a call to just let him know what the final points of our comments might be.

Regards,
Manny.

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The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 12, 1997 08:04pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Christopher D. Walker, EXCQA (CHRISTOPHER D. WALKER)

EXT.: 80729

SUBJECT: HNP Sector Strategy Paper, White Cover Draft -- Comments

Alex

This is much more than the usual pro forma -- congratulations on a very difficult job well done. As I am sure you already know, this is the kind of job in which it is impossible to satisfy everyone. But this is a good white cover attempt, which tries to be responsive to the earlier discussions on overall direction and priorities. Like everyone else I am sure, I have comments -- but please read them in the light of this paragraph.

I have annotated my copy of the report heavily; please borrow it if you wish. The following summarises my main points:

Overall balance -- for my taste, the draft is insufficiently focused on the specifics of the HPN sector. In particular, the operational implications of many issues which are routine for those working in the sector (e.g. the real levels of immunisation coverage; correct technology for malaria vector control, etc. etc.) will not be routine to many of those reading this document. A stronger flavour of these more "technical" issues would help to make it more HPN sector specific. Financing, rightly, has a very strong theme -- but seems to be somewhat over emphasised, and may be seen by some as the latest vertical program.

Poorest countries -- there are many references to the priority that we intend to attach to these countries, but not enough on the specifics of what we intend to do about them. p47 col1 is an attempt in the right direction (I have some specific suggestions), but the earlier discussion needs to be more focused and lead into these more. Similarly what we can <u>really</u> do about the rural poor in the poorer countries needs amplification; if its not much, maybe we should be suitably modest?

Key areas -- as I am sure others will also suggest, there are some key areas which are glossed over in the text. The key role of staffing/manpower is my personal hobbyhorse. But also how to foster good management is critical, progress here would solve many of the sector's other problems.

NGOs -- there is a terminology problem as sometimes (always?) you use non-government as exactly that, rather than the more common usage for

NGOs. This confounds the recommendations in this area. But, more importantly, my sense is that we actually say little about our strategy for working better with NGOs, leveraging their efforts, etc..

Portfolio, implementation and supervision -- the current portfolio, in reality, is little focused on. The section on p37 onwards really talks about quality at entry, certainly important, but only part of the game. As the portfolio constitutes a substantial and growing slice of the total Bank lending, from a strategic view, it is essential to demonstrate that we will do better with what we already have (especially as the signs are that the sector's performance is probably already below the Bank average). If we cannot do that, then how can you justify an even bigger slice of the cake? So, I suggest some serious discussion of the implementation and supervision problems of the existing portfolio (without being parochial, what about the virtues of proactive management, the need to be serious about projects at risk, etc., etc.) and add some recommendations in the final chapter on this. This also has implications for the staffing section --- what happened to the skills needed to supervise project implementation, for example?

I have quite a few more detailed points; let me know how I can help further.

On presentational matters:

the monitoring and special initiatives sections at the end are wrongly placed;
the story line of section IV needs sharpening;
the social contract piece (p22) needs re-writing, its bordering on the offensive at present (and we do not need to be necessarily apologetic about this subject anyway);
if your looking for cuts, much of p30-36 could go at least to an annex; and
too many boxes, cut out at least 25%.

Hope this helps and good luck

Chris

CC: Esther Babazadeh (ESTHER BABAZADEH)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 12:37pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Christopher D. Walker, EXCQA (CHRISTOPHER D. WALKER)

EXT.: 80729

SUBJECT: HNP Strategy

Alex

Sorry, one more point that I forgot last night.

The Bank's new (draft?) Strategic Compact does, of course, include several HNP measures as indicators of performance. This would in turn suggest that some clear link between the HNP strategy and the Compact would be needed?

Good luck

Chris

CC: Esther Babazadeh (ESTHER BABAZADEH)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 11:33am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Alison Evans, WDR (ALISON EVANS@A1@WBHQB)

EXT.: 39182

SUBJECT: SSP - White Cover Comments

Alex,

You asked me to provide some comments on the white cover, and specifically on the strategic focus on the role of the state and institutional reform in the HNP sectors. What follows are some initial thoughts, in no particular order. Maybe we can sit down to discuss some of them in more depth at some point.

First I should say that the document has really livened up since the earlier draft. The general message is credible, and clearly portrays some of the complexities and challenges of operating in the HNP sectors.

Notwithstanding these improvements, I am disappointed by the lack of a clear diagnosis/analysis of (what you term) 'government failure' in the HNP sectors, and am rather disconcerted by the slippage from generally weak statments about govt. failure (p23) to a strategy that appears to be favoring privatization (p24). Lest you think I have turned into a dirigiste after the WDR experience, let me share with you a few specific concerns.

1. That governments are imperfect is woefully evident, that governments are involved in many areas of provision (and even financing) that they shouldn't is also woefully evident, but without a good diagnosis of the incentive and accountability problems affecting public sector performance (from regulation to provision) we miss sight of a range of possible interventions that can not only improve public sector performance but also enhance the competitive interface between the public and the private. For example, rebalancing or refocusing on the public-private interface requires faciliting competitive pressures both within and outside government through quasi market mechanisms such as vouchers, contracting-out competitively and increased use of techniques such as co-production and user-client feedback. These, so called, 'new technologies of public action' are precisely the elements of a strategy for improving public sector performance and encouraging collaboration/competition from the private sector. We might look around for interesting lessons to be learned from the irrigation and infrastructure sectors in this regard.

2. Given that the third wave of privatization is apon us, then

the important question surely is what kind of strategy might governments with different levels of capability adopt? Where institutional capability for sophisticated financing/regulation is weak, a market-entry approach to privatization through deregulation may be better than actively transfering owernship of public facilities with all their attendant employment/political consequences. In more 'capable' institutional environments a more aggressive strategy of transfering ownership and regulation may be feasible...although still politically contentious. I do find it very curious that a case is made for private participation on the grounds that governments fail as providers when it is assumed that governments can work well as regulators! Regulation can offer as many opportunities for rent-seeking/predation as direct provision, done badly it can be extremely dangerous, done well it is often institutionally demanding. I don't see us having much experience, even in middle-income countries, of doing regulatory policy in HNP that fits different institutional capabilities .... see environment regulation for some important lessons learned.

3. On measuring health system performance... despite an interesting health regression I remain much more cautious than you appear to be in interpreting the residuals as 'indicators of system performance and policies' ....they indicate what can be explained by health policies etc...and not performance per se.

I have lots of other small comments, relating to specific points or use of data but I am sure you'll get lots of feedback on these so I'll leave my intial contribution here.

Regards
Alison

A L L - I N - 1 N O T E

DATE: 14-Mar-1997 10:52am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Alison Evans, WDR (ALISON EVANS@A1@WBHQB)

EXT.: 39182

SUBJECT: SSP - WC Review

Alex

I hope my comments didn't 'bias' the discussion too much this morning.

I fully accept your closing comments that we need to think differntly abour the Health for All paradigm, in fact I would like to have seen that stated up front. This is not to say that there are not useful elements in HfA, but it too is dangerously dogmatic in ways that are not helpful and sometimes simply wrongheaded. But.. what the strategy is currently missing is a DIAGNOSIS of the problems of public failure, the influence of institutional and political economy factors and the suggestion of OPTIONS, or as Sandy termed them CHOICES for ways forward -- that will range from new innovations within the public sector itself to an array of public-private synergistic relations to wholsale privatization.. It is in in the nature of the diagnosis, the tensions and tradeoffs that emerge and the identification of options (which may be clusters of choices) that the strategy can really make a contribution.

Anyway, best of luck for the next round.

Alison

A L L - I N - 1 N O T E

DATE: 16-Mar-1997 07:10am EST

TO: DAVID DE FERRANTI (DAVID DE FERRANTI@A1@WBHQB)

FROM: Stephen Denning, ITSDR (STEPHEN DENNING@A1@WBWASH)

EXT.: 34035

SUBJECT: HNP Sector Strategy Paper

Dave,

My sense is that the sector strategy paper is in good shape and that you were getting sensible feedback from the review meeting, which should help in further polishing the paper to ensure an even smoother reception at the OPC and the Board. I think you have a very good product, given the groundrules.

My concern is however with the groundrules. The paper contains only a fraction of the knowledge that has been acquired and ventilated by the preparation team, and this is inevitable given the format. Pressures to shorten and nuance the paper further will further reduce this fraction. One does have to wonder what the shelf life of the product will be, and the contrast with the rather large cost of the process of preparation will probably be striking.

The normal rationalization of this typical outcome is to say that "the process is more more important the product", which is to accept that the knowledge acquired will largely remain tacit in the heads of staff members, rather than being shared with the collectivity.

The idea of knowledge management is not to accept this outcome and to strive to capture this knowledge for sharing inside and outside the organization. To accomplish this a very different format is needed, and although there are no good examples of it in the Bank, there are examples in other fields that give a pretty good idea of what it would look like in the Bank. The main elements are described in the attachment.

One question is whether you would like to try to capture some of the acquired knowledge in preparing the strategy paper in this fashion before the team disperses (maybe it already has dispersed) and people get back into their operational routines.

It would not be easy or quick to finish, though groupware and other techniques could expedite the process significantly. Even if it cannot be completed (in one sense, it never gets completed) at this time, even capturing people's thoughts in electronic form will greatly expedite the task when it is attempted.

This might not be the moment to attempt it. You may want to focus on getting out the strategy paper. Helen's absence may make it problematic.

But if you could pull it off, you would have something immense potential value, and a head start on the whole issue of best practice in the HNP sector.

So if you did want to assign someone and have a shot at this path breaking innovation, this is to signify my readiness to discuss the implications and to work with your people to make it happen.

Let me know in due course,

Steve

ELEMENTS OF CAPTURING BEST (AND WORST) PRACTICE

The main elements are:

- the capturing of valid patterns of action (what works)
- each pattern contains elements such as the problem, the context, the action and its consequences, the evidence, commentary and the source of the expertise.
- patterns form networks of patterns.
- patterns of different levels of generality and differen degrees of robustness.
- patterns of worst practice (things that don't work) are also capture

  the presentation is modular
- the knowledge about the patterns keeps evolving so that the patterns are easier to update if they are in electronic form.

A L L - I N - 1   N O T E

DATE: 16-Mar-1997 05:14pm

TO: DAVID DE FERRANTI (DAVID DE FERRANTI @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Note From Steve Denning

I think Mr. Denning raises some interesting points.

I have kept a detailed record of the process so far in my project file which is quite organized. This includes the agenda and minutes to all significant meetings, including the regional consultations. It would be quite easy to write this up after we finish the exercise or if we get some downtime during the process. But I would not suggest that we get sidetracked on this right now. As it is I am spending a lot of weekends and evenings just trying to keep the main product on course and I cannot see on the foreseeable horizon when I would have time to do a write up of the process part of the exercise.

In addition to the process part which Mr. Denning refers to, the SSP has already contributed significantly to our overall HNP knowledge base in terms of:

1. An updated global health expenditure data base
2. An updated HNP status data base
3. Several background papers
4. A couple of regional papers which hopefully will eventually include a paper per region (but I eased off insisting on this during the fall when we got a negative reaction from EAP). ECA, MNA, AFR and LAC have however proceeded with their own regional strategies.
5. Possibly a main background paper if the OPC accepts our proposal for a shorter SSP.

I will follow up with Mr. Denning to explore some of his ideas which we may want to follow up on later.

CC: HELEN SAXENIAN (HELEN SAXENIAN @A1@WBHQB)
CC: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

A L L - I N - 1 N O T E

DATE: 16-Mar-1997 05:43pm

TO: Stephen Denning (STEPHEN DENNING)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: HNP SSP - Inputs during WC Review Process

Many thanx for your intervention at the time of the review meeting on Friday and for taking the time to review the document.

Mr. de Ferranti has also forwarded your comments about trying to capture some of the experience of this exercise for the HNP Network knowledgebase. I think you raised some interesting points in this regard.

I have kept a detailed record of the process so far in my project file which is quite organized. This includes the agenda and minutes to all significant meetings, including the regional consultations. It would be quite easy to write this up after we finish the exercise or if we get some downtime during the process. We could easy get the team to add some of their own ideas through groupware.

Furthermore, most of the correspondence relating to the SSP has been through electronic mail. I have been saving all of this in electronic form in a multiple cross-referenced database according to:

1. Topic areas;
2. Regional inputs;
3. Main partners (OPC, Peer Reviewer, Core Team Regional teams, outside comments, etc.)
4. Stages of the process.

In addition process, the SSP has already contributed significantly to our overall HNP knowledge base in terms of:

1. An updated global health expenditure database;
2. An updated HNP status database;
3. Several background papers;
4. A couple of regional papers which hopefully will eventually include a paper per region. The ECA, MNA, AFR and LAC papers are at an advanced stage; and
5. Possibly a main background paper if the OPC accepts our proposal for a shorter SSP.

It would be good to get together with you to discuss some of this after I get caught up a bit. Would you be

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 05:25pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jaime Biderman, OPRPG (JAIME M. BIDERMAN@A1@WBHQB)

EXT.: 32257

SUBJECT: HNP Sector Srategy Paper - White Cover Review

1. At the request of Myrna Alexander, I reviewed the draft strategy paper and have a number of comments and suggestions that I hope will be useful. From an OPR/EXC perspective, I focused mainly on its treatment of past performance (since the "evaluative content" of many sector and thematic papers has been considered weak by OED/CODE) and its treatment of the ongoing portfolio (since OPR/QAG are responsible for overall portfolio analysis and monitoring).

2. Analysis of Past Performance. Although the paper has a brief discussion of lessons learned from past experience (p. 35 and 42, Section III), it lacks a full and systematic analysis of completed operations and lessons learned. A stronger historical perspective would strengthen its evaluative content, and serve as a key building block for the proposed strategy. Specifically, a detailed analysis of the outcomes and lessons of completed and evaluated operations (with specific examples of what has worked and not worked and why) should be considered. In particular, it would be interesting to explore why social sector projects have had better outcome and substainability ratings than other projects, as noted in recent OED Annual Reviews and mentioned in the recent QAG sponsored HDD Review of Portfolio Performance in the Human Development Sector. Incidentally, OPR has remapped OED's categories such as "human resources" into the sector classification used in operations; interestingly, this shows that in fact, for the 61 HNP operations completed and evaluated in FY80-96, 38% had unsatisfactory outcome ratings (compared to 19% for education and 32% Bankwide). If one looks only at operations completed and evaluated more recently (in FY90-96) 33% of the 20 HNP operations had unsatisfactory outcomes. So it seems that the better than average "social sector" results cited above are due to education sector projects. In any case, my point is that you should use this opportunity of a sector strategy paper to try to get underneath these percentages and tell a good story about the results to date and draw out the lessons for the future. In this connection, you may want to stay in close touch with OED since (as you probably know) they are currently preparing a study entitled "Assessing Development Effectiveness in HNP". You should also be aware that the members of CODE's sub-committee are reviewing ICRs that are relevant to sector strategy papers, including this one.

3. Analysis of Ongoing Projects. After establishing a historical context based on the results of completed projects, I would suggest a more complete and nuanced discussion of ongoing projects than what you have under "Portfolio Performance" in Section III. In particular, you may want to use the "projects at risk" concept which we introduced in the FY96 ARPP and the Portfolio Improvement Program, since the IP/DO ratings may not give you a good sense of the status of a relatively young portfolio. By the way, the proportion of HNP projects "at risk" (including potential as well as actual problem projects) as of 3/11/97 was 35% (compared to 30% at the end of FY96). Also, when you use IP/DO ratings and make comparisons to Bankwide averages, this should be based on age-adjusted analyses. The above-mentioned HDD review of portfolio performance provides some analysis using the projects at risk which could be updated and used for the strategy paper. It also provides some discussion of the issues faced by ongoing problem projects which is not fully reflected in the strategy paper. For example, many of the problems cited in the portfolio review are generic (project management, counterpart-funding, civil unrest), others may affect HNP disproportionately (implementation in federated states or in decentralized settings) and some are sector-specific (e.g., procurement of drugs). In short, the story on the performance of the active portfolio could be a lot richer and contribute more effectively to the proposed strategy.

4. Regarding supervision requirements for the ongoing (and future) portfolio, you note that the average supervision cost for HNP projects was lower than average in FY96, but the cost in staff weeks (19 s/w) is among the highest for major sectors (and has been the highest for several years). Neither the dollar nor the s/w costs include trust fund resources which as you point out, loom very large in the HNP sector. Hence, a key issue for the future is how to get better results for a rapidly growing portfolio (13% p.a. in volume or commitment terms?) with high supervision requirements (even if you assume improving quality at entry).

5. Miscellaneous comments:

(a) In your discussions of knowledge management, there is no reference to the dissemination and use of evaluation findings. At the risk of belaboring this point, the network should review, digest, synthesize, and disseminate ICR and audit findings, and strongly encourage all staff to learn and apply the lessons derived from completed Bank operations.

(b) The role of water and sanitation improvements is not highlighted in your discussions of improved health status. How important are these?

(c) The Executive Summary needs more than just editorial help. I found it quite ahistorical (you immediately

launch into refocused missions, new strategic directions, roles, approaches and reforms with no discussion of the past and present record of the sector). It is also quite loose and unclear.

6. I hope that these comments and suggestions are helpful. I would be glad to elaborate on any points at the review meeting tomorrow and OPR/QAG can provide further assistance as needed.

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
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A L L - I N - 1 N O T E

DATE: 12-Mar-1997 05:05pm

TO: See Distribution Below

FROM: Samuel Lieberman, EA3PH (SAMUEL LIEBERMAN@A1@WBHQB)

EXT.: 82539

SUBJECT: comments on WC draft, HNP SAS

Alex:

I generally support the story line laid out in this draft, especially the attention given to faltering government-delivered health services and ways of remedying and moving beyond these government failures while also addressing market failures in the health field. Thank you for the earlier opportunities provided to comment on work in progress. In regard to this draft, there are several points that caught my eye--these were not discussed, at least in depth, during last month's retreat and may deserve an airing at the WC meeting.

1. rural risk-pooling--the Executive Summary (para.vi) proposes that the Bank promote such arrangements. But this suggestion is not grounded in analysis in the main text; nor does the exisitng literature and world experience seem to point to promising approaches in this regard. I thought Crease's presentation earlier this week on this topic was revealing and sobering. This option should be played down and left for active experimentation by country.

2. special initiatives--this list shows up at the very end of the paper and not plugged into the main discussion. Why are such initiatives needed and how was this list arrived at? Where is TB? How does the apparent need for such initiatives square with the sort of lending instruments pushed in the paper?

3. the UN family--a lot of space is given through text and boxes to what are UN partners are doing. But none of this has any sort of analytical or critical flavor. Is it wise and credible to go so softly on organizations which in many instances and issues are not very effective?

4. limits to reform of government services--there is a nice section on this on p.24 (left column). But something seems to get lost in the transition after that discussion to the next sections, dealing largely with health care financing. This is a crucial point for many Asian countries. That is, how to wean them off direct delivery to a different set of instruments with the same priority of assisting the poor. This needs some finetuning.

see you on Friday, SL

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A L L - I N - 1   N O T E

DATE: 12-Mar-1997 10:20am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Peter Heywood, EA3PH (PETER HEYWOOD@A1@WBHQB)

EXT.: 87326

SUBJECT: Comments on SAS White Cover

Alex,

Getting the document to this stage is an extraordinary achievement. I salute the effort you have put into pulling such a diverse set of information, with inputs from such a large number of people, into a single document. It is a huge task.

I have some comments on each section, then some more general comments.

Section I tells the story well. I think the message about the threefold challenge of continuing poverty, malnutrition and poor health, variability in performance of systems and inadequate resources comes through well.

This section would benefit from four additional points which would also strengthen the link to section IV;

1. reference to, and illustrations of, the widespread problem of many public subsidies not actually reaching the poor but in fact often being captured by higher income groups.

2. some concrete examples of the way in which poor technical content contributes to the overall inefficiency and limited effectiveness of the health systems e.g. inadequate cold chains, inadequate clinical skills, spraying in most malaria control programs, HIV/AIDS programs which do not direct enough attention to other STDs etc.

3. manpower questions, including conditions of service, quality of training (pre-service and in-service), and distribution underlie many of the problems of poor performance in health systems.

4. there is a related need to place priority on capacity building, particularly for problem identification and strategy formulation and management.

Section II. The section on targeting strategies sets the scene well.

Two important issues which could be added, perhaps under the "ongoing challenges" beginning on p 15 are incentives for health workers and sustaining the gains already made.

On the question of incentives IMCI provides a good example. If it is to implemented staff will have to spend a lot more time with each child doing the assessments and discussing treatment with the caregivers. In many systems there is little incentive (e.g. low salaries and poor or inadequate supervision) for this to be done. Unless incentives change it is likely that the enthusiasm generated by the new initiative will last for a short time only.

Sustaining the spectacular gains made in immunization coverage in some countries is also going to be difficult unless the enthusiasm and motivation is maintained once the donors move on to something else. Again, changing institutions and incentives are critical to the maintenance of these new levels of performance.

These issues, together with attention to the related issues of manpower and capacity building, provide a link to "improving the performance of government-run systems" (p 22), part of which relates to improving health care financing, a link which is missing at the moment in this section.

Section III.

Whilst you have taken a fairly descriptive approach to this section, there is a place for more emphasis on the effects of the decline in sector work, particularly in terms of project design and quality at entry. The lack of sector work decreases the effectiveness of what the Bank is financing in some countries. This relates back to the point above about limited effectiveness, incentive and sustainability. When these have been ignored the Bank ends up financing rather useless activities but often never knows because little or no attention was paid in project preparation to the issues limiting effectiveness of the system. This is critical to informed and effective policy dialogue with governments. The pressure for shorter project preparation times together with the reduction in resources for sector work has had a serious impact on the quality of projects.

I also feel that the section on "Portfolio Performance" needs to highlight the problems of inadequate project supervision, frequently tied to rapid turnover in Task Managers and decreased supervision budgets.

Under staffing issues you lament the paucity of projects on health financing and then tie it to a plea for more economists in the sector. You make this connection without any comment on whether economists have been involved to date or analysis of the reasons why governments might be reluctant to borrow for

stand alone financing projects. (In a way I find this analogous to the special pleading for stand alone nutrition projects that has been the subject of some discussion in the past. I feel that the conclusion is the same in both cases - both should be considered as possibilities when the occasion is appropriate, neither should be seen as usual.) This approach is also curiously at odds with the emphasis in some sections of the document on "sector-wide approaches".

Overall, I feel that this section is too timid about the inadequate resources (the numbers and type of staff, and the wherewithal to do the job) which have been available in recent years, the effect of new and old Bank processes and the need for change in each. It is, after all, setting the scene for Section IV on mission and strategic vision.

<u>Section IV</u>.

The section on "New Strategic Policy Directions" captures the emphasis in the earlier sections. I suggest that the "second" (p. 44) be re-worded to read something like

"Second, the Bank will emphasize the need to <u>increase the efficiency and effectiveness of health services to obtain better value for money</u>, including re-balancing public and non-government involvement."

On "New Approaches to Credit and Loans", I find the figure difficult to understand. It seems to indicate increased emphasis on "capacity building". This is inconsistent with the table on p 35, column 2 which shows that the capacity building component of the portfolio has decreased in the last decade.

<u>Action Plan</u>

This is where it comes together and I have a number of comments.

1. The emphasis on country dialogue and strategy is important.

2. The section on management of the HNP sector does not carry forward a number of the issues raised earlier or seems to lose the sense of priorities. Thus, the first priority should be staff development, then business processes and portfolio performance, followed by knowledge management and change processes. And the earlier concerns about sector work and supervision need to be highlighted here.

3. The Special Initiatives seem to be unconnected to the rest of the document. Up to this point the document is almost silent on particular disease problems. And then there is a list which, with the exception of the first, is composed entirely of specific diseases from which there are some strange omissions (e.g. TB, PEM). These raise the prospect of

more internationally-driven, vertical, and ultimately unsustainable programs, it is just that the Bank will now drive them rather than WHO. These will presumably require considerable resources, need to be country specific if they are to be effective, and are not addressed in any way (general or specific) in the SAS itself.

A better approach would be to ensure that there was adequate money in the regional budgets for focused sector and policy work on these issues, something which is acknowledged in earlier sections to be decreasing and in need of further resources. If better sector work was done on these problems (including through the use of experienced consultants) they would be more likely to be included in projects, designs would improve, supervision would be better, they would have a better chance of being sustainable and, overall, the Bank would be seen as making an important contribution to their control.

<u>Issues which are not addressed and should be.</u>

As mentioned above, the document is almost silent on two related questions which underlie the effect and sustainability of all our work - manpower and capacity building. These are fundamental to sector reform (including financing). It is most important that they are reflected in the earlier parts of the document and in the strategy to be pursued by the Bank. As mentioned above, resources for capacity building in bank projects has decreased in the last decade and we need to reverse this trend if any of the proposed strategies are to payoff.

<u>Format</u>

Overall, I find the document rather cluttered. I feel that there are just too many boxes and figures. It looks to me as if, taken together they occupy approximately 30% of the document. I would be shorter, clearer and less cluttered without quite a few of them.

In summary,

1. It is a great effort to get it this far in such a short time. I suggest the following be taken into account in preparing the next version -

2. The role of misdirected public subsidies, manpower, capacity building, incentives and sustainability in faltering service delivery needs to be acknowledged.

3. There is a need to link the "faltering services" theme to the "financing" theme and to recognize that whilst better "financing" will improve sustainability it will not, of itself, solve the incentives, manpower and capacity building questions or guarantee value for money.

4. Within the Bank, the problems of inadequate resources for sector work and supervision, and their effect on portfolio performance, need to be given more prominence.

5. The Special Initiatives section does not seem to be related to the rest of the document and needs a lot more discussion. An alternative is to deal with these issues through projects by increasing resources for sector work and supervision.

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A L L - I N - 1 N O T E

DATE: 12-Mar-1997 05:39pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Hugo Diaz, SA1PH (HUGO DIAZ@A1@WBHQB)

EXT.: 82368

SUBJECT: White Cover HNP Sector Strategy Paper

Alex,

1. Barbara asked Kathleen Finn and I to read the White Cover and give you some feedback. We have a few observations on specific points which are detailed below.

Change of Paradigm

2. We would certainly agree that we need to persuade governments that public policy in the health sector needs to include supporting the efficient development of the private sector. And we (the Bank group) need to do much more to support governments in this effort. At the same time, in countries such as Pakistan, where the private sector is underdeveloped or absent (except for quacks) in many areas of the country, we will need for the foreseeable future to continue supporting efforts to make government services more effective and efficient. The draft White Cover recognizes this point, I think.

Specific Observations

3. In page v, one of the three objectives of the Bank's mission in the HNP sector is said to be poverty alleviation, which would entail "addressing the health, nutrition and population needs of the world's poor and other vulnerable populations such as women, children, the disabled and elderly". This wording dilutes the poverty emphasis to the point of rendering it meaningless; if all of these groups were to be included under "poverty alleviation", there would be hardly anybody left out (i.e., only non-poor, adult, non-elderly, non-disabled men are left out in this formulation). We should be very clear that when we talk about "poverty alleviation" we are talking about members of poor households, of whatever age/sex. This is not to say that women and children are not faced with particular problems, but we should not confuse this point with the poverty focus.

4. In page 9, it is stated that per capita health expenditure in the USA is 700 times the corresponding figure in Nigeria. The draft does not clarify whether expenditure in local (Nigerian) currency has been converted into US$ at the official exchange rate or at a PPP-adjusted exchange rate. Looking at the table in

the same page ("Regional Patterns of Health Expenditure"), it seems likely that the official exchange rate was used. It is questionable whether this is an appropriate procedure. It substantially exaggerates the differences in terms of purchasing power, which is after all what matters.

5. In the same page, there are several statements which compare what the governments of some poor countries are spending on certain basic services (e.g., basic package of immunization) with what the WDR1993 said such services cost, on a per capita basis (the figures in US$ for these comparisons are calculated at official exchange rates). The WDR1993 gives a single per capita (US$) cost figure for all countries. This must be an average figure; even within low-income countries, there are differences across countries in the dollar price (reckoned at OERs) of health labor, and there would also be differences in the physical productivity of labor (and labor costs are the most important component of health services costs). And there are undoubtedly other reasons why US$ unit costs of various bundles of health services would differ across countries. Before we start using this single figure from the WDR for comparisons with actual per capita spending of individual countries, do we have any idea of what the dispersion around this average is? Aren't these comparisons too crude to conclude anything from them?

In addition, we need to distinguish between the per capita cost of providing a certain package of services to the entire population of the country, and the per capita fiscal cost (calculated over the entire population) to the government of subsidizing consumption of the said package for a subset of the population. See (6) below on this point.

6. The argument in page 26 is not clear. The draft says that

[A country with a per capita income in the range of US$300 to US$800, must spend in the range of 1.5 to 3 percent of GDP, or the equivalent of 7.5 to 15 percent of government revenues, to secure a stable source of financing to pay for a minimum package of essential preventive and clinical services needed by the poor and vulnerable groups (approximately US$10 per capita).]

There are several problems with this statement. First, as already noted, to talk about the "poor and vulnerable groups" as the focus of attention for public policy, with "vulnerable" defined in the way it is defined in the paper, is meaningless. It means pretty much the entire population of the country. Secondly, what does the draft mean when it says that "a country" must spend these sums? Is the paper referring to what <u>the government</u> must spend --the fiscal cost of paying for the minimum package, for whatever groups of the population we feel deserve getting this subsidy? The reference to equivalents of government revenues in the above-quoted paragraph suggests that this is indeed the case. But in that case, the per capita cost (to the government) would not be US$10, but less. For example, if we

would all agree that: (i) the government should pay for 100% of the cost of the package <u>for the poor</u>, (ii) it should pay 0% of the cost of the package for the rest of the population; and (iii) we have estimated that one-third of the population is below some agreed poverty line (i.e., are poor), then the per capita cost to the government (calculated over the entire population) would be US$3.33 rather than US$10. The cost to the government would then be equivalent to 1.1% of GDP in a country with US$300 of GDP per capita, not 3%. In other words: we cannot make any statements about how much the government of any country should spend on the "minimum package", as a percentage of GDP, unless we also specify what is the policy regarding who gets and who does not get a net government subsidy in connection with consumption of the package, specify how much is the subsidy as a proportion of cost, and quantify what these eligibility criteria mean in terms of percentages of the population.

7. In page 45, the paper recommends that the Bank "will emphasize the need... for fiscal control over health care expenditures (public and private)". The argument that governments need to be concerned with controlling <u>private</u> health expenditures is also made earlier, in page 28. In pages 26-27, concern is expressed over the "tendencies towards expenditure escalation" which "has been observed to be much greater in the private sector than public sector in middle-income countries". I think that this concern about escalating private expenditure, and associated recommendation for government intervention, needs to be justified. Its welfare rationale is not obvious. Why should this be a concern of public policy? If a rich 80-year-old wants to spend a fortune on some high-tech health intervention which will extend his life by 3 months, why should the government care? One possibility would be if he is the victim of fraud --e.g., the provider falsely claims that the patient's life would be extended by much longer than available data can justify. So there may be a rationale for certain kinds of government intervention in this context. But we need to explain with some care under what circumstances would government intervention be justified.

8. The paper makes reference to several international initiatives. While we may not be able to judge the impact of the most recent three (Cairo, Rome and Copenhagen), perhaps we could say a word about the influence in practice of Alma Ata (1977) and the World Summit for Children (1990).

9. In page 17, the 2nd to last para. refers to "fluoridation of salt" and "iodization of water". Shouldn't it be reversed?

10. In page 44, the paper recommends that the Bank provide direct support for governments to become more effective in providing a health care safety net. In this context, you may want to stress the importance of addressing governance issues, institutional capacity building and accountability (i.e., tie with page 23, "factors that influence systems performance").

We hope this is helpful and wish you good luck in finalizing the paper. Best regards,

Hugo

CC: Barbara Herz (BARBARA HERZ@A1@WBHQB)
CC: KATHLEEN FINN (KATHLEEN FINN@A1@WBWASH)

A L L - I N - 1 N O T E

DATE: 17-Mar-1997 01:19pm EST

TO: Dean Jamison (DEAN JAMISON@A1@WBHQB)

FROM: Hugo Diaz, SA1PH (HUGO DIAZ@A1@WBHQB)

EXT.: 82368

SUBJECT: Cross-Country Analysis

Hi Dean,

Thanks for sending me the paper on "Measuring Regional and Country Performance" (Annex III of the HNP Sector Strategy Paper). I will not be able to attend the meeting, but I have taken a look at the draft.

I think this type of analyis can be useful --as the paper says, a start towards developing a quantitative framework for assessing why some countries succeed and others do not in improving the health of their populations.

I was a bit confused by some aspects of the presentation in Annex III. The regression model from which Figure 1 is generated does not control for Region (i.e., it only controls for time, education, and per capita income). However, the regression model formally presented in the following page, under "Methods and Data", does control for Region. Most of the empirical results presented are generated by models that control for Region.

At a minimum, it should be explicitly indicated that the model behind Figure 1 is different from the formal model presented. But, more substantially, I am not sure that controlling for Region is a good idea. Why should we pose any relationship between the fact that a country belongs to a given Region and health status? At least some of the regions are very heterogeneous in dimensions such as climate, geography, etc. (which could conceivably be causally related to health status); this would certainly be the case with Latin America.

Wouldn't it be better to perform the analysis without controlling for Region? I think controlling for Region will make it more difficult for people to understand the results. Its interpretation is not intuitively obvious.

Also, from the point of view of the policymakers in most countries and others who shape public opinion, I would think that they would not be as interested in how their country compares to other countries in the region as they would be in how their country compares to the rest of the world. People all over the world are more and more thinking gobally.

What do you think?

Best regards,

Hugo

CC: Barbara Herz (BARBARA HERZ@A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 13, 1997 11:48am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Judith McGuire, Nutrition, HDDHE (JUDITH MCGUIRE@A1@WBHQB)

EXT.: 33452

SUBJECT: Comments on HNP/SSP White Cover

Alex,

This draft is lightyears ahead of the draft at the end of the Wintergreen retreat. Reads well, convincing, etc.

I agree with Tony Measham's comments about overplaying the financing and underplaying things like the need for more sector work and supervision resources.

Generally (and I'll say where) inadequate attention to QUALITY of health services as a determinant of outcome (certainly relative to attention to financing); not enough mention of social protection family and ESSD Network as our partners in this. ESSD through both social and gender as well as through rural development will be critical. A late thought I had: the rural sector is where health problems and health services are worst. I don't recall its being said in the SSP>

Some specific comments plus language for inclusion:

Exec Summ: second para. The Chile case is a good example not of technology and knowledge, but rather of longterm national commitment to providing high quality services with high coverage. The current SSP horse, the wrong horse, was beaten to death in WDR 93 and the same shouldn't be made here.

para. 5: I would seay "investments" not "resource transfers" since many countries don't get real transfers.

pg. vi, first bullet: add social protection and ESSD network
second bullet: add ministry of rural development or agriculture.

pg. vii: New Role as Knowledge Broker does not in any way do service to your excellent discussion on pp. 30 FF. Nor does the last chapter from which this section is pulled verbatim. Our knowledge and our advantage is not really in R&D or research (except maybe economic research). Our real knowlege advantage is in sharing across countries sector work etc. That should feature large in this section and should lead right into Tony's point about raising the alarm about lack of sector work.

pg. vii: New Approaches, first bullet. It seems internall inconsistent to speak of "sector-wide" policy framework and poverty. Poverty has to be dealt with economy wide. And many of our tools go beyond the health sector.

pg. viii, footnote. Here's where the old ugly issue of "health services" vs. health rears its ugly head again. CASs cshould be reviewed for their impact on human development, including hnp, including poverty/health services, etc. NOT just health services.

pg. 2, second column, second para. please add capital'd section "The 200 million people throught the world 90% in SSA) who are infected with schisto and AND THE 1 BILLION PEOPLE IN THE WORLD SUFFERING FROM ANEMIA suffer from chronic fatigue and other symptoms. and continue on.

pg. 5 box. first para. "infectious disease AND MALNUTRITION" please. 3rd para: please add "heart attacks FREQUENTLY DUE TO OVERNUTRITION"

pg. 6, box. other methods of reducing tobacco: effective communications for behavioral change including mass media and inpersonal counselling" where just "mass media" used to be

pg. 9 second column top: don't you want to add these would buy that "if it were spent well".

page 11, first column, bottom para is not clear. I think you want to say "For every $100 spent on drugs, $10 are wasted ......"

pg. 12, box. Don't you want to say a major policy challenge is getting public finance allocate to basic services in addition to just getting enough finance?

pg. 14, 1st column, 4th para: "the resulting administrative COST AND complexity"

pg. 14, 1st col, 5th para. at end why not add": "Height censuses of entering first graders have been particularly useful in determining which are the poorest regions which have priority for targeting social services in LAC."

pb. 15: DATES for ICN: Rome, Dec. 1992.

pg. 17, 2nd column, para 3 (food fortificaiton" should end "highly successful in reaching vulnerable populations at low cost". The DON"T TARGET the vulnerable; it's cheaper not to target food fortficiation.

Some text is missing on bottom pg. 17/top page 18 concerning community nutrition programs. Originally it came befor ethe

nutrition communications para, but some of it appears on top pg 18.

pg. 18 box. Nix "physical exercise". Many people have too high energy expenditure.

pg. 18, col. 2, para4. nix "automobiles".

pg. 23: first column, bullets: what about quality. It's mentioned in the box next door.

page. 24, 2nd column, 5th bullet. Isn't one problem that governments have poor capacity to regulate honestly and well?

pg. 32, list of publications in 2nd para: please include strategy to address poverty and hnger, 1995 (Claudia, can you give full reference?)

pg. 36. or somewhere else. How about a new box?

"Delegated Contract Management and Nutrition: a new instrument"

In Senegal the Community Nutrition Project is using a private social service entity, AGETIP, to manage public resources and provide services to the community. AGETIP contracts with community based organization to provide a clearly specified set of nutrition services. The formal health system provides backup for referral but is not involved in the deliver of community services. The project has reduced malnutrition by over 50%. It's success is due to clearly specified inputs and services and to and exquisite monitoring system which catches problems in the making.

pg. 38, bottom first column. Would you like to single out and give kudos to the Japanese for the HRD Grant which has made much of our portfolio possible?

pg. 40: emphasize more the loss of sector work and supervision.

para 3. You seem to moan about the lack of projects on health finance but isn't this more policy advice than lending? Or mightn't it fit better under SAL/SECAL than under project lending, per se?

pg. 41, top lesft column. How about note about working at community level, qualitative methods, participatory approaches needed and therefore we need ESSD folks (and because they also specialize in NGOs)

pg. 44, para 4. Hodw about mentioning the CGAPP program and the need complement income generation with hnp investments. This has been tried with small scale credit and nutrition education in Africa and Asia with some success.

pg. 44, col. 2, para 2: mention agriculture and rural devel. ministries. Mention social protection and ESSD.

pg. 45. Knowledge Broker: bring the richness from pp. 30 ff to this section. This is not really our metier. \

pg. 50: How about cross network and cross family linkages. Something should at least be SAID about that. It's critical to us in nutrition.

CC: Claudia Rokx (CLAUDIA ROKX@A1@WBHQB)
CC: Kathy Peterson (KATHY PETERSON@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:50am

TO: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: David de Ferranti, HDDDR (DAVID DE FERRANTI@A1@WBHQB)

EXT.: 38729

SUBJECT: SSP on HNP

Good strides forward. Good process.
On substance and presentation, I have a few major concerns, some of them related to points made today and some of them not. Let's discuss as soon as possible. Today if you like.

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 11:32am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Kees Kostermans - HQ Visitor, AFTH1 (KEES KOSTERMANS)

EXT.:

SUBJECT: HNP SSP White Cover --comments

Hi Alex,

It's great to be in HQ just at the time of the White Cover review of the HNP Sector Strategy Paper.

I agree with many of the comments made this morning and would like to add only two comments which haven't been explicitly voiced at the review. I'll keep them very short; I can elaborate on them if you would like that.

1. The paper is more an Hnp strategy than an HNP strategy; and within Health, financing issues receive too much attention compared to other issues affecting the effectiveness of the sector. Nutrition and Population receive too little attention (and less and less further in the paper) and are too much treated as subsectors of Health. The Bank's multisectoral involvement makes it well positioned to put Population and Nutrition issues on the development agenda of countries in discussions with Ministries of Planning, Ministries of Women's Affairs (as examples for Population), and Ministries of Agriculture or Education (as examples for Nutrition). Changes in population growth, in life expectancy, in dependency ratio are all pre-eminent general development issues which deserve the Bank's attention.

2. Doing the same or similar things as another (UN) organization does not necessarily mean a duplication of efforts, and we should certainly not hesitate to complement the efforts of other organizations if 1) we think we can do it better, 2) a joint effort is required. The fact that one organization has a comparative advantage to handle a certain aspect of H, N or P does not mean that that organization should deal only with that aspect (although one could intuitively think so).

Good luck with the further preparation of the SSP.

Kees K

CC: Birger Fredriksen (BIRGER FREDRIKSEN)
CC: RUTH KAGIA (RUTH KAGIA @A1@WBHQB)
CC: Ok Pannenborg (OK PANNENBORG)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 10:56pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Richard Skolnik, SA2PH (RICHARD SKOLNIK@A1@WBHQB)

EXT.: 80298

SUBJECT: SAS

Alex,

Thanks for including me in the SAS list.

I have now read the paper carefully.

The thrust of your conclusions seems generally OK with me.

However, I find the paper very difficult to follow. The arguments are not very tightly woven and I don't easily see the thread that should bind it all together.

It would be better, I think, to be a bit more classical in the presentation and walk the reader through key issues, what can be done about them, how we should help, and why.

I would be happier to see it read like a Mcnamara speech with some meat than like the normal Bank document. At a minimum, even if this suggestion is extreme, I think it has to be as tightly woven as one of those speeches.

Substantively, my main concern is that the paper does not seem to have enough of the substance of health in it. It will be important, I think to set up a clearer framework up front of what the health issues are. Then, it will be important to make clear how each of the things we propose to do will help to get at the heart of the key health issues. It might be good, alhough bold, to say that x, y and z are health goals that we hope to help countries reach over the next decade, etc.

Right now, there appears to be such an emphasis on the financing and systemic issues that we don't set out as clearly as we need to how we will help our clients deal with the guts of what are truly lousy services with messed up paradigms, badly trained workers, no measurement of outcomes, etc.

We need, I think, to deal not only with the necessary conditions of reform and financing, but also with the sufficient conditions of the heart and soul and technical content of a lot of health programs.

You have done some very good work on this and we have learned a

lot from working with you on this. With some careful reordering and tightening of the argument, and with a greater focus on health outcomes throughout, I am sure you will produce and excellent piece.

Let me know how I can help.

In the meantime, I have marked up the margins of my copy to show some of the specific instances of the concerns I have and I shall pass it on to you at the meeting.

Regards,

Richard

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 11:54am

TO: Richard Skolnik (RICHARD SKOLNIK @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SAS

Your comments are very perceptive and as I said in the meeting today, I think the next draft of this document has to be a different animal. We now have the background justification and the storyline which can become a nice technical publication, but the current document is a long way from what I have in my mind as a strategy paper. Part of the reason has been to educate the OPC and Board about the sector (which I think the current version does). But we now need to think about how best to deliver the final message and in what form. This surely cannot be a 50 page text with the punch line on page 45.

CC: Richard Feachem (RICHARD FEACHEM @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 11:54pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Althea Hill, EA1HR (ALTHEA HILL@A1@WBHQB)

EXT.: 84474

SUBJECT: comments on the sector paper

Dear Alex,

I don't know if I'll be able to get to the review meeting, so here are a few disjointed comments. I'm really impressed by how much you managed to get done in the time -- a very professional product.

Comments

1/ I remain very worried by the unequal attention given to nutrition and population relative to health.

For example, the issues around population as a development issue, to be treated in the overall development framework (which ought to be the Bank's comparative advantage area) are hardly touched. Yet so many countries across the world still have pop growth rates of 2% and more, which entail high dependency ratios and are not healthy for sustained economic development.

Likewise, there is hardly any discussion of PEM problems and programs -- much less even than for micro-nutrients; this is sad given that in so many countries there are still shockingly high levels of PEM. And we know that this affects cognitive as well as physical growth, development and health. (By the way, I was surprised to see on p. 52 that Philippines had better than average mortality and nutrition status -- WHAT average? PEM is running at about 30% of young children according to international standards -- not good for a middle-income country, surely).

I appreciate that it is difficult to cover three sectors adequately in the time you have had -- but it might be better just to be honest and call this a health sector paper. That might be preferable to just odd mentions and occasional boxes, which overall leave the impression that population and nutrition are side-issues attached to health.

2/ I thought the Action Plan underwhelming, particularly with regard to its impact on the poor, which is not well drawn out and seems to get rather lost here. Rather too inward-looking and focused on process rather than content. The special initiatives (which I liked the idea of, and wondered if we could add environmental, pollution-related health to the list) get less

space than internal Bank problems. The special initiatives are in fact the only part of this section where one can see a direct impact on the health of the poor.

3/ I thought the third wave privatisation section was written in a very ideological way, with lots of loaded language. It is not made at all clear how this will contribute to the 3 goals -- poverty alleviation, quality of life for populations as a whole, and financial sustainability of the health sector. Does it deserve so much space?

4/ Relatedly, it worried me that with all the experience of developed countries in different forms of health sector financing to draw from, we don't seem to be able to pick out any strong, clear, concrete lessons for countries to follow in this area in terms of what system or mix of systems offers the best buy as regards HEALTH OUTCOMES. (The paper seems to assume, for example, that private health care produces better health outcomes than public, but with no supporting evidence given -- do we know this to be true in developed countries? or are we confusing client satisfaction with clinically effective treatment?). Are we not able, after so much intensive study and such massive amounts of data, to say what forms of health financing unequivocally produce the BEST HEALTH OUTCOMES in developed countries (even using a variety of definitions of best, if we must)? Or which are the most cost-effective, again in terms of HEALTH OUTCOMES? These are very simple questions. If we can't answer them, and are just reduced to a "depends on the individual circumstances of the country" type of response, then we have actually nothing useful to say on this topic and shouldn't be giving any advice at all.

(I apologise for the caps, can't get the underlining to function on this laptop!)

5/ I think it is a very contentious statement to say (p. vii) that "the major value of Bank financing lies in its ability to potentiate.....policy advice and sharing knowledge". This seems to imply that our PHN projects don't have much value in their own right. I hope this is not what is meant. I hope also the implied faith in the quality of our policy advice can be justified. Let's not forget, for example, that the whole PHC movement originated in innovations made in developing countries quite innocent of our policy advice. Countries may sometimes have more to teach us than we have to teach them.

6/ The overall impression of the paper is a bit scattershot and unfocused. I wonder if this is because it's trying to generalise across an impossibly wide range of country circumstances. Might it not be helpful to divide countries into a few groups with similar types of endowments and problems (regardless of region) and diagnose and prescribe for them separately -- a range of strategies and goals rather than one world-wide treatment?

7/ On a pettier note, the box on Zimbabwe nutrition nowhere

mentions what the OUTCOMES of the project nutrition program were in terms of actual nutrition gains. The box on poor health services in East Asia gives a rather odd picture of Viet Nam -- the major problem here was surely the collapse of commune-level funding for commune-level facilities following decollectivisation, without adequate substitution from any other source, and hence decline in quality of services. The section on trust funds does not mention one of their major costs/disadvantages, which is the large amounts of TM time necessarily devoted to mobilisation of these sources of funding.

I hope the meeting goes well, and good luck with the paper

Althea

CC: Samuel Lieberman (SAMUEL LIEBERMAN@A1@WBHQB)
CC: Christopher Shaw (CHRISTOPHER SHAW@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 02:57pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Mariam Claeson, HDDHE (MARIAM CLAESON@A1@WBHQB)

EXT.: 38499

SUBJECT: SSP comments

Alex,

As a technical -- quality biased SSP core team member -- this is what I found important among today's comments:

It is interesting to note that there are a few common, and related, themes among the many diverse comments. Apart from the public/private story line, there was commitment to excellence and bringing expertise to the table (Skolnik), attention to doing things technically right (Heywood, McLaughlin, Peters and others) within existing resources.

It seems important, based on the comments today to:

- not cut too much of the "educational" content of the SSP in future revisions. If you do, you take out the aspects of the SSP that deals with technical content. If you had not had this educational part of the SSP you would have had many more comments and concerns about the rationale and justification for the implicit recommendations. Don't take it out!

- include attention to technical content among the options for how to address public failure -- it should be stressed that attention to the quality of carefully selected public health services (e.g. cost-effective essential health services and public health interventions) will in some places help address some of the failures (especially if the only option is to shift to privately financed un-regulated health services).

- do not suggest that the Bank be responsible for "what it does best" only and that it leaves other aspects of policy and implementation to others (they wont happen!). Instead make the Bank be responsible for bringing in the best "know how" through partnerships and through its evolving knowledge management system. Implication: more funding for supervision and TA at all stages of project development and implementation.

- Link Section 1 and 2 better to Section 3 and 4: that will help to bring out the NEW ideas and approaches and those that will address technical effectiveness and quality.

Specific comments and corrections:

Page 4. The Disease Burden Figure is wrong. You can not separate malnutrition from the other causes of DALY losses and end up with those figures. Malnutrition as risk factor accounts for 15% of GBD; it is as underlying factor that it contributes 60% to DALYs lost. Take it out -- if you need a figure showing the contribution of malnutrition, you can use the GBD pie chart with an area of malnutrition superimposed.

Minor corrections;
Page 52 second bullet, third paragraph "mortality" should be replaced by " life expectancy".
Page 14, please use "Integrated Management of Childhood Illness" at the top bar of the chart instead of "Management of the sick child" -- for consistency with the text. Also, please add to last sentence, second paragraph (second column) after Zambia ; "Many other countries have taken the first steps towards adopting this approach.

A L L - I N - 1 N O T E

DATE: 14-Mar-1997 04:49pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: April Harding, PSDPS (APRIL HARDING)

EXT.: 87371

SUBJECT: comments-hopefully useful

Alex:

Here are our comments.

Comments from PSDPS Social Sector Privatization Group on the Sector Strategy Paper for Health, Nutrition, and Population

INTRODUCTION:

1) We are very happy to be part of this team and to be invited to comment on the sector strategy paper.

2) We are very interested in collaborating with HDD, PRD, OED to develop the World Banks policies and tools in this area.

3) We are not sector experts, we come from the privatization group. But we see a lot of potential in working together.

4) Our perspective is an operational one. We are interested in seeing how policy and strategy come to bear on lending and operations.

5) Our comments on the sector strategy paper will thus reflect (4) and (5).

6) We will try and focus on broader issues concerning sector strategy for HNP in general rather than delve into details.

KEY QUESTIONS THAT COME TO MIND ON THE ISSUE OF INCREASING PRIVATE SECTOR PARTICIPATION IN HEALTH

1) Operational implications:

How should the new strategy or paradigm be reflected in Bank lending and operations? How will projects be designed to reflect the new policies and strategies? What will be different from past projects? These answers will define "implications for implementation". A thorough and candid evaluation of Bank projects in HNP might be undertaken with

regard to this issue? If so, what are the lessons from such evaluation? Are recommendations for improvement put into practice? These answers will define "effectiveness of Bank lending".

Useful lessons on projects (especially on regulatory, institutional, project design and training issues) may well come from unlikely places such as infrastructure. Our infrastructure group (or is it family now?) has been wrestling for quite some time with the issue of setting up effective regulatory institutions/mechanisms in low institutional endowment countries. They have also been working hard to inject such analysis into project design. The infrastructure group has also developed mechanisms for gathering and distilling recent lessons, and insights on best practice from outside the Bank. They have also worked hard to identify gaps in the literature and lessons that should be reflected in the World Banks reserach agenda. The infrastructure groaseved cesinr rone thinndatraf e latest lesisis istpapec wweo in this new area. Whether to in-source or out-source a specific bit of research, or the development of a certain database, or to undertake best practice analysis, might best be done in conjunction with the principles underlying our human capital development plan. That is, dont outsource the work if we need to develop our own capacities in this area.

3) The interdisciplinary (intersectoral) nature of this work requires new relationships and mechanisms for collaboration to be established. Our Mongolia social sector privatization project has required substantial collaborative input from health and education sector experts, privatization experts, (non-profit) legal and organization experts and contracting experts. All these types of people need to be involved in developing our approach or toolkit for increasing private participation in health How will this happen? Where? When?

Do we need a HDD/FPSI sub-family (PPIH-private participation in health, PPISS-private participation in social sectors) to roll out the new strategys implementation?

4) Whole v/s Part: Is it always necessary and feasible to work on across-the-board sector issues or can a piecemeal approach be undertaken? What are the advantages of a piece-meal approach?

How does one ensure that piece-meal efforts stay in line with broader sectoral objectives? A piece-meal approach is all that is feasible in many countries. How shall we respond to these situations?

5) Public-Private Partnerships: Is there a need to redefine the role of the Bank? Which areas should the Bank not be involved with? These answers will define "what the Bank ought not to do".

Good luck coming up with the next draft!

See you on Monday.

CC: Gerver Torres (GERVER TORRES)
CC: SARITA MATHUR (SARITA MATHUR @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:29pm

TO: Samuel Lieberman (SAMUEL LIEBERMAN @A1@WBHQB)

FROM: A. Edward Elmendorf, AFTH3 (A. EDWARD ELMENDORF)

EXT.: 35570

SUBJECT: RE: comments on WC draft, HNP SAS

Colleagues,

This EM has comments on the WC draft of the HNP SAS, building in part on the review meeting today.

1) The paper needs a clearer conceptual framework on which to hang its various ideas. Public finance economics - of public and private goods, externalities, etc. - seems to me to provide this, and to give a way of presenting the failures of the state which makes some sense of this beyond ideology.

2) The paper needs to be more explicit about its values, and about its units of analysis.

(a) Values: Is our priority the most poverty stricken populations, or is to maximum reductions in the burden of disease, or both? If it is poverty, then we need to have much more focus on S.Asia and Africa. If it is poverty within countries, then we need to be careful because more than half of many poor country populations would be considered poor. Furthermore, I'm not convinced that the most appropriate answer to poverty in the HNP area is targetted programs, as suggested in the paper. It seems to me that we should be open in seeking the greatest total reductions in the burden of disease, and admit that - at the margin - there will be trade-offs between this goal and poverty focus. However, the paper should assert, a la Nancy Birdsall, that in most respects the equity and poverty and public-private arguments complement rather than contradict each other.

(b) Unit of analysis/focus of our work: The paper sometimes seems to take governments as our main focus, and sometimes countries. I'd suggest that, in the HNP area especially, we need to have a much wider focus.

First, as the paper implies without being very specific on the rationale, we need to recognize that disease doesn't recognize borders, and that we must have instruments available, in selected circumstances, for inter-country programs. The concluding paragraphs of the paper recognize this, and I suggest that this instrument of the Bank's merits future expansion, not so much in terms of 'international initiatives' as inter-country and global programs. This would challenge the orthodoxy of IDA, of course.

Second, at the national level, we should discuss - and relate to - countries and not governments. This means that our HNP strategy and sector work, just like the CAS work, should involve a wide range of actors, including stakeholders in the civil society. This would reflect the fact that successful health reform engages entire countries, and not just governments, and that health and health services are the concern of all. Furthermore, while the WC SAS refers elipitcally to the possibility of IDA grants, I would be much more direct about this, and introduce IDA grants to the civil society, under circumstances to be carefully defined in subsequent papers, as an instrument of our HNP strategy work in individual countries. This would mean opening a new window at IDA, and moving our limited grant-making activities with NGOs from an external relations/SGP function into the core business processes of the institution. The proposed IDA window would also serve to fund inter-country programs.

The suggestions put forward above aim to address what I perceive to be a fundamental disconnect between our aims in the SAS and the financial instruments now available to us to address them. Among present instruments, I think the paper is too positive in addressing SECALs. Of course, given a sector-wide agenda, a SECAL is very tempting. Experience with two AFR human development SECALs (Cote d'Ivoire Human Resources Development Program and Togo HNP hybrid operation) suggests to me that this instrument is inappropriate for addressing the long-term institutional development problems which lie at the core of our HNP work in Africa. Furthermore, the SECAL successfully engages the core ministries of finance and planning .... but we found that it did not effectively involve the sectoral institutions.

3) The paper seems to take a supply orientation, and to assume, globally, that public budget allocations are sound. I would like to see much more emphasis in our work on demand variables (hitting utilization of health services more than coverage, with strong emphasis on consumer satisfaction), and on PERs as an instrument for both sector and project work. Furthermore, the SAS should require us to assure that basic public health services and public goods are taken 'off the top' of public budgets before funds are allocated for clinical care.

Good luck to Alex on the next round!

Ed

CC: ALEXANDER PREKER (ALEXANDER PREKER)
CC: CHRISTOPHER D. WALKER (CHRISTOPHER D. WALKER)
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CC:	JARAWAN, EVA Rm: H 9-035	(EVA JARAWAN)
CC:	LAKSHMINARAYANAN, RAMA Rm: E 8-044	(RAMA LAKSHMINARAYANAN @A1@WBHQB)
CC:	LEWIS, MAUREEN A. Rm: I 7-003	(MAUREEN LEWIS @A1@WBHQB)
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CC:	Birger Fredriksen	(BIRGER FREDRIKSEN)
CC:	David Berk	(DAVID BERK)
CC:	Brigitte Imperial - HQ VISITOR	(BRIGITTE IMPERIAL)

A L L - I N - 1   N O T E

DATE: 17-Mar-1997 08:41am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: EGBE OSIFO, MNSHD (EGBE OSIFO)

EXT.: 85569

SUBJECT: SAS

Alex:

Please accept my apologies for these late comments. This was mainly due to the presence of several ministerial delegations last week coupled with an upcoming mission.

I think the first SAS has been a successful heroic attempt to try and articulate a global strategy for our sector; and I would like to congratulate you and the SAS team on this. I think it provides us- the network members- an articulate framework to work with.

However, I do have several comments. Overall, I feel the document at 53 pages is still probably a bit long to ensure that it would be read by a wider audience. In our region, major sectoral documents are limited to 40 pages and most ESW is actually limited to 25 pages. I feel some of the material could be placed in annex or removed without jeopardizing the quality of the document. For example, I feel the one and a half pages on page 31 describing a historical perspective on policy analysis could be shortened.

My other comments are specific and are mainly points of clarification which I will enumerate on a page basis:

pg 10: The sentence referring to grant assistance being the most significant contribution to health financing is not reflected in Nigeria - a country identified ad having the lowest total health expenditure where a fifth of all Africans live.
pg 15: The example on the University of Zimbabwe program is unclear
pg 23: Several of the Middle Eastern countries and economies e.g Jordan, WBG probably fall in to the fiscal threat of rising costs
pg 28. three simple principles are referred to in balancing the budget but only one principle is given
pg 29. Suggest you arrange regional banks in an alphabetical order
pg 33. What are senior policy seminars on issues related to HNP policy?
pg 38. I think a positive solution to deal with trust funds concerns that were identified would be the encouragement of TF to be untied (Italy is supposedly considering this issue)

pg 50. To ensure that a user-friendly knowledge management system is fully utilized by bank staff, the availability of modern equipment (regularly updated) is required by Bank staff (which appears

challenging under the present budgetary situation).

Egbe

CC:	RICHARD FEACHEM	(RICHARD FEACHEM @A1@WBHQB)
CC:	Jacques Baudouy	(JACQUES BAUDOUY)
CC:	Maryse Pierre-Louis	(MARYSE PIERRE-LOUIS)

A L L - I N - 1   N O T E

DATE: 17-Mar-1997 10:17am

TO: Dean Jamison (DEAN JAMISON @A1@WBHQB)

FROM: Prabhat Jha, HDDHE (PRABHAT JHA)

EXT.: 87384

SUBJECT: RE: Review Meeting on Cross-Country Analyses

Dean

The following are some comments on the system performance analysis. I will try to attend the meeting this afternoon following my scheduled meeting with the legal team.

1. My main comments deal with methodology. The power of this analysis is the ability to examine differences in health outcomes over time and in a standardized way. To provide reliable results, we should minimize both systematic biases and random errors.

2. I believe that we really do not have a good handle on systematic biases and that we should so acknowledge: the methodology cannot disentangle the income effects as causal or casual. As mortality is basically the incidence times the case-fatality rate, we do not know if income reduces incidence (e.g. water and sanitation), or case-fatality rate (e.g., money to buy diarrhea treatments), or has a synergistic effect on both incidence or case-fatality rate. Lant Pritchett's attempts by using external surrogates are a neat idea, but still can't tell us what the income variable in the model represents. Finally, the overall R squareds are modest, and I wonder if Jia has done some measure of "global goodness of fit" of the different models.

3. The chief sources of random errors are likely three-fold: (a) the variability in income ranges; (b) the small number of countries compared within a region; and (c) the short time duration of observation.

4. We address point (a) somewhat by looking at four year income averages. However, I am still concerned that income fluctuations may distort the findings on performance. Thus, in the earlier version of the SAS, on page 9, the table of performance indicates that ECAs performance on male life expectancy is better than expected with income. However, the male life expectancy in ECA is generally regarded as being poor and declining. The effects appear to be driven by declining incomes and not improving health system performance.

5a. The methodology examines performance within a region.

This may create spurious results based upon small numbers. I note in the earlier LAC paper that the income elasticity for child mortality across LAC and non-LAC regions was similar (-0.21 and -0.17 respectively, page 5). In Pritchett's paper (table 2), the income elasticity (unadjusted for education) was LOWER when all 111 countries (-.12) were used, versus when 58 countries (-.24) were used. This suggests that a smaller observation set may suffer more from the play of chance.

5b. Have you considered comparisons of a region against all countries, in other words omitting the region variable in the model? This might help smooth the income curves somewhat and provide a more stable comparison of relative performance for countries. I would guess that the goodness of fit for such an approach would be higher on fewer degrees of freedom.

6a. The methodology examines five year difference, which for reasons 4 and 5, warrant caution. Again the most robust analysis may be 30 year differences, because the income curves are likely to more predictable. Pritchett's paper (Table 3) also notes that the income elasticities (and R squareds) rose with longer observation time periods. This make perfect sense: better measurements make better correlations, and prolonged periods yield better measurements.

6b. Thus could the analysis present as a main result, 1960 to 1990 performance for the key outputs and comparing all countries versus those for regions? I think this would also help avoid data-derived findings from people looking too closely at one time period.

Overall, the system analyses is very robust, and innovative. It should make powerful arguments if we choose to be both comprehensive and cautious. I will try to offer more comments at the meeting.

Regards,

Prabhat

CC: ALEXANDER PREKER (ALEXANDER PREKER)

A L L - I N - 1   N O T E

DATE: 17-Mar-1997 02:31pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Marleen Dijkman, HDDHE (MARLEEN DIJKMAN@A1@WBHQB)

EXT.: 85317

SUBJECT: SAS

I enjoyed reading the paper. Interesting food for thought and after this elaborate meeting last week only a few things.

* Holland is only a small part of the Netherlands (two provinces in the North-West of the country). If your data on page 27 apply to the whole country then it is better to use the Netherlands.

* You might consider adding an Annex with an overview of which country is in which Region in the Bank.

* In the paragraph referring to improvement of the health outcome agenda (p vi) you might consider a reference to cooperation with Ministries whose policies can heavily influence health. In Governments it is important for the (relatively weak) Health Ministries to be involved in the work of the other Ministries in order to prevent negative health effects. As you know the other Ministries can cause effects, without having to deal with the costs. I consider an awareness in the WB of possible negative health effects following from projects executed with other Ministries important.

* The new role as a knowledge broker is emphasized in the summary. However, it is not explained very much. Setting and promoting an aggressive research agenda, but not conducting the actual research; does that imply that the WB will mobilize and give out funds for research by others? The aim of reducing the disease burden of the poor is very broad. You might want to specify that.

One question: can I send the white cover (as "confidential") to the main health sector specialist in the Ministry of Foreign Affairs (Development Cooperation) and to the Minister of Health (Borst) in the Netherlands, and ask for their opinion? Of course I'd indicate this is only a preliminary version.

Good luck with the SAS and looking forward to read the new version.

Marleen

A L L - I N - 1   N O T E

DATE: 18-Mar-1997 10:27am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Chris Lovelace, EC2HR (CHRIS LOVELACE)

EXT.: 85520

SUBJECT: RE: SAS - Taming the Monster

Hi Alex: I both re-read the SSP and reviewed the CIDA and HIFA documents. I really liked the CIDA approach, but I wonder if trying that style on at this stage wouldn't be a bit like changing horses mid-stream. If you think it could be easily done, I'd go for it. Further to that thought, I also agree that the SSP (when did it stop being the SAS?) is getting too long. I like your thought of staying with it as a technical background paper and producing a shorter version more in line with the original intent - as I understood it.

re: editing the old draft, pg 28 I think your proposed wording is better. I wonder though if it doesn't need a couple of sentences explaining why this important (beyond what you've said on pg. 27-28). For me it is the perverse affect it has on behaviors on all. A prerequiste of budgetary discipline is of course that the budget is set on some rational basis and matches to the policies (as well as the revenues), eg there is no point (though governments persist in doing this) in having rosy budget projections which are groundless.

Also, I think some care needs to be taken not to be too rigid on the point less it produces its own arbitrary response (eg when we first introduced funding caps in MSP in BC, the Drs. response was "we will work til the money runs out" forcing us to be a bit more creative - same thing with intial price x Volume contracts with hospitals in NZ), therefore budgetray discipline needs to be sensible too, and include both technical mechanisms and incentives to achieve it, and has to be inexorably linked to the policies. Too often, they are not.

Finally, I think you still need to find the right balance in the 3rd wave discussion (certainly that was the tone of the WC discussion). As we've briefly discussed before, I think the wave should look more like a trend, we shouldn't be too catholic about the trend (while broadly endorsing it) and I think we also need to stress there are points along the trend line that might be useful lay-overs or even stopping points for a given country and given set of circumstances. This is where the menu actually gets very interesting with the possibility of various mixes of public/private cooperation and competition, various forms of public ownership etc.

I'd be happy to come over and chat about any of the above, or offer further comments as you wish. Chris

A L L - I N - 1   N O T E

DATE: 18-Mar-1997 10:45am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Chris Lovelace, EC2HR (CHRIS LOVELACE)

EXT.: 85520

SUBJECT: 1 more thing

Somewhere along the line, I think we've lost the "responsive to the client" message. In and of itself this is important, but it is also important to re-enforce with the board, I think speaks to our credibility as an institution, and represents an opportunity to "moderate" our views on reform and our performance without watering them down, ie we have our views,(they influence our advice and we want to be transparent about them) but they are constrained necessarily by the clients objectives (it fits nicely with our better understanding of the political economy). I don't think we actually say that anywhere. Chris

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 18, 1997 03:41pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Olga Jonas, FRMRO (OLGA JONAS)

EXT.: 34655

SUBJECT: IDA grants to NGOs

As I mentioned, the IDA Deputies did consider providing for grants to NGOs under the IDA11 agreement (FY97-99). The Bank raised the topic in February 1995 -- the enclosed is a record of the comments made by all the donors present. There was a diversity of opinions but on balance the Deputies felt that this instrument is not necessary. The paper the donors discussed -- "Prospects and Options for Effective IDA Lending" is in the mail.

There was not then (and probably still isn't now) enough convincing evidence that existing instruments were not adequate for the tasks. Also, substantial funding is available from other sources (foundations, private donors, charities) to effective NGOs. In any case, the next logical time to re-open this discussion -- if there is a stronger argument for this instrument -- would be for the IDA12 period (FY2000-02).

I also attach my previous comments -- I haven't had a chance to check whether you were able to take them into account. In particular, is there any work ongoing on indicators of impact of our projects? Does IDA lending make a difference?

Please let me know if you have any questions.

Olga

CC: FRM Hotline (CCFRM)
CC: Cheryl Francis (CHERYL FRANCIS)

Our paper "Prospects and Options for Effective IDA Lending" distributed to the IDA Deputies in early January, asked IDA donors to consider whether IDA should be allowed to give grants to non-governmental organizations (NGOs). The following are reactions from all Deputies who expressed an opinion on this issue at the IDA Deputies' meeting on February 9-10, 1995:

<u>In favor/possibly in favor/small size/limited scope</u>

* Eager for IDA to work more with NGOs. Bank to prepare a paper (US)

* Not in favor of the proposal. Especially not to Part I NGOs. Could be studied for Part II NGOs. Not a fixed idea; wants to think. (Germany)

* Not totally closed to the idea but very cautious. At most small and limited. (France)

* In favor of the proposal. But should be of limited size, not as a bribe for NGOs. Should go beyond microfinance. Would enhance quality, ownership, effectiveness of IDA projects. (Netherlands)

* Open to the idea. IDA needs to increase beneficiary participation in project design. (Canada)

* Could fund, on a matching basis, projects prepared by private sector/NGOs. (Italy)

* Consider it; give NGOs special recognition. (Ireland)

<u>No need to decide now/not convinced one way or another</u>

* Premature proposal. No need to decide on IDA resources use for this. CGAPP is OK for now. (Norway)

* Not in favor but willing to look at proposals. IDA could win advocates. (Denmark)

* Not prepared to go beyond CGAPP. (Finland)

* Keen to hear specifics. IDA should build stronger relationship with NGOs. But what gap would IDA be filling? Does IDA have comparative advantage in microcredit? (Australia)

* Not convinced that the proposal is useful. (Russia)

* Not too keen. Wait for CGAPP results. (Spain)

* Probably not a good idea. Selection of NGOs is very difficult. But NGOs need help. How can they be helped? (South Africa)

Opposed

* Not appropriate for IDA to give grants. (Japan)

* Emphatically not in favor. Not IDA's comparative advantage. NGOs not short of funds. IDA should work through recipient country governments. (United Kingdom)

* IDA should NOT buy allegiances. Do more in microenterprise lending/policy reforms in regular financial sector work. (Switzerland)

* Not acceptable; not legal under Belgian law for IDA to give grants. (Belgium)

* No case at all for this. (Portugal)

* No, IDA should not give grants. Work on microcredit. (Saudi Arabia)

* No. Possible negative impact. Cautious. (Iceland)

* Does not believe this is an efficient use of scarce IDA resources. If done, only with an upper limit. Not a way to do PR. (Korea)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: December 17, 1996 05:15pm EST

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Olga Jonas, FRMRO (OLGA JONAS)

EXT.: 34655

SUBJECT: HNP Sector Strategy

Hello,

Thank you very much for sending us the Approach Paper for the Sector Assistance Strategy (SAS) for the Health, Nutrition and Population (HNP) sector (to be discussed by the Board on January 22, with the final SAS is to be presented to the Board on May 27).

I had looked at the draft approach paper from the point of view of IDA and its priorities. The paper is comprehensive and clearly structured. Improvements in this sector are a very high priority in most of the 79 IDA-eligible countries. The following are two areas where you may want to consider increased emphasis:

Quality of CAS. The approach paper proposes the establishment of criteria for reviews of CAS, CEMs and projects with potential HNP consequences by mid-FY98 and that the first cycle of reviews be completed by end FY99. In view of the priority of HNP in most IDA countries, and the key role of the CAS in managing IDA's program, this schedule seems too drawn out. To ensure higher quality CAS, could the HNP Sector Board consider reviewing CAS for those IDA countries where HNP issues are important even before formal guidelines are established? As a side benefit, experience gained from CAS reviews over the next year or so would serve to formulate more user-friendly guidelines. Quality of CAS is very important, as the CAS has become the most important vehicle for accountability to IDA donors.

Indicators of project progress and impact. While the approach paper mentions the importance of these, there is no information on the indicators that are already in use and on the experience with them so far. Because of growing donor impatience with the absence of evidence of the results from IDA lending, the strategy paper should be as specific as possible in this area. The approach paper notes that "developing a more solid conceptual framework for assessing what constitutes quality at entry is a high priority" (implying that this has not been defined yet). Since indicators are required for all operations starting in FY97, and a retrofit of all ongoing

operations is to be accomplished by end FY97, more attention to this in the SAS would be most welcome warranted. Moreover, the IDA11 agreement (covering FY97-99) states that in the FY97 ARPP (to be drafted in the summer/fall of 1997), the reporting on project implementation and results will be "fully consistent with this new approach", ie, draw on systematic use of project impact indicators.

Please let me know if you have any questions; we look forward to hearing of the next phase.

Olga

CC: Paula Donovan (PAULA DONOVAN)
CC: Enrique Rueda-Sabater (ENRIQUE RUEDA-SABATER)
CC: FRM Hotline (CCFRM)
CC: Cheryl Francis (CHERYL FRANCIS)

A L L - I N - 1   N O T E

DATE: 06-Mar-1997 04:52pm

TO: DAVID PETERS (DAVID PETERS@A1@WBWASH)

FROM: Julie McLaughlin, AFTH1 (JULIE MCLAUGHLIN@A1@WBHQB)

EXT.: 84679

SUBJECT: SAS and Pharmaceutical Work in Africa

David,

I just received a hardcopy of an e-mail which you sent to Ed (dated 8 Feb) on pharmaceutical data and the SAS. Your final paragraph provides a good basis for a TOR for our Regional Pharmaceutical Expert (a position which Richard and Dave De Ferranti) recently argued for to our VPs.

I would add the review of drug expenditures to his/her assignments, and would propose some perimeters to explore our work on this subsector further, such as how many subsequent purchases were made within each given credit, whether any technical assessment was made by IDA of the list of items to be procured, whether/how the projects which financed drugs procurement also addressed pharmaceutical reform, or at least made some attempt to address financial sustainability, efficiency of selection distribution and use and/or cost effectiveness of drugs in treatment protocols.

There are some exceptional situations in our Region that deserve general support to the provision of essential drugs, but I am realizing that this financing is not widely employed to mobilize critical changes in the sector. For example, Alex pointed out recently that Kenya is one of the few countries in the world still fully dependent upon the international community for vaccines. It is very difficult to understand how this could be the case, and its unacceptability is compounded by the fact that IDA continues to finance an exceptionally large proportion of their contraceptives and STI drugs.

Julie

CC: YVES GENEVIER (YVES GENEVIER@A1@WBWASH)
CC: A. EDWARD ELMENDORF (A. EDWARD ELMENDORF@A1@WBWASH)
CC: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)
CC: OK PANNENBORG (OK PANNENBORG@A1@WBWASH)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 6, 1997 04:21pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Jean-Jacques Dethier, EC2CO (JEAN-JACQUES DETHIER)

EXT.: 32510

SUBJECT: RE: Your HSP SAS

Alex,

One "philosophical" point that you may want to take into account -- on page 47, 2nd column, last para.

SECALs are balance-of-payment support operations. (The word support is missing from the text). I would argue that you have a case for adjustment lending, i.e. external borrowing to cover the budget deficit/financing gap in the public sector (public sector borrowing requirement) if it is the result of policy change promoted by the reforms. In that case, it doesn't matter whether it's in health or agriculture or trade liberalization. There is no difference between SAL or SECAL.

A L L - I N - 1 N O T E

DATE: 19-Mar-1997 05:22pm EST

TO: RICHARD FEACHEM (RICHARD FEACHEM@A1@WBHQB)

FROM: Pammi Sachdeva, CGIAR (PAMMI SACHDEVA@A1@WBWASH)

EXT.: 38941

SUBJECT: Comments on draft HNP sector strategy

Richard:

I enjoyed reading the draft HNP sector strategy paper, and would like to congratulate the authors for a well-written document. The discussion chaired by you on March 14 was also very useful, for it provided an opportunity to further refine an already good report. At the end of the meeting you invited further comments by EM. I have two suggestions.

First: Clarify the key message in Section II regarding reform strategies, particularly the reference to third wave privatization as an alternative (pgs. 25-26). The present draft states that the third wave of reform has several pre-requisites, including: a) the first and second waves of privatization of commercial and infrastructural assets; b) significant constraints to be overcome (six are listed); and c) critical pre-requisites (four are listed). These pre-requisites are unlikely to be met in the short term; yet reforms are urgently needed in many countries, as the strategy paper convincingly argues.

So, it would be useful to clarify just what reforms should and can be undertaken, in light of the constraints and pre-requisities identified. My hunch is that the four critical pre-requisites identified on pg. 25 could in fact be key elements of the reform strategy itself - namely, creating a conducive policy and regulatory environment, introducing (full?) cost recovery, providing an adequate safety net, and ensuring quality control. These would then supplement other measures recommended in the report, such as securing sustainable financing, containing costs, and ensuring fiscal discipline etc. (pgs. 26-28).

Further, the report could perhaps clarify the intended meaning and operational implications of the proposed significant paradigm shift (pg. 43) and new policy paradigm (pg. 44). This could be done by making the links between the descriptive and diagnostic sections (I and III) and the prescriptive and forward-looking sections (II and IV) more transparent.

In short, I believe it would be useful to have a tighter logical connection between the existing realities of the HNP sector (constraints, opportunities, pre-requisites etc.) and the proposed or desired future (the new paradigm). This would make

the strategy more obvious; and would help to clarify the meanings of some terms used in the paper.

Second: I would suggest greater attention to issues of implementation capacity. The report does refer to governance and institutional capacity as crucial factors that influence system performance (pg. 23); and as key constraints to getting results on the ground, as identified by QAG and OED (pg. 39). The report also recognizes that the targeting of interventions to the poor is often difficult because of weak administrative structures (pg. 14), and weak government implementation capacity (pg. 21).

However, the proposed strategy focuses largely on policy-level interventions; and does not adequately emphasize the equally-crucial need for strengthening ground-level capacity for delivering services. There is only a passing reference to capacity building in the sections dealing with the proposed solutions to current problems. In my view, it would be useful to include capacity building (of government as well as non-government providers of health care) as an essential component of the proposed reform strategy - and as one of the pre-requisites for improving health outcomes for the poor.

I recognize that this business of capacity building is messy; and is not one of the Bank's greatest strengths. But the strategy document is concerned with the future - so there is still time for optimism. I therefore suggest that such measures as institutional development or capacity building be explicitly included in the proposed package of reforms for the HNP sectors; and equally, that such competence be included in the list of new skills sought among HNP staff (pg. 40).

I would be happy to clarify the above suggestions, so please feel free to share the EM with members of the drafting team or sector board. I would appreciate hearing from you as well, and an opportunity to discuss further at your convenience.

Pammi

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 12:40pm

TO: A. Edward Elmendorf (A. EDWARD ELMENDORF)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: SAS - IDA and 100 percent financing option

I have just received a memo from legal on the SSP.

Andres Rigo, points out that IDA's articles already permit making credits to parties other than a member country, providing "consent of the government of the member country". I know that the "consent" is precisely what you wanted to avoid but it may be a close second best.

(I will criculate the memo).

Please note he also has an objection to the 100 percent financing proposal, pointing out that in any event "in all cases taxes should be excluded". In this respect, he cites a recent opinion of the General Counsel.

(I will also circulate this memo opinion from the General Council).

These are issues that I believe affect the Africa Region more than most other regions (except maybe South Asia). I would therefore suggest that we try to come to agreement within your region before extending the debate more widely.

Unlike my hesitation about a new IDA window, I think we need further clarification on the 100 percent financing option (excluding taxes which I suspect is a non starter).

CC: Birger Fredriksen (BIRGER FREDRIKSEN)
CC: Ok Pannenborg (OK PANNENBORG)
CC: Helena Ribe (HELENA RIBE)
CC: RUTH KAGIA (RUTH KAGIA @A1@WBHQB)
CC: David Berk (DAVID BERK)
CC: Keith Hansen (KEITH HANSEN)
CC: JULIE MCLAUGHLIN (JULIE MCLAUGHLIN @A1@WBHQB)
CC: DENISE VAILLANCOURT (DENISE VAILLANCOURT @A1@WBHQB)
CC: Yves Genevier (YVES GENEVIER)
CC: Bruce Benton (BRUCE BENTON)
CC: Anwar Bach-Baouab (ANWAR BACH-BAOUAB)
CC: Malonga Miatudila (MALONGA MIATUDILA)
CC: Loso Boya (LOSO BOYA)
CC: Mary Mulusa (MARY MULUSA)
CC: Charles Griffin (CHARLES GRIFFIN)

CC:	Norbert Mugwagwa	(NORBERT MUGWAGWA)
CC:	Kees Kostermans - HQ Visitor	(KEES KOSTERMANS)
CC:	Brigitte Imperial - HQ VISITOR	(BRIGITTE IMPERIAL)
CC:	JUDY HARRINGTON	(JUDY HARRINGTON @A1@WBHQB)
CC:	John Elder	(JOHN ELDER)
CC:	Michele Lioy	(MICHELE LIOY)
CC:	Wendy Roseberry	(WENDY ROSEBERRY)
CC:	ROGER KEY	(ROGER KEY @A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 20, 1997 12:25pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Janet Hohnen, EA2RS (JANET HOHNEN@A1@WBHQB)

EXT.: 81217

SUBJECT: SSP, comments on the white cover

The paper was interesting and thought provoking, but by the time I reached section IV I was tired and rather confused. So I may have missed point which are in there somewhere. However I hope these comments help.

A. Purpose and target audience of the SSP exercise

1. The review meeting was told that the original purpose was to brief the Board and exchange thoughts. But this is a statement of activities, not objectives or expected results and does not justify the scale of the work, or provide a benchmark for judging the adequacy of the final product, especially in the current Bank environment. Please give (or resend) a more specific statement of the purpose and expected results of the exercise, including what would be done with the SSP when completed.

2. We need a clear sense of the threats and opportunities facing HNP work in the Bank at present and in the next 5 years. and an articulated response to these. Are we aiming for survival, maintenance, expansion, increased effectiveness, change of role, etc. What do we know of the present value and acceptability of our work to those who can affect its support or continuation.

3. If the target group is the Board, then they are presumably non-health specialists, who mostly (but not all) start with a favorable but relatively uninformed view of the sector. They will be affected by the current internal and external scrutiny of the Bank; they may be affected by the reported decreasing income of the Bank; as Chris Walker said, they will need to know that they both getting (from the HNP family) and giving (to borrowers) value for money, or have serious prospects of getting this in the future.

4. In this climate, is SSP's arbitrary central postulate of a "paradigm shift" the best way to present what is happening? Are Board members and other important audiences likely to be impressed by this new broom spin, or might they value explicit continuity in strategy development. Will the artificial construct of one single theme be credible, relevant or helpful, and will its advantages compensate for the apparent lessening of priority for client responsiveness and recognition of diversity.

5. The paper will be read by influential client representatives. If we are trying to get the government back into health in poor communities, will this paper make our dialogue more difficult?

6. The action plan in its present form has differential implications for the HNP family; there will be winners and losers. The merits of the choices and the likely effects need to be more frankly and openly displayed and debated.

B. Goals and Strategies of the HNP sector in the Bank

7. It was very disappointing not to see a clear health goal in this paper. It is noteworthy that Mr. Stiglitz stressed this health objective of the sector at both the beginning and end of his speech at the Health Financing Conference last week.

8. The following goal is suggested: "to assist member countries to achieve sustainable improvement in the health of their populations, especially the poor, and to protect people from the impoverishing effects of illness or illness care.

(the population subsector may need some additional non-health related objective)

9. How the HNP sector goal contributes to the overall mission of the Bank should be separately explained. Why Board should approve and clients should borrow for health, compared with other choices. Not every one is convinced that borrowing for health is good; the idea was reportely strongly challenged at board level recently; and there is some perception of increasing reluctance to borrow (from the Bank at least) for health in some regions. (This may be partly overcome by planned new product development - but not without serious market research.)

10. With clear sector goals, the major strategies selected by the Bank to reach these goals, inside and outside the formal health sector, can be explained, justified by summarizing the Bank's comparative advantage, client demand and priorities etc. In particular readers should clearly understand (i) that HNP work overlaps with but is not to be equated with health services work or health financing work. These are supported to the extent that they further the sector goals. and (ii) how the Bank (HNP) will actively pursue non-health-sector strategies to protect and improve health.

C. Work Across Sectors (in the Bank) to Improve Health.

11. The paper says very little if anything about this, yet the Bank has a particular advantage compared with specific health related agencies and institutions. (May be nutrition/agriculture, and health/education links are working productively). How do we help promote volume and quality in support for domestic water supply and sanitation? If the traffic injury epidemic is so bad and growing, how do we cooperate with transport sector colleagues to

tackle this? How can HNP work with agriculture to phase out tobacco growing and reduce opposition from the agriculture lobby to tobacco control. Why does design of health projects have to pass environmental, gender and ethnic minority standards in the Bank, but there is no health impact assessment of non-health projects?

D. Performance of Government in Health Service Provision.

12. The more amazing generalizations on this will no doubt be removed from the paper, and the terminology tidied up (often the term govt. seems to mean central govt.) I have the impression that the countries cited for high health status compared with economic dev./income level either have or have had until recently strong government health services.

E. Population.

13. The paper has a box on ICPD statements on population policy, but I missed mention of the Bank's role in population policy initiatives (distinct from reproductive health).
Does the Bank absolutely agree with the ICPD line. Which set of population approaches (from within and without ICPD) suit the Bank's comparative advantage? What are the cross sectoral links here? How does the Bank influence Part I countries on this issue? Does population need an annex to the paper?

(e.g. Bangladesh is given as an example of a low income country with high CPR. This is due partly to a strong population policy with a consistent delivery strategy over about 20 years, not only since ICPD as implied in the paper, and partly to long term donor support.)

F. Health Service Organization and Effectiveness.

14. Agree with the comments of division chiefs and TMs at the review meeting. The paper says much about financing but little about how Bank can help countries to get value for money through better services. Just as an example, health workforce issues are a huge challenge in many countries - numbers, skills, supervision, deployment, accountability. There is often political and economic pressure for oversupply and maldistribution of highly and/or inappropriately skilled health workers, which drives up health costs disporportionate to health gain. Curriculum and teaching reform are very slow. Overall low effectiveness of pre-service and continuing education for mid and lower level workers remains, two decades after Alma Ata and "Health for All". This is a major barrier to giving good service to the poor, and was mentioned again last month in the Bank as a constraint in the trials of introduction of the sick child package. In fact WHO and others are developing these packages around cost effective interventions, faster than the health services and continuing education systems (if they exist) can absorb them. All the other issues, management, information, supervision, QA - what will the paper say about this group of issues?

G. Balance and Relationship of HNP tasks.

15. Again the topic is presented differently in different sections of the draft, but seriously understates the interdependence of the three work tasks - operations, research and policy (and they should be presented in this order.) Sector analysis both identifies research needs and allows for the client to formulate policy options and priorities for future borrowing; lending can assist implementation of policy reform through making difficult choices and changes more palatable. Project implementation and the deeper understanding that develops during supervision generates or heightens readiness to address new or related operational research and policy development. The Bank's strategy must explicitly reinforce and exploit these relationships as should new product development.

H. Knowledge management.

16. This new activity for HNP seems justifiable as a vision for future survival of a leadership role for the Bank in the sector, the case is not yet very strong. We should take a very sober look at the Bank's past record in knowledge dissemination and what changes in skill mix and attitudes will be needed to move into what the Bank is late at and with a weak track record. This will be very expensive, Maybe the SSP should be recommending a feasibility study for this.

****

CC: Joseph Goldberg (JOSEPH GOLDBERG@A1@WBHQB)
CC: Jagadish Upadhyay (JAGADISH UPADHYAY@A1@WBHQB)
CC: darren dorkin@a1@china
CC: Junko Otani (JUNKO OTANI@A1@WBHQB)
CC: Samuel Lieberman (SAMUEL LIEBERMAN@A1@WBHQB)
CC: Willy De Geyndt (WILLY DE GEYNDT@A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 20, 1997 12:38pm

TO: Janet Hohnen (JANET HOHNEN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SSP, comments on the white cover

You read my mind. In fact I have been talking to Richard about the possibility of making section IV the Strategy and Sections I-III a supporting document for those that want more detail. But that would mean elaborating a bit more in Seciton IV on the justification of how we came up with this recommendation. I would welcome if you would promote this idea in your region.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 01:08pm

TO: JANET HOHNEN (JANET HOHNEN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Not focussing explicitly enought on health

Your memo actually helped me deal with the issue of dealing explicity with health which has also troubled me.

How is the following for a rephrasing of the first mandate.

"First, the Bank will emphasize the fundamental responsibility of governments to address the health, nutrition and population needs of the poor, and to protect other segments of the population from the impoverishing effects of illness."

This will help us avoid the accussation I have had from other people that not only the poor have health needs.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 04:52pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: A. Edward Elmendorf, AFTH3 (A. EDWARD ELMENDORF)

EXT.: 35570

SUBJECT: RE: SAS - IDA and 100 percent financing option

Alex,

You've seen how I responded to your previous communication by putting it out for comments. I'm not so inclined to push further for other reactions, at this stage, on the 100% financing option (of course, excluding taxes), beyond whatever is generated by your EM.

My reactions at this stage - and I stress that they are mine and do not represent any effort at AFR consensus building:

(a) Let's press on 100 percent financing as a possibility, with a separate and subsequent paper to review circumstances and criteria, so that the SAS does nothing but open a window.

(b) On IDA funding of NGOs, of course Helena Ribe and the others are correct that this can be done through national governments. But I've seen plenty of circumstances where they might not object to our doing it but wouldn't do it themselves with our funds. Furthermore, I'm talking not of IDA credits, as the lawyers do, but of IDA grants! Now, it's clear to me, from the CGAP and micro-credit experience, that legal considerations are not the real obstacle. I was confident that I'd get little reaction of support on my view in the Region, on grounds - if nothing else - of institutional conservativesm. And, I was right, from reactions you've seen to my EM. At this stage, while bowing to the consensus of colleagues, I don't want to lose the idea entirely from the SAS and think that you could put in something about the utility of the SGP for support to population NGOs and the value of the small grants program managed through EXT. The point would be to draw attention to these instruments and to open the potential for their expansion, if we can't go so far as to open wider dialogue on my idea of an IDA window. [I was most interested and encouraged to see, nonetheless, that a number the major IDA contributors liked the idea!]

Cheers, Ed

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 20, 1997 04:33pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Janet Hohnen, EA2RS (JANET HOHNEN@A1@WBHQB)

EXT.: 81217

SUBJECT: RE: SSP, comments on the white cover

ALex,

You may have been at Mr. Stiglitz meeting with HD people this afternoon. He made 2 comments which I would claim support earlier comments on the HNP sector paper.

1. He again reiterated the importance of focusing on actions to health status to achieve economic and human development goals. e.g. ensuring that people eat vegetables every day; controlling tobacco use; these may bring better returns than attention to health services. (My interpretation: this supports the points (a) that we must seriously work on ways to get health gain outside the health service sector, and this should be clearly addressed in the SSP, and (b) that we should be in the health service business, to the extent that we can help improve the real effectiveness for health gain and protection from impoverishment; and our initiatives in this area should be monitored and evaluated accordingly.)

2. In reflecting on recent US attempts at health reform, Mr. Stiglitz speculated that it may have been better to start by trying to fix the public system, rather than the private. (Interpretation: there is a role for public health services even in rich countries, and for supporting public health service improvements, esp. when they provide essential services to the poor.)

(Concerning your proposed change on wording of the health goal for HNP. I prefer my original wording)

Good luck

Janet

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 05:19pm

TO: A. Edward Elmendorf (A. EDWARD ELMENDORF)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SAS - IDA and 100 percent financing option

Ed,

I tried to call you. When you get in give me a ring so we can have a chat.

I agree we should keep pushing for the 100% financing and had a meeting with Alan Gelb your Chief economist at lunch today (we know each other from the time he directed and I participated in the WDR on transition economies). We had a very good chat and he is very sympathetic to the 100% financing idea. He is also sympathetic to the idea of special donor aid efforts to a small group of "desparately poor" countries. He suggested a joint meeting next time around with the Afr team and some people he would invite. He also mentioned a Mr. Harrold in your region who is working on budget (PE issues I think he meant). It sounds like this is someone who is working on the comceptual idea of how to determine optimal budget envelopes for public expenditures in the AFR region and make this consistent with the IMF policy advice. Someone in your group might want to follow up on this before we meet with Alan as a group.

As for slipping things in the SAS, life is not that simple. I am getting unsollicited comments from legal (I have no idea where they are getting my document from since it is not me sending it to them). They are very edgy (and quick to spot I must say) about things that are not consistent with Bank policy or the Articles of Agreement. At the time of the last OPC meeting they made a big stink because somewhere in the document I referred to "humanitarian aid". This time they are accusing me of slipping thing in the document that is not consistend the Articles of Agreement. The worst is that of course each time the put David De Ferranti and members of the OPC on the cc list of their correspondence -- just to make sure that I don't overlook their comments I suspect. In other words, it is virtually impossible not to either modify or be prepared for a fight when they raise an objection.

However, back to the IDA question, according the Olga, in fact our IDA recommendation relating to the SGP is not challenged so maybe that is our window of opportunity even if it is not a new IDA window.

Give me a call and we can chat a bit about this.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 10:54pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Althea Hill, EA1HR (ALTHEA HILL@A1@WBHQB)

EXT.: 84474

SUBJECT: RE: SSP and Health Care Financing

Dear Alex,

Thanks for the personal response, which I didn't by any means expect, knowing from bitter experience how harried the TM of this kind of task always is, but much appreciate.

Re population, I would emphasize that I'm not alone in the worry about losing the pop/dev agenda, I think it worries most people with a pop background in the Bank (not to mention outside). But I appreciate the difficulties you face in this respect -- and indeed I think the subject needs a full treatment of its own rather than uneasy integration into a basically health framework.

Re nutrition, I do hope that PHN can retain childhood PEM, as effective interventions for this have close links with health services and are so much a part of caring for child health (and indeed adult health too). And no other sector is going to focus on child needs in the same effective way.

Re health financing, what do I know? I just would like to see some rigorous cost-benefit analysis applied to health financing and health service systems, and so far i haven't seen much attention paid to actual health outcomes in the debate, though there's lots of data, I would think.

anyway, I'm not trying to be a nuisance, and look forward to your next draft

Althea

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 08:15pm

TO: ALTHEA HILL (ALTHEA HILL @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: SSP and Health Care Financing

Althea,

Thanx for your thoughtful comments. I have had a chance to go over the various suggestions from different people and wanted to get back to you about a couple of questions you raised in your EM.

First on population, I guess since Cairo, we are allowed to speak about maternal and child health but not population policies. I agree that this topic is not being well developed in the paper and will have to make this quite clear in the forward of the next version.

Second, we have made an attempt to address nutrition and will try to strengthen this story, especially the intersectorial and non-health sector aspects. The truth is that much of this agenda -- other than micro-nutrients -- will probably be addressed through PREM and ESSD Networks not the HD sector. I will try to clarify this.

On health financing, the one thing we have learned is that out of pocket payments do not provide social protection, private insurance has too much market failure assiciated with it. This leave government financing and social insurance as the main and most efficient channels for risk pooling in most counties except the poorest which do not have the institutional capacity to collect taxes. In these countries, community financing, with all its imperfections is the solution by default. I will try to make this crisper. But in reality this really is one area where we should be careful not to be too perscriptive since much actually does depend on country context.

We are planning to make the next verion shorter and more focussed with the current version becoming more of a technical annex. I look forward to you comments if you have time when the Yellow Cover comes out.

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 07:57am

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Tom Merrick, HDDHE (TOM MERRICK@A1@WBHQB)

EXT.: 36762

SUBJECT: RE: SSP Comments from Althea Hill

Alex,

I agree with Ane's suggestion that Althea's (and others') concerns about population could be addressed in Section I by stating that not all population outcomes are health outcomes (population cannot be reduced to reproductive health any more than to family planning) and that the main focus of the paper is on getting health systems to work better. While the section on "Origins of Good Health and Illness" recognizes that other factors affect health (including reproductive health and nutrition), a "population" outcome such as elimination of unwanted fertility has benefits to individual (more household investment in children's education) and societal (avoiding externalities associated with high rates of population growth) welfare that go beyond good health and avoiding illness (whereas the factors outside the health system that impact on nutrition ultimately do impact on health/illness).

The primary focus of the SAS is on health systems. Getting health systems to work right is very important for health status (including reproductive health/family planning). The SAS cannot be expected to fully articulate strategies for addressing issues beyond the health system. Recognizing that factors outside of the health system are important doesn't mean that the health system has to fix them (this is where attention to the social sectors at the CAS level should come in) or that the health system is responsible for fixing the other sectors (education) whose activities also affect non-health population outcomes.

The HNP SAS has a lot of good ideas and strategy for getting health systems to work better, but need not go beyond recommending that broader issues affecting health, nutrition and population (with no mention of the non-health aspects of population) be addressed in the CAS. The challenge of getting the Social Sectors right in the CAS process is bigger/more complex than what can be done in the SAS.

Tom

CC: Anne Tinker (ANNE TINKER@A1@WBHQB)
CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 11:02pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Olusoji Adeyi, EC2HR (OLUSOJI ADEYI@A1@WBHQB)

EXT.: 85835

SUBJECT: HNP Sector Strategy Paper

Alex,

Salut. The following are my observations and suggestions. I've tried to exclude the more obvious ones raised last Friday.

Organization and assumptions.

Make it possible for the reader to answer the following questions effortlessly: (i) what is this paper about? (ii) how is it organized? and (iii) what is new about it -- or what does it reaffirm?

You may want to add a paragraph to the executive summary or the first chapter to facilitate this.

You may also consider having a matrix to map your diagnoses to proposed interventions and expected outcomes -- and make your assumptions about linkages between interventions and outcomes explicit. As it stands now, there is a disturbingly unqualified belief that "the government is the problem".

New strategic policy directives

I think that the trilogy of poverty alleviation, health outcomes improvement and financial sustainability is just about right -- and more than enough to chew. There is, however, an overemphasis on knowledge at the expense of know-how. How, did I hear you ask? In my view, (and based on pre-Bank field experience in Africa and Asia, both as an expat and a national), I think that we must collaborate very actively with specialized agencies AND maintain in-house capacity to be savvy consumers of their recommendations. That message should be explicit, in the lines, not just between the lines. We cannot have an effective health sector in the Bank (as distinct from a health finance sector, which is necessary but not sufficient) if Bank staff are such generalists that they are uncritical consumers of specialized literature on health. Be explicit.

The same consideration applies to the knowledge broker role.

New approaches to using credits and loans.

I suggest that the balance between improved use of existing recurrent expenditure and the net addition of new capital investments are not mutually exclusive. The decision should be made on a case-by-case basis. You will always run the risk of overgeneralization in a paper like this. Is the Strategy

Paper a monument to command and control in a Bank/Sector that is virulently anti-government, according to the central hypothesis of the same paper?. If it is not, hence_a judicious use of qualifiers is advisable.

CAS Link

The CAS should be reviewed for, inter alia, the way in which the strategic policy framework fulfills preconditions for sustainable gains in aggregate health status (without raising unrealistic expectations of attributable improvements in health status). This is absent from the draft of March 1. Why? Isn't there is a major risk of crossing the line between the Bank's comparative advantage (to be maximized) into the realm of a supply-driven Sector Strategy Paper focusing on financing alone (to be avoided). Ditto for the section on skills mix.

Congrats on a truly superb effort. I hope that you realign it to be more congruent with the twin objectives of improving health and improving efficiency.

Regards.

Soji

CC: CHRIS LOVELACE (CHRIS LOVELACE@A1@WBWASH)
CC: GUY ELLENA (GUY ELLENA@A1@HUNGAR)
CC: VERDON S. STAINES (VERDON S. STAINES@A1@WBWASH)

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 03:16pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Davidson Gwatkin, HDDDR (DAVIDSON GWATKIN@A1@WBHQB)

EXT.: 33223

SUBJECT: The Bank as a Knowledge Broker

Alex,

Here are the thoughts I promised concerning the SAS section on "New Role as a Knowledge Broker" on pp. 45-46 on the white cover report, for you to discuss with others.

I am not at all comfortable dealing out of context with one small part of a document that I think is a fine piece and a major contribution. But I do have some thoughts about that particular small part that I suspect will be shared outside the Bank. And it seems much better for you to hear these from me now, rather than from others later.

To many, the section will be seen as presenting a heavily top-down approach toward research agenda-setting -- as a signal that the Bank plans to set the world's health policy and operational research agenda, promote it aggressively, raise money for it, and fund developing country institutions to work on it (not on what the institutions or policy makers in their countries want done, but what the Bank has decided the agenda ought to be). There's no reference I can see to participation by or consultation a la the Bank's emerging operating style; rather, on health policy/operational research, the section makes it sound more as if the Bank is moving in the opposite direction.

In taking such a position, the section places the Bank firmly and uncompromisingly on one side of the vigorous debate about global relative to national priority-setting for policy research that took place during the AD HOC Review discussions of health policy. I had thought the debate was on its way to being settled through a consensus position that saw room for and specified the role for each kind. I suspect that a Bank position like that in the current draft stands a pretty good chance of reopening it.

At the global level, the section also puts forth a go-it-alone strategy. That is, the Bank to is proceed independently and unilaterally to set the world's health research agenda, without reference to any of the other international agencies. What about the fledgling Forum for Health Research, a product of the AD HOC review being developed

with Bank support, whose role is to bring the various agencies together to agree on research priorities? What about the new mechanism for health policy research that's to be recommended to the Forum by a Swedish-Norwegian meeting next month that Dean and I are attending? The Bank intends to ignore these and other agencies, set and push its own agenda regardless of what they think priorities ought to be?

What would I propose as an alternative? Here's an partial illustrative suggestion, covering only the three bulleted sections:

"...This will be achieved by

-- Playing a leading role in establishing and gaining consensus for a research agenda on issues in which the Bank's client countries have expressed particular concern -- such as reducing the disease burden of the poor, improving perfomance of health service delivery systems through a new balance in the public/private mix, and mobilizing sustainable financing.

-- Providing leadership in mobilizing additional resources for R&D focused on these critical policy areas; and

-- Lending directly for R&D in individual countries to strengthen national capacities in conducting the country-specific research needed for policy formulation in the areas indicated."

I apologize again for focussing at such length on one small part of such a fine manuscript. But this is the one small part about which we happened to be talking, and one of those about which you asked for reactions. Hope the thoughts are of some use, if only for entertainment purposes.

Good luck, Dave

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
CC: Dean Jamison (DEAN JAMISON@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 06:20pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Diana Weil, HDDHE (DIANA WEIL@A1@WBHQB)

EXT.: 36782

SUBJECT: comments on SAS

I am sorry for the delay in sending the following comments on the SAS text. I started drafting this a week ago, and then got enmeshed in a few major "fires" at my other office all this week. I hope it is not too late for this input (Friday deadline I know). First comments refer to "my area", TB.

1. On page 18, under Re-emerging and New Communicable Diseases.

I am not sure that I agree with the referral to tuberculosis immediately following the phrase: "Prevention and treatment policies must constantly adapted to keep up with these trends." I would take out the word constantly.

I would propose the following replacement sentences for the paragraph on TB:

In tuberculosis control, the "DOTS" (Directly-observed Treatment, short course) strategy has been found to be highly cost-effective, by detecting, effectively treating, and documenting cure of infectious TB cases, to reduce morbidity and mortality and to prevent the creation and spread of drug-resistant strains. The district-based approach is being adapted, established and expanded in a range of low- and middle-income countries (e.g., China, India, Ghana, Mozambique, Vietnam, Peru, Kyrgyzstan). In China, over 300,000 patients have been successfully treated so far, under a Bank-supported project.

(the current phrasing is incorrect. It is not the drug combination that has been shown to be cost-effective, but rather the whole delivery system (including case detection and the monitoring and evaluation system).

2. Executive Summary: page vi, second bullet. In order to advance its health outcomes agenda.... the paragraph seems to suggest that the principal way for the Bank to contribute to improved health outcomes is through investment in (and analysis of) divestiture of social assets. It seems to me that the paragraph could be more evenly balanced to represent the Bank's likely continued work to facilitate wider adoption of documented cost-effective approaches (in both public and private sectors) in health care delivery and disease control (for those, through market failure, cannot be served by private market). Reducing these inefficiencies and improving quality might deliver more improvements in health outcomes in the short-run while the more complex design and process of social assets divestiture proceeds over the longer-term. This theme is in the main text, though still not sufficiently articulated I think.

3. I would suggest that there be more explanation at the end of the document (page 53 currently) of why the Bank should pursue special initiatives (i.e., justifying why they are useful so as to lessen criticism expressed at the review meeting). Looking at the current list of possibilities (which I hope could include TB -- you suggested it would -- also note that IMCI is excluded) for initiatives -- it almost looks like a carving up of elements of an "essential package". I, therefore, would suggest that it would be useful for the Bank to play a role in exploring how to increase cooperation across initiatives. Ultimately, all of the interventions listed are dealt with by the same health workers -- to train them, supervise them, and maintain their interest in any and all areas is a challenging task.

4. As expressed in the review meeting, and in the Operations training course I just attended last month, the Bank is now moving to be more "client-centered and client-responsive", will the Board want the document to express more clearly this objective?

5. Also, the role of the Regions is not very clear in Section IV.

Other comments:

Footnote 1 on page viii, CAS review point (ii): will you not include any heatlh outcome varilables?

Page 2 of text, third paragraph. I am not sure why you say "even in" the world's poorest countries....

Page 5: box on health of world's poorest billion. There is an important underestimate of the DEATHS OF WOMEN. Somewhere over 0.5 million women die solely from maternal causes, but if you include (as does the sentence in the document) communicable disease as well, the total is likely closer to 2 million. WDR 93 estimated that 724,000 girls (five and over) and women die due to tuberculosis alone. The total for women alone would likely be over 0.5 million. If we add to that malaria and HIV deaths and other communicable diseases..... I would be happy to review the new GBD book for data on this.

It would be great if the SAS helped acknowledge that women's development and family life is affected adversely not only by women's deaths and disability associated with reproductive health, but also a broader range of diseases that affect both sexes (but for which women may have greater problems seeking and receiving help).

Page 15: bullet in first column: probably shouldn't use the word "enshrined".

Page 15, second column, last paragraph: due to poor policies, immunization coverage is leveling off.... not clear what is meant by poor policies -- could a example be given, or specify further what kind of policies?

Page 19, box on New Directions in Pop and Repro health: the last paragraph (on India) follows awkwardly after the general description of the ICPD approach.

Page 24 -- in the list of constraints or challenges in pursuing social divestiture, I assume, should be well-defining the expected market failures and

preparing for them (not just the provision of statutory subsidies for the poor, but also what interventions should continue to be pursued by public sector at least during transition to private provision).

Page 26 -- bottom of box -- I saw no previous reference to the 70% risk pooling level -- so it is not clear where that figure comes from.

Page 27 -- bottom of first bullet, probably should say, "due to age or pre-existing health conditions"

Page 27, in the box -- price controls is listed as a heading and an item under the heading

Page 30 -- second paragraph, describing the gradual expansion of areas of WB loans -- why is HIV/AIDS prevention and care defined separately from health activities -- is it multisectoral?

Page 30 - third paragraph, text says 27% of total, graphic says 24% -- why difference?

Page 36 -- end of second bullets: are local governments necessarily "closer to the people" (a rhetorical question I quess)

Page 36-- top of second column -- is it clearcut that the rural poor are necessarily worse off than the marginalized urban poor (or do we just not have diaggregated statistics to measure their conditions as easily as rural poor)?

Page 36 -- bottom of Mexico box, last line -- are the results really ALL postive?

Page 44 -- second to last paragraph, isn't IMCI part of the basic package (as opposed to something extra)?

Thanks for the opportunity to read the document -- I learned a lot.

Diana

A L L - I N - 1   N O T E

DATE: 24-Mar-1997 08:52am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Jacques Baudouy, MNSHD (JACQUES BAUDOUY)

EXT.: 32525

SUBJECT: Ssp

Hi Alex -- just back from mission I am amazed by the thousand pages of comments on the white cover. For curiosity's sake how do you intend to deal with this? I am sending by separate EM my own comments that I will keep brief to the extreme... but I would be glad to discuss further with you any specific point you are interested in.

Best -- Jacques

CC: Maryse Pierre-Louis (MARYSE PIERRE-LOUIS)
CC: Eva Jarawan (EVA JARAWAN)

A L L - I N - 1   N O T E

DATE: 24-Mar-1997 09:04am

TO: Jacques Baudouy (JACQUES BAUDOUY)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: Ssp

The comments we have received have been very useful in setting a direction for the YC revisions. The task now is to shorten the document to about 30 pages, sharpen up the central message about the mandate of the Bank in HNP (as indicated in Chapter IV), tone down the private sector rethoric (while maintainig the message about greater diversification in supply and get out the next shortened draft for review by the OPC.

I know you must be very busy so, if you are going provide me with feedback, my suggestion would be to wait a couple of weeks and I will give you a copy of the early revised draft to have a look at. I have found your previous personal inputs very useful and would welcome this again before the next formal review.

CC: Maryse Pierre-Louis (MARYSE PIERRE-LOUIS)
CC: Eva Jarawan (EVA JARAWAN)

A L L - I N - 1   N O T E

DATE: 22-Mar-1997 03:57am

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Kathie Krumm, EA2CH (KATHIE KRUMM@A1@CHINA)

EXT.: 4000

SUBJECT: RE: SAS - WC

thanks--it wasn't lack of courage but lack of time. I'm glad you got some substantive comments the last go around. On next version, please feel free to tell me where I should focus my attention.

A L L - I N - 1   N O T E

DATE: 07-Apr-1997 06:51pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Logan Brenzel, HDDHE (LOGAN BRENZEL@A1@WBHQB)

EXT.: 34983

SUBJECT: Comments on the Draft SSP

As I mentioned, I have a few comments on the draft Sector Strategy Paper which may or may not be useful to you at this point.

Executive Summary

1) Does the word "population" also include reproductive health? You may wish to make a footnote up-front that reproductive health includes population activities.

2) Regarding the Bank's new role as a Knowledge Broker: do we have the skills mix necessary in the sector now for promoting an aggressive research agenda? and what exactly does out-sourcing the HNP research agenda mean? What role will the DEC have?

3) It seems to me that one of the prerequisites to using new approaches in the sector for lending is having adequate and timely ESW. In a climate of diminishing resources, how will this be ensured?

Section I:

1) Under origins of good health and illness, you may wish to mention that education for girls has the effect of delaying age at marriage, thereby reducing marital fertility rates.

2) Under impact on quality of life and productivity, the fourth paragraph starts out by discussing declining youth dependency ratios, but ends up discussing ratios from aging. This was confusing to me.

3) Under Inadequate Resources: I thought the minimum for a basic package was $12 per capita rather than $10. Perhaps Annex 2 will explain.

4) One point which needs to be raised is that because an intervention is cost-effective, does not mean that it is necessarily affordable, particularly in countries with very large population sizes.

5) The HNP Sector has a lot to learn from the social protection literature and sector on targeting. Would it make sense here to recommend that we need to measure the effectiveness and efficiency of our targeting efforts? I think there is a lot of rhetoric about targeting the vulnerable and the poor without much quantitative analysis to support claims in the HNP Sector. We may have some misconceptions in our sector about who the poor and vulnerable really are, and generalizations probably do not enhance effectiveness of projects. For instance,

the middle-class may be "vulnerable" to changes in government policies which restrict subsidies or raise taxes on imports, etc., which may have adverse health outcomes. In Pakistan, less than 2% of the population uses the rural, public health system, with most of the poor using traditional or private sector providers, including quacks.

Section II:

1) The section on reproductive health could be strengthened. Would it be possible to mention the relationship between good maternal outcomes and infant and child health as an example of investment in human capital. The use of the term "grotesque" in the box on FMG seems out of place and quite strong.

2) The box on Reproductive Health and Cairo: the last paragraph needs to be integrated better into the text.

3) Under Improving Performance: what about improving the quantity and quality of the manpower which works in the HNP sector in developing countries? This is often one of the major constraints to implementation, particularly in low-income countries.

4) There is a lot of focus in the document on the 3rd wave of privatization, but could you describe the first and second waves more. I think there are many countries which are in these stages.

5) One issue which is implict but not directly stated is the role of "incentives" in the health sector. I agree that a government that cannot provide the right incentives for public sector provision may have difficulty in regulating or controlling private sector provision of the right mix of HNP services at an acceptable level of quality. Could we focus more attention in our work in the sector on helping governments to get the incentives right?

6) Under Securing Sustainability: For countries which cannot afford the basic package, it seems to me that donor assistance will play a substantial role in the financing of these services. From a public finance perspective, user charges should only be relevant for the essential clinical care portions of the basic package. User charges also tend to have a limited role in overall health care financing. Further, cost recovery systems can be associated with cost escalation, at they create incentives for providers to over-prescribe in order to generate needed revenue, particularly in a financially decentralized system. Finally, user charges may be a regressive policy for certain population groups, if means testing, etc. are not successfully employed. Perhaps you could mention that the objective of mobilizing resources through user charges and community financing schemes should not be at the expense of other objectives, such as equity and efficiency in the sector.

7) Under Evolution in the Lending Portfolio: specific, targeted interventions do not only focus on the poor. For instance, HIV/AIDS prevention programs usually target wider population groups.

8) Do we know why the Bank's lending is not reaching the intended target groups (poor and vulnerable)? How much is due to these groups not being appropriately targeted or effectively targeted? How much is due to the difficulty of means testing and implementing targeting programs? How much is related to systemic and

political reasons, or insufficient knowledge about the health-seeking behavior of beneficiaries?

9) I would be interested to see the results of Annex 3 if possible.

CC: Tom Merrick (TOM MERRICK@A1@WBHQB)
CC: Anne Tinker (ANNE TINKER@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 09-Mar-1997 04:34pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Davidson Gwatkin, HDDDR (DAVIDSON GWATKIN@A1@WBHQB)

EXT.: 33223

SUBJECT: RE: FYI - Number on the world's poor.

Alex,

I'm writing from home and don't have anything readily at hand. But I think I have somewhere in my office a copy of the Martin Ravallion paper that is the source of the figure for the 1.3 billion people living below the poverty line. I'll try to find it and send it to you tomorrow.

As I remember, the paper has regional but not country breakdowns. I don't think it has any figures for the wealthy population groups. (Manny, Martin, and colleagues make a point of focussing on ABSOLUTE poverty -- that is, the people below a certain level of income -- and not on RELATIVE poverty -- that is, the degree of difference between upper and lower groups. This places them on one side of a clear divide within the anti-poverty business, on the other from the people who worry more about relative poverty and its equity implications. People in health tend to talk more about equity, thus giving them a somewhat different outlook than the Bank -- although not important enough to spend much time worrying about.)

As I recall, Manny is away next week, as he was last week, at a Harvard course. So there may be a delay in getting a response from him. But the Ravallion paper I hope to get to you has about all that Manny's office has produced, I think.

On another topic, I'm currently in process of putting the final touches on a set of revised tables concerning the burden of diseases for the world's richest and poorest, which appear in your draft. I'll have these to you in the next couple of days. There's not enough difference between them and the earlier version to affect the conclusions.

Best, Dave

A L L - I N - 1 N O T E

DATE: 06-Mar-1997 04:13pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Akiko Maeda, HDDHE (AKIKO MAEDA)

EXT.: 80367

SUBJECT: Thinking strategically about data management

Alex,

In going over the latest version of the statistical annex tables for the SAS, I have noticed that you introduced a number of new variables in the health service/utilization category (e.g. hospitals, primary care units, etc).

Whilst I agree with you that Bank staff should be made aware of the magnitude of "missing" information in the sector and the importance of collecting essential data, I believe this point will become lost if we overload the data base with a large number of variables. You will recall that we had several meetings back in October to decide what were the key variables to be collected for the global data base. There was a reason for selecting the variables that we did at the outset. One of the most important hallmarks of good data management, and one which is frequently overlooked, is parsimony. There is a trade off between the real informational value of an additional variable, and the increase in the cost of data collection and analysis, as well as the multiplication of the sources of error introduced by that new variable. The other point I wanted to make has been raised already by Ed: there are certainly further refinements that can be made at the regional level, but these will vary from region to region, and from country to country. Trying to accomodate all the regions down to this level will clutter up the global data base.

For the time being, I strongly recommend that we stay with the variables that we have picked already. Even for these basic indicators, we show many blanks in the columns - sufficient to send the message that we need to be more proactive and systematic in collecting data for the sector. That message should be made explicit in the text.

As for the decisions about just what are the key indicators and how should a standardized data base on the sector look like, these require region-specific review and discussion. For example, a variation of the national health accounts format can be devised for each country that have key elements that are common to all NHAs, while including country-specific items that are peculiar to that country. SAS statistical annex

provides some of the basic raw materials for initiating such discussions. It is not the appropriate instrument for elaborating on precisely how such a database should look like.

As a general comment, SAS data should be presented as an invitation to the regions to expand and deepen their analysis of the trends in the sector. I understand and appreciate that you are trying to stimulate a discussion, and to the extent that playing a devil's advocate can achieve that end, it is well worth taking a stance on some key issues, however controversial they may be. However, too much interpretation of data can backfire - it might give the impression that you are banishing all thought process from the regional staff.

Rather than doing modeling and regressions, at this stage it might be more helpful to provide the kind of visual presentation that we normally do in the "exploratory data analysis" phase of any data management process. YOu have seen my earlier versions of the scatter plots, by region and by income levels, of the variable of interest (e.g. per capita health expenditure) vs. log income level. These pictoral presentation of the same data that are presented in the SAS tables offer rich material for stimulating discussion among the regional staff.

CC: EDUARD R. BOS (EDUARD R. BOS @A1@WBHQB)
CC: GEORGE SCHIEBER (GEORGE SCHIEBER @A1@WBHQB)
CC: VIVIAN HON (VIVIAN HON @A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 31, 1997 10:06pm

TO: See Distribution Below

FROM: Alan Gelb, AFTMI (ALAN GELB@A1@WBHQB)

EXT.: 37667

SUBJECT: Normative Benchmarking of Health and Education Spending

Gentlemen:

As you know we plan a regional project in the area of benchmarking social spending in Africa, with the objective of moving towards a normative budget framework for adequate service delivery and for a fiscal approach towards aid. Recent developments suggest that this thrust is right on target -- but we may be called on to provide some indicative estimates of appropriate minimal levels of spending quite soon, as an input into a G7 initiative planned for Denver in June.

Suppose you were asked the following questions:

for a representative low-income country in Africa, what would be

a) appropriate and adequate, yet realistic, health and education packages

b) the cost of such packages, say in PPP $ per head.

The objective is to provide a framework for a G7 guarantee of adequate investment in people for well-managed countries as part of a larger G7 initiative that includes trade reform and the environment for investment.

How would you respond? I know from Alex that the Health Strategy paper seeks to develop such guidelines.

Grateful for any inputs,

Alan.

DISTRIBUTION:

TO:	BIRGER FREDRIKSEN	(BIRGER FREDRIKSEN@A1@WBWASH)
TO:	PETER HARROLD	(PETER HARROLD@A1@WBWASH)
TO:	ALEXANDER PREKER	(ALEXANDER PREKER@A1@WBWASH)
CC:	CLAUDIA CARTER	(CLAUDIA CARTER@A1@WBWASH)
CC:	L. Alan Winters	(L. ALAN WINTERS@A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

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TO: See Distribution Below

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How would you respond? I know from Alex that the Health Strategy paper seeks to develop such guidelines.

Grateful for any inputs,

Alan.

DISTRIBUTION:

TO: BIRGER FREDRIKSEN (BIRGER FREDRIKSEN@A1@WBWASH)
TO: PETER HARROLD (PETER HARROLD@A1@WBWASH)
TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)
CC: CLAUDIA CARTER (CLAUDIA CARTER@A1@WBWASH)
CC: L. Alan Winters (L. ALAN WINTERS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 07-Apr-1997 06:51pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Logan Brenzel, HDDHE (LOGAN BRENZEL@A1@WBHQB)

EXT.: 34983

SUBJECT: Comments on the Draft SSP

As I mentioned, I have a few comments on the draft Sector Strategy Paper which may or may not be useful to you at this point.

Executive Summary

1) Does the word "population" also include reproductive health? You may wish to make a footnote up-front that reproductive health includes population activities.

2) Regarding the Bank's new role as a Knowledge Broker: do we have the skills mix necessary in the sector now for promoting an aggressive research agenda? and what exactly does out-sourcing the HNP research agenda mean? What role will the DEC have?

3) It seems to me that one of the prerequisites to using new approaches in the sector for lending is having adequate and timely ESW. In a climate of diminishing resources, how will this be ensured?

Section I:

1) Under origins of good health and illness, you may wish to mention that education for girls has the effect of delaying age at marriage, thereby reducing marital fertility rates.

2) Under impact on quality of life and productivity, the fourth paragraph starts out by discussing declining youth dependency ratios, but ends up discussing ratios from aging. This was confusing to me.

3) Under Inadequate Resources: I thought the minimum for a basic package was $12 per capita rather than $10. Perhaps Annex 2 will explain.

4) One point which needs to be raised is that because an intervention is cost-effective, does not mean that it is necessarily affordable, particularly in countries with very large population sizes.

5) The HNP Sector has a lot to learn from the social protection literature and sector on targeting. Would it make sense here to recommend that we need to measure the effectiveness and efficiency of our targeting efforts? I think there is a lot of rhetoric about targeting the vulnerable and the poor without much quantitative analysis to support claims in the HNP Sector. We may have some misconceptions in our sector about who the poor and vulnerable really are, and generalizations probably do not enhance effectiveness of projects. For instance,

the middle-class may be "vulnerable" to changes in government policies which restrict subsidies or raise taxes on imports, etc., which may have adverse health outcomes. In Pakistan, less than 2% of the population uses the rural, public health system, with most of the poor using traditional or private sector providers, including quacks.

Section II:

1) The section on reproductive health could be strengthened. Would it be possible to mention the relationship between good maternal outcomes and infant and child health as an example of investment in human capital. The use of the term "grotesque" in the box on FMG seems out of place and quite strong.

2) The box on Reproductive Health and Cairo: the last paragraph needs to be integrated better into the text.

3) Under Improving Performance: what about improving the quantity and quality of the manpower which works in the HNP sector in developing countries? This is often one of the major constraints to implementation, particularly in low-income countries.

4) There is a lot of focus in the document on the 3rd wave of privatization, but could you describe the first and second waves more. I think there are many countries which are in these stages.

5) One issue which is implict but not directly stated is the role of "incentives" in the health sector. I agree that a government that cannot provide the right incentives for public sector provision may have difficulty in regulating or controlling private sector provision of the right mix of HNP services at an acceptable level of quality. Could we focus more attention in our work in the sector on helping governments to get the incentives right?

6) Under Securing Sustainability: For countries which cannot afford the basic package, it seems to me that donor assistance will play a substantial role in the financing of these services. From a public finance perspective, user charges should only be relevant for the essential clinical care portions of the basic package. User charges also tend to have a limited role in overall health care financing. Further, cost recovery systems can be associated with cost escalation, at they create incentives for providers to over-prescribe in order to generate needed revenue, particularly in a financially decentralized system. Finally, user charges may be a regressive policy for certain population groups, if means testing, etc. are not successfully employed. Perhaps you could mention that the objective of mobilizing resources through user charges and community financing schemes should not be at the expense of other objectives, such as equity and efficiency in the sector.

7) Under Evolution in the Lending Portfolio: specific, targeted interventions do not only focus on the poor. For instance, HIV/AIDS prevention programs usually target wider population groups.

8) Do we know why the Bank's lending is not reaching the intended target groups (poor and vulnerable)? How much is due to these groups not being appropriately targeted or effectively targeted? How much is due to the difficulty of means testing and implementing targeting programs? How much is related to systemic and

political reasons, or insufficient knowledge about the health-seeking behavior of beneficiaries?

9) I would be interested to see the results of Annex 3 if possible.

CC: Tom Merrick (TOM MERRICK@A1@WBHQB)
CC: Anne Tinker (ANNE TINKER@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 03:16pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Davidson Gwatkin, HDDDR (DAVIDSON GWATKIN@A1@WBHQB)

EXT.: 33223

SUBJECT: The Bank as a Knowledge Broker

Alex,

Here are the thoughts I promised concerning the SAS section on "New Role as a Knowledge Broker" on pp. 45-46 on the white cover report, for you to discuss with others.

I am not at all comfortable dealing out of context with one small part of a document that I think is a fine piece and a major contribution. But I do have some thoughts about that particular small part that I suspect will be shared outside the Bank. And it seems much better for you to hear these from me now, rather than from others later.

To many, the section will be seen as presenting a heavily top-down approach toward research agenda-setting -- as a signal that the Bank plans to set the world's health policy and operational research agenda, promote it aggressively, raise money for it, and fund developing country institutions to work on it (not on what the institutions or policy makers in their countries want done, but what the Bank has decided the agenda ought to be). There's no reference I can see to participation by or consultation a la the Bank's emerging operating style; rather, on health policy/operational research, the section makes it sound more as if the Bank is moving in the opposite direction.

In taking such a position, the section places the Bank firmly and uncompromisingly on one side of the vigorous debate about global relative to national priority-setting for policy research that took place during the AD HOC Review discussions of health policy. I had thought the debate was on its way to being settled through a consensus position that saw room for and specified the role for each kind. I suspect that a Bank position like that in the current draft stands a pretty good chance of reopening it.

At the global level, the section also puts forth a go-it-alone strategy. That is, the Bank to is proceed independently and unilaterally to set the world's health research agenda, without reference to any of the other international agencies. What about the fledgling Forum for Health Research, a product of the AD HOC review being developed

with Bank support, whose role is to bring the various agencies together to agree on research priorities? What about the new mechanism for health policy research that's to be recommended to the Forum by a Swedish-Norwegian meeting next month that Dean and I are attending? The Bank intends to ignore these and other agencies, set and push its own agenda regardless of what they think priorities ought to be?

What would I propose as an alternative? Here's an partial illustrative suggestion, covering only the three bulleted sections:

"...This will be achieved by

-- Playing a leading role in establishing and gaining consensus for a research agenda on issues in which the Bank's client countries have expressed particular concern -- such as reducing the disease burden of the poor, improving perfomance of health service delivery systems through a new balance in the public/private mix, and mobilizing sustainable financing.

-- Providing leadership in mobilizing additional resources for R&D focused on these critical policy areas; and

-- Lending directly for R&D in individual countries to strengthen national capacities in conducting the country-specific research needed for policy formulation in the areas indicated."

I apologize again for focussing at such length on one small part of such a fine manuscript. But this is the one small part about which we happened to be talking, and one of those about which you asked for reactions. Hope the thoughts are of some use, if only for entertainment purposes.

Good luck, Dave

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
CC: Dean Jamison (DEAN JAMISON@A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 12, 1997 03:50pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Martin Ravallion, PRDPH (MARTIN RAVALLION@A1@WBHQB)

EXT.: 36859

SUBJECT: PRDPH Comments on the HNP Sector Strategy Paper (White Cover)

Thank you for sending Manny Jimenez the white cover version of this paper. I am acting for him, while he is on management training at Harvard. I thought he would be unable to find time to review the paper, and so reviewed it myself, with help from others. But, as it turned out, your paper was interesting enough to attract him from the rigors of training. So you ended up scoring quite a few comments from PRDPH. Mine follow immediately, then those of Harold Alderman, Martha Ainsworth, Manny and Lant Pritchett.

As you will see, the paper's main messages were generally quite well received. But we still had a number of substantive concerns about the content. The quality of the analysis was a common one, with bearing on some of the implications drawn for sector policy. For example, we took strong objection to the method used for measuring a country's performance in delivering health care services. The pitfalls (which others in PRD have raised before) of the "cost-effectiveness ratios" used here are brought out well in Lant's comments. "Over-sell" and lack of focus in the paper were other common concerns (Martha's questions are good ones). I think I can speak for all of us in recommending a major edit, cutting heavily on places, focusing the paper more, and tightening up the logic and analytics throughout. A more objective, circumspect, style seems to be called for, and more caution about what we do and don't know. Not surprisingly, we all reacted strongly to the (rather odd) statements made about "out-sourcing" the Bank's research.

We hope these comments will help in revising the paper prior to going to the Board.

I personally read the Executive Summary and the first and last sections. (Other reviewers went further into other chapters.) My reactions were as follows:

1. The broad contours of the strategy outlined in the overview and conclusion seem sensible enough, though I am surprised that anyone thinks they add up to a "new policy paradigm" (p.44). Where the paper seems weakest is in the logic and analytics, and

Section 1 seemed very weak to me. These weaknesses may or may not have implications for the detailed implementation of the proposed strategy. But it is worrying that impartial analysis has clearly given way in many places to (thinly disguised) sector-advocacy. This could hardly lead to good policy making and public spending in the sector, let alone the economy as a whole.

2. The problems can probably be fixed in time. A more objective tone can be achieved by avoiding the loaded judgments which regularly creep into key sentences. The following are examples from the first page of the Executive Summary:

* Para 1: Why "more importantly" in the first sentence of the ES? Doubtful, or at least contentious.

* Para 2: What are the "improvements" that the 2nd sentence is referring to? Presumably the para is referring to gains since 1990. Is the author really claiming that these had nothing to do with income gains, but were solely to do with "improvements" (not related to incomes, one way or another) and "interventions" within the sector? That would seem extraordinary.

* Para 3: I would argue that the main reason why the number of poor is not falling is lack of economic growth, though this depends in part on education and health. Actually, I think we have established pretty convincingly that, when sustained growth in average living standards occurs, the poor almost invariably benefit. (I can provide references.)

3. However, the conclusion readers are being asked to draw here is that "..in many growing economies, a substantial poverty group fails to participate in [economic growth]" and (hence) the "..number [of poor] has failed to decline" (page v), but that the sector policies proposed here will change that. And in the final section of the paper we are told that "a substantial poverty group fail to participate in the benefits of improved economic conditions" (p.43). The paper should be more careful in distinguishing between:

(i) lack of poverty reduction due to the poor not participating in the economic growth that has occurred in a country (implying redistribution in favor of the nonpoor); and

(ii) lack of poverty reduction due to lack of sustained growth in average living standards.

The first is quite unusual, as the body of objective evidence from country experience now confirms. Put bluntly, the real culprit is (ii).

4. This does not mean, however, that delivering basic health services to poor people is irrelevant. Indeed, I would argue that basic health and education is important to:

(i) economic growth (and, hence, poverty reduction), and

(ii) non-income dimensions of human welfare.

In short, one does not need to argue that incomes are unimportant to defend the need for a pro-poor health strategy.

5. As it is, I would recommend deleting the entire "overview" section of the ES and the paras in the last section which repeat these claims.

6. I don't understand why "financial sustainability" is put at the same level as "poverty alleviation" and [raising] "the quality of people's lives" in defining the three "central missions" of the sector (p. v of ES and last section). Things like financial sustainability can be important, but only in so far as they bear on human welfare broadly defined. So I would be inclined to subsume the third mission under the first two.

7. There is a risk of a serious credibility problem in the frequent references to the "new HNP mission", the "new HNP strategy" and the "new policy paradigm". The risk is that (informed) readers will respond "what's new?", while (uninformed) readers will question why we weren't doing this all along. For example, I do not see how some of the things listed in the lower half of p. vi in the ES can be identified as the indications that "the Bank will change the way it works with clients in achieving their HNP objectives". Have we not been talking to Ministries before? Have we not been saying for 20 years that HNP programs have a role in poverty reduction? (Read the 1980 WDR, let alone the 1990!)

8. "As a general rule, the Bank will focus on framing ... research questions, and in assessing and disseminating the results, rather than conducting the research" (p.vii, and repeated on p.45). The author can't possibly mean "the Bank" here. That would imply the end of in-house research, which is news to me and others (not just in the Research Department). I am also skeptical that non-researchers can properly evaluate research by others.

9. I would be careful about drawing too much solace from the 1996 Human Development Report or its antecedents. Consider, for example, the left-side box on p.3, drawn from HDR, 1996. What can one conclude from the statement that no country has had a long period of economic growth which did not come hand in hand with improvements in "human development"? The box (following HDR logic) wants us to conclude that "economic growth is not sustainable without human development". One might just as easily infer that causality runs the other way -- that sustained economic growth typically does generate improvements in basic health and education -- a conclusion the box is clearly not well disposed towards. The evidence alone does not tell us which is

right. An objective analysis would be more careful. (On this and related issues you might like to have a look at my paper, "Good and Bad Growth".)

10. Another example: p.3 right-side box, also from HDR 1996, though this source should be referenced. The box tells us that "Recent Growth has Failed to Benefit A Quarter of the World's Population". Again it is important to distinguish the two cases I define above; to say that "growth failed the poor" is surely somewhat deceptive when in fact there was no growth. As it is the headline is ambiguous, if not deceptive.

11. I had serious concerns about the way in which performance in health care delivery is calculated by "factoring out" effects on health outcomes attributed to higher average incomes, lower inequality, and higher female education -- the remainder is attributed to health care delivery (p.7-8). This is deemed a "powerful technique" (p.7). However, I am not so sure. There are three concerns:

(i) The method assumes that health care did not also lead to higher incomes, lower inequality, and/or better education. The authors surely don't believe that! Indeed, this assumption directly contradicts claims made earlier in the paper, such as on p.2 where we are told that "healthy and well-educated people make an economy more productive" (i.e., raise average income). You can't have it both ways: if health care also raises incomes (and possibly makes incomes more equally distributed, and also possibly facilitates better education of women) then the method this paper has used to measure the contribution of the health care system is biased. I would note also that (based on other regressions of this sort that I have seen) the variables that are being "factored out" here probably explain 90% or so of the cross-country variance in the levels of the health indicators. So maybe health care deliver matters little, independently of these other variables. (What, by the way, was the R-squared for these regressions?)

(ii) The method also assumes that there are no other independent factors influencing health outcomes i.e., that everything else (after factoring out average incomes etc) is due to health care delivery. That too is very hard to accept. If nothing else there will be measurement errors in the health outcome indicator. But surely there are other determinants too, such as environmental factors.

(iii) Even aside from these measurement issues, it is unclear to me how one should interpret "good performance", as assessed by this technique. Consider two countries both of which have unusually low under 5 mortality (say) given their average incomes (ignore the other factors for exposition purposes). This method deems them both to be equally successful in health care delivery. Yet they could have got there in two very different ways. Country A implemented a ghastly set of macro and trade

policies which reduced average incomes but had little adverse effects on U5M; so country A had low U5M given its average income. By contrast, country B got there by excellent health-care programs which did not have an adverse effect on average income.

12. In short, this "powerful technique" for measuring sector performance is questionable methodologically, and potentially deceptive. I doubt very much if this method is measuring what it claims to measure. I would certainly be worried if this was presented to the Board as something the Bank condoned. I would strongly recommend dropping this approach for now, and the country-level measures of health-sector "performance" based on it (to be included in a forthcoming Annex to the paper).

13. The paper needs to establish why we should be concerned about the fact that health care is a normal good (p.9 and elsewhere), i.e., one for which consumption increases as income increases. To the contrary, I would have thought it very odd indeed if health care was not a normal good i.e., if it was an inferior good (one for which consumption falls as income rises).

14. I am not disinclined to think that poor countries under invest in basic health care. I just do not think you have made that case here. Furthermore, the question is still open in my view, so it should not be sanctified by a Board paper. It must be judged on a case by case basis.

15. Unless given a good argument to the contrary, how can we override the judgments poor people themselves make about what is in their own interests? Other parts of the Bank are telling us to listen to the people. The fact that poor people choose to spend little on something -- like health care -- that you happen to think is important, does not constitute a case for public action to change their choice. One must establish that there is a reason why they may be choosing unwisely; if you can't find one, then you must surely respect their own judgments; to do otherwise is little more than self-serving paternalism. And it could make poor people even poorer.

16. I am reminder of some old debates on housing and urban poverty. There was a widely held view (apparently still held in some circles) that governments should use urban planning regulations to force poor people to spend more than they do on housing; this was (oddly) thought to be in their own interests. Yet the cost to the poor could be large from (in effect) pushing them off their notional demand schedules. If there is an anti-poverty case for doing so it must depend on identifying reasons why their choices are wrong for them -- such as health externalities associated with sub-standard housing -- and even then it does not follow that the planning regulations are welfare improving.

17. In a similar vein: p.10, box "Low-income countries have weak capacity to raise revenue". Actually, that does not follow

from the graph on p.10, showing that the share of government revenues as a % of GDP rises as GDP rises. Indeed, I suspect that all the graph reflects is that publicly provided goods tend to have an income elasticity of demand over one i.e., they are "luxury goods". It may have very little to do with capacity constraints on ability to raise revenue.

18. Something is amiss in the discussion of "tendencies towards expenditure escalation" (p.11). There is an odd interpretation of income elasticities here. (Income elasticities for housing in poor countries are also over one; but I have never heard anyone say that this implied "escalating housing expenditures".) And footnote 5 is wrong as stated, and would be only a little better if "inflation" was replaced by "income". (An income elasticity over one means that the percentage of income devoted to health care rises as income rises, all other things held constant.)

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A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:03am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Martin Ravallion, PRDPH (MARTIN RAVALLION@A1@WBHQB)

EXT.: 36859

SUBJECT: Review meeting

Alas another commitment meant I could not attend the review meeting for your report, but I asked Lant Pritchett to attend. And you have our many written comments. Any questions, please get back to me, or any of the others. Manny will be back Monday (and I will be leaving on mission Tuesday for one week).

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
CC: Emmanuel Jimenez (EMMANUEL JIMENEZ@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 12:15pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Martin Ravallion, PRDPH (MARTIN RAVALLION@A1@WBHQB)

EXT.: 36859

SUBJECT: RE: Review meeting

Good, though I do hope we can get you to agree with more than a couple of the (many) points we made! Happy to try.

Judging from the 1997 HDR, I still see some distance from my views and UNDP (HDRO), and so do they; but with time I think they will come around. This is a topic in which broad agreement on "big picture" points is not too difficult. However, the devil is in the details, as are the policy implications.

A L L - I N - 1   N O T E

DATE: 10-Mar-1997 12:05pm EST

TO: See Distribution Below

FROM: Harold Alderman, PRDPH   (HAROLD ALDERMAN@A1@WBHQB)

EXT.: 30372

SUBJECT: Comments on HNP sector paper

The draft sector strategy has two dominant strengths. First, it is explicit in recognizing that despite major new directions under consideration, the starting point for any changes is its history. This, of course, is largely by way of background for the refocusing proposed. The second dominant strength, then, is the manner in which this refocusing parallels new directions in financing economic growth in other sectors.

Indeed, while the core messages of the need to consider the interplay of private and public actors or that the Bank should be a knowledge broker are adequately developed in the context of the health sector, these are by no means specific to that sector. A number of the other innovations such as new lending instruments (for example, for post conflict resolution) and changes in staffing also indicate that the sector is moving in parallel with the Bank in general. Similarly, the need for more sector work 40 transcends the HNP sector.

I have little to add on these elements. Where the draft disappoints is in regards to the details that should be more sector specific. These are occasionally lacking or, if presented, are decreed with little attempt at persuasion or justification.

For example, no justification is presented for the research strategy proposed. Nor are any details offered on the mechanism by which the Bank will be able to provide leadership in framing operational analysis and mobilizing resources. Moreover, the stated exception to the outsourcing is embarrassingly self-serving. Again, no justification of this choice is presented.

It is widely known that the uncertainly of research outcomes mocks any attempt at putting all one's

research efforts in one basket. Moreover, and probably more important, given the diversity of the sector and the instruments used, the Bank requires a knowledge base that reflects the range of programs and approaches in which the Bank expects to lead.

Although I find the report's pronouncement on research to be among the most glaring errors, I will not devote more space to counter this view, simply because I anticipate that colleagues will address this at length. However, I do want to add one general comment which is as much about the presentation of the recommendations as their content. A recent review on how information makes policy in the Journal of Economic Literature by Robert Nelson drew the distinction between three sources of decision making: interest, ideology, and information. If the Bank wants to be perceived as making its internal policy on the latter, it needs to both generate information and take the time to use that information to persuade.

While the treatment of research is one example of the report failing to rationalize its recommendations, this tendency is found elsewhere as well. For example, page 36 states that three broad categories require fresh approaches with no indication why the current approaches are not working. Indeed, page 15 offers a list of cost effective approaches that overlaps with those that page 36 implies are in need of overhaul.

Unfortunately, where the report does try to offer evidence to bolster its approaches, it often fails to convince. Four examples of very weak analysis:

1) While the analysis of residuals in a regression can be used to motivate further work, it is naive to draw any conclusions from the blank check that residuals offer. Thus, the methodology on page 7 and 8 is not a powerful tool, but simplistic rhetorical device.

2) Even though the argument that economic growth is not sustainable without human development is credible, page 3 hardly makes the case. One case easily find counter examples by a perusal of the Tables in any WDR. Indeed, using the 1996 WDR one would place Sri Lanka in the upper left not the upper right.

3) The argument of expenditure escalation makes a point of a difference in private and public income

elasticities for middle income countries that may not even be statistically significant while making no mention of far greater differences for low and high income countries that do not support the point being made. It gives the strong impression that the conclusion was drawn in spite of, and not due to, the evidence in the table. Furthermore, the discussion hints that expenditure growth drives cost escalation. One can not go too far on this without information of the supply response of providers which is not discussed. Incidently, footnote 5 is wrong: the final word should be income not inflation.

4). While the overall arguments for new sector staff (and a new mixes within sub-disciplines) sound valid, the comparison of the number of high level staff in the sector with total Bank staffing does not advance these arguments.

Also, in regards to sub-sector portfolio, the HNP paper might be better billed as a H(np) paper. There is virtually no mention of population strategy and that on nutrition (eg page 17 and 18) seems undeveloped. Too much is lumped under a catch all of community nutrition. Also the emphasis on fortification fails to mention the alternatives of supplementation and dietary change which at least need to be considered. Moreover, in the last decade or more the emphasis on vitamin A and iodine has gone well beyond alleviation of clinical manifestation of blindness and of cretinism. The discussion makes no mention of the broader audience.

Though less important to the arguments in this report the box on page 6 is also not convincing. For a 10% cigarette tax to increase public revenues by 5%, the share of expenditures on cigarettes [exclusive of the tax] to GNP must be half of the ratio of all revenues to GNP. I do not know the numbers for China, but its worth double checking these. Is also worth double checking the pharmaceutical budget presented on page 11. It implies that 88% of all drug expenditures are wasted.

Three final quibbles: First, while the report should be congratulated for taking up the issue of FGM (page 17), this valiant step is weakened, because there is no information on the effectiveness of the bold measure that have been praised. Critics argue that these are ineffective or even counter-productive.

Second, there are far better partners for the Bank within governments than the Ministry of Interior who often are responsible for police and security measures. Page vi lists this ministry as one often involved in caring for poverty groups. I can just picture an outside critic putting a spin on what this caring implies.

Third page 28 promises three simple policies, but I see only one.
{{SUB}}

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TO:	Shanta Devarajan	(SHANTA DEVARAJAN@A1@WBHQB)
TO:	Jeffrey Hammer	(JEFFREY HAMMER@A1@WBHQB)
TO:	Martin Ravallion	(MARTIN RAVALLION@A1@WBHQB)
TO:	Emmanuel Jimenez	(EMMANUEL JIMENEZ@A1@WBHQB)

A L L - I N - 1 N O T E

DATE: 20-Mar-1997 10:08pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Harold Alderman, PRDPH (HAROLD ALDERMAN@A1@WBHQB)

EXT.: 30372

SUBJECT: RE: HNP SSP

To folow on my earlier comments:

Regarding the box on high growth and human capital investment: I don't doubt the overall point, but I find the approach useful as a rhetorical tool rather than an analytical one. The specific comment I made (regarding Sri Lanka) is merely that it doesn't fit the argument since the 1996 WDR lists the growth of GNP per capita in Sri Lanka (1985-94) at only 2.9% while the box had a cut off at 3%. Moreover, if one used the 1995 WDR, Sri Lanka has a growth of only 2.7, that is less than the 3.1 for Pakistan, which is on nobody's list investment in human resources. [For some reason this figure for Pakistan drops to 1.3 in the 1996 WDR. Maybe a typo].

The more general point is that after the fact, one can find cases to illustrate a point, but such arguments are usually very selective in their use of examples. They may serve as a counter example show that x is not a necessary condition for y (eg. high income is not necessary to have low indicators of life expectancy) but this may not serve to make a general conclusion. As Aristotle said: its easier to dispose than propose. Substituting another country might advance the rhetorical point, but doesn't change the fact that the approach is selective.

As to FGM. I raised the issue of the impact of legislation because it has been argued that by making the practice illegal without there being a corresponding change in its popularity it becomes more likely that the operation occurs under village rather than clinical conditions. If so, the impact on the victims might be negative. This is, as you might imagine, very hard to document, but it strikes me as plausible. Its a complex topic; there was a Bank sponsored review, probably by thye gender group, but I do not know the author(s).

I would be glad to reread the nutrition section in the next draft. However, I am leaving for mission right after HD week. I would hope that a few staff members who are trained nutritionists (Judy Mcguire and Richard Seifman come first to mind) might be available to offer comments.

Regards.

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 08:55am

TO: Harold Alderman (HAROLD ALDERMAN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: HNP SSP

Many thanx for the clarifications.

Actually, the next draft won't be ready until after you probably get back. Both Judith and Richard have been valuable contributors to the current volume. In fact most of what is in there was written by them (although I take full responsibility for any errors), that is why having an independent reviewer on this part of the document would still be useful.

Have a good mission.

A L L - I N - 1 N O T E

DATE: 12-Mar-1997 11:05am EST

TO: Martin Ravallion (MARTIN RAVALLION@A1@WBHQB)

FROM: Lant Pritchett, PRDPH (LANT PRITCHETT@A1@WBHQB)

EXT.: 33777

SUBJECT: Sector report

Martin,

I think the basic messages of the report are sound: that health is a complicated sector in terms of the mix of market failures, that the record of government failures is simialrly impressive (or depressive) and complex, and that the focus of the Bank should be on facilitating an inteleectual and political proces that leads to the right mix of responsibilities and incentives across the actors-- and that mix will strongly differ across levels of capacity and development.

which is not to say that the report is sound (else what's a white cover for?) and there are many rough edges on this gem. I hope the report had multile authors cause it certainly has multiple personalities.

I am sure my collegues will point out the egregious: the silly and ideologically quirky bit about cost escalation, the failure to be clear the the residuals of a health regression are not an indicator of health policy: they aer an indicator of the most that health policy can possibly explain.

Let me just point out two things.

First, I was struck on finishing the report that the single most important thing about health care expenditures from a policy point of view was not documented: that some disease conditions have low treatment costs per episode and others have very high treatment cost per episode. This fact is central to most of the policy and country health conditions that the report was discussing, yet this did not come through clearly.

Let me make an analogy (although one constant tension between eoncomists and sector sepcialists is that specialists tend to see their sector as unique while economists see mainly analytic similarities). I think the economic sector most like health is the automotive sector.

In both there are:

operating expenses: gas, food
routnie maintenance: oil, preventive care
minor predictable repairs : brakes, diarrhea
major catastrophic expenses: major accidents, splenectomy

Now here are the non purchase costs of operating a car per mile in th US (assuming 10,000 miles annually):

gas and oil:	6.7
maintenance:	2.2
tires	.9
Insurance	7.2
license, reg	1.7

Now we all agree that the fact that the cost per mile of gas and oil (6.7) and of insurance (and hence less the mark-up for insurance costs, the costs associated with insruance) (7.2) are roughly the same is completely irrelevant for policy, right? don't we? None of us would propose that since the rare exogenous event of a major auto accident requires insurance that this creates some implications for the market for tires, right?

I used to think the most pernicious thing about cost effectiveness was the potential confusion between "medical intervention" cost effectiveness--which has no policy implications and "public sector" cost effectiveness which does.

Now I have beomce convinced the problem with cost effectiveness goes much much deeper than that: it is taking the ratio between cost and health gain in the first place that is the really the problem.

Cost per mile is precisely the wrong thing as cost per mile confuses small regular expenditures like oil or ORS with large unpredictable expendituers like body (shop) work.

Here's the kind of crazy line of reasoning this taking of ratios can lead to (and I am not saying the report does this, just that others do do this with the ratios as an enabler):

a) we all know the government nees to interevene in health becuase health expenditures are large and unpredictable and insurance markets don't work,

b) if government is going to be involved then we want to have cost effective expenditures,

c) therefore the government should finance what has a high ratio of benefit to cost,

d) empirically it usually (though not always) turns out that things that are relativly cheap per episode (immunizations, ORS, family planning) are highly cost effective, therefore

e) governments should spend less on hospitals and more on basic care.

This is like starting from auto accident expenditures as a rationale for government intervention (and governments should indeed mandate auto insurance) and concluding the government should finance only oil and no body work.

The report could be much clearer about its differentiated messages if it put more emphasis on the cost per episode and not cost per DALY or cost per

population to provide because:

a) the reason the evolution of disease conditions between diarrhea and heart surgery and cancer is important is the cost per episode differences.

b) cost escalation is a problem with disease conditions with high cost per episode

c) the real problem with health care markets are the insurance problems is when there are three actors: the consumer, the provider and the financer as any two want to gang up on the third. SO, while there is supplier induced demand I am sure the problem is incredibly worse for body shops (where, conditional on exceeding the decuctible the consumer has little incentive) than for brake repairs. The problem is then incredibly worse when there are three and one is a monoplist and potential disaster when two are (e.g. centrally run health services which combine provision and finance).

My second point is that family planning as a health intervention is an effective shibboleth of analytic influence.

lant

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The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 10, 1997 02:52pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Mead Over, PRDEI (MEAD OVER@A1@WBHQB)

EXT.: 33451

SUBJECT: Comments on HNP Sector Strategy Paper

Alex,

The Sector Strategy Paper for the HNP Family is a comprehensive and ambitious document. In most respects, the document is sound and it launches the Bank's HNP family in the right direction. My comments can be organized around three themes where I believe the document can be strengthened: the role of the government in the HNP sectors, the definition of "health sector reform" and the nature of Bank-supported and Bank-performed research in the HNP sectors. Minor editorial comments are appended.

The Role of the Government in the HNP Sectors

The SSP states on page 21 that there are three reasons that the government plays a role in the health sector: "to protect the poor (equity), to correct for market failure (efficiency); and to deliver a social contract (social choice)."

The third of these justifications is interesting. Does the government also have a social contract to build roads? to provide a safety net for the poor? to subsidize staples for urban residents? to provide clean air and water? to uphold the rule of law? provide for national defense? If so, in the presence of scarce resources, which of these contracts takes precedence over the others?

The text on this page states that a "social contract" to provide health care "often leads to unbalanced investments, lack of sustainability, disregard for quality of care and disrespect for individual choice. Not only does this [the social contract?] contribute significantly to a discrediting of many of the more positive aspects of government involvement in the HNP sector, but it [the contract?] may also undermine parallel poverty alleviation strategies when it leads to an indirect subsidization of the rich" (SSP, p. 21).

This tantalizing bit of political economics should be elaborated in at least another paragraph. Why does government commitment to a social contract to provide HNP services

"discredit many of the more positive aspects of government involvement"? Why does such a contract often lead "to an indirect subsidization of the rich"? Are such negative effects of a social contract also present when the contract is to provide for the rule of law? for national defense? Do such negative effects occur in all countries or only in certain countries? Is there a body of research or analysis in or outside the Bank on which one can draw here? (Also the antecedents in the quoted paragraph would be clearer, if the paragraph were less compressed.)

After this short section which seems to argue that the Bank should disregard "social contracts" where they exist, there is a box on China which says that "Chinese policy makers are now faced with the urgent need to build [for the health sector] a new regulatory framework, financing system, safety net and quality control mechanism for the expanding private sector to underpinning [sic] its [China's?] past social progress in terms of health outcomes and recent economic growth."

As juxtaposed with the text quoted above, the message of this box is not clear. Is this an example of a country seeing the light and deciding to disregard a social contract which used to exist, but is now considered financially unsustainable and politically obsolete? Or is this an example of a country that is struggling to establish a new, more modest, social contract which aims not to make care universally accessible, but only to correct the equity and efficiency problems which arise in an unfettered private market for health care? Or is this an example of a country which used to support a social contract to make health care accessible to all, was forced to renege on this contract during a period of liberalization, but now feels "an urgent need to build" a new social contract? The box does not currently distinguish between these three alternative views of the changes currently under way in the Chinese health system and so provides the reader with less clarity than would be desirable on the Bank's views on these matters.

<u>Health Sector Reform and Mechanism Design</u>

The term "health sector reform" has become common in the international health policy community, but its meaning is not clear. To some it means strengthen government services, while to others it means establish privately owned and operated health maintenance organizations in developing countries. The HNP SSP should state clearly the Bank's definition of and view towards health sector reform.

A recent publication from WHO states that one of the principles of health care reform is "solidarity," which is defined as: "each individual contributes to the system in accordance with his or her capacity, and each one receives health care when he or she needs it" (Antezana and Velasquez, Dec. 1996,

p. 7). On the next page, the same document asks rhetorically "whether by definition the role of the State is not to vouchsafe for each citizen's security, education and health" (ibid.).

In contrast, the HNP SSP states in the executive summary that "the World Bank subscribes to an emerging policy paradigm for the role of government in the health sector ... Often this [redefinition] will require a diminished role of the state as direct service provider..." (p. vi).

While both documents are sufficiently vague that their authors could claim to mean what the other document says, the tone is certainly quite different in the two documents. The implication of the language in the WHO document is that the authors intend to preserve as large a role as possible for the state. (Echoing a Marxist slogan, the solidarity principle as expressed is at odds with the principles of equity and efficiency.) In contrast, the SSP's executive summary seems to commit the Bank to arguing for a diminished role in most circumstances.

I have three suggestions for the SSP on this topic. First, the executive summary should state even more clearly that "health sector reform" will typically require a reduction in the government's role to a minimum set of "core" activities which are justifiable on the basis of equity and efficiency considerations.

Second, the text of Section II (pages 13-28) should be revised to support this main message. The current draft of Section II does not clearly argue for a reduced government role. Indeed a possible interpretation of the China box referred to above is that the government's role should be increased.

Third, in my view a critical element of "health sector reform" which is not directly discussed in the current draft of the HNP SSP is that of designing a system of rules, regulations, norms and operating procedures within which:

- patients can be insured against large health care expenditure risks,
- taxpayers can be protected from large public health expenditures,
- providers can be assured contractually agreed payments at rates that compensate them adequately for their educational investments,
- health care services with large externalities are appropriately subsidized,
- equity concerns are addressed,
- public health sector budgets are balanced,
- opportunism (i.e. cheating) by all parties is kept to a minimum and
- paperwork costs are a small percentage of total health care costs.

Designing such a system is an example of the type of

problem addressed by the new sub-field of economics called "mechanism design." There is clearly no single optimal solution to this complex problem. Rather the best solution will be country-specific, depending on the country's administrative capacity, existing health care structures, legal system, epidemiology, literacy rate, etc.. A good solution is recognizable partly by the fact that few of the actors in the system have the incentive to try to beat it. It is likely that poor countries will be forced by the scarcity of their resources to adopt systems which attain fewer of the above list of objectives, but social choice will determine which of those a given country will choose to sacrifice.

In view of the complexity of the mechanism design problem inherent in health sector reform, it may be difficult for Bank staff and/or country nationals to identify the best design in an SAR. This is an area where operational research in the context of pilot health sector reform experiments is likely to be not only desirable, but imperative, in order to avoid the danger of saddling clients with health sector reform plans that later prove inappropriate to the specifics of that country.

<u>Bank-supported and Bank-performed research in the HNP sectors</u>.

The executive summary of the SSP states that "[a]s a general rule, the Bank will focus on framing operational analyses and research questions, and in assessing and disseminating the results rather than conducting the research. ... The Bank is committed to developing a strong in-house capacity [to create and maintain] a database on public and private sources of health care financing and expenditures. This will be one of the few exceptions to the strategy of "out-sourcing" much of the Bank's HNP research agenda." Similar language is on pages 45-46 in the section entitled "New Role as a Knowledge Broker."

In my view, this proposed stance towards research has five flaws:

- o it commits the Bank to "operational research" that is in fact not very "operations oriented" and not very "research",
- o it ignores the comparative advantage of Bank research on the health sector,
- o it misses an opportunity to "strengthen the monitoring of impact,"
- o it condemns Bank operational staff to reliance on ad hoc recruitment of one-mission consultants for advice on the most difficult problems of health project design,
- o it is at odds with the proposed new role of the Bank as a "Knowledge Bank."

The ground-breaking work on public and private health sector expenditures in developing countries was done by David de

Ferranti in a set of background papers for the Bank's 1987 health sector policy paper. With the importance of the topic well-established and initial estimates for the major aggregates provided by background papers for the 1993 WDR, at this aggregate level this area is no longer an intellectual frontier and therefore there is no reason for the Bank to play a role different than the one it plays in gathering macroeconomic data for the IMF and Bank government expenditure statistics. Indeed, work on public and private health expenditures would simply be an extension of that existing macro-economic data gathering exercise, which is not typically characterized as research. (For example, this activity would not be eligible for funding from the Bank's research budget.) In addition to not being research, the proposed subject is not very "operations" oriented because it does not advance knowledge on the internal processes or "operations" of the health system in a given country.

The Bank's largest comparative advantage in research in the HNP sector derives from the fact that it designs and funds many new health projects or health sector adjustment loans every year, each of which is an experiment in some facet of "mechanism design." While university researchers are used to making do with NON-experimental data on health system performance, Bank researchers can obtain actual experimental data, in some cases complete with matching data from control groups. (For example, a current research project in the education sector analyzes the results of education decentralization experiments in five countries in three regions, all of which are funded by Bank credits or loans.) Since governments are likely to be wary of quickly publicizing data on the performance of their important policy reform initiatives, Bank researchers have the additional advantage of being able to guarantee that the data will remain confidential as long as the government requires. Furthermore, because of the difficulty and tedium of designing a health reform project to include the appropriate baseline data collection and monitoring elements, the best academic health systems specialists and health economists may not want to undertake such tasks, hoping instead to get the data at the end of the experiment. (An example of a role for Bank researchers ruled out by the SSP's stance on research is in the box on the Mexico health sector reform project on page 36.)

The SSP states that it is "strengthening the monitoring of the impact" of HNP projects by including as an appendix, and proposing the maintenance of, a database of national level statistical indicators and a set of "HNP Development Diamonds" (pp. 51-53). While statistical annexes are a positive contribution and the HNP development diamond is a clever presentation device, it is hard to imagine these aggregate tools being particularly useful to OED analysts of a project's impact five years after it has been completed. The best way to strengthen the monitoring of the impact of HNP projects is to build into them substantial monitoring and evaluation components and require Bank personnel to analyze the resulting data. Bank

research personnel are the natural candidates to design and manage these activities.

Because the proposed research stance rules out the participation of Bank researchers in the study of the design of appropriate health sector reform mechanisms, the Bank will only be able to accumulate in its "knowledge base" the BTOs of its outside experts. Too few Bank staff will develop the skills and the tacit (i.e. unwritten) knowledge of health system design to enable them to transmit knowledge from one country experience to another, to serve as useful expert advisors to client countries or Bank operational staff or to participate in the global discussion of health sector reform issues. Bank staff will be forced to rely on temporary consultants for expert advice on health sector reform issues. Rather than being a repository of knowledge about health sector reform issues, a role for which the Bank has a comparative advantage, the institution will be reduced to being a consumer of the opinions of outside experts. Far from attaining the goal of being a "knowledge bank," the institution will become an "opinion bandwagon" on HNP issues.

<u>Minor Editorial Comments</u>

p. 8, para. 2: Replace the term "factored out" with "controlled for."

p. 11, para. 6: The sentence states: "Tendencies toward expenditure escalation has [sic] been observed to be much greater in the private sector than public sector in middle-income countries (see below for elasticities at different income levels)." However in the middle income level the table gives the income elasticities of public and private health expenditure to be: 1.00 and 1.08 respectively. The elasticity of 1.08 is NOT much greater than 1.00. Since the elasticity of total expenditure in this group is given as 1.14, and it should be a weighted average of the public and private elasticities, I suspect that the 1.08 is a typo and should be 1.80.

p. 16, Box on Vaccination: Should the last sentence read: "Although the government spends over 15 percent of its public HEALTH budget on Kenyatta Hospital..." ?

p. 28: The text states that "There are three simple policies which..." and then gives only one.

p. 36, Box on Mexico: The box on Mexico's Bank-financed health sector reforms describes the financing of "cost-effective packages" of health services for the poorest states, but does not mention the important insurance role of a government health care system. If the state is only financing cost-effective (i.e. cheap) interventions, what provision has Mexico made to enable the poor to get insurance coverage for the rare expensive and cost-ineffective procedures?

p. 38: The list of challenges to improving HNP performance omits the difficulty of mechanism design described above and the challenge of designing monitoring and evaluation instruments which accurately measure the incentives faced by all the actors in the system, in order to assure that all (or most) have the proper incentive to comply with the rules and that those incentives guide the actors towards the operational goals of health care reform cited above.

p. 40, para. 4: The last sentence should read: "... only two of the Bank's current 156 HNP projects deal EXCLUSIVELY with improving resource mobilization and efficiency in health care financing."

p. 50: The figure showing the HNP family omits the DEC vice-presidency.

I regret that I will be on mission on March 14, the day of the review meeting.

Mead

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The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 12, 1997 04:57pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: HNP Sector Assistance Strategy

Alex

I was pleased to see a discussion of the need to improve the performance of the public sector. Understanding incentives facing civil servants is a crucial aspect of policy analysis in health. I was also pleased to see mentioned that markets fail and that this is a reason for government (and a necessary condition for Bank) intervention even though the nature of market failure never seems to inform anything said about policy.

The report seems to have changed a lot from earlier outlines and versions. I think the standards of evidence on what is and isn't known about policies in the health sector need to be higher. This shows up in 1) the analysis of residuals 2) confidence of assertions on cause and effect of policies 3) lack of attention to analyses of the problems of markets and incentives in public service and 4) miscellaneous statements with insufficient support.

The analysis of residuals
(I got carried away with this - bail out when you've had enough)

The clearest example of the need for higher standards of proof is the measurement of "the performance of health care delivery systems, and health, nutrition and population policies" (p. 7 and following and the forthcoming Annex) (emphasis mine). To run a regression and use the residuals (i.e., the part we don't know about) as a measure of some specific concept with a specific interpretation is...is... I can't think of a word I can use in mixed company.

You could just as well have said that a new methodology was developed to assess the status of women in society (since we know that their influence on purchases of food and health care and other kinds of behavior in the home is large). All the effect not captured by income, its distribution as measured by Gini coefficients (not the right measure since the right one would depend on the variable used for income) and female education should be attributed to our new measure of women's status.

Or, you could say that you've found a (heretofore difficult to assess) measure of the "quality" of environmental policies in the countries (both biological and industrial, perhaps). Either of these two are just as legitimate names for your measure. The residual of the equations is made up of <u>everything else that could possibly affect health status</u> - <u>not just health systems and health policy</u>. If you want to see what the effect of systems and policies are, you include variables directly related to them in the regression. What happens when you do that?

A further, methodological, problem. When we think about the quality of health systems and policy (the true concept, not the proposed measure) wouldn't you expect to find that richer countries have better policies? Or that more educated people pick (and make better use of) better health systems? Or that better health systems contribute to educational achievement? Unless there is something wrong with your computer package, you'll find that your measure of health status is completely uncorrelated with income or (female) education since residuals are constructed to be uncorrelated with the other explanatory variables in the equation. What are we to make of health systems and policies which are not affected by (or affect) either income or education?

In short, it is always wrong to use a residual as a measure of anything in particular. It is extremely deceptive to call it "good health systems and policies" and contend it measures "effective preventive and curative interventions" (p. 8) or abilities to deliver a basic package of cost-effective interventions without a shred of evidence that the residual is correlated with any of these specific policies.

I didn't pick environment and women's status out of the air. I was surprised to find almost no mention of water or sanitation (forgetting industrial environmental problems). When the list of ministries which will be counterparts was presented, we got Ministries of Interior (!) but no Public Works Department. The mention of infrastructure was solely in the context of dealing with privatization, not in finding cross-sectoral investments (water, sanitation, swamp drainage) to improve health. We <u>have</u> evidence that these public policies (often real public goods) improve health status. Ditto for women's decisions within households (though the connection with policy is more context specific).

I suspect you'll have some difficulty mustering evidence of the independent effect of systems and policies. Several times in the text, Korea and Chile are identified as having distinct problems in their health systems (related to actual characteristics of the countries' policies). On pages 10, 22 and 28 we see them illustrating examples of the problems of private insurance and multiple sources of finance. They get distinctly low marks on those pages. Yet they rank third and fourth <u>BEST</u> in the under 5 mortality "residual" (p 8), right above Sri Lanka. What characteristic of their health systems or policies did you

have in mind and what makes these policies similar to Sri Lanka's? Did they have public provision of a basic package of cost-effective medical interventions? You don't say. (The answer is no.) Maybe they have good genes. Whatever it is, they did not get good outcomes because their private insurance system is bad (it probably is bad - it just doesn't have anything to do with your measure of it).

Enough on residuals.

Cause and Effect

The larger question is what is asserted about what we know about health policies, their effects on health status and the contribution the latter makes to development. The residual discussion gives the impression that we've measured this (and that the effect is very strong - the "better" the health system the better is health by definition). Other places in the paper make it seem like this is a settled issue: on page 13 we hear that the 1990 WDR and the 1996 HDR (!) have demonstrated that health status is integral to rising incomes, etc. They did no such thing. the HDR asserted that that was true but only showed evidence that income contributes to the elements in their index (I assume someone else will discuss problems with the index). They did not show causality going the other way (necessary for circles - virtuous or otherwise). I believe there is such a relationship and know of some examples showing an effect of nutrition on productivity and education but evidence is not given in these documents.

Elsewhere the efficacy of policy (particularly, it seems, the policy of cost effective basic packages) is asserted as if this were known. Page 13: policies are critical links in the vicious and virtuous circles; page 21: threats to good health are well known and affordable solutions are available; page 15: the past decades have provided a rich laboratory for learning about affordable and effective policies and implementation strategies. The last sentence would be true if anyone had actually designed credible studies of these things - unfortunately few people did. The next sentence is more telling: "Five recent initiatives have been highly influential in shaping international opinion about ...global policy direction." The key word is opinion, there is precious little evidence on this at all.

Analyzing Markets

If we want to set an agenda for the sector, we should address the need to apply (and sometimes develop) good methods for analyzing policies, for knowing what the likely consequences of policy reform we suggest will be and how to modify them in light of local market contexts. Lots of things mess up these markets and lots of policies address these market failures to differing degrees. In some places true public goods like sanitation or simple IEC campaigns are lacking, in others private

health care is really bad, in others the problem that insurance markets don't exist is paramount. Sorting out how policies interact with people's behavior is what should take up our time, energy and analytic efforts. Few of the appropriate policies are going to generalize from one case to another, though the method of analysis might.

Miscellany

Several times there is a disconnect between the stated goal of government, the policy recommendation that goes with it, and the evidence provided to support it. Social protection is asserted to be a goal yet when affordable policies are discussed (p. 11 - management of sick child, etc.) nothing seems related to "protecting" most people from unexpected losses. Poverty alleviation is proposed as a major goal of health policy but the "cost-effective" services on page 14 don't have necessary connections with poverty - wouldn't school health and nutrition programs miss the poor entirely in the (many) countries that don't have universal enrollments? Didn't AIDS affect mostly the well-off in Africa (at least until recently)? Isn't the income elasticity high for tobacco and alcohol (at least at low incomes)? Do poor people use public clinical services for care of sick children or prenatal/delivery/family planning services more than do rich people? What do these things have to do with poverty?

Which leads to the last paragraph of page 11. 1) The definition of income elasticity is wrong; 2) the table does not show what is asserted in the paragraph (even if the miscalculation or misprint on middle income countries is corrected); 3) an income elasticity greater than one (which on a budget share weighted basis characterizes half the economy - income elasticities must average unity) does not indicate anything wrong (like cost escalation, inappropriate or otherwise); and 4) the clearest inferences from the table are left unsaid. These are that health care is not the best vehicle for income redistribution (we'd really want to find a commodity with a negative income elasticity to subsidize rather than a normal good - let alone one with an elasticity greater than unity) and that public provision seems to have done worse than even the private sector in serving the poor. Perhaps we should look into why the public sector has done so badly before we cede it the responsibility to provide clinical services (to the poor no less). You know my objections to the use of cost-effectiveness as defined in the figure on page 14 as a criterion for inclusion in a "basic package" (itself a debateable policy option) so I won't go into that argument again.

One other area in which the public sector doesn't appear to perform so well is in pharmaceuticals. Some of the problems identified on page 11 probably affect the private sectors as well as public (overprescription and bad selection) but another 60% seems to be due to problems specific to public sectors since

private sectors would probably try hard to control plain old waste (here is one place where the pursuit of profits is good). You did a good job on pages 23 and 24 in identifying places where public services could use improvement. Maybe we should try to get a handle on balancing the many problems of private sectors (supplier induced demand, monopoly problems, you know the list) with these problems with the public. Maybe some things which seem "cost-effective" aren't really when you put them in the context of actual delivery systems.

Page 11 raises another point concerning the need to see what makes policy work, and at what (real) cost. The fact that under some idealized sets of conditions, lots of problems can be solved with only a little money is basically irrelevant as a guide to real policies. A good example comes from the analysis of poverty alleviation programs. Poverty gaps (the amount of money it would take to get everyone up to the poverty line) are often calculated and are always some absurdly low number like 1.5% - 2% of GDP. Do we really think we can eliminate poverty with one year's modest growth? Of course not. Pursuing this modest goal with real life policies (with incentive effects, costs of administration, targetting, etc. etc.) turns this seemingly trivial redistribution into the deepest problem of development. So calculating the resource needs for covering the services in the second paragraph on page 11 (regardless of whether these are the highest priorities for public intervention or not), in the context of real-life policies is pure fiction.

Other places where presented evidence does not relate to policies proposed or problems identified: p. 27 where did the figure of 75% for predictable sources of revenue come from? This all depends on how people respond to incentives, prices, etc. and is all context specific. Similarly, why is 6% of GDP the appropriate cutoff point for concern over the fiscal effect of health spending (p. 28)? You've established that people like to spend on health when they get richer (and to get the government to do it for them). Why cut it off at 6%?.

Why are multiple sources of finance so bad (page 28)? The scatterplot, besides having nothing to do with its title, seems to repeat the point on income elasticity just noted. If they also use multiple sources of finance then it shows that people in richer countries like them. If there is a problem here we need some measure of welfare and show how it is related to market outcomes when there are multiple sources. Comparing the text and the table makes it appear that you want Slovenia, Hungary and the Czech Republic to emulate Albania, Georgia and Turkmenistan!

To summarize:

1) The paper exaggerates what is known about policy and promotes dissemination of specific policy directions without having demonstrated their advantages over alternatives.

2)It does not link the problems of market failures to policy remedies for them (this is true of all methods of analysis that rely on the burden of disease and cost-effectiveness figures as presented in the 1993 WDR).

3) It does not provide a basis for guiding research (or knowledge dissemination) in the areas most needed for determining the effects of policy, ie. by understanding the behavior of consumers, providers (public and private) and markets. This makes the claim that the Bank will not do research in-house all the more curious since it is in the economics of health that the Bank must have an advantage over other actors in the international health field.

I hope this is of some help.

Jeff

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A L L - I N - 1 N O T E

DATE: 18-Mar-1997 07:33pm

TO: Jeffrey Hammer (JEFFREY HAMMER @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: More on residuals

Very useful information.

Actually, I think your group has quite succeeded in convincing me that we should not attribute any causality to the residual - something I was never particularly wild about. So any version of this analysis which might make it into the next version will certainly not claim any attribution.

At the same time, identifying which countries have better health status outcomes after you control for income and education levels has some merit in its own and may actually be more valid than just comparing outcomes not controlling for anything which is what most people do. So we are still going to play around with this analysis for a bit longer.

Of course all cross country comparisons are fraught with some methodological problems and I think a major flaw with the current analysis might actually be the regional breakdown which limits the sample size as well as the variations in income over time when these are pronounced. It clearly makes poorly performing countries look good due to the lag between income and possible effect on health status.

So, yes your inputs to this exercise have been very valuable, and no I don't think we are just being stubborn in trying to go beyond the usual presentation of just standard indicators.

CC: Shanta Devarajan (SHANTA DEVARAJAN @A1@WBHQB)
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CC: Lant Pritchett (LANT PRITCHETT @A1@WBHQB)

A L L - I N - 1 N O T E

DATE: 18-Mar-1997 03:36pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: More on residuals

Alex -

I hear tell that there is still some possibility that the residual "analysis" you presented in the last version of the SAS will make it into the next version. Let me give it one more shot.

Among the possible determinants of a regression line (and the residuals recovered from it) are simple transformations of the variables which are included. We may know that income is important to health status but do we know if it is the logarithm of income, a linear relation or any of the infinite varieties of other non-linear specifications that most closely explains health status? We don't know. We don't have a theory of health determination anywhere near precise enough to distinguish one from the other on a priori grounds. For the estimation of coefficients on variables with real data, this agnosticism on the functional form is not always that important. You can play with the forms to improve matters a little and the overall interpretation of the model won't usually change much (unless the true relation is very non-linear).

What can change a lot, however, is the pattern and size of individual residuals even if the distribution of all residuals is pretty invariant to specification. Since we don't usually name residuals, we don't usually care what they are, individually, and are content if the distribution is normal, or something. When we are claiming something particular about the interpretation of each residual, however, this change in the calculated residual is important.

I'm sending you a simulation I ran on made-up data in which the true relationship is that the dependent variable (health status) is equal to the square root of the independent variable (income) plus a random error (which we will define as the effect of health policy). Instead of regressing health status on the square-root of income, though, I used the log of income as would be standard if we didn't already know the answer but knew that the relation was concave. I then took the residuals of that regression and compared them to the "true" effect, the error term in the perfectly specified model.

When the R-squared of the mis-specified (logarithmic) model

was .96, the correlation between the residuals of the regression and the true effect was as close to zero as you could get. The reason is that the small deviations due to the random noise were swamped by the deviation of the log function from the square-root function. Both functions fit very well, the random component doesn't count for much and the entire "residual" is the difference between two arbitrary mathematical relations.

The dramatic effect (zero correlation) is attenuated as you increase the noise in the constructed variable relative to the systematic effect of "income". But at levels of R-squared obtained by Lant (.92), the correlation of residuals with the true effect is .72, squared is about .5. So, the residuals claimed to be health policy may be moderately well correlated with the true residuals but nowhere near enough to say they "measure" the unexplained part of the relation. And this is due solely to a minor error in specification of functional form - an error which no one would think twice about making or searching through other functional forms to correct.

Regardless of how confident some might be that the left-out part of the health status equation is due to health policy (itself an unsupported position), it can't be the case that countries health systems and policy are sensitively related to the function we arbitrarily choose to model income's effect on health status.

Jeff

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A L L - I N - 1 N O T E

DATE: 17-Mar-1997 11:00am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: A thought or two on the SAS

Alex -

I confess confusion at the reaction to the paper. There might be a way to help on both the poor/middle income country and the public/private concerns.

Think yin and yang. You can define the role of the private sector explicitly or you can let it be implicit in what the government isn't doing. In most countries (Eastern Europe might be the major exception - I'll come back to that) there is quite a large private sector and there is no reason to deliberately promote it. You can count on it cropping up and serving all the profitable (curative care, probably not too expensive) bits of the system. So, you can drop all references to promotion and concentrate on having the Bank help the borrowing country governments decide on what they should do (not what the private sector should do). For that, you can focus on how to have the government make the best contribution it can given the reaction of the rest of the system (private).

Think yang and yin. You can define the government role as everything not mapped out explicitly for the private sector (which seems to be the default option in some people's minds) or you can define it in terms of correcting the known set of specific market failures. The government can be charged explicitly with attacking the worst ones first and continuing until you run out of money or you run out of ability to fix them. Only at the last step do you need to get specific about government failures - to show that the government can't do everything just because failures exist in the private market. Its own failures argue for reluctance to charge in on any perceived imperfection of information. The Bank, through its sector work, can help identify the worst market failures and thereby help set priorities. These priorities will be different across countries and depend sensitively on the particular mixture of screw-ups on the part of both private and public sectors in each country. Figuring this all out is hard work (and will look an awful lot like research, if done well) but that seems to be the thing which generalizes across all countries.

By focussing on fixing the market failures, you simultaneously avoid seeming to bash governments one-sidedly and

say the right thing. I also think that in the poorer countries, applying this rule would tend to restrict the role of government in provision of curative, especially primary care, rather than expanding it but without any reference to promoting private services. Poor countries have other, more pressing things to do first.

The exception of Eastern Europe may have to made explicit. Here, there may be a reason for promoting a private sector just to take care of things that the government no longer thinks it can handle. I don't know. You have a lot more experience on this type of country. Just make it clear that such active promotion is only relevant to certain circumstances.

For helping the poor, the literature is large and not easy to summarize neatly. The same concern as above applies here: the right answer depends on circumstances. Sometimes geographic targetting works OK, sometimes self-selection to low amenity services, sometimes concentrating on services (infectious disease control), sometimes school-based things work (if the poor go to school but not if they don't), maybe MCH if the poor visit such services more than others (they very well might since, as you argued, they have more kids), etc. etc. Which of these make sense requires a careful look at who the poor are, what they do and how things the ministry of health does affects them. We can help countries take that look but we can't expect blanket prescriptions to work everywhere.

A minor aside: I was chatting with Lant and we (probably he) came up with an odd asymmetry. "Market failures" have with them a long history of theoretical characterization which make us think them systemic problems of market systems. Empirically, we have the United States to point out, the general lack of insurance markets and, maybe, the sense that people in poor countries (with large private sectors) are still sick (though why we think they wouldn't be, I don't know) and so the private sector must not be serving them well, particularly the poor. We fit any casual empirical impressions straight into a firm theoretical structure.

On government failures we have no such theory to indicate that problems are systemic. Therefore, we tend to think of the quite large numbers of cases of government failures (poor people bypassing free care to pay a private practitioner, no drugs, etc) as governments just "happening to fail" rather than necessarily failing. If you "happen" to fail, this can be fixed with better management (i.e., even more government). If you have a good, systemic reason to fail (incentives in supplier - induced demand, say), then this can't be fixed by just encouraging better performance and you need more government.

I think this asymmetry of standards of proof afforded by good theory on one side and not-so-good theory on the other leads to some strange beliefs on our part. Like why do we think that

the tendency to exploit patients (through supplier-induced demand) would be greater than the tendency to never show up for work at public clinics when you're paid on salary? I have no doubt that both problems exist. We should be helping the governments figure out which one is bigger and, more importantly, which is easier and cheaper to fix.

Jeff

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A L L - I N - 1 N O T E

DATE: 11-Mar-1997 11:39am EST

TO: Martin Ravallion (MARTIN RAVALLION@A1@WBHQB)

FROM: Martha Ainsworth, PRDPH (MARTHA AINSWORTH@A1@WBHQB)

EXT.: 34121

SUBJECT: Comments on the HNP Sector Strategy

Martin,

Because of the exigencies of the Policy Research Report on AIDS, I regret that I haven't been able to give the HNP strategy paper the time such a key document deserves. Since others have focused on some of the specifics, let me offer more global comments about objectives, audience and messages, as well as the issue of research in HNP. Clearly, a lot of hard work has gone into the document and there are many interesting case studies highlighted in the boxes.

Objectives and audience

This is a massive paper, 53 pages single spaced, with lots of boxes and substantial annexes we haven't seen. Yet, I came away confused about both the objectives and audience. A huge amount of this paper is descriptive -- of health problems, of health financing systems, of "best practices", of past Bank policies, etc. I got very impatient. What's new here? Where's the edge? Why am I reading it? What question are we answering? Even the foreword lacks a statement of the objective of the paper; instead it merely describes the contents. Is the audience the Board? Is this supposed to be a directive for Bank staff in the sector from the Board? Is the audience the borrowers? The public?

Messages

1. In a paper that is labelled "stategic", I expected something much more focused, concise and analytical, honing in on priorities for public sector and Bank involvement, the rationale for the priorities, a plan of action and what is needed in terms of new information or analysis to help us get there. In fact, there is no mention of the role of government until page 21, almost halfway through the paper. Even there the discussion is descriptive -- "Why do governments intervene?" Where is the discussion of when governments should intervene and the rationale for the health reforms that are recommended? Where is the discussion of why many countries can't or don't want to "do the right thing?" And of what we need to know to do a better job of helping them to do this?

The paper looks too much like part of a WDR (but not as thorough as it would need to be) with stuff on the rationale for Bank operations tacked on at the end. The "strategic policy directions" aren't discussed until page 43! If the analysis of the health situation hasn't changed much since the WDR 1993, can't these arguments be quickly summarized and updated? Can't we highlight what is new? The section called "Global policy directions" (basically best practices) can be put in an annex; the section on the HNP sector (what it has done in the past and is doing now) could also be put in an annex. Basically, if the document is really strategic, it should be organized around Section IV, bringing forth only that additional information needed to support the main points.

2. With respect to the three main strategic directions, I agree with the three in principle, but:

(a) Has the goal of more equitable and efficient allocation of resources within public health systems been dropped?

(b) Where is the distinction between public and private benefits of different health care interventions and "public sector" cost-effectiveness, as opposed to medical cost effectiveness? The notion of a basic package of health services doesn't seem to make the distinction between services that are public goods, those with externalities and those with purely private benefits; in the countries with the fewest resources where funds are inadequate to finance the "package", how can a policy maker prioritize among the elements?

Research

The fact that DEC was not among those consulted for this paper is glaring in its inadequate treatment of research. A consensus on "best practices", adhering to a low-cost and cost-effective package of health services in the 1993 WDR, and maintaining a data base on health finance in developing countries will not be sufficient to design, monitor or evaluate the progress of Bank lending and government programs in improving health outcomes. The paper, while making the case that the Bank should set the research agenda, in fact makes no suggestions on what that agenda should be. The suggestion to use the talents of local researchers more often is laudable, but in many countries the skills do not exist to do the necessary analysis with sufficient rigor.

How will the Bank go about monitoring the performance of health systems in improving health status? Neither analysis of residuals (I'd suggest dropping it from the beginning of the paper) nor monitoring of "key indicators" will not be adequate to attribute an outcome to a specific programmatic or policy change. I'd suggest a very active program to prospectively evaluate the impact of specific reforms on the performance of health systems and on health outcomes across countries, using whenever possible

pilot projects or sequenced implementation of interventions. This requires substantial coordination across projects and countries, a common analytic framework and sustained effort over an extended period. Such research is already underway in the education sector.

The key to improving health, nutrition and childbearing decisions is understanding individual responses to policy and programmatic interventions. It is not the health system per se that determines health status, and the recommended reduction in the scope of government activities highlights the need to understand what policy and regulatory decisions will help people to make better choices. Past Bank research on the demand for health care, as well as on nutrition, childbearing and family planning, has highlighted the role of prices, quality and access to services in individual decisions, and the fact that individuals are the key decision-makers. It has also highlighted the complementarities between human resource sectors.

Neither of these perspectives are apparent in this report, which has a very "top-down" flavor. But the success of Bank-supported programs depends criticially on understanding these individual responses. With respect to health decisions, the research has often stopped at utilization of health care or choice of provider. But the objective of health policy is not to raise demand for health care per se; it is to improve health outcomes. The research agenda needs to incorporate both the intermediate decisions and final outcomes. We need more prospective studies of the impact of specific inputs, perhaps in the context of pilot projects, on decisions and outcomes. In the context of "reproductive health", how do the specific characteristics of services influence outcomes? Does "unmet need" have any meaning at all?

The impact of decentralization and community-based management of health care is another huge issue on the horizon that could have major repercussions on the effectiveness of programs. It is essential that we take these opportunities to evaluate their success in different settings.

Finally, we also need to understand why so many countries do not implement efficient and equitable solutions. Why do they often do the "wrong thing"? Is it just implementational capacity or lack of information? Political economy issues would seem to loom large. Are there examples of countries that have been able to act in spite of political problems? What can be learned from these experiences?

I hope this helps.

Martha

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 6, 1997 02:55pm

TO: Marlaine Lockheed (MARLAINE LOCKHEED@A1@WBHQB)

FROM: Dean Jamison, HDDHE (DEAN JAMISON@A1@WBHQB)

EXT.: 32924

SUBJECT: The Effects of Education and Health on Earnings in MENA

Marlaine,

Subsequent to our phone conversation yesterday morning I asked my post-doc, Jia Wang, to run the regressions you requested to assess the effects of health and education on earnings in MENA. We are using the standard data set for this kind of work: income (PPP adjusted) and per capita capital stocks from the Penn World Tables; years of education of the working age population (male) from the series constructed by Barro and Lee. We add to that Ed Bos's estimates of the probability that a male dies between age 15 and 45 in the country at the indicated time as an indicator of the health of the work force. We run the analyses for 40 or 50 low- and middle-income countries with observations on each country at 5-year intervals between 1960 and 1990. We first look at all countries then add in an indicator variable for MENA as well as the interaction of that indicator with the education and health variables. This gives us MENA-specific estimates of the effects of education and health.

The story is as follows:

1. Without including MENA-specific effects, education has the standard positive impact on income levels (and, since our model is basically Cobb-Douglass, a first-differenced model would show an effect of the same elasticity on income growth rates). When we introduce health into the model, it appears that the education variable had been picking up some of a health effect: the size of the education coefficient is reduced by about one third with health included. The health effect is quite strong; a 10% reduction in the adult male mortality rate translates into about a 4.5% increase in the per capita income. Interestingly, in all the models the coefficient on our time variable is negative, suggesting TFP DECLINES, particularly when human resource investments are factored in.

2. When an indicator variable for MENA countries is included, there is an upward shift in income -- presumably from the oil-exporting countries. (Following Lant Pritchett's example, we have crated an indicator variable for energy-exporters, but we didn't include it in these runs.) Interacting MENA with education and health leads to MENA-specific

estimates of their effects. In both cases the estimate deviation of MENA from the global average is statistically quite insignificant. If one takes the sign of the effect as having any interest, though, it would appear that health improvements have more of an effect in MENA than anywhere and education has LESS of an effect. (Could this be a reflection of a curriculum heavy on Koranic studies?)

Jia Wang is pretty fully employed these days in our work with Alex Preker, but you might let her know if you'd like a further look at this. Meanwhile I'll fax you the regressions (all random-effects GLS).

Dean

CC:	JACQUES BAUDOUY	(JACQUES BAUDOUY@A1@WBWASH)
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A L L - I N - 1   N O T E

DATE: 02-Mar-1997 07:00pm

TO: DEAN JAMISON (DEAN JAMISON @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Reletive Performance Measures

Dean,

Your lead in write up still needs a lot of editing. Also, it does not yet argue a convincing case for why we care about all this. I know what the argument is but the text does not state it. Also, I think for this to be relevant to the CAS we need some sort of summary table that identifies high risk countries.

ie couties that are sliding quickly or in the dumps. And then we need to say what we - the Bank and countries ought to do about this - and how to track if things are getting better.

Otherwise it is nice stuff for a journal article but not very relevant for the SAS.

I am not trying to harsh but only anticipate the type of reaction we will get from operations. I would like to see this stuff in the SAS but have a gut feeling we will have to fight for this to happen. So the stronger you can present the argument of "relevance" and "what to do about it" the more likely it is that we will make it fly with the SAS.

CC: SANCTA WATLEY (SANCTA WATLEY @A1@WBHQB)

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: March 18, 1997

TO: Mr. Richard Feachem

FROM: Andres Rigo

EXTENSION: 81782

SUBJECT: **Sector Strategy Paper (SSP) - Health, Nutrition and Population (HNP) Sector White Cover Review**

Further to the attached EM to Mr. Coll of last Friday, I would like to bring to your attention a number of issues raised by the proposals contained in the draft paper regarding the use of the various lending instruments.

1. The financing of 100% of expenditures for a project may raise issues of local cost financing and in all cases taxes should be excluded. I attach for your information a recent opinion of the General Counsel on the topic of financing local expenditures.

2. As regards the "new IDA window", IDA's Articles of Agreement permit to make credits directly to parties other than a member country. The consent of the government of the member country where the project is located is required. The donors of the funds for the replenishment in question would also need to agree.

3. It is not clear what is intended in item (iii) of the paragraph on "increase product selectivity" (p. 47) and how it differs from the on-lending arrangements in (ii).

4. It is not clear to what extent the proposed "shift to non-balance of payment SECALs" is meant to be an innovation or whether it can be accommodated within the recent revisited policy on SALs.

I assume this paper is intended to be reviewed by the Policy Committee. It would be helpful to accompany it with a transmittal note outlining the areas for which a policy change is recommended.

Attachment

cc. Messrs. Preker and Coll (w/o attachment)

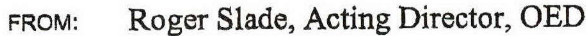
THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: March 20, 1997

TO: Mr. Richard Feachem, HDDHE

FROM: Roger Slade, Acting Director, OED



EXTENSION: 8-1293

SUBJECT: **HNP Sector Strategy Paper: OED Comments on White Cover Draft**

1. The paper appropriately focuses on the institutional constraints to effective health services delivery in developing countries. It further identifies financing mechanisms and incentive arrangements, including the public/private balance, as areas where the Bank can make valuable and perhaps unique contributions to the policy dialogue. We endorse that emphasis, but we believe more precision is necessary to achieve the "paradigm shift" that the paper recommends.

2. The paper usefully focuses on the institutional dimensions of health policy, centering on defining and then achieving an appropriate role for government in the sector. In its current form, the paper seems to emphasize the notion of government failure in service provision, without sufficient recognition of the many trade-offs that need to be considered in identifying or implementing policies designed to overcome these failures. Ultimate choices will ideally be determined through the democratic process, but political influence from stakeholders is inevitable.

3. Nor does the paper emphasize that the optimal way to modify the public/private balance depends heavily on local context, including the regulatory and legal capacities of governments, traditions of medical professionals, and the strengths and weaknesses of the private sector. Any one of a variety of arrangements (outright privatization, subsidies to demand, changing the incentives of civil servants) might be the most desirable in a given country.

4. Two experts in the field, both of whom are friendly to markets, are eloquent on this point. George Schieber writes: *"Developing countries looking to the OECD countries for models of health care financing are faced with what appears to be four basic models: a national service approach, a social insurance approach, a provincial government health insurance approach, and a private insurance approach. Yet, the health care financing of each OECD country is exceedingly complex, highly country-specific, and every country is really a combination of these models. Indeed, arguably, the models themselves are unimportant."* And Alain Enthoven, one of the inventors of "managed competition" in the health sector, argues: *"Each country's health care system reflects intimately its own history, culture and political, social and economic systems. One*

country cannot simply 'adopt' another's health care system and reasonably expect success."

5. We think the paper's arguments regarding institutional issues are best expressed in specifics, not in the abstract. Future drafts might make a more deliberate effort to sketch out what is, and what is not, empirically demonstrated about the development effectiveness of alternative mixes of public and private responsibility in the sector. Work on OED's HNP study suggests that the unknowns far outweigh established facts on these issues. Moreover, OED's study indicates that the Bank's own project experience with the design and implementation of alternatives to public provision is strikingly thin. A future draft of the strategy might turn this gap in our knowledge base into a virtue by being more explicit about the need to take a "learning by doing" approach to the evolution of policy and inviting our clients to become more active participants in the process of defining and experimenting with alternative institutional arrangements in the sector.

6. OED's ongoing review of experience in HNP suggests that, as in other sectors, political commitment is critical for the success of specific investments, but that it is an especially difficult variable to identify and analyze. It would be useful for future drafts of the paper to be more explicit about how the Bank might better equip itself (through additional staff skills, partnerships with local actors, more participatory approaches to sectoral policy analysis, and investment design) to both understand and employ the politics of the sector to achieve health policy goals. Achieving a shift in the role of government in the sector will place heavy demands on a relatively weak area of Bank capacity, as reflected in the performance record of past projects. More than two-thirds of the 62 completed HNP projects reviewed in the preparation of OED's ongoing study of HNP reported significant problems in achieving institutional change and in capacity building. Evidence of difficulty in improving public provision of services would suggest some need for caution in arguing that governments will be better able to regulate and guide nongovernmental action in the sector.

7. Although Section IV of the paper reviews trends in the volume and objectives of the Bank's HNP portfolio, it provides little discussion of how effective this lending has been "on the ground." The problem of defining and then measuring development effectiveness in this sector is a major challenge, not only for OED, but also for the HNP strategy. The current draft of the paper suggests criteria to assess health system performance (which are consistent with the approach being taken in the OED study), but it does not discuss the relevance of these criteria for assessing the development effectiveness of Bank activity in the sector. Although the "HNP Development Diamond" is a useful step toward developing national level indicators of sectoral performance, the paper doesn't yet provide a framework for judging the development effectiveness of specific investments or policy dialogue. The statement on page 52 that benchmarks for developing a set of indicators are "to be developed" is encouraging, but plans for evaluating the overall HNP strategy and the particular form it takes in specific countries should receive greater attention.

8. To ensure that our clients become active participants in the learning process, we suggest that the paper highlight the Bank's role in helping client countries develop greater capacity to evaluate health policy. There is scope for recommending more specific attention to this issue in the context of specific investments. It would be useful to draw a link between the need for greater monitoring and evaluation capacity and the feasibility/desirability of pursuing innovations such as the "pilot project facility."

9. The paper's vision for the Bank as a "knowledge broker" in the sector is welcome and appropriate in the context of the new Bank. As noted above, however, this draft reports little on the Bank's own record of achievement as measured by "results on the ground."[1] In the past, we have tended to undervalue evaluation as well as dissemination of the lessons learned through our projects, although this pattern is clearly changing through the activities of the HNP Board. Given the large scale and wide variety of lending that has occurred, it would seem logical to extend the "knowledge broker" recommendation to include more deliberative, participative work with borrowers to evaluate our efforts during and after implementation. Involving borrowers more actively in the process of sharing "lessons learned" also would contribute to greater accountability (a necessary companion to the more flexible and comprehensive lending approaches the strategy recommends) and create incentives for more vigorous evaluation efforts. More attention to this matter in the report is desirable.

cc: Messrs./Mmes. Picciotto (DGO); de Ferranti (HDDDR); Preker (HDDHE); Biderman (OPRPG); Stout, Gauri, Johnston, Raney (OEDD1)

[1] Sixty percent of evaluated HNP projects are rated as satisfactory.

A L L - I N - 1   N O T E

DATE:

TO: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Suggested Agenda for SSP White Cover Review Meeting

The following provides a suggested agenda for the review meeting.

1. Brief opening statement by David de Ferranti about objective and audience for document as well as links to the HD network since there will be some people at the meeting from outside the sector and Bank such as IFC and PSD (the Foreword provides the context for this).

2. Brief statement about purpose of meeting and expected outcome by Richard Feachem:

- seek reaction to paper
- guidance on contents and presentation that needs further work; and
- agreement on next steps

3. Comments from Peer Reviews present (five have submitted written comments - two or three will be represented at the meeting).

4. Comments from others present (I suggest asking for comments from IFC and PSD who I expect to attend).

5. General comments from the floor.

6. Discussion around critical issues.

7. Summing up of recommendations and next steps.

CC: DAVID DE FERRANTI (DAVID DE FERRANTI @A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 12, 1997 04:57pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: HNP Sector Assistance Strategy

Alex

I was pleased to see a discussion of the need to improve the performance of the public sector. Understanding incentives facing civil servants is a crucial aspect of policy analysis in health. I was also pleased to see mentioned that markets fail and that this is a reason for government (and a necessary condition for Bank) intervention even though the nature of market failure never seems to inform anything said about policy.

The report seems to have changed a lot from earlier outlines and versions. I think the standards of evidence on what is and isn't known about policies in the health sector need to be higher. This shows up in 1) the analysis of residuals 2) confidence of assertions on cause and effect of policies 3) lack of attention to analyses of the problems of markets and incentives in public service and 4) miscellaneous statements with insufficient support.

The analysis of residuals
(I got carried away with this - bail out when you've had enough)

The clearest example of the need for higher standards of proof is the measurement of "the performance of health care delivery systems, and health, nutrition and population policies" (p. 7 and following and the forthcoming Annex) (emphasis mine). To run a regression and use the residuals (i.e., the part we don't know about) as a measure of some specific concept with a specific interpretation is...is... I can't think of a word I can use in mixed company.

You could just as well have said that a new methodology was developed to assess the status of women in society (since we know that their influence on purchases of food and health care and other kinds of behavior in the home is large). All the effect not captured by income, its distribution as measured by Gini coefficients (not the right measure since the right one would depend on the variable used for income) and female education should be attributed to our new measure of women's status.

Or, you could say that you've found a (heretofore difficult to assess) measure of the "quality" of environmental policies in the countries (both biological and industrial, perhaps). Either of these two are just as legitimate names for your measure. The residual of the equations is made up of everything else that could possibly affect health status - not just health systems and health policy. If you want to see what the effect of systems and policies are, you include variables directly related to them in the regression. What happens when you do that?

A further, methodological, problem. When we think about the quality of health systems and policy (the true concept, not the proposed measure) wouldn't you expect to find that richer countries have better policies? Or that more educated people pick (and make better use of) better health systems? Or that better health systems contribute to educational achievement? Unless there is something wrong with your computer package, you'll find that your measure of health status is completely uncorrelated with income or (female) education since residuals are constructed to be uncorrelated with the other explanatory variables in the equation. What are we to make of health systems and policies which are not affected by (or affect) either income or education?

In short, it is always wrong to use a residual as a measure of anything in particular. It is extremely deceptive to call it "good health systems and policies" and contend it measures "effective preventive and curative interventions" (p. 8) or abilities to deliver a basic package of cost-effective interventions without a shred of evidence that the residual is correlated with any of these specific policies.

I didn't pick environment and women's status out of the air. I was surprised to find almost no mention of water or sanitation (forgetting industrial environmental problems). When the list of ministries which will be counterparts was presented, we got Ministries of Interior (!) but no Public Works Department. The mention of infrastructure was solely in the context of dealing with privatization, not in finding cross-sectoral investments (water, sanitation, swamp drainage) to improve health. We have evidence that these public policies (often real public goods) improve health status. Ditto for women's decisions within households (though the connection with policy is more context specific).

I suspect you'll have some difficulty mustering evidence of the independent effect of systems and policies. Several times in the text, Korea and Chile are identified as having distinct problems in their health systems (related to actual characteristics of the countries' policies). On pages 10, 22 and 28 we see them illustrating examples of the problems of private insurance and multiple sources of finance. They get distinctly low marks on those pages. Yet they rank third and fourth BEST in the under 5 mortality "residual" (p 8), right above Sri Lanka. What characteristic of their health systems or policies did you

have in mind and what makes these policies similar to Sri Lanka's? Did they have public provision of a basic package of cost-effective medical interventions? You don't say. (The answer is no.) Maybe they have good genes. Whatever it is, they did not get good outcomes because their private insurance system is bad (it probably is bad - it just doesn't have anything to do with your measure of it).

Enough on residuals.

Cause and Effect

The larger question is what is asserted about what we know about health policies, their effects on health status and the contribution the latter makes to development. The residual discussion gives the impression that we've measured this (and that the effect is very strong - the "better" the health system the better is health by definition). Other places in the paper make it seem like this is a settled issue: on page 13 we hear that the 1990 WDR and the 1996 HDR (!) have demonstrated that health status is integral to rising incomes, etc. They did no such thing. the HDR asserted that that was true but only showed evidence that income contributes to the elements in their index (I assume someone else will discuss problems with the index). They did not show causality going the other way (necessary for circles - virtuous or otherwise). I believe there is such a relationship and know of some examples showing an effect of nutrition on productivity and education but evidence is not given in these documents.

Elsewhere the efficacy of policy (particularly, it seems, the policy of cost effective basic packages) is asserted as if this were known. Page 13: policies are critical links in the vicious and virtuous circles; page 21: threats to good health are well known and affordable solutions are available; page 15: the past decades have provided a rich laboratory for learning about affordable and effective policies and implementation strategies. The last sentence would be true if anyone had actually designed credible studies of these things - unfortunately few people did. The next sentence is more telling: "Five recent initiatives have been highly influential in shaping international opinion about ...global policy direction." The key word is opinion, there is precious little evidence on this at all.

Too cynical

Analyzing Markets

If we want to set an agenda for the sector, we should address the need to apply (and sometimes develop) good methods for analyzing policies, for knowing what the likely consequences of policy reform we suggest will be and how to modify them in light of local market contexts. Lots of things mess up these markets and lots of policies address these market failures to differing degrees. In some places true public goods like sanitation or simple IEC campaigns are lacking, in others private

Good but need concrete operationalization

health care is really bad, in others the problem that insurance markets don't exist is paramount. Sorting out how policies interact with people's behavior is what should take up our time, energy and analytic efforts. Few of the appropriate policies are going to generalize from one case to another, though the method of analysis might.

Miscellany

Several times there is a disconnect between the stated goal of government, the policy recommendation that goes with it, and the evidence provided to support it. Social protection is asserted to be a goal yet when affordable policies are discussed (p. 11 - management of sick child, etc.) nothing seems related to "protecting" most people from unexpected losses. Poverty alleviation is proposed as a major goal of health policy but the "cost-effective" services on page 14 don't have necessary connections with poverty - wouldn't school health and nutrition programs miss the poor entirely in the (many) countries that don't have universal enrollments? Didn't AIDS affect mostly the well-off in Africa (at least until recently)? Isn't the income elasticity high for tobacco and alcohol (at least at low incomes)? Do poor people use public clinical services for care of sick children or prenatal/delivery/family planning services more than do rich people? What do these things have to do with poverty?

Which leads to the last paragraph of page 11. 1) The definition of income elasticity is wrong; 2) the table does not show what is asserted in the paragraph (even if the miscalculation or misprint on middle income countries is corrected); 3) an income elasticity greater than one (which on a budget share weighted basis characterizes half the economy - income elasticities must average unity) does not indicate anything wrong (like cost escalation, inappropriate or otherwise); and 4) the clearest inferences from the table are left unsaid. These are that health care is not the best vehicle for income redistribution (we'd really want to find a commodity with a negative income elasticity to subsidize rather than a normal good - let alone one with an elasticity greater than unity) and that public provision seems to have done worse than even the private sector in serving the poor. Perhaps we should look into why the public sector has done so badly before we cede it the responsibility to provide clinical services (to the poor no less). You know my objections to the use of cost-effectiveness as defined in the figure on page 14 as a criterion for inclusion in a "basic package" (itself a debateable policy option) so I won't go into that argument again.

One other area in which the public sector doesn't appear to perform so well is in pharmaceuticals. Some of the problems identified on page 11 probably affect the private sectors as well as public (overprescription and bad selection) but another 60% seems to be due to problems specific to public sectors since

private sectors would probably try hard to control plain old waste (here is one place where the pursuit of profits is good). You did a good job on pages 23 and 24 in identifying places where public services could use improvement. Maybe we should try to get a handle on balancing the many problems of private sectors (supplier induced demand, monopoly problems, you know the list) with these problems with the public. Maybe some things which seem "cost-effective" aren't really when you put them in the context of actual delivery systems.

Page 11 raises another point concerning the need to see what makes policy work, and at what (real) cost. The fact that under some idealized sets of conditions, lots of problems can be solved with only a little money is basically irrelevant as a guide to real policies. A good example comes from the analysis of poverty alleviation programs. Poverty gaps (the amount of money it would take to get everyone up to the poverty line) are often calculated and are always some absurdly low number like 1.5% - 2% of GDP. Do we really think we can eliminate poverty with one year's modest growth? Of course not. Pursuing this modest goal with real life policies (with incentive effects, costs of administration, targetting, etc. etc.) turns this seemingly trivial redistribution into the deepest problem of development. So calculating the resource needs for covering the services in the second paragraph on page 11 (regardless of whether these are the highest priorities for public intervention or not), in the context of real-life policies is pure fiction.

Other places where presented evidence does not relate to policies proposed or problems identified: p. 27 where did the figure of 75% for predictable sources of revenue come from? This all depends on how people respond to incentives, prices, etc. and is all context specific. Similarly, why is 6% of GDP the appropriate cutoff point for concern over the fiscal effect of health spending (p. 28)? You've established that people like to spend on health when they get richer (and to get the government to do it for them). Why cut it off at 6%?.

Why are multiple sources of finance so bad (page 28)? The scatterplot, besides having nothing to do with its title, seems to repeat the point on income elasticity just noted. If they also use multiple sources of finance then it shows that people in richer countries like them. If there is a problem here we need some measure of welfare and show how it is related to market outcomes when there are multiple sources. Comparing the text and the table makes it appear that you want Slovenia, Hungary and the Czech Republic to emulate Albania, Georgia and Turkmenistan!

Yes it does

To summarize:

1) The paper exaggerates what is known about policy and promotes dissemination of specific policy directions without having demonstrated their advantages over alternatives.

2)It does not link the problems of market failures to policy remedies for them (this is true of all methods of analysis that rely on the burden of disease and cost-effectiveness figures as presented in the 1993 WDR).

3) It does not provide a basis for guiding research (or knowledge dissemination) in the areas most needed for determining the effects of policy, ie. by understanding the behavior of consumers, providers (public and private) and markets. This makes the claim that the Bank will not do research in-house all the more curious since it is in the economics of health that the Bank must have an advantage over other actors in the international health field.

I hope this is of some help.

Jeff

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CC:	Lant Pritchett	(LANT PRITCHETT@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 18-Mar-1997 03:36pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: More on residuals

Alex -

I hear tell that there is still some possibility that the residual "analysis" you presented in the last version of the SAS will make it into the next version. Let me give it one more shot.

Among the possible determinants of a regression line (and the residuals recovered from it) are simple transformations of the variables which are included. We may know that income is important to health status but do we know if it is the logarithm of income, a linear relation or any of the infinite varieties of other non-linear specifications that most closely explains health status? We don't know. We don't have a theory of health determination anywhere near precise enough to distinguish one from the other on a priori grounds. For the estimation of coefficients on variables with real data, this agnosticism on the functional form is not always that important. You can play with the forms to improve matters a little and the overall interpretation of the model won't usually change much (unless the true relation is very non-linear).

What can change a lot, however, is the pattern and size of individual residuals even if the distribution of all residuals is pretty invariant to specification. Since we don't usually name residuals, we don't usually care what they are, individually, and are content if the distribution is normal, or something. When we are claiming something particular about the interpretation of each residual, however, this change in the calculated residual is important.

I'm sending you a simulation I ran on made-up data in which the true relationship is that the dependent variable (health status) is equal to the square root of the independent variable (income) plus a random error (which we will define as the effect of health policy). Instead of regressing health status on the square-root of income, though, I used the log of income as would be standard if we didn't already know the answer but knew that the relation was concave. I then took the residuals of that regression and compared them to the "true" effect, the error term in the perfectly specified model.

When the R-squared of the mis-specified (logarithmic) model

was .96, the correlation between the residuals of the regression and the true effect was as close to zero as you could get. The reason is that the small deviations due to the random noise were swamped by the deviation of the log function from the square-root function. Both functions fit very well, the random component doesn't count for much and the entire "residual" is the difference between two arbitrary mathematical relations.

The dramatic effect (zero correlation) is attenuated as you increase the noise in the constructed variable relative to the systematic effect of "income". But at levels of R-squared obtained by Lant (.92), the correlation of residuals with the true effect is .72, squared is about .5. So, the residuals claimed to be health policy may be moderately well correlated with the true residuals but nowhere near enough to say they "measure" the unexplained part of the relation. And this is due solely to a minor error in specification of functional form - an error which no one would think twice about making or searching through other functional forms to correct.

Regardless of how confident some might be that the left-out part of the health status equation is due to health policy (itself an unsupported position), it can't be the case that countries health systems and policy are sensitively related to the function we arbitrarily choose to model income's effect on health status.

Jeff

CC: Shanta Devarajan (SHANTA DEVARAJAN@A1@WBHQB)
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A L L - I N - 1   N O T E

DATE: 17-Mar-1997 11:00am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jeffrey Hammer, PRDPE (JEFFREY HAMMER@A1@WBHQB)

EXT.: 81410

SUBJECT: A thought or two on the SAS

Alex -

I confess confusion at the reaction to the paper. There might be a way to help on both the poor/middle income country and the public/private concerns.

Think yin and yang. You can define the role of the private sector explicitly or you can let it be implicit in what the government isn't doing. In most countries (Eastern Europe might be the major exception - I'll come back to that) there is quite a large private sector and there is no reason to deliberately promote it. You can count on it cropping up and serving all the profitable (curative care, probably not too expensive) bits of the system. So, you can drop all references to promotion and concentrate on having the Bank help the borrowing country governments decide on what they should do (not what the private sector should do). For that, you can focus on how to have the government make the best contribution it can given the reaction of the rest of the system (private).

Think yang and yin. You can define the government role as everything not mapped out explicitly for the private sector (which seems to be the default option in some people's minds) or you can define it in terms of correcting the known set of specific market failures. The government can be charged explicitly with attacking the worst ones first and continuing until you run out of money or you run out of ability to fix them. Only at the last step do you need to get specific about government failures - to show that the government can't do everything just because failures exist in the private market. Its own failures argue for reluctance to charge in on any perceived imperfection of information. The Bank, through its sector work, can help identify the worst market failures and thereby help set priorities. These priorities will be different across countries and depend sensitively on the particular mixture of screw-ups on the part of both private and public sectors in each country. Figuring this all out is hard work (and will look an awful lot like research, if done well) but that seems to be the thing which generalizes across all countries.

By focussing on fixing the market failures, you simultaneously avoid seeming to bash governments one-sidedly and

say the right thing. I also think that in the poorer countries, applying this rule would tend to restrict the role of government in provision of curative, especially primary care, rather than expanding it but without any reference to promoting private services. Poor countries have other, more pressing things to do first.

The exception of Eastern Europe may have to made explicit. Here, there may be a reason for promoting a private sector just to take care of things that the government no longer thinks it can handle. I don't know. You have a lot more experience on this type of country. Just make it clear that such active promotion is only relevant to certain circumstances.

For helping the poor, the literature is large and not easy to summarize neatly. The same concern as above applies here: the right answer depends on circumstances. Sometimes geographic targetting works OK, sometimes self-selection to low amenity services, sometimes concentrating on services (infectious disease control), sometimes school-based things work (if the poor go to school but <u>not if they don't</u>), maybe MCH if the poor visit such services more than others (they very well might since, as you argued, they have more kids), etc. etc. Which of these make sense requires a careful look at who the poor are, what they do and how things the ministry of health does affects them. We can help countries take that look but we can't expect blanket prescriptions to work everywhere.

A minor aside: I was chatting with Lant and we (probably he) came up with an odd asymmetry. "Market failures" have with them a long history of theoretical characterization which make us think them systemic problems of market systems. Empirically, we have the United States to point out, the general lack of insurance markets and, maybe, the sense that people in poor countries (with large private sectors) are still sick (though why we think they wouldn't be, I don't know) and so the private sector must not be serving them well, particularly the poor. We fit any casual empirical impressions straight into a firm theoretical structure.

On government failures we have no such theory to indicate that problems are systemic. Therefore, we tend to think of the quite large numbers of cases of government failures (poor people bypassing free care to pay a private practitioner, no drugs, etc) as governments just "happening to fail" rather than necessarily failing. If you "happen" to fail, this can be fixed with better management (i.e., even more government). If you have a good, systemic reason to fail (incentives in supplier - induced demand, say), then this can't be fixed by just encouraging better performance and you need more government.

I think this asymmetry of standards of proof afforded by good theory on one side and not-so-good theory on the other leads to some strange beliefs on our part. Like why do we think that

the tendency to exploit patients (through supplier-induced demand) would be greater than the tendency to never show up for work at public clinics when you're paid on salary? I have no doubt that both problems exist. We should be helping the governments figure out which one is bigger and, more importantly, which is easier and cheaper to fix.

Jeff

CC: Lant Pritchett (LANT PRITCHETT@A1@WBHQB)
CC: Shanta Devarajan (SHANTA DEVARAJAN@A1@WBHQB)
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CC: Maureen Lewis (MAUREEN LEWIS@A1@WBHQB)

A L L - I N - 1 N O T E

DATE:

TO: LANT PRITCHETT (LANT PRITCHETT @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Valuable contribution to HNP Sector Strategy Paper

Many thanx for your valuable contribution to our discussion today on country performance. Dean will be summing up our conclusions from the meeting in a separate EM.

I am in the process of going through a careful revision of the White Cover based on inputs received from various reviewers. The comments received from your group were particularly valuable.

I want to highlight one point which seems to have caused a lot of concern in PRD but which I think represents a misunderstanding.

In the paper we make reference to "outsourcing" research. In this context we were referring to basic HNP clinical research such as epidemiological studies of disease patterns etc. We do not feel the Bank should build up a significant in-house capacity in this area. On the other hand, we fully agree that the Bank SHOULD continue to have a strong in-house capacity in conducting substantive economic sector work (ESW) and research related to HNP financing and economic issues. This distinction will be made more clearly in the revised draft.

CC: JEFFREY HAMMER (JEFFREY HAMMER @A1@WBHQB)
CC: MEAD OVER (MEAD OVER @A1@WBHQB)
CC: LYN SQUIRE (LYN SQUIRE @A1@WBHQB)
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CC: EMMANUEL JIMENEZ (EMMANUEL JIMENEZ @A1@WBHQB)
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CC: MARTHA AINSWORTH (MARTHA AINSWORTH @A1@WBHQB)
CC: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)
CC: DEAN JAMISON (DEAN JAMISON @A1@WBHQB)
CC: DAVID DE FERRANTI (DAVID DE FERRANTI @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 18-Mar-1997 07:33pm

TO: Jeffrey Hammer (JEFFREY HAMMER @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: More on residuals

Very useful information.

Actually, I think your group has quite succeeded in convincing me that we should not attribute any causality to the residual - something I was never particularly wild about. So any version of this analysis which might make it into the next version will certainly not claim any attribution.

At the same time, identifying which countries have better health status outcomes after you control for income and education levels has some merit in its own and may actually be more valid than just comparing outcomes not controlling for anything which is what most people do. So we are still going to play around with this analysis for a bit longer.

Of course all cross country comparisons are fraught with some methodological problems and I think a major flaw with the current analysis might actually be the regional breakdown which limits the sample size as well as the variations in income over time when these are pronounced. It clearly makes poorly performing countries look good due to the lag between income and possible effect on health status.

So, yes your inputs to this exercise have been very valuable, and no I don't think we are just being stubborn in trying to go beyond the usual presentation of just standard indicators.

CC: Shanta Devarajan (SHANTA DEVARAJAN @A1@WBHQB)
CC: Martin Ravallion (MARTIN RAVALLION @A1@WBHQB)
CC: Lant Pritchett (LANT PRITCHETT @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 19-Mar-1997 05:22pm EST

TO: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

FROM: Pammi Sachdeva, CGIAR (PAMMI SACHDEVA)

EXT.: 38941

SUBJECT: Comments on draft HNP sector strategy

Richard:

I enjoyed reading the draft HNP sector strategy paper, and would like to congratulate the authors for a well-written document. The discussion chaired by you on March 14 was also very useful, for it provided an opportunity to further refine an already good report. At the end of the meeting you invited further comments by EM. I have two suggestions.

First: Clarify the key message in Section II regarding reform strategies, particularly the reference to third wave privatization as an alternative (pgs. 25-26). The present draft states that the third wave of reform has several pre-requisites, including: a) the first and second waves of privatization of commercial and infrastructural assets; b) significant constraints to be overcome (six are listed); and c) critical pre-requisites (four are listed). These pre-requisites are unlikely to be met in the short term; yet reforms are urgently needed in many countries, as the strategy paper convincingly argues.

So, it would be useful to clarify just what reforms should and can be undertaken, in light of the constraints and pre-requisities identified. My hunch is that the four critical pre-requisites identified on pg. 25 could in fact be key elements of the reform strategy itself - namely, creating a conducive policy and regulatory environment, introducing (full?) cost recovery, providing an adequate safety net, and ensuring quality control. These would then supplement other measures recommended in the report, such as securing sustainable financing, containing costs, and ensuring fiscal discipline etc. (pgs. 26-28).

Further, the report could perhaps clarify the intended meaning and operational implications of the proposed significant paradigm shift (pg. 43) and new policy paradigm (pg. 44). This could be done by making the links between the descriptive and diagnostic sections (I and III) and the prescriptive and forward-looking sections (II and IV) more transparent.

In short, I believe it would be useful to have a tighter logical connection between the existing realities of the HNP sector (constraints, opportunities, pre-requisites etc.) and the proposed or desired future (the new paradigm). This would make

the strategy more obvious; and would help to clarify the meanings of some terms used in the paper.

Second: I would suggest greater attention to issues of implementation capacity. The report does refer to governance and institutional capacity as crucial factors that influence system performance (pg. 23); and as key constraints to getting results on the ground, as identified by QAG and OED (pg. 39). The report also recognizes that the targeting of interventions to the poor is often difficult because of weak administrative structures (pg. 14), and weak government implementation capacity (pg. 21).

However, the proposed strategy focuses largely on policy-level interventions; and does not adequately emphasize the equally-crucial need for strengthening ground-level capacity for delivering services. There is only a passing reference to capacity building in the sections dealing with the proposed solutions to current problems. In my view, it would be useful to include capacity building (of government as well as non-government providers of health care) as an essential component of the proposed reform strategy - and as one of the pre-requisites for improving health outcomes for the poor.

I recognize that this business of capacity building is messy; and is not one of the Bank's greatest strengths. But the strategy document is concerned with the future - so there is still time for optimism. I therefore suggest that such measures as institutional development or capacity building be explicitly included in the proposed package of reforms for the HNP sectors; and equally, that such competence be included in the list of new skills sought among HNP staff (pg. 40).

I would be happy to clarify the above suggestions, so please feel free to share the EM with members of the drafting team or sector board. I would appreciate hearing from you as well, and an opportunity to discuss further at your convenience.

Pammi

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 11:23am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jacques Van Der Gaag, HDDDR (JACQUES VAN DER GAAG@A1@WBHQB)

EXT.: 31991

SUBJECT: SSP

Alex,

just some thoughts that relate to the discussion this morning.

If you make the drastic change in the paper that we discussed earlier, and put all the policy stuff in an Annex, the reader will directly be confronted with "the new paradigm". As it reads now one can get the impression that the larger role for the private sector is motivated by the failure of the public sector. But that is only because you start with an analysis of the public sector. If you would have started with describing the current failure of much of the private sector, your new paradigm may have been: a larger role for the public sector. What is missing from the paper is a discussion/assesment of the current private role.

The private sector already plays a large role: about half the financing is private; most public doctors run private practices; chances are that most of the pharmaceutical sector is private. Add to that church-based and other NGO involvement, and you find a very large "private sector". I suggest that you make that clear in the paper.

What you should also make clear is that much of the current private sector activities are by default, as a response to government failure. Failure in financing the "free care", failure in delivering to the poor, etc. Most importantly, much of this private sector activity takes place in a hostile environment: sometimes private sector activity is made illegal; sometimes there is no legal status for non-profit organizations; blanked public subsidies undermine private initiatives; the tax structure may discourage private practice, etc.

Presenting it this way, the new paradigm would be: a larger role for the private sector, not by default, but as a STRATEGIC CHOICE.

This would have clear implications for how we do bussiness, for how we approach the government. It would also underscore that we are not talking about the private sector as opposed to the public sector, but rather about the relative roles each of these sectors need to play to take advantage of the relative strenghs of the other. This would lead to a more eloborate discussion of the

various functions of the government, other than "financing" versus "provision". This should include regulations, licensing, information, mandating, quality control, tax incentives, the legal framework, etc. Implications of this strategic choice for how the bank will go about doing its "new" bussiness, and what new skills we need, follow in part from this list; currently we mostly call for "more NGO involvement" because the government fails. Instead, we should discuss with the government what it can do succesfully to facilitate the private sector, to remove obstacles, to provide incentives, and - pardon the jargon - to form a partnership with the private sector. Lessons from the experience with infrastructure are relevant here.

In the end, even this "new" paradigm is not entirely new. It would be useful to go through a handful of projects that pursue this route, and discuss the experience to date (Uruguay comes to mind).

Finally, there is no question that the bank has a comparative advantage in this area. PERs, public sector reforms, strenghthening of the legal system, strengthening the finacial sector, etc. all are relevant. One can also think of (as someone suggested at the meeting) the importance of assessing the country's general "environment" for private sector involvement in the health sector.

I hope this is helpful.

jacques.

CC: David de Ferranti (DAVID DE FERRANTI@A1@WBHQB)
CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 07:45pm

TO: Jacques Van Der Gaag (JACQUES VAN DER GAAG @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SSP for HNP

Jacques,

Very useful comments. Also your market up draft has been very useful - please let me have the rest.

I will be writing a briefing note on the comments I have received prior to the review meeting on Friday but I want to flag two issues raised by DEC at this early stage (they have given the paper an unusually thorough read which I really appreciate - there are no real surprises).

One set of issues go over old territory about the Musgrove-Hammer disagreement (i.e., should the state finance high-risk low-frequency events - traditional insurance economics argument; or should the state finance lower-risk more-frequent events but which are not affordable to many of the world's poor - traditional welfare economics argument). This represents two clearly opposing schools of thought. We have a bit of both in the paper right now. I am already meeting individually with people in DEC to try to arrive at an acceptable balance - I personally do not feel comfortable going all the way in either direction. This won't get sorted out by Friday.

Like you, DEC also raises the issue about the Bank's role in research Here, however, I think we need to distinguish between: "pure research", "operational research" and "substantive economic sector work". The paper makes a very strong case for increased substantive economic sector work (ESW). Somehow several people in DEC are taking us to task on research when in fact what they are really referring to is ESW which we also support in the paper. As for the actual contents of the "pure/operational research", I think we will not sort this out before Friday. In fact, I suspect that there is a substantive difference between how this issues is viewed by the by the HNP Sector Board with DEC which needs to be sorted out before the next draft since it is a major part of the recommendation in the paper.

CC: Richard Feachem (RICHARD FEACHEM @A1@WBHQB)

CC: David de Ferranti (DAVID DE FERRANTI @A1@WBHQB)

A L L - I N - 1 N O T E

DATE: 17-Mar-1997 01:19pm EST

TO: Dean Jamison (DEAN JAMISON@A1@WBHQB)

FROM: Hugo Diaz, SA1PH (HUGO DIAZ@A1@WBHQB)

EXT.: 82368

SUBJECT: Cross-Country Analysis

Hi Dean,

Thanks for sending me the paper on "Measuring Regional and Country Performance" (Annex III of the HNP Sector Strategy Paper). I will not be able to attend the meeting, but I have taken a look at the draft.

I think this type of analyis can be useful --as the paper says, a start towards developing a quantitative framework for assessing why some countries succeed and others do not in improving the health of their populations.

I was a bit confused by some aspects of the presentation in Annex III. The regression model from which Figure 1 is generated does not control for Region (i.e., it only controls for time, education, and per capita income). However, the regression model formally presented in the following page, under "Methods and Data", does control for Region. Most of the empirical results presented are generated by models that control for Region.

At a minimum, it should be explicitly indicated that the model behind Figure 1 is different from the formal model presented. But, more substantially, I am not sure that controlling for Region is a good idea. Why should we pose any relationship between the fact that a country belongs to a given Region and health status? At least some of the regions are very heterogeneous in dimensions such as climate, geography, etc. (which could conceivably be causally related to health status); this would certainly be the case with Latin America.

Wouldn't it be better to perform the analysis without controlling for Region? I think controlling for Region will make it more difficult for people to understand the results. Its interpretation is not intuitively obvious.

Also, from the point of view of the policymakers in most countries and others who shape public opinion, I would think that they would not be as interested in how their country compares to other countries in the region as they would be in how their country compares to the rest of the world. People all over the world are more and more thinking gobally.

What do you think?

Best regards,

Hugo

CC: Barbara Herz (BARBARA HERZ@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 17-Mar-1997 10:17am

TO: Dean Jamison (DEAN JAMISON @A1@WBHQB)

FROM: Prabhat Jha, HDDHE (PRABHAT JHA)

EXT.: 87384

SUBJECT: RE: Review Meeting on Cross-Country Analyses

Dean

The following are some comments on the system performance analysis. I will try to attend the meeting this afternoon following my scheduled meeting with the legal team.

1. My main comments deal with methodology. The power of this analysis is the ability to examine differences in health outcomes over time and in a standardized way. To provide reliable results, we should minimize both systematic biases and random errors.

2. I believe that we really do not have a good handle on systematic biases and that we should so acknowledge: the methodology cannot disentangle the income effects as causal or casual. As mortality is basically the incidence times the case-fatality rate, we do not know if income reduces incidence (e.g. water and sanitation), or case-fatality rate (e.g., money to buy diarrhea treatments), or has a synergistic effect on both incidence or case-fatality rate. Lant Pritchett's attempts by using external surrogates are a neat idea, but still can't tell us what the income variable in the model represents. Finally, the overall R squareds are modest, and I wonder if Jia has done some measure of "global goodness of fit" of the different models.

3. The chief sources of random errors are likely three-fold: (a) the variability in income ranges; (b) the small number of countries compared within a region; and (c) the short time duration of observation.

4. We address point (a) somewhat by looking at four year income averages. However, I am still concerned that income fluctuations may distort the findings on performance. Thus, in the earlier version of the SAS, on page 9, the table of performance indicates that ECAs performance on male life expectancy is better than expected with income. However, the male life expectancy in ECA is generally regarded as being poor and declining. The effects appear to be driven by declining incomes and not improving health system performance.

5a. The methodology examines performance within a region.

This may create spurious results based upon small numbers. I note in the earlier LAC paper that the income elasticity for child mortality across LAC and non-LAC regions was similar (-0.21 and -0.17 respectively, page 5). In Pritchett's paper (table 2), the income elasticity (unadjusted for education) was LOWER when all 111 countries (-.12) were used, versus when 58 countries (-.24) were used. This suggests that a smaller observation set may suffer more from the play of chance.

5b. Have you considered comparisons of a region against all countries, in other words omitting the region variable in the model? This might help smooth the income curves somewhat and provide a more stable comparison of relative performance for countries. I would guess that the goodness of fit for such an approach would be higher on fewer degrees of freedom.

6a. The methodology examines five year difference, which for reasons 4 and 5, warrant caution. Again the most robust analysis may be 30 year differences, because the income curves are likely to more predictable. Pritchett's paper (Table 3) also notes that the income elasticities (and R squareds) rose with longer observation time periods. This make perfect sense: better measurements make better correlations, and prolonged periods yield better measurements.

6b. Thus could the analysis present as a main result, 1960 to 1990 performance for the key outputs and comparing all countries versus those for regions? I think this would also help avoid data-derived findings from people looking too closely at one time period.

Overall, the system analyses is very robust, and innovative. It should make powerful arguments if we choose to be both comprehensive and cautious. I will try to offer more comments at the meeting.

Regards,

Prabhat

CC: ALEXANDER PREKER (ALEXANDER PREKER)

A L L - I N - 1   N O T E

DATE: 14-Apr-1997 12:24pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Logan Brenzel, HDDHE (LOGAN BRENZEL@A1@WBHQB)

EXT.: 34983

SUBJECT: Page ii in the SSP

What do you think about the following paragraph for page ii:

First, given the plurality of the medical marketplace in most developing countries, the priority for government involvement in the health sector should be to redress market failures in the provision and consumption of services. This can be accomplished through regulation and promotion of the private sector; provision of public goods, such as health information and vector control; and, policy leadership. Where the public sector chooses to finance or provide health services to offset market failures (e.g., programs to control communicable diseases, or mechanisms for risk pooling in cases of market failures for health insurance) or to achieve equity goals (e.g., subsidizing public health interventions and curative services for poorer households), these interventions must be affordable.

In the next paragraph (under Second,...) add cost-effectiveness as one of the ways in which governments can improve the performance of the health sector.

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 04:49pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: April Harding, PSDPS (APRIL HARDING)

EXT.: 87371

SUBJECT: comments-hopefully useful

Alex:

Here are our comments.

Comments from PSDPS Social Sector Privatization Group on the Sector Strategy Paper for Health, Nutrition, and Population

INTRODUCTION:

1) We are very happy to be part of this team and to be invited to comment on the sector strategy paper.

2) We are very interested in collaborating with HDD, PRD, OED to develop the World Banks policies and tools in this area.

3) We are not sector experts, we come from the privatization group. But we see a lot of potential in working together.

4) Our perspective is an operational one. We are interested in seeing how policy and strategy come to bear on lending and operations.

5) Our comments on the sector strategy paper will thus reflect (4) and (5).

6) We will try and focus on broader issues concerning sector strategy for HNP in general rather than delve into details.

KEY QUESTIONS THAT COME TO MIND ON THE ISSUE OF INCREASING PRIVATE SECTOR PARTICIPATION IN HEALTH

1) Operational implications:

How should the new strategy or paradigm be reflected in Bank lending and operations? How will projects be designed to reflect the new policies and strategies? What will be different from past projects? These answers will define "implications for implementation". A thorough and candid evaluation of Bank projects in HNP might be undertaken with

regard to this issue? If so, what are the lessons from such evaluation? Are recommendations for improvement put into practice? These answers will define "effectiveness of Bank lending".

Useful lessons on projects (especially on regulatory, institutional, project design and training issues) may well come from unlikely places such as infrastructure. Our infrastructure group (or is it family now?) has been wrestling for quite some time with the issue of setting up effective regulatory institutions/mechanisms in low institutional endowment countries. They have also been working hard to inject such analysis into project design. The infrastructure group has also developed mechanisms for gathering and distilling recent lessons, and insights on best practice from outside the Bank. They have also worked hard to identify gaps in the literature and lessons that should be reflected in the World Banks reserach agenda. The infrastructure groaseved cesinr rone thinndatraf e latest lesisis istpapec wweo in this new area. Whether to in-source or out-source a specific bit of research, or the development of a certain database, or to undertake best practice analysis, might best be done in conjunction with the principles underlying our human capital development plan. That is, dont outsource the work if we need to develop our own capacities in this area.

3) The interdisciplinary (intersectoral) nature of this work requires new relationships and mechanisms for collaboration to be established. Our Mongolia social sector privatization project has required substantial collaborative input from health and education sector experts, privatization experts, (non-profit) legal and organization experts and contracting experts. All these types of people need to be involved in developing our approach or toolkit for increasing private participation in health How will this happen? Where? When?

Do we need a HDD/FPSI sub-family (PPIH-private participation in health, PPISS-private participation in social sectors) to roll out the new strategys implementation?

4) Whole v/s Part: Is it always necessary and feasible to work on across-the-board sector issues or can a piecemeal approach be undertaken? What are the advantages of a piece-meal approach?

How does one ensure that piece-meal efforts stay in line with broader sectoral objectives? A piece-meal approach is all that is feasible in many countries. How shall we respond to these situations?

5) Public-Private Partnerships: Is there a need to redefine the role of the Bank? Which areas should the Bank not be involved with? These answers will define "what the Bank ought not to do".

Good luck coming up with the next draft!

See you on Monday.

CC:	Gerver Torres	(GERVER TORRES)
CC:	SARITA MATHUR	(SARITA MATHUR @A1@WBHQB)

A L L - I N - 1 N O T E

DATE: 19-Mar-1997 05:22pm EST

TO: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

FROM: Pammi Sachdeva, CGIAR (PAMMI SACHDEVA)

EXT.: 38941

SUBJECT: Comments on draft HNP sector strategy

Richard:

I enjoyed reading the draft HNP sector strategy paper, and would like to congratulate the authors for a well-written document. The discussion chaired by you on March 14 was also very useful, for it provided an opportunity to further refine an already good report. At the end of the meeting you invited further comments by EM. I have two suggestions.

First: Clarify the key message in Section II regarding reform strategies, particularly the reference to third wave privatization as an alternative (pgs. 25-26). The present draft states that the third wave of reform has several pre-requisites, including: a) the first and second waves of privatization of commercial and infrastructural assets; b) significant constraints to be overcome (six are listed); and c) critical pre-requisites (four are listed). These pre-requisites are unlikely to be met in the short term; yet reforms are urgently needed in many countries, as the strategy paper convincingly argues.

So, it would be useful to clarify just what reforms should and can be undertaken, in light of the constraints and pre-requisities identified. My hunch is that the four critical pre-requisites identified on pg. 25 could in fact be key elements of the reform strategy itself - namely, creating a conducive policy and regulatory environment, introducing (full?) cost recovery, providing an adequate safety net, and ensuring quality control. These would then supplement other measures recommended in the report, such as securing sustainable financing, containing costs, and ensuring fiscal discipline etc. (pgs. 26-28).

Further, the report could perhaps clarify the intended meaning and operational implications of the proposed significant paradigm shift (pg. 43) and new policy paradigm (pg. 44). This could be done by making the links between the descriptive and diagnostic sections (I and III) and the prescriptive and forward-looking sections (II and IV) more transparent.

In short, I believe it would be useful to have a tighter logical connection between the existing realities of the HNP sector (constraints, opportunities, pre-requisites etc.) and the proposed or desired future (the new paradigm). This would make

the strategy more obvious; and would help to clarify the meanings of some terms used in the paper.

Second: I would suggest greater attention to issues of implementation capacity. The report does refer to governance and institutional capacity as crucial factors that influence system performance (pg. 23); and as key constraints to getting results on the ground, as identified by QAG and OED (pg. 39). The report also recognizes that the targeting of interventions to the poor is often difficult because of weak administrative structures (pg. 14), and weak government implementation capacity (pg. 21).

However, the proposed strategy focuses largely on policy-level interventions; and does not adequately emphasize the equally-crucial need for strengthening ground-level capacity for delivering services. There is only a passing reference to capacity building in the sections dealing with the proposed solutions to current problems. In my view, it would be useful to include capacity building (of government as well as non-government providers of health care) as an essential component of the proposed reform strategy - and as one of the pre-requisites for improving health outcomes for the poor.

I recognize that this business of capacity building is messy; and is not one of the Bank's greatest strengths. But the strategy document is concerned with the future - so there is still time for optimism. I therefore suggest that such measures as institutional development or capacity building be explicitly included in the proposed package of reforms for the HNP sectors; and equally, that such competence be included in the list of new skills sought among HNP staff (pg. 40).

I would be happy to clarify the above suggestions, so please feel free to share the EM with members of the drafting team or sector board. I would appreciate hearing from you as well, and an opportunity to discuss further at your convenience.

Pammi

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 06:20pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Diana Weil, HDDHE (DIANA WEIL@A1@WBHQB)

EXT.: 36782

SUBJECT: comments on SAS

I am sorry for the delay in sending the following comments on the SAS text. I started drafting this a week ago, and then got enmeshed in a few major "fires" at my other office all this week. I hope it is not too late for this input (Friday deadline I know). First comments refer to "my area", TB.

1. On page 18, under Re-emerging and New Communicable Diseases.

I am not sure that I agree with the referral to tuberculosis immediately following the phrase: "Prevention and treatment policies must constantly adapted to keep up with these trends." I would take out the word constantly.

I would propose the following replacement sentences for the paragraph on TB:

In tuberculosis control, the "DOTS" (Directly-observed Treatment, short course) strategy has been found to be highly cost-effective, by detecting, effectively treating, and documenting cure of infectious TB cases, to reduce morbidity and mortality and to prevent the creation and spread of drug-resistant strains. The district-based approach is being adapted, established and expanded in a range of low- and middle-income countries (e.g., China, India, Ghana, Mozambique, Vietnam, Peru, Kyrgyzstan). In China, over 300,000 patients have been successfully treated so far, under a Bank-supported project.

(the current phrasing is incorrect. It is not the drug combination that has been shown to be cost-effective, but rather the whole delivery system (including case detection and the monitoring and evaluation system).

2. Executive Summary: page vi, second bullet. In order to advance its health outcomes agenda.... the paragraph seems to suggest that the principal way for the Bank to contribute to improved health outcomes is through investment in (and analysis of) divestiture of social assets. It seems to me that the paragraph could be more evenly balanced to represent the Bank's likely continued work to facilitate wider adoption of documented cost-effective approaches (in both public and private sectors) in health care delivery and disease control (for those, through market failure, cannot be served by private market). Reducing these inefficiencies and improving quality might deliver more improvements in health outcomes in the short-run while the more complex design and process of social assets divestiture proceeds over the longer-term. This theme is in the main text, though still not sufficiently articulated I think.

3. I would suggest that there be more explanation at the end of the document (page 53 currently) of why the Bank should pursue special initiatives (i.e., justifying why they are useful so as to lessen criticism expressed at the review meeting). Looking at the current list of possibilities (which I hope could include TB -- you suggested it would -- also note that IMCI is excluded) for initiatives -- it almost looks like a carving up of elements of an "essential package". I, therefore, would suggest that it would be useful for the Bank to play a role in exploring how to increase cooperation across initiatives. Ultimately, all of the interventions listed are dealt with by the same health workers -- to train them, supervise them, and maintain their interest in any and all areas is a challenging task.

4. As expressed in the review meeting, and in the Operations training course I just attended last month, the Bank is now moving to be more "client-centered and client-responsive", will the Board want the document to express more clearly this objective?

5. Also, the role of the Regions is not very clear in Section IV.

Other comments:

Footnote 1 on page viii, CAS review point (ii): will you not include any heatlh outcome varilables?

Page 2 of text, third paragraph. I am not sure why you say "even in" the world's poorest countries....

Page 5: box on health of world's poorest billion. There is an important underestimate of the DEATHS OF WOMEN. Somewhere over 0.5 million women die solely from maternal causes, but if you include (as does the sentence in the document) communicable disease as well, the total is likely closer to 2 million. WDR 93 estimated that 724,000 girls (five and over) and women die due to tuberculosis alone. The total for women alone would likely be over 0.5 million. If we add to that malaria and HIV deaths and other communicable diseases..... I would be happy to review the new GBD book for data on this.

It would be great if the SAS helped acknowledge that women's development and family life is affected adversely not only by women's deaths and disability associated with reproductive health, but also a broader range of diseases that affect both sexes (but for which women may have greater problems seeking and receiving help).

Page 15: bullet in first column: probably shouldn't use the word "enshrined".

Page 15, second column, last paragraph: due to poor policies, immunization coverage is leveling off.... not clear what is meant by poor policies -- could a example be given, or specify further what kind of policies?

Page 19, box on New Directions in Pop and Repro health: the last paragraph (on India) follows awkwardly after the general description of the ICPD approach.

Page 24 -- in the list of constraints or challenges in pursuing social divestiture, I assume, should be well-defining the expected market failures and

preparing for them (not just the provision of statutory subsidies for the poor, but also what interventions should continue to be pursued by public sector at least during transition to private provision).

Page 26 -- bottom of box -- I saw no previous reference to the 70% risk pooling level -- so it is not clear where that figure comes from.

Page 27 -- bottom of first bullet, probably should say, "due to age or pre-existing health conditions"

Page 27, in the box -- price controls is listed as a heading and an item under the heading

Page 30 -- second paragraph, describing the gradual expansion of areas of WB loans -- why is HIV/AIDS prevention and care defined separately from health activities -- is it multisectoral?

Page 30 - third paragraph, text says 27% of total, graphic says 24% -- why difference?

Page 36 -- end of second bullets: are local governments necessarily "closer to the people" (a rhetorical question I quess)

Page 36-- top of second column -- is it clearcut that the rural poor are necessarily worse off than the marginalized urban poor (or do we just not have diaggregated statistics to measure their conditions as easily as rural poor)?

Page 36 -- bottom of Mexico box, last line -- are the results really ALL postive?

Page 44 -- second to last paragraph, isn't IMCI part of the basic package (as opposed to something extra)?

Thanks for the opportunity to read the document -- I learned a lot.

Diana

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 08:25pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Anne Tinker, HDDHE (ANNE TINKER@A1@WBHQB)

EXT.: 33683

SUBJECT: RE: SSP Comments from Althea Hill

Alx, there has been a tension all along as to whether this is a health or broad HNP paper. I think it would clarify the issue, since its got to be short and is aimed at the health sector, to have a para up front recognizing the important aspects of pop and nut and stating that they are not going to be the subject of the paper because of its focus on the health sector.

CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: TOM MERRICK (TOM MERRICK@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 07:57am

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Tom Merrick, HDDHE (TOM MERRICK@A1@WBHQB)

EXT.: 36762

SUBJECT: RE: SSP Comments from Althea Hill

Alex,

I agree with Ane's suggestion that Althea's (and others') concerns about population could be addressed in Section I by stating that not all population outcomes are health outcomes (population cannot be reduced to reproductive health any more than to family planning) and that the main focus of the paper is on getting health systems to work better. While the section on "Origins of Good Health and Illness" recognizes that other factors affect health (including reproductive health and nutrition), a "population" outcome such as elimination of unwanted fertility has benefits to individual (more household investment in children's education) and societal (avoiding externalities associated with high rates of population growth) welfare that go beyond good health and avoiding illness (whereas the factors outside the health system that impact on nutrition ultimately do impact on health/illness).

The primary focus of the SAS is on health systems. Getting health systems to work right is very important for health status (including reproductive health/family planning). The SAS cannot be expected to fully articulate strategies for addressing issues beyond the health system. Recognizing that factors outside of the health system are important doesn't mean that the health system has to fix them (this is where attention to the social sectors at the CAS level should come in) or that the health system is responsible for fixing the other sectors (education) whose activities also affect non-health population outcomes.

The HNP SAS has a lot of good ideas and strategy for getting health systems to work better, but need not go beyond recommending that broader issues affecting health, nutrition and population (with no mention of the non-health aspects of population) be addressed in the CAS. The challenge of getting the Social Sectors right in the CAS process is bigger/more complex than what can be done in the SAS.

Tom

CC: Anne Tinker (ANNE TINKER@A1@WBHQB)
CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:50am

TO: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)
TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: David de Ferranti, HDDDR (DAVID DE FERRANTI@A1@WBHQB)

EXT.: 38729

SUBJECT: SSP on HNP

Good strides forward. Good process.

On substance and presentation, I have a few major concerns, some of them related to points made today and some of them not. Let's discuss as soon as possible. Today if you like.

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 20, 1997 12:25pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Janet Hohnen, EA2RS (JANET HOHNEN@A1@WBHQB)

EXT.: 81217

SUBJECT: SSP, comments on the white cover

The paper was interesting and thought provoking, but by the time I reached section IV I was tired and rather confused. So I may have missed point which are in there somewhere. However I hope these comments help.

A. Purpose and target audience of the SSP exercise

1. The review meeting was told that the original purpose was to brief the Board and exchange thoughts. But this is a statement of activities, not objectives or expected results and does not justify the scale of the work, or provide a benchmark for judging the adequacy of the final product, especially in the current Bank environment. Please give (or resend) a more specific statement of the purpose and expected results of the exercise, including what would be done with the SSP when completed.

2. We need a clear sense of the threats and opportunities facing HNP work in the Bank at present and in the next 5 years. and an articulated response to these. Are we aiming for survival, maintenance, expansion, increased effectiveness, change of role, etc. What do we know of the present value and acceptability of our work to those who can affect its support or continuation.

3. If the target group is the Board, then they are presumably non-health specialists, who mostly (but not all) start with a favorable but relatively uninformed view of the sector. They will be affected by the current internal and external scrutiny of the Bank; they may be affected by the reported decreasing income of the Bank; as Chris Walker said, they will need to know that they both getting (from the HNP family) and giving (to borrowers) value for money, or have serious prospects of getting this in the future.

4. In this climate, is SSP's arbitrary central postulate of a "paradigm shift" the best way to present what is happening? Are Board members and other important audiences likely to be impressed by this new broom spin, or might they value explicit continuity in strategy development. Will the artificial construct of one single theme be credible, relevant or helpful, and will its advantages compensate for the apparent lessening of priority for client responsiveness and recognition of diversity.

5. The paper will be read by influential client representatives. If we are trying to get the government back into health in poor communities, will this paper make our dialogue more difficult?

6. The action plan in its present form has differential implications for the HNP family; there will be winners and losers. The merits of the choices and the likely effects need to be more frankly and openly displayed and debated.

B. Goals and Strategies of the HNP sector in the Bank

7. It was very disappointing not to see a clear health goal in this paper. It is noteworthy that Mr. Stiglitz stressed this health objective of the sector at both the beginning and end of his speech at the Health Financing Conference last week.

8. The following goal is suggested: "to assist member countries to achieve sustainable improvement in the health of their populations, especially the poor, and to protect people from the impoverishing effects of illness or illness care.

(the population subsector may need some additional non-health related objective)

9. How the HNP sector goal contributes to the overall mission of the Bank should be separately explained. Why Board should approve and clients should borrow for health, compared with other choices. Not every one is convinced that borrowing for health is good; the idea was reportely strongly challenged at board level recently; and there is some perception of increasing reluctance to borrow (from the Bank at least) for health in some regions. (This may be partly overcome by planned new product development - but not without serious market research.)

10. With clear sector goals, the major strategies selected by the Bank to reach these goals, inside and outside the formal health sector, can be explained, justified by summarizing the Bank's comparative advantage, client demand and priorities etc. In particular readers should clearly understand (i) that HNP work overlaps with but is not to be equated with health services work or health financing work. These are supported to the extent that they further the sector goals. and (ii) how the Bank (HNP) will actively pursue non-health-sector strategies to protect and improve health.

C. Work Across Sectors (in the Bank) to Improve Health.

11. The paper says very little if anything about this, yet the Bank has a particular advantage compared with specific health related agencies and institutions. (May be nutrition/agriculture, and health/education links are working productively). How do we help promote volume and quality in support for domestic water supply and sanitation? If the traffic injury epidemic is so bad and growing, how do we cooperate with transport sector colleagues to

tackle this? How can HNP work with agriculture to phase out tobacco growing and reduce opposition from the agriculture lobby to tobacco control. Why does design of health projects have to pass environmental, gender and ethnic minority standards in the Bank, but there is no health impact assessment of non-health projects?

D. Performance of Government in Health Service Provision.

12. The more amazing generalizations on this will no doubt be removed from the paper, and the terminology tidied up (often the term govt. seems to mean central govt.) I have the impression that the countries cited for high health status compared with economic dev./income level either have or have had until recently strong government health services.

E. Population.

13. The paper has a box on ICPD statements on population policy, but I missed mention of the Bank's role in population policy initiatives (distinct from reproductive health).
Does the Bank absolutely agree with the ICPD line. Which set of population approaches (from within and without ICPD) suit the Bank's comparative advantage? What are the cross sectoral links here? How does the Bank influence Part I countries on this issue? Does population need an annex to the paper?

(e.g. Bangladesh is given as an example of a low income country with high CPR. This is due partly to a strong population policy with a consistent delivery strategy over about 20 years, not only since ICPD as implied in the paper, and partly to long term donor support.)

F. Health Service Organization and Effectiveness.

14. Agree with the comments of division chiefs and TMs at the review meeting. The paper says much about financing but little about how Bank can help countries to get value for money through better services. Just as an example, health workforce issues are a huge challenge in many countries - numbers, skills, supervision, deployment, accountability. There is often political and economic pressure for oversupply and maldistribution of highly and/or inappropriately skilled health workers, which drives up health costs disporportionate to health gain. Curriculum and teaching reform are very slow. Overall low effectiveness of pre-service and continuing education for mid and lower level workers remains, two decades after Alma Ata and "Health for All". This is a major barrier to giving good service to the poor, and was mentioned again last month in the Bank as a constraint in the trials of introduction of the sick child package. In fact WHO and others are developing these packages around cost effective interventions, faster than the health services and continuing education systems (if they exist) can absorb them. All the other issues, management, information, supervision, QA - what will the paper say about this group of issues?

G. Balance and Relationship of HNP tasks.

15. Again the topic is presented differently in different sections of the draft, but seriously understates the interdependence of the three work tasks - operations, research and policy (and they should be presented in this order.) Sector analysis both identifies research needs and allows for the client to formulate policy options and priorities for future borrowing; lending can assist implementation of policy reform through making difficult choices and changes more palatable. Project implementation and the deeper understanding that develops during supervision generates or heightens readiness to address new or related operational research and policy development. The Bank's strategy must explicitly reinforce and exploit these relationships as should new product development.

H. Knowledge management.

16. This new activity for HNP seems justifiable as a vision for future survival of a leadership role for the Bank in the sector, the case is not yet very strong. We should take a very sober look at the Bank's past record in knowledge dissemination and what changes in skill mix and attitudes will be needed to move into what the Bank is late at and with a weak track record. This will be very expensive, Maybe the SSP should be recommending a feasibility study for this.

****

CC: Joseph Goldberg (JOSEPH GOLDBERG@A1@WBHQB)
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The World Bank/IFC/MIGA
OFFICE MEMORANDUM

DATE: March 20, 1997 12:38pm

TO: Janet Hohnen (JANET HOHNEN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SSP, comments on the white cover

You read my mind. In fact I have been talking to Richard about the possibility of making section IV the Strategy and Sections I-III a supporting document for those that want more detail. But that would mean elaborating a bit more in Seciton IV on the justification of how we came up with this recommendation. I would welcome if you would promote this idea in your region.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 01:08pm

TO: JANET HOHNEN (JANET HOHNEN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Not focussing explicitly enought on health

Your memo actually helped me deal with the issue of dealing explicity with health which has also troubled me.

How is the following for a rephrasing of the first mandate.

"First, the Bank will emphasize the fundamental responsibility of governments to address the health, nutrition and population needs of the poor, and to protect other segments of the population from the impoverishing effects of illness."

This will help us avoid the accussation I have had from other people that not only the poor have health needs.

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 05:05pm

TO: See Distribution Below

FROM: Samuel Lieberman, EA3PH   (SAMUEL LIEBERMAN@A1@WBHQB)

EXT.: 82539

SUBJECT: comments on WC draft, HNP SAS

Alex:

I generally support the story line laid out in this draft, especially the attention given to faltering government-delivered health services and ways of remedying and moving beyond these government failures while also addressing market failures in the health field. Thank you for the earlier opportunities provided to comment on work in progress. In regard to this draft, there are several points that caught my eye--these were not discussed, at least in depth, during last month's retreat and may deserve an airing at the WC meeting.

1. rural risk-pooling--the Executive Summary (para.vi) proposes that the Bank promote such arrangements. But this suggestion is not grounded in analysis in the main text; nor does the exisitng literature and world experience seem to point to promising approaches in this regard. I thought Crease's presentation earlier this week on this topic was revealing and sobering. This option should be played down and left for active experimentation by country.

2. special initiatives--this list shows up at the very end of the paper and not plugged into the main discussion. Why are such initiatives needed and how was this list arrived at? Where is TB? How does the apparent need for such initiatives square with the sort of lending instruments pushed in the paper?

3. the UN family--a lot of space is given through text and boxes to what are UN partners are doing. But none of this has any sort of analytical or critical flavor. Is it wise and credible to go so softly on organizations which in many instances and issues are not very effective?

4. limits to reform of government services--there is a nice section on this on p.24 (left column). But something seems to get lost in the transition after that discussion to the next sections, dealing largely with health care financing. This is a crucial point for many Asian countries. That is, how to wean them off direct delivery to a different set of instruments with the same priority of assisting the poor. This needs some finetuning.

see you on Friday, SL

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TO:	SHRESTHA, LAURA B. Rm: S 9-040	(LAURA SHRESTHA@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 05:25pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Jaime Biderman, OPRPG (JAIME M. BIDERMAN@A1@WBHQB)

EXT.: 32257

SUBJECT: HNP Sector Srategy Paper - White Cover Review

1. At the request of Myrna Alexander, I reviewed the draft strategy paper and have a number of comments and suggestions that I hope will be useful. From an OPR/EXC perspective, I focused mainly on its treatment of past performance (since the "evaluative content" of many sector and thematic papers has been considered weak by OED/CODE) and its treatment of the ongoing portfolio (since OPR/QAG are responsible for overall portfolio analysis and monitoring).

2. Analysis of Past Performance. Although the paper has a brief discussion of lessons learned from past experience (p. 35 and 42, Section III), it lacks a full and systematic analysis of completed operations and lessons learned. A stronger historical perspective would strengthen its evaluative content, and serve as a key building block for the proposed strategy. Specifically, a detailed analysis of the outcomes and lessons of completed and evaluated operations (with specific examples of what has worked and not worked and why) should be considered. In particular, it would be interesting to explore why social sector projects have had better outcome and substainability ratings than other projects, as noted in recent OED Annual Reviews and mentioned in the recent QAG sponsored HDD Review of Portfolio Performance in the Human Development Sector. Incidentally, OPR has remapped OED's categories such as "human resources" into the sector classification used in operations; interestingly, this shows that in fact, for the 61 HNP operations completed and evaluated in FY80-96, 38% had unsatisfactory outcome ratings (compared to 19% for education and 32% Bankwide). If one looks only at operations completed and evaluated more recently (in FY90-96) 33% of the 20 HNP operations had unsatisfactory outcomes. So it seems that the better than average "social sector" results cited above are due to education sector projects. In any case, my point is that you should use this opportunity of a sector strategy paper to try to get underneath these percentages and tell a good story about the results to date and draw out the lessons for the future. In this connection, you may want to stay in close touch with OED since (as you probably know) they are currently preparing a study entitled "Assessing Development Effectiveness in HNP". You should also be aware that the members of CODE's sub-committee are reviewing ICRs that are relevant to sector strategy papers, including this one.

3. Analysis of Ongoing Projects. After establishing a historical context based on the results of completed projects, I would suggest a more complete and nuanced discussion of ongoing projects than what you have under "Portfolio Performance" in Section III. In particular, you may want to use the "projects at risk" concept which we introduced in the FY96 ARPP and the Portfolio Improvement Program, since the IP/DO ratings may not give you a good sense of the status of a relatively young portfolio. By the way, the proportion of HNP projects "at risk" (including potential as well as actual problem projects) as of 3/11/97 was 35% (compared to 30% at the end of FY96). Also, when you use IP/DO ratings and make comparisons to Bankwide averages, this should be based on age-adjusted analyses. The above-mentioned HDD review of portfolio performance provides some analysis using the projects at risk which could be updated and used for the strategy paper. It also provides some discussion of the issues faced by ongoing problem projects which is not fully reflected in the strategy paper. For example, many of the problems cited in the portfolio review are generic (project management, counterpart-funding, civil unrest), others may affect HNP disproportionately (implementation in federated states or in decentralized settings) and some are sector-specific (e.g., procurement of drugs). In short, the story on the performance of the active portfolio could be a lot richer and contribute more effectively to the proposed strategy.

4. Regarding supervision requirements for the ongoing (and future) portfolio, you note that the average supervision cost for HNP projects was lower than average in FY96, but the cost in staff weeks (19 s/w) is among the highest for major sectors (and has been the highest for several years). Neither the dollar nor the s/w costs include trust fund resources which as you point out, loom very large in the HNP sector. Hence, a key issue for the future is how to get better results for a rapidly growing portfolio (13% p.a. in volume or commitment terms?) with high supervision requirements (even if you assume improving quality at entry).

5. Miscellaneous comments:

(a) In your discussions of knowledge management, there is no reference to the dissemination and use of evaluation findings. At the risk of belaboring this point, the network should review, digest, synthesize, and disseminate ICR and audit findings, and strongly encourage all staff to learn and apply the lessons derived from completed Bank operations.

(b) The role of water and sanitation improvements is not highlighted in your discussions of improved health status. How important are these?

(c) The Executive Summary needs more than just editorial help. I found it quite ahistorical (you immediately

launch into refocused missions, new strategic directions, roles, approaches and reforms with no discussion of the past and present record of the sector). It is also quite loose and unclear.

6. I hope that these comments and suggestions are helpful. I would be glad to elaborate on any points at the review meeting tomorrow and OPR/QAG can provide further assistance as needed.

CC:	Richard Feachem	(RICHARD FEACHEM@A1@WBHQB)
CC:	David de Ferranti	(DAVID DE FERRANTI@A1@WBHQB)
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CC:	jzaldivar1@notes.worldbank.org@internet	

A L L - I N - 1   N O T E

DATE: 18-Mar-1997 10:27am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Chris Lovelace, EC2HR (CHRIS LOVELACE)

EXT.: 85520

SUBJECT: RE: SAS - Taming the Monster

Hi Alex: I both re-read the SSP and reviewed the CIDA and HIFA documents. I really liked the CIDA approach, but I wonder if trying that style on at this stage wouldn't be a bit like changing horses mid-stream. If you think it could be easily done, I'd go for it. Further to that thought, I also agree that the SSP (when did it stop being the SAS?) is getting too long. I like your thought of staying with it as a technical background paper and producing a shorter version more in line with the original intent - as I understood it.

re: editing the old draft, pg 28 I think your proposed wording is better. I wonder though if it doesn't need a couple of sentences explaining why this important (beyond what you've said on pg. 27-28). For me it is the perverse affect it has on behaviors on all. A prerequiste of budgetary discipline is of course that the budget is set on some rational basis and matches to the policies (as well as the revenues), eg there is no point (though governments persist in doing this) in having rosy budget projections which are groundless.

Also, I think some care needs to be taken not to be too rigid on the point less it produces its own arbitrary response (eg when we first introduced funding caps in MSP in BC, the Drs. response was "we will work til the money runs out" forcing us to be a bit more creative - same thing with intial price x Volume contracts with hospitals in NZ), therefore budgetray discipline needs to be sensible too, and include both technical mechanisms and incentives to achieve it, and has to be inexorably linked to the policies. Too often, they are not.

Finally, I think you still need to find the right balance in the 3rd wave discussion (certainly that was the tone of the WC discussion). As we've briefly discussed before, I think the wave should look more like a trend, we shouldn't be too catholic about the trend (while broadly endorsing it) and I think we also need to stress there are points along the trend line that might be useful lay-overs or even stopping points for a given country and given set of circumstances. This is where the menu actually gets very interesting with the possibility of various mixes of public/private cooperation and competition, various forms of public ownership etc.

I'd be happy to come over and chat about any of the above, or offer further comments as you wish. Chris

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 05:39pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Hugo Diaz, SA1PH (HUGO DIAZ@A1@WBHQB)

EXT.: 82368

SUBJECT: White Cover HNP Sector Strategy Paper

Alex,

1. Barbara asked Kathleen Finn and I to read the White Cover and give you some feedback. We have a few observations on specific points which are detailed below.

Change of Paradigm

2. We would certainly agree that we need to persuade governments that public policy in the health sector needs to include supporting the efficient development of the private sector. And we (the Bank group) need to do much more to support governments in this effort. At the same time, in countries such as Pakistan, where the private sector is underdeveloped or absent (except for quacks) in many areas of the country, we will need for the foreseeable future to continue supporting efforts to make government services more effective and efficient. The draft White Cover recognizes this point, I think.

Specific Observations

3. In page v, one of the three objectives of the Bank's mission in the HNP sector is said to be poverty alleviation, which would entail "addressing the health, nutrition and population needs of the world's poor and other vulnerable populations such as women, children, the disabled and elderly". This wording dilutes the poverty emphasis to the point of rendering it meaningless; if all of these groups were to be included under "poverty alleviation", there would be hardly anybody left out (i.e., only non-poor, adult, non-elderly, non-disabled men are left out in this formulation). We should be very clear that when we talk about "poverty alleviation" we are talking about members of poor households, of whatever age/sex. This is not to say that women and children are not faced with particular problems, but we should not confuse this point with the poverty focus.

4. In page 9, it is stated that per capita health expenditure in the USA is 700 times the corresponding figure in Nigeria. The draft does not clarify whether expenditure in local (Nigerian) currency has been converted into US$ at the official exchange rate or at a PPP-adjusted exchange rate. Looking at the table in

the same page ("Regional Patterns of Health Expenditure"), it seems likely that the official exchange rate was used. It is questionable whether this is an appropriate procedure. It substantially exaggerates the differences in terms of purchasing power, which is after all what matters.

5. In the same page, there are several statements which compare what the governments of some poor countries are spending on certain basic services (e.g., basic package of immunization) with what the WDR1993 said such services cost, on a per capita basis (the figures in US$ for these comparisons are calculated at official exchange rates). The WDR1993 gives a single per capita (US$) cost figure for all countries. This must be an average figure; even within low-income countries, there are differences across countries in the dollar price (reckoned at OERs) of health labor, and there would also be differences in the physical productivity of labor (and labor costs are the most important component of health services costs). And there are undoubtedly other reasons why US$ unit costs of various bundles of health services would differ across countries. Before we start using this single figure from the WDR for comparisons with actual per capita spending of individual countries, do we have any idea of what the dispersion around this average is? Aren't these comparisons too crude to conclude anything from them?

In addition, we need to distinguish between the per capita cost of providing a certain package of services to the entire population of the country, and the per capita fiscal cost (calculated over the entire population) to the government of subsidizing consumption of the said package for a subset of the population. See (6) below on this point.

6. The argument in page 26 is not clear. The draft says that

[A country with a per capita income in the range of US$300 to US$800, must spend in the range of 1.5 to 3 percent of GDP, or the equivalent of 7.5 to 15 percent of government revenues, to secure a stable source of financing to pay for a minimum package of essential preventive and clinical services needed by the poor and vulnerable groups (approximately US$10 per capita).]

There are several problems with this statement. First, as already noted, to talk about the "poor and vulnerable groups" as the focus of attention for public policy, with "vulnerable" defined in the way it is defined in the paper, is meaningless. It means pretty much the entire population of the country. Secondly, what does the draft mean when it says that "a country" must spend these sums? Is the paper referring to what the government must spend --the fiscal cost of paying for the minimum package, for whatever groups of the population we feel deserve getting this subsidy? The reference to equivalents of government revenues in the above-quoted paragraph suggests that this is indeed the case. But in that case, the per capita cost (to the government) would not be US$10, but less. For example, if we

No

would all agree that: (i) the government should pay for 100% of the cost of the package for the poor, (ii) it should pay 0% of the cost of the package for the rest of the population; and (iii) we have estimated that one-third of the population is below some agreed poverty line (i.e., are poor), then the per capita cost to the government (calculated over the entire population) would be US$3.33 rather than US$10. The cost to the government would then be equivalent to 1.1% of GDP in a country with US$300 of GDP per capita, not 3%. In other words: we cannot make any statements about how much the government of any country should spend on the "minimum package", as a percentage of GDP, unless we also specify what is the policy regarding who gets and who does not get a net government subsidy in connection with consumption of the package, specify how much is the subsidy as a proportion of cost, and quantify what these eligibility criteria mean in terms of percentages of the population.

Not necessarily

7. In page 45, the paper recommends that the Bank "will emphasize the need... for fiscal control over health care expenditures (public and private)". The argument that governments need to be concerned with controlling private health expenditures is also made earlier, in page 28. In pages 26-27, concern is expressed over the "tendencies towards expenditure escalation" which "has been observed to be much greater in the private sector than public sector in middle-income countries". I think that this concern about escalating private expenditure, and associated recommendation for government intervention, needs to be justified. Its welfare rationale is not obvious. Why should this be a concern of public policy? If a rich 80-year-old wants to spend a fortune on some high-tech health intervention which will extend his life by 3 months, why should the government care? One possibility would be if he is the victim of fraud --e.g., the provider falsely claims that the patient's life would be extended by much longer than available data can justify. So there may be a rationale for certain kinds of government intervention in this context. But we need to explain with some care under what circumstances would government intervention be justified.

8. The paper makes reference to several international initiatives. While we may not be able to judge the impact of the most recent three (Cairo, Rome and Copenhagen), perhaps we could say a word about the influence in practice of Alma Ata (1977) and the World Summit for Children (1990).

9. In page 17, the 2nd to last para. refers to "fluoridation of salt" and "iodization of water". Shouldn't it be reversed?

?

10. In page 44, the paper recommends that the Bank provide direct support for governments to become more effective in providing a health care safety net. In this context, you may want to stress the importance of addressing governance issues, institutional capacity building and accountability (i.e., tie with page 23, "factors that influence systems performance").

We hope this is helpful and wish you good luck in finalizing the paper. Best regards,

Hugo

CC: Barbara Herz (BARBARA HERZ@A1@WBHQB)
CC: KATHLEEN FINN (KATHLEEN FINN@A1@WBWASH)

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 10:20am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Peter Heywood, EA3PH (PETER HEYWOOD@A1@WBHQB)

EXT.: 87326

SUBJECT: Comments on SAS White Cover

Alex,

Getting the document to this stage is an extraordinary achievement. I salute the effort you have put into pulling such a diverse set of information, with inputs from such a large number of people, into a single document. It is a huge task.

I have some comments on each section, then some more general comments.

Section I tells the story well. I think the message about the threefold challenge of continuing poverty, malnutrition and poor health, variability in performance of systems and inadequate resources comes through well.

This section would benefit from four additional points which would also strengthen the link to section IV;

1. reference to, and illustrations of, the widespread problem of many public subsidies not actually reaching the poor but in fact often being captured by higher income groups.

2. some concrete examples of the way in which poor technical content contributes to the overall inefficiency and limited effectiveness of the health systems e.g. inadequate cold chains, inadequate clinical skills, spraying in most malaria control programs, HIV/AIDS programs which do not direct enough attention to other STDs etc.

3. manpower questions, including conditions of service, quality of training (pre-service and in-service), and distribution underlie many of the problems of poor performance in health systems.

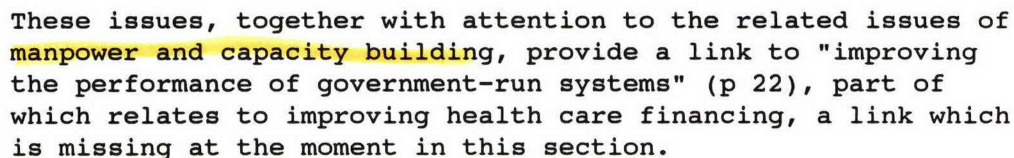
4. there is a related need to place priority on capacity building, particularly for problem identification and strategy formulation and management.

Section II. The section on targeting strategies sets the scene well.

Two important issues which could be added, perhaps under the "ongoing challenges" beginning on p 15 are incentives for health workers and sustaining the gains already made.

On the question of incentives IMCI provides a good example. If it is to implemented staff will have to spend a lot more time with each child doing the assessments and discussing treatment with the caregivers. In many systems there is little incentive (e.g. low salaries and poor or inadequate supervision) for this to be done. Unless incentives change it is likely that the enthusiasm generated by the new initiative will last for a short time only.

Sustaining the spectacular gains made in immunization coverage in some countries is also going to be difficult unless the enthusiasm and motivation is maintained once the donors move on to something else. Again, changing institutions and incentives are critical to the maintenance of these new levels of performance.



These issues, together with attention to the related issues of manpower and capacity building, provide a link to "improving the performance of government-run systems" (p 22), part of which relates to improving health care financing, a link which is missing at the moment in this section.

Section III.

Whilst you have taken a fairly descriptive approach to this section, there is a place for more emphasis on the effects of the decline in sector work, particularly in terms of project design and quality at entry. The lack of sector work decreases the effectiveness of what the Bank is financing in some countries. This relates back to the point above about limited effectiveness, incentive and sustainability. When these have been ignored the Bank ends up financing rather useless activities but often never knows because little or no attention was paid in project preparation to the issues limiting effectiveness of the system. This is critical to informed and effective policy dialogue with governments. The pressure for shorter project preparation times together with the reduction in resources for sector work has had a serious impact on the quality of projects.

I also feel that the section on "Portfolio Performance" needs to highlight the problems of inadequate project supervision, frequently tied to rapid turnover in Task Managers and decreased supervision budgets.

Under staffing issues you lament the paucity of projects on health financing and then tie it to a plea for more economists in the sector. You make this connection without any comment on whether economists have been involved to date or analysis of the reasons why governments might be reluctant to borrow for

stand alone financing projects. (In a way I find this analogous to the special pleading for stand alone nutrition projects that has been the subject of some discussion in the past. I feel that the conclusion is the same in both cases - both should be considered as possibilities when the occasion is appropriate, neither should be seen as usual.) This approach is also curiously at odds with the emphasis in some sections of the document on "sector-wide approaches".

Overall, I feel that this section is too timid about the inadequate resources (the numbers and type of staff, and the wherewithal to do the job) which have been available in recent years, the effect of new and old Bank processes and the need for change in each. It is, after all, setting the scene for Section IV on mission and strategic vision.

Section IV.

The section on "New Strategic Policy Directions" captures the emphasis in the earlier sections. I suggest that the "second" (p. 44) be re-worded to read something like

"Second, the Bank will emphasize the need to increase the efficiency and effectiveness of health services to obtain better value for money, including re-balancing public and non-government involvement."

On "New Approaches to Credit and Loans", I find the figure difficult to understand. It seems to indicate increased emphasis on "capacity building". This is inconsistent with the table on p 35, column 2 which shows that the capacity building component of the portfolio has decreased in the last decade.

Action Plan

This is where it comes together and I have a number of comments.

1. The emphasis on country dialogue and strategy is important.

2. The section on management of the HNP sector does not carry forward a number of the issues raised earlier or seems to lose the sense of priorities. Thus, the first priority should be staff development, then business processes and portfolio performance, followed by knowledge management and change processes. And the earlier concerns about sector work and supervision need to be highlighted here.

3. The Special Initiatives seem to be unconnected to the rest of the document. Up to this point the document is almost silent on particular disease problems. And then there is a list which, with the exception of the first, is composed entirely of specific diseases from which there are some strange omissions (e.g. TB, PEM). These raise the prospect of

more internationally-driven, vertical, and ultimately unsustainable programs, it is just that the Bank will now drive them rather than WHO. These will presumably require considerable resources, need to be country specific if they are to be effective, and are not addressed in any way (general or specific) in the SAS itself.

A better approach would be to ensure that there was adequate money in the regional budgets for focused sector and policy work on these issues, something which is acknowledged in earlier sections to be decreasing and in need of further resources. If better sector work was done on these problems (including through the use of experienced consultants) they would be more likely to be included in projects, designs would improve, supervision would be better, they would have a better chance of being sustainable and, overall, the Bank would be seen as making an important contribution to their control.

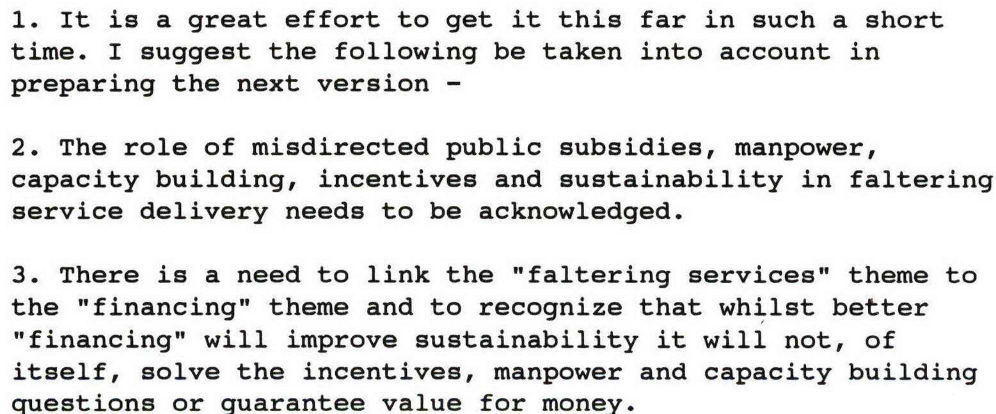
Issues which are not addressed and should be.

As mentioned above, the document is almost silent on two related questions which underlie the effect and sustainability of all our work - manpower and capacity building. These are fundamental to sector reform (including financing). It is most important that they are reflected in the earlier parts of the document and in the strategy to be pursued by the Bank. As mentioned above, resources for capacity building in bank projects has decreased in the last decade and we need to reverse this trend if any of the proposed strategies are to payoff.

Format

Overall, I find the document rather cluttered. I feel that there are just too many boxes and figures. It looks to me as if, taken together they occupy approximately 30% of the document. I would be shorter, clearer and less cluttered without quite a few of them.

In summary,



1. It is a great effort to get it this far in such a short time. I suggest the following be taken into account in preparing the next version -

2. The role of misdirected public subsidies, manpower, capacity building, incentives and sustainability in faltering service delivery needs to be acknowledged.

3. There is a need to link the "faltering services" theme to the "financing" theme and to recognize that whilst better "financing" will improve sustainability it will not, of itself, solve the incentives, manpower and capacity building questions or guarantee value for money.

4. Within the Bank, the problems of inadequate resources for sector work and supervision, and their effect on portfolio performance, need to be given more prominence.

5. The Special Initiatives section does not seem to be related to the rest of the document and needs a lot more discussion. An alternative is to deal with these issues through projects by increasing resources for sector work and supervision.

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A L L - I N - 1 N O T E

DATE: 14-Mar-1997 02:57pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Mariam Claeson, HDDHE (MARIAM CLAESON@A1@WBHQB)

EXT.: 38499

SUBJECT: SSP comments

Alex,

As a technical -- quality biased SSP core team member -- this is what I found important among today's comments:

It is interesting to note that there are a few common, and related, themes among the many diverse comments. Apart from the public/private story line, there was commitment to excellence and bringing expertise to the table (Skolnik), attention to doing things technically right (Heywood, McLaughlin, Peters and others) within existing resources.

It seems important, based on the comments today to:

- not cut too much of the "educational" content of the SSP in future revisions. If you do, you take out the aspects of the SSP that deals with technical content. If you had not had this educational part of the SSP you would have had many more comments and concerns about the rationale and justification for the implicit recommendations. Don't take it out!

- include attention to technical content among the options for how to address public failure -- it should be stressed that attention to the quality of carefully selected public health services (e.g. cost-effective essential health services and public health interventions) will in some places help address some of the failures (especially if the only option is to shift to privately financed un-regulated health services).

- do not suggest that the Bank be responsible for "what it does best" only and that it leaves other aspects of policy and implementation to others (they wont happen!). Instead make the Bank be responsible for bringing in the best "know how" through partnerships and through its evolving knowledge management system. Implication: more funding for supervision and TA at all stages of project development and implementation.

- Link Section 1 and 2 better to Section 3 and 4: that will help to bring out the NEW ideas and approaches and those that will address technical effectiveness and quality.

Specific comments and corrections:

Page 4. The Disease Burden Figure is wrong. You can not separate malnutrition from the other causes of DALY losses and end up with those figures. Malnutrition as risk factor accounts for 15% of GBD; it is as underlying factor that it contributes 60% to DALYs lost. Take it out -- if you need a figure showing the contribution of malnutrition, you can use the GBD pie chart with an area of malnutrition superimposed.

Minor corrections;
Page 52 second bullet, third paragraph "mortality" should be replaced by " life expectancy".
Page 14, please use "Integrated Management of Childhood Illness" at the top bar of the chart instead of "Management of the sick child" -- for consistency with the text. Also, please add to last sentence, second paragraph (second column) after Zambia ; "Many other countries have taken the first steps towards adopting this approach.

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 13, 1997 11:48am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Judith McGuire, Nutrition, HDDHE (JUDITH MCGUIRE@A1@WBHQB)

EXT.: 33452

SUBJECT: Comments on HNP/SSP White Cover

Alex,

This draft is lightyears ahead of the draft at the end of the Wintergreen retreat. Reads well, convincing, etc.

I agree with Tony Measham's comments about overplaying the financing and underplaying things like the need for more sector work and supervision resources.

Generally (and I'll say where) inadequate attention to QUALITY of health services as a determinant of outcome (certainly relative to attention to financing); not enough mention of social protection family and ESSD Network as our partners in this. ESSD through both social and gender as well as through rural development will be critical. A late thought I had: the rural sector is where health problems and health services are worst. I don't recall its being said in the SSP>

Some specific comments plus language for inclusion:

Exec Summ: second para. The Chile case is a good example not of technology and knowledge, but rather of longterm national commitment to providing high quality services with high coverage. The current SSP horse, the wrong horse, was beaten to death in WDR 93 and the same shouldn't be made here.

para. 5: I would seay "investments" not "resource transfers" since many countries don't get real transfers.

pg. vi, first bullet: add social protection and ESSD network
second bullet: add ministry of rural development or agriculture.

pg. vii: New Role as Knowledge Broker does not in any way do service to your excellent discussion on pp. 30 FF. Nor does the last chapter from which this section is pulled verbatim. Our knowledge and our advantage is not really in R&D or research (except maybe economic research). Our real knowlege advantage is in sharing across countries sector work etc. That should feature large in this section and should lead right into Tony's point about raising the alarm about lack of sector work.

pg. vii: New Approaches, first bullet. It seems internall inconsistent to speak of "sector-wide" policy framework and poverty. Poverty has to be dealt with economy wide. And many of our tools go beyond the health sector.

pg. viii, footnote. Here's where the old ugly issue of "health services" vs. health rears its ugly head again. CASs cshould be reviewed for their impact on human development, including hnp, including poverty/health services, etc. NOT just health services.

pg. 2, second column, second para. please add capital'd section "The 200 million people throught the world 90% in SSA) who are infected with schisto and AND THE 1 BILLION PEOPLE IN THE WORLD SUFFERING FROM ANEMIA suffer from chronic fatigue and other symptoms. and continue on.

pg. 5 box. first para. "infectious disease AND MALNUTRITION" please. 3rd para: please add "heart attacks FREQUENTLY DUE TO OVERNUTRITION"

pg. 6, box. other methods of reducing tobacco: effective communications for behavioral change including mass media and inpersonal counselling" where just "mass media" used to be

pg. 9 second column top: don't you want to add these would buy that "if it were spent well".

page 11, first column, bottom para is not clear. I think you want to say "For every $100 spent on drugs, $10 are wasted ......"

pg. 12, box. Don't you want to say a major policy challenge is getting public finance allocate to basic services in addition to just getting enough finance?

pg. 14, 1st column, 4th para: "the resulting administrative COST AND complexity"

pg. 14, 1st col, 5th para. at end why not add": "Height censuses of entering first graders have been particularly useful in determining which are the poorest regions which have priority for targeting social services in LAC."

pb. 15: DATES for ICN: Rome, Dec. 1992.

pg. 17, 2nd column, para 3 (food fortificaiton" should end "highly successful in reaching vulnerable populations at low cost". The DON"T TARGET the vulnerable; it's cheaper not to target food fortficiation.

Some text is missing on bottom pg. 17/top page 18 concerning community nutrition programs. Originally it came befor ethe

nutrition communications para, but some of it appears on top pg 18.

pg. 18 box. Nix "physical exercise". Many people have too high energy expenditure.

pg. 18, col. 2, para4. nix "automobiles".

pg. 23: first column, bullets: what about quality. It's mentioned in the box next door.

page. 24, 2nd column, 5th bullet. Isn't one problem that governments have poor capacity to regulate honestly and well?

pg. 32, list of publications in 2nd para: please include strategy to address poverty and hnger, 1995 (Claudia, can you give full reference?)

pg. 36. or somewhere else. How about a new box?

"Delegated Contract Management and Nutrition: a new instrument"

In Senegal the Community Nutrition Project is using a private social service entity, AGETIP, to manage public resources and provide services to the community. AGETIP contracts with community based organization to provide a clearly specified set of nutrition services. The formal health system provides backup for referral but is not involved in the deliver of community services. The project has reduced malnutrition by over 50%. It's success is due to clearly specified inputs and services and to and exquisite monitoring system which catches problems in the making.

pg. 38, bottom first column. Would you like to single out and give kudos to the Japanese for the HRD Grant which has made much of our portfolio possible?

pg. 40: emphasize more the loss of sector work and supervision.

para 3. You seem to moan about the lack of projects on health finance but isn't this more policy advice than lending? Or mightn't it fit better under SAL/SECAL than under project lending, per se?

pg. 41, top lesft column. How about note about working at community level, qualitative methods, participatory approaches needed and therefore we need ESSD folks (and because they also specialize in NGOs)

pg. 44, para 4. Hodw about mentioning the CGAPP program and the need complement income generation with hnp investments. This has been tried with small scale credit and nutrition education in Africa and Asia with some success.

pg. 44, col. 2, para 2: mention agriculture and rural devel. ministries. Mention social protection and ESSD.

pg. 45. Knowledge Broker: bring the richness from pp. 30 ff to this section. This is not really our metier. \

pg. 50: How about cross network and cross family linkages. Something should at least be SAID about that. It's critical to us in nutrition.

CC: Claudia Rokx (CLAUDIA ROKX@A1@WBHQB)
CC: Kathy Peterson (KATHY PETERSON@A1@WBHQB)

To: Claudia Rokx
Fax: 1 202-522-3234 (Washington, USA)
#PAGES: 8
From - Judy McGuire (Room 330)

Claudia Rokx –

Please get the nutrition minipak from Kathy P. (Sanghvi attached to Email last week). Please give a copy to Alex Preker to include in the SAS in addition to IMCI. Please ask Alex to add text on minipak as follows: (draft March 1, 1997)

Page 17, 2nd column. after ¶ on nutrition communications –

"A minimum package of nutrition services within health services is necessary to complement food fortification, community nutrition, and communications for behavioral change. This minimum package includes: breastfeeding promotion, promotion of appropriate complementary feeding, vitamin A supplementation for children (where vitamin A deficiency is a problem), universal iron-folate supplementation of pregnant women, and promotion of iodized salt. These interventions are well-known, accepted and address the most frequent nutrition problems. It is similar to the nutrition package in IMCI. Adaptation of complementary feeding to the local situation is necessary."

Thanks,
Judy

Draft 2/25/97

2/27 draft from Tina Sanghvi To be discussed with her 3/3/97

Introduction to

NUTRITION MINIMUM PACKAGE "Minpak"

Selected Nutrition Interventions for Integration in Health Services Universally

Please make copies and distribute to
Marian Claeson
Venancio Vella
Dick Seifman
Claudia
— Thanks. Judy

Draft

February, 1997

Section 1. Introduction

There is a great deal of evidence that malnutrition, even mild malnutrition, can increase the likelihood of mortality from a number of different disease entities (Pelletier et al., 1993 and 1995). The nutrition interventions listed in Table 1 are those which have already been demonstrated to have a public health impact and which can be implemented in a relatively cost-effective manner. A technical justification for each is given in the next section.

[INSERT WHO PIE CHART "Distribution of 12.2 million deaths among under 5 year olds in all developing countries, 1993" ABOUT HERE -- LABEL 'FIGURE 1']

According to current estimates, at least 70% of all childhood mortality is due to five major medical conditions: diarrheal diseases, acute lower respiratory tract infections (ARI), malnutrition, malaria and measles. In order to have a measurable impact on childhood morbidity and mortality in developing countries, health programs need to integrate nutrition interventions - at a minimum, those interventions that have a proven, and cost-effective impact on infant and child mortality. For example, among diarrheal disease interventions breastfeeding and promotion and vitamin A supplementation are the most cost-effective. Moreover, since children often have multiple conditions at the same time, managing just one of these may not prevent their death from other underlying conditions. Programs are increasingly addressing all of the most common causes of morbidity and mortality at the same time. Health facilities will always play a crucial role in the provision of primary health care including nutrition. However, some services need to be delivered beyond the health facility, so that an integrated package of preventive interventions can be provided to the entire community.

BASICS, the Centers for Disease Control and Prevention (CDC) and USAID have developed a conceptual framework, the *Pathway to Survival*, to assist with the development and monitoring of integrated child health programs (Waldman et al., 1996). This framework outlines the key steps between a child being well, developing an illness, and then surviving this illness. See Figure 2. A substantial component of this pathway takes place at the level of the home and the community. In the home, a number of simple strategies have been demonstrated to prevent childhood illness, including: breastfeeding; appropriate complementary feeding practices; basic hygiene practices (hand washing); and receiving a full course of infant vaccines in the first year of life. An integrated package of preventive interventions needs to focus on these areas (also see Emphasis Child Survival Behaviors, Murray et al, 1997).

A short-list of six nutrition interventions - the Minimum Package or "Minpak" - were selected by consensus of authorities in public health nutrition. The selection criteria included: demonstrated relationship with mortality and morbidity, measurability, and amenability to change through cost-effective public health programs. Table 1 lists the interventions and related strategies. Program activities for supporting these strategies involve development of technical guidelines/protocols, assuring supplies, training, supervision, monitoring and evaluation, as an integral part of the broader health program.

Section 2. Technical Justification for Minpak Interventions

Minimum package interventions are not new. Evidence over the past 2 to 3 decades has led to a global commitment for these interventions as illustrated by the World Summit for Children goals, International Conference of Nutrition targets, and follow-up activities by countries in developing their own action plans. Nutrition interventions are now considered among the most cost-effective in health (Phillips et al, 1996, Horton et al, 1996, Sanghvi, 1996, Sanghvi, 1992). See Figure 3. The evidence is summarized below and provides some examples of the supporting scientific justification.

[FIGURE 3 ON COST-EFFECTIVENESS ABOUT HERE]

Exclusive breastfeeding for about 6 months.

Relative to infants who are exclusively breastfed (defined as an infant who is given no liquid or solid other than breast-milk), infants not breastfed at all have at least 14 times the risk of death due to diarrhea. The risk is greatest in the first two months of life. Risk of death from respiratory disease is 4 times, and for other infections, 2.5 times greater for non-breast-fed infants as compared with those exclusively breast-fed (Victora et al., 1987; Feachem and Koblinsky, 1984).

Data from Bangladesh, Brazil, Peru and the Philippines show that premature supplementation of breastfeeding is associated with greater risk of diarrheal morbidity and death. Even the introduction of herbal teas and water to exclusively breast-fed infants increases the risk of diarrheal morbidity and death. Introduction of other foods and fluids decreases the amount of breast-milk supply, decreasing nutritional intakes; complementary foods decrease the absorption of iron contained in breast-milk. Supplementary foods most commonly used in low income households rarely compensate for the nutrients in the breast-milk displaced. Health workers need to be careful not to counsel mothers to introduce supplements prematurely (Brown et al., 1990; Popkin et al., 1990; Victora et al., 1989)

There are good programmatic data to suggest that breastfeeding practices can be improved in a number of populations and that improving exclusive breastfeeding practices can reduce infant morbidity and mortality, in particular from diarrhea (Horton et al, 1996, Lutter etal, 1997, Winikoff and Baer, 1980; Mata et al., 1981). New data suggest that HIV-AIDS can be transmitted through breastmilk in a small proportion of cases, and WHO recommendations on counseling confirmed HIV-positive mothers are being developed (UNAIDS statement, 1996).

From 6-24 months, provide appropriate complementary feeding and continue breastfeeding.

Absence of frequent and sustained breast-feeding is a significant risk factor for nutritional deficiencies beyond the second year of life. Children who remain breast-fed are 65 to 90 percent less likely to develop vitamin A deficiency signs (Sommer and West, 1996). However, breast-milk alone does not provide all nutrients needed by an infant over six months of age (Scrimshaw et al, 1996). By six months other factors converge as well: developmental "readiness" to obtain and ingest semi-solids, the gastrointestinal tract is mature enough to digest a diversity of foods, the immune system is more prepared to respond to environmental pathogens in complementary foods.

following day with the following levels: below 6 months of age: 50,000 IU per dose; 6-11 months of age: 100,000 IU per dose; 12 months of age and older: 200,000 IU per dose.

For all pregnant women, give iron/folate tablets

Iron deficiency anemia is the world's most common nutritional deficiency. It affects pregnant and lactating women in particular as well as children under 3 years of age (ACC/SCN, 1991). Anemia in mothers predisposes to stillbirths, neonatal mortality and low birth weight in children and increases the risk of maternal mortality (Walsh et al., 1993). Anemic mothers are also less likely to implement routine child care tasks or engage in activity requiring energy expenditure due to the debilitating effects of iron deficiency on aerobic capacity and productivity (Stoltzfus, 1994). Daily supplementation with ferrous sulphate tablets (often including folic acid) at a level of 60 to 120 milligrams of elemental iron per day for the last two trimesters (in combination with de-worming if necessary) is a low cost intervention, and currently reflected in health guidelines for in most countries (OMNI 1996; Levin et al., 1993; McGuire and Galloway, 1994).

For all families, use iodized salt

Iodine deficiency is the world's greatest single cause of brain damage and mental retardation. It is caused by a deficiency of iodine in the soil and therefore in locally grown foods (WHO/UNICEF/ICCIDD, 1993). Iodine deficiency is associated with stillbirths and fetal wastage, and impaired cognitive function in developing children. As adults, these individuals have limited productivity. A large number of developing countries have geographic areas where there is a high prevalence of iodine deficiency. Salt iodization is one of the lowest cost nutrition interventions, and universal iodization is currently underway (McGuire and Galloway, 1994).

4. A mechanism to track progress and flag early constraints (e.g. monitoring and evaluation plan) is required. This involves integrating appropriate indicators and decision tools within broader health monitoring and evaluation systems.

Adjustments may be needed in existing policies and national guidelines to support achievement of desired targets. Assessments of the current status of programs and opportunities/constraints for strengthening these are a first step in planning. Table 2 is an example of a generic checklist that can help identify priority areas.

Box 2. Adapting Minpak-Related Behaviors to Community Context: Example of Breastfeeding and Complementary Feeding Behaviors in Madagascar

Qualitative research was conducted in rural areas of two focus districts (Antsirabe II and Fianarantsoa) where child survival program improvement models are being developed by MOH with BASICS assistance (Steele, 1996). The objective was to develop locally acceptable and feasible behaviors related to the first and second Minpak interventions on infant and child feeding. The research showed that mothers were willing to adopt the following improvements because "they want their child to be healthy" : breastfeed at least ten times during a 24-hour period and stop other liquids for infants under four months; thicken rice porridge, enrich with energy and micronutrient-rich foods, increase the number of complementary feedings; and coax children with poor appetites to eat more frequently. They were willing to accept these recommendation sif the counselor was "knowledgeable". Some families did not have resources to add enrichment ingredients daily.

Given this information, a IEC and community mobilization strategy to address this behavior included: working with health workers and community influentials to encourage families; in-service training of health center staff on counseling mothers and using child weighing as a tool to reinforce these recommendations; organizing periodic community weighings of young children for sensitization regarding malnutrition and feeding practices, and public meetings to talk about the importance of recognizing malnutrition in children, and its prevention through improved feeding combined with other child health interventions (measles immunization, seeking sick child care in a timely fashion etc).

Objectives of the program are: increasing the proportion of community leaders and caretakers who know the importance of child feeding for child survival and growth, advantages of exclusive breastfeeding,; and increasing the proportion of caretakers who are feeding their children appropriately in addition to following other recommended health practices.

Supplementary vitamin A to prevent vitamin A deficiency	- National policy on protocols and supplies - Fortification policy if determined to be more cost-effective than supplements - Pre-service curriculum	- same as above - For fortification-based programs: Quality assurance and surveillance guidelines	- same as above - For fortification-based programs: training includes importance, possible participation in monitoring/ surveillance	same as above	same as above	- Supply systems functioning for: capsules, fortificant, pre-mix, training tools etc.	- same as above - logo for fortified foods
Vitamin A for case management	- Guidelines on case management - Updated policies on case management of PEM[2] - Pre-service curriculum	same as above	same as above	same as above	samé as above	same as above	same as above
Prenatal iron supplements	- Policy for antenatal care includes iron/folate protocols and supplies - Pre-service curriculum	same as above	same as above	same as above	same as above	same as above	same as above

Section 4. Developing a Plan of Action and Tracking Results

The health manager will need detailed information on current internationally recommended protocols and guidelines for implementing each Minpak intervention. These protocols, combined with lessons learned regarding training, supervision, supplies and logistics, monitoring and evaluation, and IEC/behavior change strategies are given in Nutrition Essentials (estimated publication by BASICS in 1996). In the interim, existing information related to breastfeeding, complementary feeding, and micronutrients (vitamin A, iron and iodine) can be obtained from WHO and UNICEF, or by contacting BASICS in Rosslyn, Virginia.

Plans of action will need to address each of the following program components systematically:

- Updating policies and technical guidelines

- Developing training objectives, plans and tools

- Developing supervision tools and systems

- Identifying monitoring and evaluation indicators and methods

- Reviewing logistics and supplies constraints and addressing them

- Developing a strategy and plans for IEC and community mobilization

Since the Minpak is not intended to be a vertical or free-standing program, each action needs to fit into the broader health program. For example, in Madagascar, child feeding messages are woven into a calendar of IEC themes designed to provide relevant information according to seasonal patterns of disease. Some activities, however, are best planned and implemented separately. For example, household trials, a comprehensive testing of feeding behaviors are undertaken prior to the development of health worker training activities. Similarly, because supply issues concerning vitamin A capsules or iron/folate may have received little attention in the past, program managers may find it useful to conduct a simple, focused situational analysis of these issues. A mothers' counseling card can be pre-tested in isolation of other materials if the latter are already well-developed. In fact, Minpak related developmental activities are often undertaken separately to provide focused attention so that nutrition activities can catch up with other child health interventions. Nevertheless, the intended result is a complete integration of Minpak within the broader health services.

Table 3. Examples of Indicators for Minpak Monitoring and Evaluation

Indicators
Population Level: - % infants 0-4 months exclusively breastfeeding - % infants 6-12m fed according to recommendations (re:IMCI Food Box) - % infants 12-23m fed according to recommendations (re:IMCI Food Box) - % children 6-71 months who received one vitamin A capsule within the past 6 months - % pregnant women with hemoglobin < 11 grams/100 ml - % households consuming iodized salt
Program Level: - No. health facilities providing an integrated package of child health and nutrition services (program-specific definition) - No. health facilities where > 75 % mothers of infants < 12 months were counseled on infant feeding appropriate counseling on child feeding - No. communities/households with access to trained staff and supplies for the Minpak interventions
Health Worker Level: - No. workers with adequate interpersonal and counseling skills - No. of hospital staff following protocols for case management of severe PEM - No. health center staff following referral rules, protocols and counseling guidelines for Minpak - No. community workers following appropriate guidelines

Private Sector Partnerships	- Support given to sugar industry, NFNC, NCSR etc. on vitamin A fortification - Sensitization conducted on six Nutrition Components of Health and job aids developed and disseminated to private providers (physicians, nurses, community practitioners, pharmacists, traditional healers etc.)	- National sugar fort. initiated by 3/98 - No. NGOs and private institutions with trained staff and supplies to implement NCH	- Quality control and monitoring in place	- % HH consuming fortified sugar - Adequacy of vitamin A levels in sugar	- % children 1-5 yrs. with adequate vitamin A intakes
Health Worker Perform.	- Performance standards for all levels (DHMTs to HW, CHW, TBAs and other community-based workers) developed - In-service training and supervision strategy, action plans and materials developed for all levels - Pre-service training and supervision strategy, action plans and materials developed for all levels as part of, or extension of WELLSTART's breastfeeding strategy for pre-service training - Complementary feeding guidelines (based on IMCI and other research in Zambia) developed into training modules and integrated with breastfeeding training courses	- In-services training of all levels in NCH - No. DHMTs providing in-service training and supervision on NCH - Pre-service curriculum on NCH in use by medical, nursing and nutrition schools - BFHI assistance identified and plan put into action - All BFHI training expanded to include Food Box recommendations	- No. hospitals with trained staff - No. health centers with trained staff - No. communities with staff trained in NCH	- % of hospital staff following protocols - % HW following referral rules, protocols and counseling guidelines for NCH interventions - No. CHW, TBAs community workers following appropriate guidelines	- No. health facilities providing an integrated package of services including NCH - No. health facilities meeting quality standards for NCH - No. households and children < 5 with access to quality, integrated care (including NCH) - Case fatality of malnutrition cases - Measles case fatality

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Acknowledgements

We appreciate the comments and insights of the following experts who helped define the list of six minimum package interventions:

Kenneth Brown	Reynaldo Martorell
Ian Darnton-Hill	Audrey Naylor
Kay Dewey	Margaret Parlato
Marcia Griffiths	Ellen Piwoz
Sandra Huffman	Keith West

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 04:52pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: A. Edward Elmendorf, AFTH3 (A. EDWARD ELMENDORF)

EXT.: 35570

SUBJECT: RE: SAS - IDA and 100 percent financing option

Alex,

You've seen how I responded to your previous communication by putting it out for comments. I'm not so inclined to push further for other reactions, at this stage, on the 100% financing option (of course, excluding taxes), beyond whatever is generated by your EM.

My reactions at this stage - and I stress that they are mine and do not represent any effort at AFR consensus building:

(a) Let's press on 100 percent financing as a possibility, with a separate and subsequent paper to review circumstances and criteria, so that the SAS does nothing but open a window.

(b) On IDA funding of NGOs, of course Helena Ribe and the others are correct that this can be done through national governments. But I've seen plenty of circumstances where they might not object to our doing it but wouldn't do it themselves with our funds. Furthermore, I'm talking not of IDA credits, as the lawyers do, but of IDA grants! Now, it's clear to me, from the CGAP and micro-credit experience, that legal considerations are not the real obstacle. I was confident that I'd get little reaction of support on my view in the Region, on grounds - if nothing else - of institutional conservativesm. And, I was right, from reactions you've seen to my EM. At this stage, while bowing to the consensus of colleagues, I don't want to lose the idea entirely from the SAS and think that you could put in something about the utility of the SGP for support to population NGOs and the value of the small grants program managed through EXT. The point would be to draw attention to these instruments and to open the potential for their expansion, if we can't go so far as to open wider dialogue on my idea of an IDA window. [I was most interested and encouraged to see, nonetheless, that a number the major IDA contributors liked the idea!]

Cheers, Ed

The World Bank/IFC/MIGA
OFFICE MEMORANDUM

DATE: March 20, 1997 04:33pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Janet Hohnen, EA2RS (JANET HOHNEN@A1@WBHQB)

EXT.: 81217

SUBJECT: RE: SSP, comments on the white cover

ALex,

You may have been at Mr. Stiglitz meeting with HD people this afternoon. He made 2 comments which I would claim support earlier comments on the HNP sector paper.

1. He again reiterated the importance of focusing on actions to health status to achieve economic and human development goals. e.g. ensuring that people eat vegetables every day; controlling tobacco use; these may bring better returns than attention to health services. (My interpretation: this supports the points (a) that we must seriously work on ways to get health gain outside the health service sector, and this should be clearly addressed in the SSP, and (b) that we should be in the health service business, to the extent that we can help improve the real effectiveness for health gain and protection from impoverishment; and our initiatives in this area should be monitored and evaluated accordingly.)

2. In reflecting on recent US attempts at health reform, Mr. Stiglitz speculated that it may have been better to start by trying to fix the public system, rather than the private. (Interpretation: there is a role for public health services even in rich countries, and for supporting public health service improvements, esp. when they provide essential services to the poor.)

(Concerning your proposed change on wording of the health goal for HNP. I prefer my original wording)

Good luck

Janet

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 05:19pm

TO: A. Edward Elmendorf (A. EDWARD ELMENDORF)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SAS - IDA and 100 percent financing option

Ed,

I tried to call you. When you get in give me a ring so we can have a chat.

I agree we should keep pushing for the 100% financing and had a meeting with Alan Gelb your Chief economist at lunch today (we know each other from the time he directed and I participated in the WDR on transition economies). We had a very good chat and he is very sympathetic to the 100% financing idea. He is also sympathetic to the idea of special donor aid efforts to a small group of "desparately poor" countries. He suggested a joint meeting next time around with the Afr team and some people he would invite. He also mentioned a Mr. Harrold in your region who is working on budget (PE issues I think he meant). It sounds like this is someone who is working on the comceptual idea of how to determine optimal budget envelopes for public expenditures in the AFR region and make this consistent with the IMF policy advice. Someone in your group might want to follow up on this before we meet with Alan as a group.

As for slipping things in the SAS, life is not that simple. I am getting unsollicited comments from legal (I have no idea where they are getting my document from since it is not me sending it to them). They are very edgy (and quick to spot I must say) about things that are not consistent with Bank policy or the Articles of Agreement. At the time of the last OPC meeting they made a big stink because somewhere in the document I referred to "humanitarian aid". This time they are accusing me of slipping thing in the document that is not consistend the Articles of Agreement. The worst is that of course each time the put David De Ferranti and members of the OPC on the cc list of their correspondence -- just to make sure that I don't overlook their comments I suspect. In other words, it is virtually impossible not to either modify or be prepared for a fight when they raise an objection.

However, back to the IDA question, according the Olga, in fact our IDA recommendation relating to the SGP is not challenged so maybe that is our window of opportunity even if it is not a new IDA window.

Give me a call and we can chat a bit about this.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 05:19pm

TO: A. Edward Elmendorf (A. EDWARD ELMENDORF)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

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Give me a call and we can chat a bit about this.

Alexandre V. Abrantes
03/14/97 12:30 PM

To: Alexander S. Preker/Person/World Bank
cc: Richard G. Feachem/Person/World Bank, Xavier E. Coll/Person/World Bank, Julian F. Schweitzer/Person/World Bank, Maureen A. Lewis/Person/World Bank, C. Ok Pannenborg/Person/World Bank, A. Edward Elmendorf/Person/World Bank, Samuel S. Lieberman/Person/World Bank, Barbara K. Herz/Person/World Bank, Indra Pathmanathan/Person/World Bank, Jacques F. Baudouy/Person/World Bank, Eva Jarawan/Person/World Bank, James Christopher Lovelace/Person/World Bank, Alain Colliou/Person/World Bank
Subject: SSP -- Sector Strategy Paper. HNP sector. Comments by Alexandre Abrantes.

Alex:

1. Thank you for asking for my comments. Sorry I could not attend this morning. We have a Argentina delegation discussing our country sector strategy, something along the lines of the Brazil SAS which I sent you and you were kind enough to comment.

2. I like this version of the SAS much more than the earlier and agree with most of the new strategy which is being proposed.

4. I like most of the report and underwrite its recommendation. My relative frustration is still with the relative little focus on health when we talk about the refocused mission of the HNP sector. The Bank role is not only look at the poverty alleviation aspects of health, not only in addressing the needs of the poor and "vulnerable". In addition, there is the whole area of helping Government refocus in the public health agenda, in the public goods, in the interventions with large externalities, in the areas where there are significant market failures. In all three areas, there is a role for Governments and for the Bank to help them do it right.

3. I will concentrate my comments on things which I liked the least, and you can assume I liked the remainder. In your final revision you may want to consider the following:

Executive Summary, overview: you compare the improvements in Chile and the United States in the 1900s. Then you suggest that such improvements result form new KAP, i.e. in the area of smoking, and in the area of treatment, i.e. TB. I believe that it is well documented that the major contributor for the improvement in mortality and life expectancy in the past one hundred years is attributable firts to impovement of environmental conditions, second to improved KAP in the area of hygiene and nutrition and third to health services, i.e. vaccines and treatment of infectious diseases (McKeown). Better KAP on smoking may be contributing to health improvements today, to what had anything to the improvements seen in the past hundred years.

Bank's refocused mission, poverty alleviation: I have problems with the "vulnerable" populations concept which WHO has made popular and which is so encompassing that it ends up not being very useful, only men aged 15-65 five do not fall into the category, but if we add the vulnerability to occupational hazards, they will also be included. We are all vulnerable after all... In addition the elderly are often not among the poor but among the more afluent, both in the US and in many rural and tribal societies.

Within description of the re-definition of the role of the state and non-governmental and NGO sectors in HNP, you may want to consider the need to assist governments rescue the more traditional public health role, which has in many countries been overcrowded by the immediate demands of direct medical care administration. If the Bank could assist Governments to refocus in integrated strategies to address the main sources of the burden of disease, i.e. injury control, cardiovascular disease, we would be doing significant work. If the Bank could assist Governments to refocus on public goods, or interventions with signicant externalities, we would be providing a need service. Note that this has nothing to do with poverty alleviation or with providing basic services to the poor. The government has

to provide it for the whole population, regardless of income.

I am not sure I understanding what you are trying to say when you write that in order to advance its health outcomes agenda the Bank will work on the divesture of social assets and facilitate the flow of credits to NGOs. If you are saying that more of our projects will be implemented through NGOs, then you may want to explain it in a more direct way and want to link it with better access and/or quality of services, not directly with the health outcomes.

In the sector background and development challenges, you may want to add environmental management as one of the engines that will drive the health transition. It was important in the past and I believe it is still very important in areas such as injury control, re-emerging and new communicable diseases, etc

In the section on techniques for targeting the poor I was pleased to see that we moved away from the "WHO vulnerable groups concept, mothers, infants, children, school children, adolescents, women in reproductive years, working persons, elderly". One more good reason to purge the concept from the summary above.

In the section of the third wave privatization, you may want to strengthen the part in whihc you say although there is more room for the non governmental sector in health care delivery, "divestment of social assets" will not be a panacea to solve all lack of access and poor efficiency problems. It will be prudent to warn that such move will also bring new problems, or "new challenges" as the politically correct will prefer, and anticipate two or three. It will also be prudent to say that for certain areas, for certain services, for certain clients, there will still be the need for public provision due to lack of interest or conditions for an efficient private market operation. You may want to add to the list of options (a) professional cooperatives leasing public facilities and under contract to provide the basic services, or (b) franchising, which was discussed in the Bank recently.

All the best

Alexandre Abrantes

A L L - I N - 1   N O T E

DATE: 17-Mar-1997 02:31pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Marleen Dijkman, HDDHE (MARLEEN DIJKMAN@A1@WBHQB)

EXT.: 85317

SUBJECT: SAS

I enjoyed reading the paper. Interesting food for thought and after this elaborate meeting last week only a few things.

* Holland is only a small part of the Netherlands (two provinces in the North-West of the country). If your data on page 27 apply to the whole country then it is better to use the Netherlands.

* You might consider adding an Annex with an overview of which country is in which Region in the Bank.

* In the paragraph referring to improvement of the health outcome agenda (p vi) you might consider a reference to cooperation with Ministries whose policies can heavily influence health. In Governments it is important for the (relatively weak) Health Ministries to be involved in the work of the other Ministries in order to prevent negative health effects. As you know the other Ministries can cause effects, without having to deal with the costs. I consider an awareness in the WB of possible negative health effects following from projects executed with other Ministries important.

* The new role as a knowledge broker is emphasized in the summary. However, it is not explained very much. Setting and promoting an aggressive research agenda, but not conducting the actual research; does that imply that the WB will mobilize and give out funds for research by others? The aim of reducing the disease burden of the poor is very broad. You might want to specify that.

One question: can I send the white cover (as "confidential") to the main health sector specialist in the Ministry of Foreign Affairs (Development Cooperation) and to the Minister of Health (Borst) in the Netherlands, and ask for their opinion? Of course I'd indicate this is only a preliminary version.

Good luck with the SAS and looking forward to read the new version.

Marleen

A L L - I N - 1 N O T E

DATE: 17-Mar-1997 08:41am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: EGBE OSIFO, MNSHD (EGBE OSIFO)

EXT.: 85569

SUBJECT: SAS

Alex:

Please accept my apologies for these late comments. This was mainly due to the presence of several ministerial delegations last week coupled with an upcoming mission.

I think the first SAS has been a successful heroic attempt to try and articulate a global strategy for our sector; and I would like to congratulate you and the SAS team on this. I think it provides us- the network members- an articulate framework to work with.

However, I do have several comments. Overall, I feel the document at 53 pages is still probably a bit long to ensure that it would be read by a wider audience. In our region, major sectoral documents are limited to 40 pages and most ESW is actually limited to 25 pages. I feel some of the material could be placed in annex or removed without jeopardizing the quality of the document. For example, I feel the one and a half pages on page 31 describing a historical perspective on policy analysis could be shortened.

My other comments are specific and are mainly points of clarification which I will enumerate on a page basis:

pg 10: The sentence referring to grant assistance being the most significant contribution to health financing is not reflected in Nigeria - a country identified ad having the lowest total health expenditure where a fifth of all Africans live.
pg 15: The example on the University of Zimbabwe program is unclear
pg 23: Several of the Middle Eastern countries and economies e.g Jordan, WBG probably fall in to the fiscal threat of rising costs
pg 28. three simple principles are referred to in balancing the budget but only one principle is given
pg 29. Suggest you arrange regional banks in an alphabetical order
pg 33. What are senior policy seminars on issues related to HNP policy?
pg 38. I think a positive solution to deal with trust funds concerns that were identified would be the encouragement of TF to be untied (Italy is supposedly considering this issue)

pg 50. To ensure that a user-friendly knowledge management system is fully utilized by bank staff, the availability of modern equipment (regularly updated) is required by Bank staff (which appears

challenging under the present budgetary situation).

Egbe

CC: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)
CC: Jacques Baudouy (JACQUES BAUDOUY)
CC: Maryse Pierre-Louis (MARYSE PIERRE-LOUIS)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 11:54pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Althea Hill, EA1HR (ALTHEA HILL@A1@WBHQB)

EXT.: 84474

SUBJECT: comments on the sector paper

Dear Alex,

I don't know if I'll be able to get to the review meeting, so here are a few disjointed comments. I'm really impressed by how much you managed to get done in the time -- a very professional product.

Comments

1/ I remain very worried by the unequal attention given to nutrition and population relative to health.

For example, the issues around population as a development issue, to be treated in the overall development framework (which ought to be the Bank's comparative advantage area) are hardly touched. Yet so many countries across the world still have pop growth rates of 2% and more, which entail high dependency ratios and are not healthy for sustained economic development.

Likewise, there is hardly any discussion of PEM problems and programs -- much less even than for micro-nutrients; this is sad given that in so many countries there are still shockingly high levels of PEM. And we know that this affects cognitive as well as physical growth, development and health. (By the way, I was surprised to see on p. 52 that Philippines had better than average mortality and nutrition status -- WHAT average? PEM is running at about 30% of young children according to international standards -- not good for a middle-income country, surely).

I appreciate that it is difficult to cover three sectors adequately in the time you have had -- but it might be better just to be honest and call this a health sector paper. That might be preferable to just odd mentions and occasional boxes, which overall leave the impression that population and nutrition are side-issues attached to health.

2/ I thought the Action Plan underwhelming, particularly with regard to its impact on the poor, which is not well drawn out and seems to get rather lost here. Rather too inward-looking and focused on process rather than content. The special initiatives (which I liked the idea of, and wondered if we could add environmental, pollution-related health to the list) get less

space than internal Bank problems. The special initiatives are in fact the only part of this section where one can see a direct impact on the health of the poor.

3/ I thought the third wave privatisation section was written in a very ideological way, with lots of loaded language. It is not made at all clear how this will contribute to the 3 goals -- poverty alleviation, quality of life for populations as a whole, and financial sustainability of the health sector. Does it deserve so much space?

4/ Relatedly, it worried me that with all the experience of developed countries in different forms of health sector financing to draw from, we don't seem to be able to pick out any strong, clear, concrete lessons for countries to follow in this area in terms of what system or mix of systems offers the best buy as regards HEALTH OUTCOMES. (The paper seems to assume, for example, that private health care produces better health outcomes than public, but with no supporting evidence given -- do we know this to be true in developed countries? or are we confusing client satisfaction with clinically effective treatment?). Are we not able, after so much intensive study and such massive amounts of data, to say what forms of health financing unequivocally produce the BEST HEALTH OUTCOMES in developed countries (even using a variety of definitions of best, if we must)? Or which are the most cost-effective, again in terms of HEALTH OUTCOMES? These are very simple questions. If we can't answer them, and are just reduced to a "depends on the individual circumstances of the country" type of response, then we have actually nothing useful to say on this topic and shouldn't be giving any advice at all.

(I apologise for the caps, can't get the underlining to function on this laptop!)

5/ I think it is a very contentious statement to say (p. vii) that "the major value of Bank financing lies in its ability to potentiate.....policy advice and sharing knowledge". This seems to imply that our PHN projects don't have much value in their own right. I hope this is not what is meant. I hope also the implied faith in the quality of our policy advice can be justified. Let's not forget, for example, that the whole PHC movement originated in innovations made in developing countries quite innocent of our policy advice. Countries may sometimes have more to teach us than we have to teach them.

6/ The overall impression of the paper is a bit scattershot and unfocused. I wonder if this is because it's trying to generalise across an impossibly wide range of country circumstances. Might it not be helpful to divide countries into a few groups with similar types of endowments and problems (regardless of region) and diagnose and prescribe for them separately -- a range of strategies and goals rather than one world-wide treatment?

7/ On a pettier note, the box on Zimbabwe nutrition nowhere

mentions what the OUTCOMES of the project nutrition program were in terms of actual nutrition gains. The box on poor health services in East Asia gives a rather odd picture of Viet Nam -- the major problem here was surely the collapse of commune-level funding for commune-level facilities following decollectivisation, without adequate substitution from any other source, and hence decline in quality of services. The section on trust funds does not mention one of their major costs/disadvantages, which is the large amounts of TM time necessarily devoted to mobilisation of these sources of funding.

I hope the meeting goes well, and good luck with the paper

Althea

CC: Samuel Lieberman (SAMUEL LIEBERMAN@A1@WBHQB)
CC: Christopher Shaw (CHRISTOPHER SHAW@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 08:15pm

TO: ALTHEA HILL (ALTHEA HILL @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: SSP and Health Care Financing

Althea,

Thanx for your thoughtful comments. I have had a chance to go over the various suggestions from different people and wanted to get back to you about a couple of questions you raised in your EM.

First on population, I guess since Cairo, we are allowed to speak about maternal and child health but not population policies. I agree that this topic is not being well developed in the paper and will have to make this quite clear in the forward of the next version.

Second, we have made an attempt to address nutrition and will try to strengthen this story, especially the intersectorial and non-health sector aspects. The truth is that much of this agenda -- other than micro-nutrients -- will probably be addressed through PREM and ESSD Networks not the HD sector. I will try to clarify this.

On health financing, the one thing we have learned is that out of pocket payments do not provide social protection, private insurance has too much market failure assiciated with it. This leave government financing and social insurance as the main and most efficient channels for risk pooling in most counties except the poorest which do not have the institutional capacity to collect taxes. In these countries, community financing, with all its imperfections is the solution by default. I will try to make this crisper. But in reality this really is one area where we should be careful not to be too perscriptive since much actually does depend on country context.

We are planning to make the next verion shorter and more focussed with the current version becoming more of a technical annex. I look forward to you comments if you have time when the Yellow Cover comes out.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 10:54pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Althea Hill, EA1HR (ALTHEA HILL@A1@WBHQB)

EXT.: 84474

SUBJECT: RE: SSP and Health Care Financing

Dear Alex,

Thanks for the personal response, which I didn't by any means expect, knowing from bitter experience how harried the TM of this kind of task always is, but much appreciate.

Re population, I would emphasize that I'm not alone in the worry about losing the pop/dev agenda, I think it worries most people with a pop background in the Bank (not to mention outside). But I appreciate the difficulties you face in this respect -- and indeed I think the subject needs a full treatment of its own rather than uneasy integration into a basically health framework.

Re nutrition, I do hope that PHN can retain childhood PEM, as effective interventions for this have close links with health services and are so much a part of caring for child health (and indeed adult health too). And no other sector is going to focus on child needs in the same effective way.

Re health financing, what do I know? I just would like to see some rigorous cost-benefit analysis applied to health financing and health service systems, and so far i haven't seen much attention paid to actual health outcomes in the debate, though there's lots of data, I would think.

anyway, I'm not trying to be a nuisance, and look forward to your next draft

Althea

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 07:57am

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Tom Merrick, HDDHE (TOM MERRICK@A1@WBHQB)

EXT.: 36762

SUBJECT: RE: SSP Comments from Althea Hill

Alex,

I agree with Ane's suggestion that Althea's (and others') concerns about population could be addressed in Section I by stating that not all population outcomes are health outcomes (population cannot be reduced to reproductive health any more than to family planning) and that the main focus of the paper is on getting health systems to work better. While the section on "Origins of Good Health and Illness" recognizes that other factors affect health (including reproductive health and nutrition), a "population" outcome such as elimination of unwanted fertility has benefits to individual (more household investment in children's education) and societal (avoiding externalities associated with high rates of population growth) welfare that go beyond good health and avoiding illness (whereas the factors outside the health system that impact on nutrition ultimately do impact on health/illness).

The primary focus of the SAS is on health systems. Getting health systems to work right is very important for health status (including reproductive health/family planning). The SAS cannot be expected to fully articulate strategies for addressing issues beyond the health system. Recognizing that factors outside of the health system are important doesn't mean that the health system has to fix them (this is where attention to the social sectors at the CAS level should come in) or that the health system is responsible for fixing the other sectors (education) whose activities also affect non-health population outcomes.

The HNP SAS has a lot of good ideas and strategy for getting health systems to work better, but need not go beyond recommending that broader issues affecting health, nutrition and population (with no mention of the non-health aspects of population) be addressed in the CAS. The challenge of getting the Social Sectors right in the CAS process is bigger/more complex than what can be done in the SAS.

Tom

CC: Anne Tinker (ANNE TINKER@A1@WBHQB)
CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 11:02pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Olusoji Adeyi, EC2HR (OLUSOJI ADEYI@A1@WBHQB)

EXT.: 85835

SUBJECT: HNP Sector Strategy Paper

Alex,

Salut. The following are my observations and suggestions. I've tried to exclude the more obvious ones raised last Friday.

Organization and assumptions.

Make it possible for the reader to answer the following questions effortlessly: (i) what is this paper about? (ii) how is it organized? and (iii) what is new about it -- or what does it reaffirm?

You may want to add a paragraph to the executive summary or the first chapter to facilitate this.

You may also consider having a matrix to map your diagnoses to proposed interventions and expected outcomes -- and make your assumptions about linkages between interventions and outcomes explicit. As it stands now, there is a disturbingly unqualified belief that "the government is the problem".

New strategic policy directives

I think that the trilogy of poverty alleviation, health outcomes improvement and financial sustainability is just about right -- and more than enough to chew. There is, however, an overemphasis on knowledge at the expense of know-how. How, did I hear you ask? In my view, (and based on pre-Bank field experience in Africa and Asia, both as an expat and a national), I think that we must collaborate very actively with specialized agencies AND maintain in-house capacity to be savvy consumers of their recommendations. That message should be explicit, in the lines, not just between the lines. We cannot have an effective health sector in the Bank (as distinct from a health finance sector, which is necessary but not sufficient) if Bank staff are such generalists that they are uncritical consumers of specialized literature on health. Be explicit.

The same consideration applies to the knowledge broker role.

New approaches to using credits and loans.

I suggest that the balance between improved use of existing recurrent expenditure and the net addition of new capital investments are not mutually exclusive. The decision should be made on a case-by-case basis. You will always run the risk of overgeneralization in a paper like this. Is the Strategy

Paper a monument to command and control in a Bank/Sector that is virulently anti-government, according to the central hypothesis of the same paper?. If it is not, hence_a judicious use of qualifiers is advisable.

CAS Link

The CAS should be reviewed for, inter alia, the way in which the strategic policy framework fulfills preconditions for sustainable gains in aggregate health status (without raising unrealistic expectations of attributable improvements in health status). This is absent from the draft of March 1. Why? Isn't there is a major risk of crossing the line between the Bank's comparative advantage (to be maximized) into the realm of a supply-driven Sector Strategy Paper focusing on financing alone (to be avoided). Ditto for the section on skills mix.

Congrats on a truly superb effort. I hope that you realign it to be more congruent with the twin objectives of improving health and improving efficiency.

Regards.

Soji

CC: CHRIS LOVELACE (CHRIS LOVELACE@A1@WBWASH)
CC: GUY ELLENA (GUY ELLENA@A1@HUNGAR)
CC: VERDON S. STAINES (VERDON S. STAINES@A1@WBWASH)

A L L - I N - 1 N O T E

DATE: 14-Mar-1997 11:32am

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Kees Kostermans - HQ Visitor, AFTH1 (KEES KOSTERMANS)

EXT.:

SUBJECT: HNP SSP White Cover --comments

Hi Alex,

It's great to be in HQ just at the time of the White Cover review of the HNP Sector Strategy Paper.

I agree with many of the comments made this morning and would like to add only two comments which haven't been explicitly voiced at the review. I'll keep them very short; I can elaborate on them if you would like that.

1. The paper is more an Hnp strategy than an HNP strategy; and within Health, financing issues receive too much attention compared to other issues affecting the effectiveness of the sector. Nutrition and Population receive too little attention (and less and less further in the paper) and are too much treated as subsectors of Health. The Bank's multisectoral involvement makes it well positioned to put Population and Nutrition issues on the development agenda of countries in discussions with Ministries of Planning, Ministries of Women's Affairs (as examples for Population), and Ministries of Agriculture or Education (as examples for Nutrition). Changes in population growth, in life expectancy, in dependency ratio are all pre-eminent general development issues which deserve the Bank's attention.

2. Doing the same or similar things as another (UN) organization does not necessarily mean a duplication of efforts, and we should certainly not hesitate to complement the efforts of other organizations if 1) we think we can do it better, 2) a joint effort is required. The fact that one organization has a comparative advantage to handle a certain aspect of H, N or P does not mean that that organization should deal only with that aspect (although one could intuitively think so).

Good luck with the further preparation of the SSP.

Kees K

CC: Birger Fredriksen (BIRGER FREDRIKSEN)
CC: RUTH KAGIA (RUTH KAGIA @A1@WBHQB)
CC: Ok Pannenborg (OK PANNENBORG)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 10:56pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Richard Skolnik, SA2PH (RICHARD SKOLNIK@A1@WBHQB)

EXT.: 80298

SUBJECT: SAS

Alex,

Thanks for including me in the SAS list.

I have now read the paper carefully.

The thrust of your conclusions seems generally OK with me.

However, I find the paper very difficult to follow. The arguments are not very tightly woven and I don't easily see the thread that should bind it all together.

It would be better, I think, to be a bit more classical in the presentation and walk the reader through key issues, what can be done about them, how we should help, and why.

I would be happier to see it read like a Mcnamara speech with some meat than like the normal Bank document. At a minimum, even if this suggestion is extreme, I think it has to be as tightly woven as one of those speeches.

Substantively, my main concern is that the paper does not seem to have enough of the substance of health in it. It will be important, I think to set up a clearer framework up front of what the health issues are. Then, it will be important to make clear how each of the things we propose to do will help to get at the heart of the key health issues. It might be good, alhough bold, to say that x, y and z are health goals that we hope to help countries reach over the next decade, etc.

Right now, there appears to be such an emphasis on the financing and systemic issues that we don't set out as clearly as we need to how we will help our clients deal with the guts of what are truly lousy services with messed up paradigms, badly trained workers, no measurement of outcomes, etc.

We need, I think, to deal not only with the necessary conditions of reform and financing, but also with the sufficient conditions of the heart and soul and technical content of a lot of health programs.

Is that really our comparative advantage

You have done some very good work on this and we have learned a

lot from working with you on this. With some careful reordering and tightening of the argument, and with a greater focus on health outcomes throughout, I am sure you will produce and excellent piece.

Let me know how I can help.

In the meantime, I have marked up the margins of my copy to show some of the specific instances of the concerns I have and I shall pass it on to you at the meeting.

Regards,

Richard

CC: Richard Feachem (RICHARD FEACHEM@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:29pm

TO: Samuel Lieberman (SAMUEL LIEBERMAN @A1@WBHQB)

FROM: A. Edward Elmendorf, AFTH3 (A. EDWARD ELMENDORF)

EXT.: 35570

SUBJECT: RE: comments on WC draft, HNP SAS

Colleagues,

This EM has comments on the WC draft of the HNP SAS, building in part on the review meeting today.

1) The paper needs a clearer conceptual framework on which to hang its various ideas. Public finance economics - of public and private goods, externalities, etc. - seems to me to provide this, and to give a way of presenting the failures of the state which makes some sense of this beyond ideology.

2) The paper needs to be more explicit about its values, and about its units of analysis.

(a) Values: Is our priority the most poverty stricken populations, or is to maximum reductions in the burden of disease, or both? If it is poverty, then we need to have much more focus on S.Asia and Africa. If it is poverty within countries, then we need to be careful because more than half of many poor country populations would be considered poor. Furthermore, I'm not convinced that the most appropriate answer to poverty in the HNP area is targetted programs, as suggested in the paper. It seems to me that we should be open in seeking the greatest total reductions in the burden of disease, and admit that - at the margin - there will be trade-offs between this goal and poverty focus. However, the paper should assert, a la Nancy Birdsall, that in most respects the equity and poverty and public-private arguments complement rather than contradict each other.

(b) Unit of analysis/focus of our work: The paper sometimes seems to take governments as our main focus, and sometimes countries. I'd suggest that, in the HNP area especially, we need to have a much wider focus.

First, as the paper implies without being very specific on the rationale, we need to recognize that disease doesn't recognize borders, and that we must have instruments available, in selected circumstances, for inter-country programs. The concluding paragraphs of the paper recognize this, and I suggest that this instrument of the Bank's merits future expansion, not so much in terms of 'international initiatives' as inter-country and global programs. This would challenge the orthodoxy of IDA, of course.

Second, at the national level, we should discuss - and relate to - countries and not governments. This means that our HNP strategy and sector work, just like the CAS work, should involve a wide range of actors, including stakeholders in the civil society. This would reflect the fact that successful health reform engages entire countries, and not just governments, and that health and health services are the concern of all. Furthermore, while the WC SAS refers elipitcally to the possibility of IDA grants, I would be much more direct about this, and introduce IDA grants to the civil society, under circumstances to be carefully defined in subsequent papers, as an instrument of our HNP strategy work in individual countries. This would mean opening a new window at IDA, and moving our limited grant-making activities with NGOs from an external relations/SGP function into the core business processes of the institution. The proposed IDA window would also serve to fund inter-country programs.

The suggestions put forward above aim to address what I perceive to be a fundamental disconnect between our aims in the SAS and the financial instruments now available to us to address them. Among present instruments, I think the paper is too positive in addressing SECALs. Of course, given a sector-wide agenda, a SECAL is very tempting. Experience with two AFR human development SECALs (Cote d'Ivoire Human Resources Development Program and Togo HNP hybrid operation) suggests to me that this instrument is inappropriate for addressing the long-term institutional development problems which lie at the core of our HNP work in Africa. Furthermore, the SECAL successfully engages the core ministries of finance and planning .... but we found that it did not effectively involve the sectoral institutions.

3) The paper seems to take a supply orientation, and to assume, globally, that public budget allocations are sound. I would like to see much more emphasis in our work on demand variables (hitting utilization of health services more than coverage, with strong emphasis on consumer satisfaction), and on PERs as an instrument for both sector and project work. Furthermore, the SAS should require us to assure that basic public health services and public goods are taken 'off the top' of public budgets before funds are allocated for clinical care.

Good luck to Alex on the next round!

Ed

CC:	ALEXANDER PREKER	(ALEXANDER PREKER)
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CC:	Birger Fredriksen	(BIRGER FREDRIKSEN)
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CC:	Brigitte Imperial - HQ VISITOR	(BRIGITTE IMPERIAL)

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 11:54am

TO: Richard Skolnik (RICHARD SKOLNIK @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: SAS

Your comments are very perceptive and as I said in the meeting today, I think the next draft of this document has to be a different animal. We now have the background justification and the storyline which can become a nice technical publication, but the current document is a long way from what I have in my mind as a strategy paper. Part of the reason has been to educate the OPC and Board about the sector (which I think the current version does). But we now need to think about how best to deliver the final message and in what form. This surely cannot be a 50 page text with the punch line on page 45.

CC: Richard Feachem (RICHARD FEACHEM @A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 11-Mar-1997 11:39am EST

TO: Martin Ravallion (MARTIN RAVALLION@A1@WBHQB)

FROM: Martha Ainsworth, PRDPH (MARTHA AINSWORTH@A1@WBHQB)

EXT.: 34121

SUBJECT: Comments on the HNP Sector Strategy

Martin,

Because of the exigencies of the Policy Research Report on AIDS, I regret that I haven't been able to give the HNP strategy paper the time such a key document deserves. Since others have focused on some of the specifics, let me offer more global comments about objectives, audience and messages, as well as the issue of research in HNP. Clearly, a lot of hard work has gone into the document and there are many interesting case studies highlighted in the boxes.

Objectives and audience

This is a massive paper, 53 pages single spaced, with lots of boxes and substantial annexes we haven't seen. Yet, I came away confused about both the objectives and audience. A huge amount of this paper is descriptive -- of health problems, of health financing systems, of "best practices", of past Bank policies, etc. I got very impatient. What's new here? Where's the edge? Why am I reading it? What question are we answering? Even the foreword lacks a statement of the objective of the paper; instead it merely describes the contents. Is the audience the Board? Is this supposed to be a directive for Bank staff in the sector from the Board? Is the audience the borrowers? The public?

Messages

1. In a paper that is labelled "stategic", I expected something much more focused, concise and analytical, honing in on priorities for public sector and Bank involvement, the rationale for the priorities, a plan of action and what is needed in terms of new information or analysis to help us get there. In fact, there is no mention of the role of government until page 21, almost halfway through the paper. Even there the discussion is descriptive -- "Why do governments intervene?" Where is the discussion of when governments should intervene and the rationale for the health reforms that are recommended? Where is the discussion of why many countries can't or don't want to "do the right thing?" And of what we need to know to do a better job of helping them to do this?

The paper looks too much like part of a WDR (but not as thorough as it would need to be) with stuff on the rationale for Bank operations tacked on at the end. The "strategic policy directions" aren't discussed until page 43! If the analysis of the health situation hasn't changed much since the WDR 1993, can't these arguments be quickly summarized and updated? Can't we highlight what is new? The section called "Global policy directions" (basically best practices) can be put in an annex; the section on the HNP sector (what it has done in the past and is doing now) could also be put in an annex. Basically, if the document is really strategic, it should be organized around Section IV, bringing forth only that additional information needed to support the main points.

2. With respect to the three main strategic directions, I agree with the three in principle, but:

(a) Has the goal of more equitable and efficient allocation of resources within public health systems been dropped?

(b) Where is the distinction between public and private benefits of different health care interventions and "public sector" cost-effectiveness, as opposed to medical cost effectiveness? The notion of a basic package of health services doesn't seem to make the distinction between services that are public goods, those with externalities and those with purely private benefits; in the countries with the fewest resources where funds are inadequate to finance the "package", how can a policy maker prioritize among the elements?

Research

The fact that DEC was not among those consulted for this paper is glaring in its inadequate treatment of research. A consensus on "best practices", adhering to a low-cost and cost-effective package of health services in the 1993 WDR, and maintaining a data base on health finance in developing countries will not be sufficient to design, monitor or evaluate the progress of Bank lending and government programs in improving health outcomes. The paper, while making the case that the Bank should set the research agenda, in fact makes no suggestions on what that agenda should be. The suggestion to use the talents of local researchers more often is laudable, but in many countries the skills do not exist to do the necessary analysis with sufficient rigor.

How will the Bank go about monitoring the performance of health systems in improving health status? Neither analysis of residuals (I'd suggest dropping it from the beginning of the paper) nor monitoring of "key indicators" will not be adequate to attribute an outcome to a specific programmatic or policy change. I'd suggest a very active program to prospectively evaluate the impact of specific reforms on the performance of health systems and on health outcomes across countries, using whenever possible

pilot projects or sequenced implementation of interventions. This requires substantial coordination across projects and countries, a common analytic framework and sustained effort over an extended period. Such research is already underway in the education sector.

The key to improving health, nutrition and childbearing decisions is understanding individual responses to policy and programmatic interventions. It is not the health system per se that determines health status, and the recommended reduction in the scope of government activities highlights the need to understand what policy and regulatory decisions will help people to make better choices. Past Bank research on the demand for health care, as well as on nutrition, childbearing and family planning, has highlighted the role of prices, quality and access to services in individual decisions, and the fact that individuals are the key decision-makers. It has also highlighted the complementarities between human resource sectors.

Neither of these perspectives are apparent in this report, which has a very "top-down" flavor. But the success of Bank-supported programs depends criticially on understanding these individual responses. With respect to health decisions, the research has often stopped at utilization of health care or choice of provider. But the objective of health policy is not to raise demand for health care per se; it is to improve health outcomes. The research agenda needs to incorporate both the intermediate decisions and final outcomes. We need more prospective studies of the impact of specific inputs, perhaps in the context of pilot projects, on decisions and outcomes. In the context of "reproductive health", how do the specific characteristics of services influence outcomes? Does "unmet need" have any meaning at all?

The impact of decentralization and community-based management of health care is another huge issue on the horizon that could have major repercussions on the effectiveness of programs. It is essential that we take these opportunities to evaluate their success in different settings.

Finally, we also need to understand why so many countries do not implement efficient and equitable solutions. Why do they often do the "wrong thing"? Is it just implementational capacity or lack of information? Political economy issues would seem to loom large. Are there examples of countries that have been able to act in spite of political problems? What can be learned from these experiences?

I hope this helps.

Martha

CC: Harold Alderman (HAROLD ALDERMAN@A1@WBHQB)
CC: Mead Over (MEAD OVER@A1@WBHQB)
CC: Emmanuel Jimenez (EMMANUEL JIMENEZ@A1@WBHQB)
CC: Lant Pritchett (LANT PRITCHETT@A1@WBHQB)
CC: Jeffrey Hammer (JEFFREY HAMMER@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 12-Mar-1997 11:05am EST

TO: Martin Ravallion (MARTIN RAVALLION@A1@WBHQB)

FROM: Lant Pritchett, PRDPH (LANT PRITCHETT@A1@WBHQB)

EXT.: 33777

SUBJECT: Sector report

Martin,

I think the basic messages of the report are sound: that health is a complicated sector in terms of the mix of market failures, that the record of government failures is similalrly impressive (or depressive) and complex, and that the focus of the Bank should be on facilitating an inteleectual and political proces that leads to the right mix of responsibilities and incentives across the actors-- and that mix will strongly differ across levels of capacity and development.

which is not to say that the report is sound (else what's a white cover for?) and there are many rough edges on this gem. I hope the report had multile authors cause it certainly has multiple personalities.

I am sure my collegues will point out the egregious: the silly and ideologically quirky bit about cost escalation, the failure to be clear the the residuals of a health regression are not an indicator of health policy: they aer an indicator of the most that health policy can possibly explain.

Let me just point out two things.

First, I was struck on finishing the report that the single most important thing about health care expenditures from a policy point of view was not documented: that some disease conditions have low treatment costs per episode and others have very high treatment cost per episode. This fact is central to most of the policy and country health conditions that the report was discussing, yet this did not come through clearly.

Nonsense

Let me make an analogy (although one constant tension between eoncomists and sector sepcialists is that specialists tend to see their sector as unique while economists see mainly analytic similarities). I think the economic sector most like health is the automotive sector.

In both there are:

operating expenses: gas, food
routnie maintenance: oil, preventive care
minor predictable repairs : brakes, diarrhea
major catastrophic expenses: major accidents, splenectomy

Now here are the non purchase costs of operating a car per mile in th US (assuming 10,000 miles annually):

gas and oil:	6.7
maintenance:	2.2
tires	.9
Insurance	7.2
license, reg	1.7

Now we all agree that the fact that the cost per mile of gas and oil (6.7) and of insurance (and hence less the mark-up for insurance costs, the costs associated with insruance) (7.2) are roughly the same is completely irrelevant for policy, right? don't we? None of us would propose that since the rare exogenous event of a major auto accident requires insurance that this creates some implications for the market for tires, right?

I used to think the most pernicious thing about cost effectiveness was the potential confusion between "medical intervention" cost effectiveness--which has no policy implications and "public sector" cost effectiveness which does.

Now I have beomce convinced the problem with cost effectiveness goes much much deeper than that: it is taking the ratio between cost and health gain in the first place that is the really the problem.

Cost per mile is precisely the wrong thing as cost per mile confuses small regular expenditures like oil or ORS with large unpredictable expendituers like body (shop) work.

Here's the kind of crazy line of reasoning this taking of ratios can lead to (and I am not saying the report does this, just that others do do this with the ratios as an enabler):

a) we all know the government nees to interevene in health becuase health expenditures are large and unpredictable and insurance markets don't work,

b) if government is going to be involved then we want to have cost effective expenditures,

c) therefore the government should finance what has a high ratio of benefit to cost,

d) empirically it usually (though not always) turns out that things that are relativly cheap per episode (immunizations, ORS, family planning) are highly cost effective, therefore

e) governments should spend less on hospitals and more on basic care.

This is like starting from auto accident expenditures as a rationale for government intervention (and governments should indeed mandate auto insurance) and concluding the government should finance only oil and no body work.

The report could be much clearer about its differentiated messages if it put more emphasis on the cost per episode and not cost per DALY or cost per

population to provide because:

a) the reason the evolution of disease conditions between diarrhea and heart surgery and cancer is important is the cost per episode differences.

b) cost escalation is a problem with disease conditions with high cost per episode

c) the real problem with health care markets are the insurance problems is when there are three actors: the consumer, the provider and the financer as any two want to gang up on the third. SO, while there is supplier induced demand I am sure the problem is incredibly worse for body shops (where, conditional on exceeding the decuctible the consumer has little incentive) than for brake repairs. The problem is then incredibly worse when there are three and one is a monoplist and potential disaster when two are (e.g. centrally run health services which combine provision and finance).

My second point is that family planning as a health intervention is an effective shibboleth of analytic influence.

lant

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A L L - I N - 1 N O T E

DATE: 10-Mar-1997 12:05pm EST

TO: See Distribution Below

FROM: Harold Alderman, PRDPH (HAROLD ALDERMAN@A1@WBHQB)

EXT.: 30372

SUBJECT: Comments on HNP sector paper

The draft sector strategy has two dominant strengths. First, it is explicit in recognizing that despite major new directions under consideration, the starting point for any changes is its history. This, of course, is largely by way of background for the refocusing proposed. The second dominant strength, then, is the manner in which this refocusing parallels new directions in financing economic growth in other sectors.

Indeed, while the core messages of the need to consider the interplay of private and public actors or that the Bank should be a knowledge broker are adequately developed in the context of the health sector, these are by no means specific to that sector. A number of the other innovations such as new lending instruments (for example, for post conflict resolution) and changes in staffing also indicate that the sector is moving in parallel with the Bank in general. Similarly, the need for more sector work 40 transcends the HNP sector.

I have little to add on these elements. Where the draft disappoints is in regards to the details that should be more sector specific. These are occasionally lacking or, if presented, are decreed with little attempt at persuasion or justification.

For example, no justification is presented for the research strategy proposed. Nor are any details offered on the mechanism by which the Bank will be able to provide leadership in framing operational analysis and mobilizing resources. Moreover, the stated exception to the outsourcing is embarrassingly self-serving. Again, no justification of this choice is presented.

It is widely known that the uncertainly of research outcomes mocks any attempt at putting all one's

research efforts in one basket. Moreover, and probably more important, given the diversity of the sector and the instruments used, the Bank requires a knowledge base that reflects the range of programs and approaches in which the Bank expects to lead.

Although I find the report's pronouncement on research to be among the most glaring errors, I will not devote more space to counter this view, simply because I anticipate that colleagues will address this at length. However, I do want to add one general comment which is as much about the presentation of the recommendations as their content. A recent review on how information makes policy in the Journal of Economic Literature by Robert Nelson drew the distinction between three sources of decision making: interest, ideology, and information. If the Bank wants to be perceived as making its internal policy on the latter, it needs to both generate information and take the time to use that information to persuade.

While the treatment of research is one example of the report failing to rationalize its recommendations, this tendency is found elsewhere as well. For example, page 36 states that three broad categories require fresh approaches with no indication why the current approaches are not working. Indeed, page 15 offers a list of cost effective approaches that overlaps with those that page 36 implies are in need of overhaul.

Unfortunately, where the report does try to offer evidence to bolster its approaches, it often fails to convince. Four examples of very weak analysis:

1) While the analysis of residuals in a regression can be used to motivate further work, it is naive to draw any conclusions from the blank check that residuals offer. Thus, the methodology on page 7 and 8 is not a powerful tool, but simplistic rhetorical device.

2) Even though the argument that economic growth is not sustainable without human development is credible, page 3 hardly makes the case. One case easily find counter examples by a perusal of the Tables in any WDR. Indeed, using the 1996 WDR one would place Sri Lanka in the upper left not the upper right.

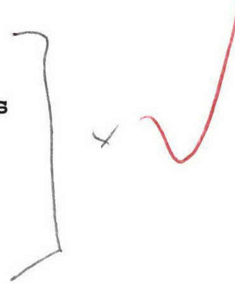
3) The argument of expenditure escalation makes a point of a difference in private and public income

elasticities for middle income countries that may not even be statistically significant while making no mention of far greater differences for low and high income countries that do not support the point being made. It gives the strong impression that the conclusion was drawn in spite of, and not due to, the evidence in the table. Furthermore, the discussion hints that expenditure growth drives cost escalation. One can not go too far on this without information of the supply response of providers which is not discussed. Incidently, footnote 5 is wrong: the final word should be income not inflation.

4). While the overall arguments for new sector staff (and a new mixes within sub-disciplines) sound valid, the comparison of the number of high level staff in the sector with total Bank staffing does not advance these arguments.

Also, in regards to sub-sector portfolio, the HNP paper might be better billed as a H(np) paper. There is virtually no mention of population strategy and that on nutrition (eg page 17 and 18) seems undeveloped. Too much is lumped under a catch all of community nutrition. Also the emphasis on fortification fails to mention the alternatives of supplementation and dietary change which at least need to be considered. Moreover, in the last decade or more the emphasis on vitamin A and iodine has gone well beyond alleviation of clinical manifestation of blindness and of cretinism. The discussion makes no mention of the broader audience.

Though less important to the arguments in this report the box on page 6 is also not convincing. For a 10% cigarette tax to increase public revenues by 5%, the share of expenditures on cigarettes [exclusive of the tax] to GNP must be half of the ratio of all revenues to GNP. I do not know the numbers for China, but its worth double checking these. Is also worth double checking the pharmaceutical budget presented on page 11. It implies that 88% of all drug expenditures are wasted.



Three final quibbles: First, while the report should be congratulated for taking up the issue of FGM (page 17), this valiant step is weakened, because there is no information on the effectiveness of the bold measure that have been praised. Critics argue that these are ineffective or even counter-productive.

Second, there are far better partners for the Bank within governments than the Ministry of Interior who often are responsible for police and security measures. Page vi lists this ministry as one often involved in caring for poverty groups. I can just picture an outside critic putting a spin on what this caring implies.

Third page 28 promises three simple policies, but I see only one.
{{SUB}}

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A L L - I N - 1   N O T E

DATE: 21-Mar-1997 08:55am

TO: Harold Alderman (HAROLD ALDERMAN @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: RE: HNP SSP

Many thanx for the clarifications.

Actually, the next draft won't be ready until after you probably get back. Both Judith and Richard have been valuable contributors to the current volume. In fact most of what is in there was written by them (although I take full responsibility for any errors), that is why having an independent reviewer on this part of the document would still be useful.

Have a good mission.

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 10:08pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Harold Alderman, PRDPH (HAROLD ALDERMAN@A1@WBHQB)

EXT.: 30372

SUBJECT: RE: HNP SSP

To folow on my earlier comments:

Regarding the box on high growth and human capital investment: I don't doubt the overall point, but I find the approach useful as a rhetorical tool rather than an analytical one. The specific comment I made (regarding Sri Lanka) is merely that it doesn't fit the argument since the 1996 WDR lists the growth of GNP per capita in Sri Lanka (1985-94) at only 2.9% while the box had a cut off at 3%. Moreover, if one used the 1995 WDR, Sri Lanka has a growth of only 2.7, that is less than the 3.1 for Pakistan, which is on nobody's list investment in human resources. [For some reason this figure for Pakistan drops to 1.3 in the 1996 WDR. Maybe a typo].

The more general point is that after the fact, one can find cases to illustrate a point, but such arguments are usually very selective in their use of examples. They may serve as a counter example show that x is not a necessary condition for y (eg. high income is not necessary to have low indicators of life expectancy) but this may not serve to make a general conclusion. As Aristotle said: its easier to dispose than propose. Substituting another country might advance the rhetorical point, but doesn't change the fact that the approach is selective.

As to FGM. I raised the issue of the impact of legislation because it has been argued that by making the practice illegal without there being a corresponding change in its popularity it becomes more likely that the operation occurs under village rather than clinical conditions. If so, the impact on the victims might be negative. This is, as you might imagine, very hard to document, but it strikes me as plausible. Its a complex topic; there was a Bank sponsored review, probably by thye gender group, but I do not know the author(s).

I would be glad to reread the nutrition section in the next draft. However, I am leaving for mission right after HD week. I would hope that a few staff members who are trained nutritionists (Judy Mcguire and Richard Seifman come first to mind) might be available to offer comments.

Regards.

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 10, 1997 02:52pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Mead Over, PRDEI (MEAD OVER@A1@WBHQB)

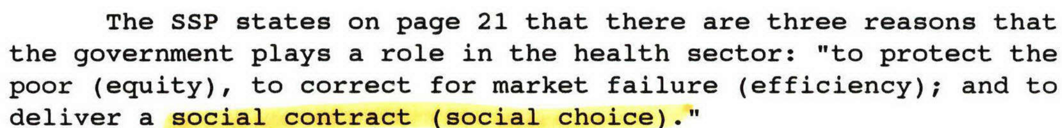
EXT.: 33451

SUBJECT: Comments on HNP Sector Strategy Paper

Alex,

The Sector Strategy Paper for the HNP Family is a comprehensive and ambitious document. In most respects, the document is sound and it launches the Bank's HNP family in the right direction. My comments can be organized around three themes where I believe the document can be strengthened: the role of the government in the HNP sectors, the definition of "health sector reform" and the nature of Bank-supported and Bank-performed research in the HNP sectors. Minor editorial comments are appended.

The Role of the Government in the HNP Sectors



The SSP states on page 21 that there are three reasons that the government plays a role in the health sector: "to protect the poor (equity), to correct for market failure (efficiency); and to deliver a social contract (social choice)."

The third of these justifications is interesting. Does the government also have a social contract to build roads? to provide a safety net for the poor? to subsidize staples for urban residents? to provide clean air and water? to uphold the rule of law? provide for national defense? If so, in the presence of scarce resources, which of these contracts takes precedence over the others?

The text on this page states that a "social contract" to provide health care "often leads to unbalanced investments, lack of sustainability, disregard for quality of care and disrespect for individual choice. Not only does this [the social contract?] contribute significantly to a discrediting of many of the more positive aspects of government involvement in the HNP sector, but it [the contract?] may also undermine parallel poverty alleviation strategies when it leads to an indirect subsidization of the rich" (SSP, p. 21).

This tantalizing bit of political economics should be elaborated in at least another paragraph. Why does government commitment to a social contract to provide HNP services

"discredit many of the more positive aspects of government involvement"? Why does such a contract often lead "to an indirect subsidization of the rich"? Are such negative effects of a social contract also present when the contract is to provide for the rule of law? for national defense? Do such negative effects occur in all countries or only in certain countries? Is there a body of research or analysis in or outside the Bank on which one can draw here? (Also the antecedents in the quoted paragraph would be clearer, if the paragraph were less compressed.)

After this short section which seems to argue that the Bank should disregard "social contracts" where they exist, there is a box on China which says that "Chinese policy makers are now faced with the urgent need to build [for the health sector] a new regulatory framework, financing system, safety net and quality control mechanism for the expanding private sector to underpinning [sic] its [China's?] past social progress in terms of health outcomes and recent economic growth."

As juxtaposed with the text quoted above, the message of this box is not clear. Is this an example of a country seeing the light and deciding to disregard a social contract which used to exist, but is now considered financially unsustainable and politically obsolete? Or is this an example of a country that is struggling to establish a new, more modest, social contract which aims not to make care universally accessible, but only to correct the equity and efficiency problems which arise in an unfettered private market for health care? Or is this an example of a country which used to support a social contract to make health care accessible to all, was forced to renege on this contract during a period of liberalization, but now feels "an urgent need to build" a new social contract? The box does not currently distinguish between these three alternative views of the changes currently under way in the Chinese health system and so provides the reader with less clarity than would be desirable on the Bank's views on these matters.

Health Sector Reform and Mechanism Design

The term "health sector reform" has become common in the international health policy community, but its meaning is not clear. To some it means strengthen government services, while to others it means establish privately owned and operated health maintenance organizations in developing countries. The HNP SSP should state clearly the Bank's definition of and view towards health sector reform.

A recent publication from WHO states that one of the principles of health care reform is "solidarity," which is defined as: "each individual contributes to the system in accordance with his or her capacity, and each one receives health care when he or she needs it" (Antezana and Velasquez, Dec. 1996,

p. 7). On the next page, the same document asks rhetorically "whether by definition the role of the State is not to vouchsafe for each citizen's security, education and health" (ibid.).

In contrast, the HNP SSP states in the executive summary that "the World Bank subscribes to an emerging policy paradigm for the role of government in the health sector ... Often this [redefinition] will require a diminished role of the state as direct service provider..." (p. vi).

While both documents are sufficiently vague that their authors could claim to mean what the other document says, the tone is certainly quite different in the two documents. The implication of the language in the WHO document is that the authors intend to preserve as large a role as possible for the state. (Echoing a Marxist slogan, the solidarity principle as expressed is at odds with the principles of equity and efficiency.) In contrast, the SSP's executive summary seems to commit the Bank to arguing for a diminished role in most circumstances.

I have three suggestions for the SSP on this topic. First, the executive summary should state even more clearly that "health sector reform" will typically require a reduction in the government's role to a minimum set of "core" activities which are justifiable on the basis of equity and efficiency considerations.

Second, the text of Section II (pages 13-28) should be revised to support this main message. The current draft of Section II does not clearly argue for a reduced government role. Indeed a possible interpretation of the China box referred to above is that the government's role should be increased.

Third, in my view a critical element of "health sector reform" which is not directly discussed in the current draft of the HNP SSP is that of designing a system of rules, regulations, norms and operating procedures within which:

- o patients can be insured against large health care expenditure risks,
- o taxpayers can be protected from large public health expenditures,
- o providers can be assured contractually agreed payments at rates that compensate them adequately for their educational investments,
- o health care services with large externalities are appropriately subsidized,
- o equity concerns are addressed,
- o public health sector budgets are balanced,
- o opportunism (i.e. cheating) by all parties is kept to a minimum and
- o paperwork costs are a small percentage of total health care costs.

Designing such a system is an example of the type of

problem addressed by the new sub-field of economics called "mechanism design." There is clearly no single optimal solution to this complex problem. Rather the best solution will be country-specific, depending on the country's administrative capacity, existing health care structures, legal system, epidemiology, literacy rate, etc.. A good solution is recognizable partly by the fact that few of the actors in the system have the incentive to try to beat it. It is likely that poor countries will be forced by the scarcity of their resources to adopt systems which attain fewer of the above list of objectives, but social choice will determine which of those a given country will choose to sacrifice.

In view of the complexity of the mechanism design problem inherent in health sector reform, it may be difficult for Bank staff and/or country nationals to identify the best design in an SAR. This is an area where operational research in the context of pilot health sector reform experiments is likely to be not only desirable, but imperative, in order to avoid the danger of saddling clients with health sector reform plans that later prove inappropriate to the specifics of that country.

Bank-supported and Bank-performed research in the HNP sectors.

The executive summary of the SSP states that "[a]s a general rule, the Bank will focus on framing operational analyses and research questions, and in assessing and disseminating the results rather than conducting the research. ... The Bank is committed to developing a strong in-house capacity [to create and maintain] a database on public and private sources of health care financing and expenditures. This will be one of the few exceptions to the strategy of "out-sourcing" much of the Bank's HNP research agenda." Similar language is on pages 45-46 in the section entitled "New Role as a Knowledge Broker."

In my view, this proposed stance towards research has five flaws:

- o it commits the Bank to "operational research" that is in fact not very "operations oriented" and not very "research",
- o it ignores the comparative advantage of Bank research on the health sector,
- o it misses an opportunity to "strengthen the monitoring of impact,"
- o it condemns Bank operational staff to reliance on ad hoc recruitment of one-mission consultants for advice on the most difficult problems of health project design,
- o it is at odds with the proposed new role of the Bank as a "Knowledge Bank."

The ground-breaking work on public and private health sector expenditures in developing countries was done by David de

Ferranti in a set of background papers for the Bank's 1987 health sector policy paper. With the importance of the topic well-established and initial estimates for the major aggregates provided by background papers for the 1993 WDR, at this aggregate level this area is no longer an intellectual frontier and therefore there is no reason for the Bank to play a role different than the one it plays in gathering macroeconomic data for the IMF and Bank government expenditure statistics. Indeed, work on public and private health expenditures would simply be an extension of that existing macro-economic data gathering exercise, which is not typically characterized as research. (For example, this activity would not be eligible for funding from the Bank's research budget.) In addition to not being research, the proposed subject is not very "operations" oriented because it does not advance knowledge on the internal processes or "operations" of the health system in a given country.

The Bank's largest comparative advantage in research in the HNP sector derives from the fact that it designs and funds many new health projects or health sector adjustment loans every year, each of which is an experiment in some facet of "mechanism design." While university researchers are used to making do with NON-experimental data on health system performance, Bank researchers can obtain actual experimental data, in some cases complete with matching data from control groups. (For example, a current research project in the education sector analyzes the results of education decentralization experiments in five countries in three regions, all of which are funded by Bank credits or loans.) Since governments are likely to be wary of quickly publicizing data on the performance of their important policy reform initiatives, Bank researchers have the additional advantage of being able to guarantee that the data will remain confidential as long as the government requires. Furthermore, because of the difficulty and tedium of designing a health reform project to include the appropriate baseline data collection and monitoring elements, the best academic health systems specialists and health economists may not want to undertake such tasks, hoping instead to get the data at the end of the experiment. (An example of a role for Bank researchers ruled out by the SSP's stance on research is in the box on the Mexico health sector reform project on page 36.)

The SSP states that it is "strengthening the monitoring of the impact" of HNP projects by including as an appendix, and proposing the maintenance of, a database of national level statistical indicators and a set of "HNP Development Diamonds" (pp. 51-53). While statistical annexes are a positive contribution and the HNP development diamond is a clever presentation device, it is hard to imagine these aggregate tools being particularly useful to OED analysts of a project's impact five years after it has been completed. The best way to strengthen the monitoring of the impact of HNP projects is to build into them substantial monitoring and evaluation components and require Bank personnel to analyze the resulting data. Bank

research personnel are the natural candidates to design and manage these activities.

Because the proposed research stance rules out the participation of Bank researchers in the study of the design of appropriate health sector reform mechanisms, the Bank will only be able to accumulate in its "knowledge base" the BTOs of its outside experts. Too few Bank staff will develop the skills and the tacit (i.e. unwritten) knowledge of health system design to enable them to transmit knowledge from one country experience to another, to serve as useful expert advisors to client countries or Bank operational staff or to participate in the global discussion of health sector reform issues. Bank staff will be forced to rely on temporary consultants for expert advice on health sector reform issues. Rather than being a repository of knowledge about health sector reform issues, a role for which the Bank has a comparative advantage, the institution will be reduced to being a consumer of the opinions of outside experts. Far from attaining the goal of being a "knowledge bank," the institution will become an "opinion bandwagon" on HNP issues.

Minor Editorial Comments

p. 8, para. 2: Replace the term "factored out" with "controlled for."

p. 11, para. 6: The sentence states: "Tendencies toward expenditure escalation has [sic] been observed to be much greater in the private sector than public sector in middle-income countries (see below for elasticities at different income levels)." However in the middle income level the table gives the income elasticities of public and private health expenditure to be: 1.00 and 1.08 respectively. The elasticity of 1.08 is NOT much greater than 1.00. Since the elasticity of total expenditure in this group is given as 1.14, and it should be a weighted average of the public and private elasticities, I suspect that the 1.08 is a typo and should be 1.80.

p. 16, Box on Vaccination: Should the last sentence read: "Although the government spends over 15 percent of its public HEALTH budget on Kenyatta Hospital..." ?

p. 28: The text states that "There are three simple policies which..." and then gives only one.

p. 36, Box on Mexico: The box on Mexico's Bank-financed health sector reforms describes the financing of "cost-effective packages" of health services for the poorest states, but does not mention the important insurance role of a government health care system. If the state is only financing cost-effective (i.e. cheap) interventions, what provision has Mexico made to enable the poor to get insurance coverage for the rare expensive and cost-ineffective procedures?

p. 38: The list of challenges to improving HNP performance omits the difficulty of mechanism design described above and the challenge of designing monitoring and evaluation instruments which accurately measure the incentives faced by all the actors in the system, in order to assure that all (or most) have the proper incentive to comply with the rules and that those incentives guide the actors towards the operational goals of health care reform cited above.

p. 40, para. 4: The last sentence should read: "... only two of the Bank's current 156 HNP projects deal EXCLUSIVELY with improving resource mobilization and efficiency in health care financing."

p. 50: The figure showing the HNP family omits the DEC vice-presidency.

I regret that I will be on mission on March 14, the day of the review meeting.

Mead

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The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 12, 1997 08:04pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Christopher D. Walker, EXCQA (CHRISTOPHER D. WALKER)

EXT.: 80729

SUBJECT: HNP Sector Strategy Paper, White Cover Draft -- Comments

Alex

This is much more than the usual pro forma -- congratulations on a very difficult job well done. As I am sure you already know, this is the kind of job in which it is impossible to satisfy everyone. But this is a good white cover attempt, which tries to be responsive to the earlier discussions on overall direction and priorities. Like everyone else I am sure, I have comments -- but please read them in the light of this paragraph.

I have annotated my copy of the report heavily; please borrow it if you wish. The following summarises my main points:

Overall balance -- for my taste, the draft is insufficiently focused on the specifics of the HPN sector. In particular, the operational implications of many issues which are routine for those working in the sector (e.g. the real levels of immunisation coverage; correct technology for malaria vector control, etc. etc.) will not be routine to many of those reading this document. A stronger flavour of these more "technical" issues would help to make it more HPN sector specific. Financing, rightly, has a very strong theme -- but seems to be somewhat over emphasised, and may be seen by some as the latest vertical program.

Poorest countries -- there are many references to the priority that we intend to attach to these countries, but not enough on the specifics of what we intend to do about them. p47 col1 is an attempt in the right direction (I have some specific suggestions), but the earlier discussion needs to be more focused and lead into these more. Similarly what we can really do about the rural poor in the poorer countries needs amplification; if its not much, maybe we should be suitably modest?

Key areas -- as I am sure others will also suggest, there are some key areas which are glossed over in the text. The key role of staffing/manpower is my personal hobbyhorse. But also how to foster good management is critical, progress here would solve many of the sector's other problems.

NGOs -- there is a terminology problem as sometimes (always?) you use non-government as exactly that, rather than the more common usage for

NGOs. This confounds the recommendations in this area. But, more importantly, my sense is that we actually say little about our strategy for working better with NGOs, leveraging their efforts, etc..

Portfolio, implementation and supervision -- the current portfolio, in reality, is little focused on. The section on p37 onwards really talks about quality at entry, certainly important, but only part of the game. As the portfolio constitutes a substantial and growing slice of the total Bank lending, from a strategic view, it is essential to demonstrate that we will do better with what we already have (especially as the signs are that the sector's performance is probably already below the Bank average). If we cannot do that, then how can you justify an even bigger slice of the cake? So, I suggest some serious discussion of the implementation and supervision problems of the existing portfolio (without being parochial, what about the virtues of proactive management, the need to be serious about projects at risk, etc., etc.) and add some recommendations in the final chapter on this. This also has implications for the staffing section --- what happened to the skills needed to supervise project implementation, for example?

I have quite a few more detailed points; let me know how I can help further.

On presentational matters:

the monitoring and special initiatives sections at the end are wrongly placed;
the story line of section IV needs sharpening;
the social contract piece (p22) needs re-writing, its bordering on the offensive at present (and we do not need to be necessarily apologetic about this subject anyway);
if your looking for cuts, much of p30-36 could go at least to an annex; and
too many boxes, cut out at least 25%.

Hope this helps and good luck

Chris

CC: Esther Babazadeh (ESTHER BABAZADEH)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 12:37pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Christopher D. Walker, EXCQA (CHRISTOPHER D. WALKER)

EXT.: 80729

SUBJECT: HNP Strategy

Alex

Sorry, one more point that I forgot last night.

The Bank's new (draft?) Strategic Compact does, of course, include several HNP measures as indicators of performance. This would in turn suggest that some clear link between the HNP strategy and the Compact would be needed?

Good luck

Chris

CC: Esther Babazadeh (ESTHER BABAZADEH)

1-2

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 13, 1997 06:25am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Anthony Measham, SA2RS (ANTHONY MEASHAM@A1@DELHI)

EXT.:

SUBJECT: Health, Nutrition and Population sector strategy paper

Alex:

I'm please to comment on the white cover draft.

Overall, it's a good piece, with much to like:

- I support the main messages;
- good analysis, e.g., the methodology for assessing performance of health care delivery systems;
- clear review of where we've been and where we are now;
- lots of good country examples and boxes;
- the main messages resonate in India;
- clearly written and flows well.

Three substantive points need shoring up, in my view:

- risk pooling is overplayed. It's important, sure; neglected, true; but the financial sustainability of the sector depends on many factors, while the report - in places, e.g., p. 43 and the exec. summary - does not convey the number and complexity of factors and oversimplifies, in my view;

- sector work is underplayed. Its importance is clearly shown (pp 32-33) and the recent neglect highlighted. But then the theme is not carried through: the neglect is stated in para. 2 on page 40 but the report fails to: include a strong recommendation for action to increase resources for esw; link this to the knowledge broker role on page 45; and include the need for action in the exec. summary.

- the recommendation of links with IFC, privatization ministries, and the private sector network needs to address the current lack of fit between their predominant interest (bottom line and rightly so) and the key WDR 1993 point that investments in tertiary hospitals (where bottom line potential is highest) yield relatively scant health returns. Why not use this opportunity to interest IFC in HMOs?

Finally, the exec summary is weak. It does scant justice to the paper; doesn't flow well; and, most importantly, does not

convey the analytical rationale for the new strategic directions.

Good luck with the review and regards,

Tony

CC:	INDRA PATHMANATHAN	(INDRA PATHMANATHAN@A1@WBHQB)
CC:	SALIM HABAYEB	(SALIM HABAYEB@A1@WBHQB)
CC:	RICHARD SKOLNIK	(RICHARD SKOLNIK@A1@WBHQB)
CC:	MARIA CLARK	(MARIA CLARK@A1@WBHQB)
CC:	PRABHAT JHA	(PRABHAT JHA@A1@WBWASH)
CC:	RICHARD FEACHEM	(RICHARD FEACHEM@A1@WBHQB)
CC:	DAVID DE FERRANTI	(DAVID DE FERRANTI@A1@WBHQB)
CC:	SAMUEL LIEBERMAN	(SAMUEL LIEBERMAN@A1@WBHQB)
CC:	BARBARA HERZ	(BARBARA HERZ@A1@WBHQB)
CC:	TOM MERRICK	(TOM MERRICK@A1@WBHQB)
CC:	WILLIAM MCGREEVEY	(WILLIAM MCGREEVEY@A1@WBHQB)
CC:	JUDITH MCGUIRE	(JUDITH MCGUIRE@A1@WBHQB)
CC:	Edwin Lim	(EDWIN LIM@A1@DELHI)

A L L - I N - 1   N O T E

DATE: 13-Mar-1997 11:33am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Alison Evans, WDR (ALISON EVANS@A1@WBHQB)

EXT.: 39182

SUBJECT: SSP - White Cover Comments

Alex,

You asked me to provide some comments on the white cover, and specifically on the strategic focus on the role of the state and institutional reform in the HNP sectors. What follows are some initial thoughts, in no particular order. Maybe we can sit down to discuss some of them in more depth at some point.

First I should say that the document has really livened up since the earlier draft. The general message is credible, and clearly portrays some of the complexities and challenges of operating in the HNP sectors.

Notwithstanding these improvements, I am disappointed by the lack of a clear diagnosis/analysis of (what you term) 'government failure' in the HNP sectors, and am rather disconcerted by the slippage from generally weak statments about govt. failure (p23) to a strategy that appears to be favoring privatization (p24). Lest you think I have turned into a dirigiste after the WDR experience, let me share with you a few specific concerns.

1. That governments are imperfect is woefully evident, that governments are involved in many areas of provision (and even financing) that they shouldn't is also woefully evident, but without a good diagnosis of the incentive and accountability problems affecting public sector performance (from regulation to provision) we miss sight of a range of possible interventions that can not only improve public sector performance but also enhance the competitive interface between the public and the private. For example, rebalancing or refocusing on the public-private interface requires faciliting competitive pressures both within and outside government through quasi market mechanisms such as vouchers, contracting-out competitively and increased use of techniques such as co-production and user-client feedback. These, so called, 'new technologies of public action' are precisely the elements of a strategy for improving public sector performance and encouraging collaboration/competition from the private sector. We might look around for interesting lessons to be learned from the irrigation and infrastructure sectors in this regard.

2. Given that the third wave of privatization is apon us, then

the important question surely is what kind of strategy might governments with different levels of capability adopt? Where institutional capability for sophisticated financing/regulation is weak, a market-entry approach to privatization through deregulation may be better than actively transfering owernship of public facilities with all their attendant employment/political consequences. In more 'capable' institutional environments a more aggressive strategy of transfering ownership and regulation may be feasible...although still politically contentious. I do find it very curious that a case is made for private participation on the grounds that governments fail as providers when it is assumed that governments can work well as regulators! Regulation can offer as many opportunities for rent-seeking/predation as direct provision, done badly it can be extremely dangerous, done well it is often institutionally demanding. I don't see us having much experience, even in middle-income countries, of doing regulatory policy in HNP that fits different institutional capabilities .... see environment regulation for some important lessons learned.

3. On measuring health system performance... despite an interesting health regression I remain much more cautious than you appear to be in interpreting the residuals as 'indicators of system performance and policies' ....they indicate what can be explained by health policies etc...and not performance per se.

I have lots of other small comments, relating to specific points or use of data but I am sure you'll get lots of feedback on these so I'll leave my intial contribution here.

Regards
Alison

A L L - I N - 1   N O T E

DATE: 14-Mar-1997 10:52am

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Alison Evans, WDR (ALISON EVANS@A1@WBHQB)

EXT.: 39182

SUBJECT: SSP - WC Review

Alex

I hope my comments didn't 'bias' the discussion too much this morning.

I fully accept your closing comments that we need to think differntly abour the Health for All paradigm, in fact I would like to have seen that stated up front. This is not to say that there are not useful elements in HfA, but it too is dangerously dogmatic in ways that are not helpful and sometimes simply wrongheaded. But.. what the strategy is currently missing is a DIAGNOSIS of the problems of public failure, the influence of institutional and political economy factors and the suggestion of OPTIONS, or as Sandy termed them CHOICES for ways forward -- that will range from new innovations within the public sector itself to an array of public-private synergistic relations to wholsale privatization.. It is in in the nature of the diagnosis, the tensions and tradeoffs that emerge and the identification of options (which may be clusters of choices) that the strategy can really make a contribution.

Anyway, best of luck for the next round.

Alison

A L L - I N - 1 N O T E

DATE: 11-Mar-1997 04:06pm EST

TO: See Distribution Below

FROM: mjimenez, (mjimenez@tgm2.hbs.edu@INTERNET)

EXT.:

SUBJECT: HNP Sector Strategy

Martin and company,

As you know, I spend my 1.5-day weekends at home from "school". But yesterday morning, My flight to Boston took 5 hours longer than it should have due to the weather (I was actually on 3 flights, 2 of which were cancelled). So, I had some time to read this paper, although I was in a pretty sour mood when I did so, having awakened at 5 am to try to be on time for class at 9 am.

I don't have trouble with some of the main messages -- addressing the poor's needs, rebalancing public-private action for example. But I had 2 main comments.

1. The report argues that the Bank will "frame" questions, assess and disseminate results of research, rather than conduct it. This may be the right way to go in HNP, but there is no justification (or even a discussion) of why it might be so. This is the first time i hear of it. Granted, the Bank has not had an extensive HNP research agenda as in the past. But a strategy paper should visit that result and ask whether it is the right way to go. We all know some of the arguments against just being a "broker" of research (or is the right expression, "breaking research"?): pretty soon, the brokers will not be able to tell good research from poor research. Witness USAid. THe report would have the Bank be a data colleection agency. The right way to set strategy in this area has to be in the same way that the report claims to set strategy for operations: assess existing work, ask whether it makes sense to be only a financier versus a provider of research, and if some research is going to be provided set priorities based on needs as well as comparative advantage (I'm not sure data collection in HNP is ours). At the moment, there is NO mention of current RSB-funded work -- it's as if it didn't exist. What about the AIDS work, the work on population in Africa, Harold's nutrition stuff, the past research on the price elasticity of health demand? I would suggest the ff: (a) start a dialogue now with us (we have offered to discuss this with the SEctor Board, right Harold?) on what research in HNP should be and (b) then, discuss what should be"farmed out" versus what makes sense to do in-house. Even if we conclude that ALL analytical work should be done out-house (and the quality may indeed go in that direction) we should go through this exercise. And if some work will be done within the Bank, it is important to set priorities given budget constraints.

2. The paper makes a strong pitch for HNP spending in order to alleviate poverty. This may be an excellent idea and some of the worst consequences

of being poor are reflected in HNP-type outcomes. But the question then is: is this the best way to spend public monies in order to help the poor. There is no discussion of the alternative ways of helping the poor. THere is not even any mention made of who benefits from different types of public spending on HNP -- a growing literature within the Bank on this. This is an area that requires clearer justification and substantiation. I know that this is not a researcj paper so it may not be that important in practical terms to clean this up but...

I leave Jeff and Lant the field to comment on the use of DALYs to motivate the reforms in HNP (althought I think they're careful not to say that they should be used to set policy priorities -- not sure on this)

Other commnets:

p. 2 and the exec summar. This may not have been the intention, but the report seems to imply that the goal of poverty reduction is associated with improved life expectancy, while the quality of life is associated with improved poverty. I think the report should just say that the goals are improving human welfare through reducing poverty and enhancing productivity -- improved life expectancy and "quality of life' are only indicators.

Section 2. this can be shortened a lot by the consolidation of the policy discussions. Policies at the moment are discussed before the subsection on "health care reform strategies." In general, the report should distinguish between diagnosis and reform ?

p. 8, middle para says that because broad socio-economic determinants have been 'factored out', the rest should be due to interventions. The rest of the subsection concludes the opposite. This is just overstated. In fact, there's no evidence shown on how much of the variiation in performance is due to public interventions.

p. 17. The report argues that it is now possible to "focus" nutrition programs by addrssing undernutrition, micronutrient malnutrition and overnutrition. I don't see how this is focusing.

p. 26 The report argues that if there is a "gap" between the 3 % of GDP target and actuals, there should be aggressive international assistance. I'm no expert on aid effectivenss, but what's the evidence on this. If I were a poor country, there's no way I'd crank up expenses to 3 percent of GDP and then be taxed at a 100% rate. I would stay away from these 'targets" that are mechanical.

p. 30 ARe the numbers on HD lending %'s projects or values of loans?

Martin, thanks for coordinating on this one. BEfore we send the reply, it might be politic to give Alex a call to just let him know what the final points of our comments might be.

Regards,
Manny.

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Subject: HNP Sector Strategy
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A L L - I N - 1 N O T E

DATE: 16-Mar-1997 07:10am EST

TO: DAVID DE FERRANTI (DAVID DE FERRANTI@A1@WBHQB)

FROM: Stephen Denning, ITSDR (STEPHEN DENNING@A1@WBWASH)

EXT.: 34035

SUBJECT: HNP Sector Strategy Paper

Dave,

My sense is that the sector strategy paper is in good shape and that you were getting sensible feedback from the review meeting, which should help in further polishing the paper to ensure an even smoother reception at the OPC and the Board. I think you have a very good product, given the groundrules.

My concern is however with the groundrules. The paper contains only a fraction of the knowledge that has been acquired and ventilated by the preparation team, and this is inevitable given the format. Pressures to shorten and nuance the paper further will further reduce this fraction. One does have to wonder what the shelf life of the product will be, and the contrast with the rather large cost of the process of preparation will probably be striking.

The normal rationalization of this typical outcome is to say that "the process is more more important the product", which is to accept that the knowledge acquired will largely remain tacit in the heads of staff members, rather than being shared with the collectivity.

The idea of knowledge management is not to accept this outcome and to strive to capture this knowledge for sharing inside and outside the organization. To accomplish this a very different format is needed, and although there are no good examples of it in the Bank, there are examples in other fields that give a pretty good idea of what it would look like in the Bank. The main elements are described in the attachment.

One question is whether you would like to try to capture some of the acquired knowledge in preparing the strategy paper in this fashion before the team disperses (maybe it already has dispersed) and people get back into their operational routines.

It would not be easy or quick to finish, though groupware and other techniques could expedite the process significantly. Even if it cannot be completed (in one sense, it never gets completed) at this time, even capturing people's thoughts in electronic form will greatly expedite the task when it is attempted.

This might not be the moment to attempt it. You may want to focus on getting out the strategy paper. Helen's absence may make it problematic.

But if you could pull it off, you would have something immense potential value, and a head start on the whole issue of best practice in the HNP sector.

So if you did want to assign someone and have a shot at this path breaking innovation, this is to signify my readiness to discuss the implications and to work with your people to make it happen.

Let me know in due course,

Steve

ELEMENTS OF CAPTURING BEST (AND WORST) PRACTICE

The main elements are:

- the capturing of valid patterns of action (what works)
- each pattern contains elements such as the problem, the context, the action and its consequences, the evidence, commentary and the source of the expertise.
- patterns form networks of patterns.
- patterns of different levels of generality and differen degrees of robustness.
- patterns of worst practice (things that don't work) are also capture

the presentation is modular

- the knowledge about the patterns keeps evolving so that the patterns are easier to update if they are in electronic form.

A L L - I N - 1 N O T E

DATE: 16-Mar-1997 05:14pm

TO: DAVID DE FERRANTI (DAVID DE FERRANTI @A1@WBHQB)

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Note From Steve Denning

I think Mr. Denning raises some interesting points.

I have kept a detailed record of the process so far in my project file which is quite organized. This includes the agenda and minutes to all significant meetings, including the regional consultations. It would be quite easy to write this up after we finish the exercise or if we get some downtime during the process. But I would not suggest that we get sidetracked on this right now. As it is I am spending a lot of weekends and evenings just trying to keep the main product on course and I cannot see on the foreseeable horizon when I would have time to do a write up of the process part of the exercise.

In addition to the process part which Mr. Denning refers to, the SSP has already contributed significantly to our overall HNP knowledge base in terms of:

1. An updated global health expenditure data base
2. An updated HNP status data base
3. Several background papers
4. A couple of regional papers which hopefully will eventually include a paper per region (but I eased off insisting on this during the fall when we got a negative reaction from EAP). ECA, MNA, AFR and LAC have however proceeded with their own regional strategies.
5. Possibly a main background paper if the OPC accepts our proposal for a shorter SSP.

I will follow up with Mr. Denning to explore some of his ideas which we may want to follow up on later.

CC: HELEN SAXENIAN (HELEN SAXENIAN @A1@WBHQB)
CC: RICHARD FEACHEM (RICHARD FEACHEM @A1@WBHQB)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: March 18, 1997 03:41pm

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Olga Jonas, FRMRO (OLGA JONAS)

EXT.: 34655

SUBJECT: IDA grants to NGOs

As I mentioned, the IDA Deputies did consider providing for grants to NGOs under the IDA11 agreement (FY97-99). The Bank raised the topic in February 1995 -- the enclosed is a record of the comments made by all the donors present. There was a diversity of opinions but on balance the Deputies felt that this instrument is not necessary. The paper the donors discussed -- "Prospects and Options for Effective IDA Lending" is in the mail.

There was not then (and probably still isn't now) enough convincing evidence that existing instruments were not adequate for the tasks. Also, substantial funding is available from other sources (foundations, private donors, charities) to effective NGOs. In any case, the next logical time to re-open this discussion -- if there is a stronger argument for this instrument -- would be for the IDA12 period (FY2000-02).

I also attach my previous comments -- I haven't had a chance to check whether you were able to take them into account. In particular, is there any work ongoing on indicators of impact of our projects? Does IDA lending make a difference?

Please let me know if you have any questions.

Olga

CC: FRM Hotline (CCFRM)
CC: Cheryl Francis (CHERYL FRANCIS)

Our paper "Prospects and Options for Effective IDA Lending" distributed to the IDA Deputies in early January, asked IDA donors to consider whether IDA should be allowed to give grants to non-governmental organizations (NGOs). The following are reactions from all Deputies who expressed an opinion on this issue at the IDA Deputies' meeting on February 9-10, 1995:

<u>In favor/possibly in favor/small size/limited scope</u>

* Eager for IDA to work more with NGOs. Bank to prepare a paper (US)

* Not in favor of the proposal. Especially not to Part I NGOs. Could be studied for Part II NGOs. Not a fixed idea; wants to think. (Germany)

* Not totally closed to the idea but very cautious. At most small and limited. (France)

* In favor of the proposal. But should be of limited size, not as a bribe for NGOs. Should go beyond microfinance. Would enhance quality, ownership, effectiveness of IDA projects. (Netherlands)

* Open to the idea. IDA needs to increase beneficiary participation in project design. (Canada)

* Could fund, on a matching basis, projects prepared by private sector/NGOs. (Italy)

* Consider it; give NGOs special recognition. (Ireland)

<u>No need to decide now/not convinced one way or another</u>

* Premature proposal. No need to decide on IDA resources use for this. CGAPP is OK for now. (Norway)

* Not in favor but willing to look at proposals. IDA could win advocates. (Denmark)

* Not prepared to go beyond CGAPP. (Finland)

* Keen to hear specifics. IDA should build stronger relationship with NGOs. But what gap would IDA be filling? Does IDA have comparative advantage in microcredit? (Australia)

* Not convinced that the proposal is useful. (Russia)

* Not too keen. Wait for CGAPP results. (Spain)

* Probably not a good idea. Selection of NGOs is very difficult. But NGOs need help. How can they be helped? (South Africa)

<u>Opposed</u>

* Not appropriate for IDA to give grants. (Japan)

* Emphatically not in favor. Not IDA's comparative advantage. NGOs not short of funds. IDA should work through recipient country governments. (United Kingdom)

* IDA should NOT buy allegiances. Do more in microenterprise lending/policy reforms in regular financial sector work. (Switzerland)

* Not acceptable; not legal under Belgian law for IDA to give grants. (Belgium)

* No case at all for this. (Portugal)

* No, IDA should not give grants. Work on microcredit. (Saudi Arabia)

* No. Possible negative impact. Cautious. (Iceland)

* Does not believe this is an efficient use of scarce IDA resources. If done, only with an upper limit. Not a way to do PR. (Korea)

The World Bank/IFC/MIGA
O F F I C E   M E M O R A N D U M

DATE: December 17, 1996 05:15pm EST

TO: Alexander Preker (ALEXANDER PREKER)

FROM: Olga Jonas, FRMRO (OLGA JONAS)

EXT.: 34655

SUBJECT: HNP Sector Strategy

Hello,

Thank you very much for sending us the Approach Paper for the Sector Assistance Strategy (SAS) for the Health, Nutrition and Population (HNP) sector (to be discussed by the Board on January 22, with the final SAS is to be presented to the Board on May 27).

I had looked at the draft approach paper from the point of view of IDA and its priorities. The paper is comprehensive and clearly structured. Improvements in this sector are a very high priority in most of the 79 IDA-eligible countries. The following are two areas where you may want to consider increased emphasis:

Quality of CAS. The approach paper proposes the establishment of criteria for reviews of CAS, CEMs and projects with potential HNP consequences by mid-FY98 and that the first cycle of reviews be completed by end FY99. In view of the priority of HNP in most IDA countries, and the key role of the CAS in managing IDA's program, this schedule seems too drawn out. To ensure higher quality CAS, could the HNP Sector Board consider reviewing CAS for those IDA countries where HNP issues are important even before formal guidelines are established? As a side benefit, experience gained from CAS reviews over the next year or so would serve to formulate more user-friendly guidelines. Quality of CAS is very important, as the CAS has become the most important vehicle for accountability to IDA donors.

Indicators of project progress and impact. While the approach paper mentions the importance of these, there is no information on the indicators that are already in use and on the experience with them so far. Because of growing donor impatience with the absence of evidence of the results from IDA lending, the strategy paper should be as specific as possible in this area. The approach paper notes that "developing a more solid conceptual framework for assessing what constitutes quality at entry is a high priority" (implying that this has not been defined yet). Since indicators are required for all operations starting in FY97, and a retrofit of all ongoing

operations is to be accomplished by end FY97, more attention to this in the SAS would be most welcome warranted. Moreover, the IDA11 agreement (covering FY97-99) states that in the FY97 ARPP (to be drafted in the summer/fall of 1997), the reporting on project implementation and results will be "fully consistent with this new approach", ie, draw on systematic use of project impact indicators.

Please let me know if you have any questions; we look forward to hearing of the next phase.

Olga

CC: Paula Donovan (PAULA DONOVAN)
CC: Enrique Rueda-Sabater (ENRIQUE RUEDA-SABATER)
CC: FRM Hotline (CCFRM)
CC: Cheryl Francis (CHERYL FRANCIS)

A L L - I N - 1   N O T E

DATE: 21-Mar-1997 07:57am

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Tom Merrick, HDDHE (TOM MERRICK@A1@WBHQB)

EXT.: 36762

SUBJECT: RE: SSP Comments from Althea Hill

Alex,

I agree with Ane's suggestion that Althea's (and others') concerns about population could be addressed in Section I by stating that not all population outcomes are health outcomes (population cannot be reduced to reproductive health any more than to family planning) and that the main focus of the paper is on getting health systems to work better. While the section on "Origins of Good Health and Illness" recognizes that other factors affect health (including reproductive health and nutrition), a "population" outcome such as elimination of unwanted fertility has benefits to individual (more household investment in children's education) and societal (avoiding externalities associated with high rates of population growth) welfare that go beyond good health and avoiding illness (whereas the factors outside the health system that impact on nutrition ultimately do impact on health/illness).

The primary focus of the SAS is on health systems. Getting health systems to work right is very important for health status (including reproductive health/family planning). The SAS cannot be expected to fully articulate strategies for addressing issues beyond the health system. Recognizing that factors outside of the health system are important doesn't mean that the health system has to fix them (this is where attention to the social sectors at the CAS level should come in) or that the health system is responsible for fixing the other sectors (education) whose activities also affect non-health population outcomes.

The HNP SAS has a lot of good ideas and strategy for getting health systems to work better, but need not go beyond recommending that broader issues affecting health, nutrition and population (with no mention of the non-health aspects of population) be addressed in the CAS. The challenge of getting the Social Sectors right in the CAS process is bigger/more complex than what can be done in the SAS.

Tom

CC: Anne Tinker (ANNE TINKER@A1@WBHQB)
CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

A L L - I N - 1   N O T E

DATE: 20-Mar-1997 08:25pm

TO: Alexander Preker (ALEXANDER PREKER@A1@WBWASH)

FROM: Anne Tinker, HDDHE (ANNE TINKER@A1@WBHQB)

EXT.: 33683

SUBJECT: RE: SSP Comments from Althea Hill

Alx, there has been a tension all along as to whether this is a health or broad HNP paper. I think it would clarify the issue, since its got to be short and is aimed at the health sector, to have a para up front recognizing the important aspects of pop and nut and stating that they are not going to be the subject of the paper because of its focus on the health sector.

CC: EDNA JONAS (EDNA JONAS@A1@WBHQB)
CC: TOM MERRICK (TOM MERRICK@A1@WBHQB)
CC: EDUARD R. BOS (EDUARD R. BOS@A1@WBHQB)

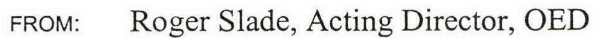
THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: March 20, 1997

TO: Mr. Richard Feachem, HDDHE

FROM: Roger Slade, Acting Director, OED



EXTENSION: 8-1293

SUBJECT: **HNP Sector Strategy Paper: OED Comments on White Cover Draft**

1. The paper appropriately focuses on the institutional constraints to effective health services delivery in developing countries. It further identifies financing mechanisms and incentive arrangements, including the public/private balance, as areas where the Bank can make valuable and perhaps unique contributions to the policy dialogue. We endorse that emphasis, but we believe more precision is necessary to achieve the "paradigm shift" that the paper recommends.

2. The paper usefully focuses on the institutional dimensions of health policy, centering on defining and then achieving an appropriate role for government in the sector. In its current form, the paper seems to emphasize the notion of government failure in service provision, without sufficient recognition of the many trade-offs that need to be considered in identifying or implementing policies designed to overcome these failures. Ultimate choices will ideally be determined through the democratic process, but political influence from stakeholders is inevitable.

3. Nor does the paper emphasize that the optimal way to modify the public/private balance depends heavily on local context, including the regulatory and legal capacities of governments, traditions of medical professionals, and the strengths and weaknesses of the private sector. Any one of a variety of arrangements (outright privatization, subsidies to demand, changing the incentives of civil servants) might be the most desirable in a given country.

4. Two experts in the field, both of whom are friendly to markets, are eloquent on this point. George Schieber writes: *"Developing countries looking to the OECD countries for models of health care financing are faced with what appears to be four basic models: a national service approach, a social insurance approach, a provincial government health insurance approach, and a private insurance approach. Yet, the health care financing of each OECD country is exceedingly complex, highly country-specific, and every country is really a combination of these models. Indeed, arguably, the models themselves are unimportant."* And Alain Enthoven, one of the inventors of "managed competition" in the health sector, argues: *"Each country's health care system reflects intimately its own history, culture and political, social and economic systems. One*

country cannot simply 'adopt' another's health care system and reasonably expect success."

5. We think the paper's arguments regarding institutional issues are best expressed in specifics, not in the abstract. Future drafts might make a more deliberate effort to sketch out what is, and what is not, empirically demonstrated about the development effectiveness of alternative mixes of public and private responsibility in the sector. Work on OED's HNP study suggests that the unknowns far outweigh established facts on these issues. Moreover, OED's study indicates that the Bank's own project experience with the design and implementation of alternatives to public provision is strikingly thin. A future draft of the strategy might turn this gap in our knowledge base into a virtue by being more explicit about the need to take a "learning by doing" approach to the evolution of policy and inviting our clients to become more active participants in the process of defining and experimenting with alternative institutional arrangements in the sector.

6. OED's ongoing review of experience in HNP suggests that, as in other sectors, political commitment is critical for the success of specific investments, but that it is an especially difficult variable to identify and analyze. It would be useful for future drafts of the paper to be more explicit about how the Bank might better equip itself (through additional staff skills, partnerships with local actors, more participatory approaches to sectoral policy analysis, and investment design) to both understand and employ the politics of the sector to achieve health policy goals. Achieving a shift in the role of government in the sector will place heavy demands on a relatively weak area of Bank capacity, as reflected in the performance record of past projects. More than two-thirds of the 62 completed HNP projects reviewed in the preparation of OED's ongoing study of HNP reported significant problems in achieving institutional change and in capacity building. Evidence of difficulty in improving public provision of services would suggest some need for caution in arguing that governments will be better able to regulate and guide nongovernmental action in the sector.

7. Although Section IV of the paper reviews trends in the volume and objectives of the Bank's HNP portfolio, it provides little discussion of how effective this lending has been "on the ground." The problem of defining and then measuring development effectiveness in this sector is a major challenge, not only for OED, but also for the HNP strategy. The current draft of the paper suggests criteria to assess health system performance (which are consistent with the approach being taken in the OED study), but it does not discuss the relevance of these criteria for assessing the development effectiveness of Bank activity in the sector. Although the "HNP Development Diamond" is a useful step toward developing national level indicators of sectoral performance, the paper doesn't yet provide a framework for judging the development effectiveness of specific investments or policy dialogue. The statement on page 52 that benchmarks for developing a set of indicators are "to be developed" is encouraging, but plans for evaluating the overall HNP strategy and the particular form it takes in specific countries should receive greater attention.

8. To ensure that our clients become active participants in the learning process, we suggest that the paper highlight the Bank's role in helping client countries develop greater capacity to evaluate health policy. There is scope for recommending more specific attention to this issue in the context of specific investments. It would be useful to draw a link between the need for greater monitoring and evaluation capacity and the feasibility/desirability of pursuing innovations such as the "pilot project facility."

9. The paper's vision for the Bank as a "knowledge broker" in the sector is welcome and appropriate in the context of the new Bank. As noted above, however, this draft reports little on the Bank's own record of achievement as measured by "results on the ground."[1] In the past, we have tended to undervalue evaluation as well as dissemination of the lessons learned through our projects, although this pattern is clearly changing through the activities of the HNP Board. Given the large scale and wide variety of lending that has occurred, it would seem logical to extend the "knowledge broker" recommendation to include more deliberative, participative work with borrowers to evaluate our efforts during and after implementation. Involving borrowers more actively in the process of sharing "lessons learned" also would contribute to greater accountability (a necessary companion to the more flexible and comprehensive lending approaches the strategy recommends) and create incentives for more vigorous evaluation efforts. More attention to this matter in the report is desirable.

cc: Messrs./Mmes. Picciotto (DGO); de Ferranti (HDDDR); Preker (HDDHE); Biderman (OPRPG); Stout, Gauri, Johnston, Raney (OEDD1)

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[1] Sixty percent of evaluated HNP projects are rated as satisfactory.

A L L - I N - 1   N O T E

DATE: 07-Apr-1997 06:51pm

TO: ALEXANDER PREKER (ALEXANDER PREKER@A1@WBWASH)

FROM: Logan Brenzel, HDDHE (LOGAN BRENZEL@A1@WBHQB)

EXT.: 34983

SUBJECT: Comments on the Draft SSP

As I mentioned, I have a few comments on the draft Sector Strategy Paper which may or may not be useful to you at this point.

Executive Summary

1) Does the word "population" also include reproductive health? You may wish to make a footnote up-front that reproductive health includes population activities.

2) Regarding the Bank's new role as a Knowledge Broker: do we have the skills mix necessary in the sector now for promoting an aggressive research agenda? and what exactly does out-sourcing the HNP research agenda mean? What role will the DEC have?

3) It seems to me that one of the prerequisites to using new approaches in the sector for lending is having adequate and timely ESW. In a climate of diminishing resources, how will this be ensured?

Section I:

1) Under origins of good health and illness, you may wish to mention that education for girls has the effect of delaying age at marriage, thereby reducing marital fertility rates.

2) Under impact on quality of life and productivity, the fourth paragraph starts out by discussing declining youth dependency ratios, but ends up discussing ratios from aging. This was confusing to me.

3) Under Inadequate Resources: I thought the minimum for a basic package was $12 per capita rather than $10. Perhaps Annex 2 will explain.

4) One point which needs to be raised is that because an intervention is cost-effective, does not mean that it is necessarily affordable, particularly in countries with very large population sizes.

5) The HNP Sector has a lot to learn from the social protection literature and sector on targeting. Would it make sense here to recommend that we need to measure the effectiveness and efficiency of our targeting efforts? I think there is a lot of rhetoric about targeting the vulnerable and the poor without much quantitative analysis to support claims in the HNP Sector. We may have some misconceptions in our sector about who the poor and vulnerable really are, and generalizations probably do not enhance effectiveness of projects. For instance,

the middle-class may be "vulnerable" to changes in government policies which restrict subsidies or raise taxes on imports, etc., which may have adverse health outcomes. In Pakistan, less than 2% of the population uses the rural, public health system, with most of the poor using traditional or private sector providers, including quacks.

<u>Section II:</u>

1) The section on reproductive health could be strengthened. Would it be possible to mention the relationship between good maternal outcomes and infant and child health as an example of investment in human capital. The use of the term "grotesque" in the box on FMG seems out of place and quite strong.

2) The box on Reproductive Health and Cairo: the last paragraph needs to be integrated better into the text.

3) Under Improving Performance: what about improving the quantity and quality of the manpower which works in the HNP sector in developing countries? This is often one of the major constraints to implementation, particularly in low-income countries.

4) There is a lot of focus in the document on the 3rd wave of privatization, but could you describe the first and second waves more. I think there are many countries which are in these stages.

5) One issue which is implict but not directly stated is the role of "incentives" in the health sector. I agree that a government that cannot provide the right incentives for public sector provision may have difficulty in regulating or controlling private sector provision of the right mix of HNP services at an acceptable level of quality. Could we focus more attention in our work in the sector on helping governments to get the incentives right?

6) Under Securing Sustainability: For countries which cannot afford the basic package, it seems to me that donor assistance will play a substantial role in the financing of these services. From a public finance perspective, user charges should only be relevant for the essential clinical care portions of the basic package. User charges also tend to have a limited role in overall health care financing. Further, cost recovery systems can be associated with cost escalation, at they create incentives for providers to over-prescribe in order to generate needed revenue, particularly in a financially decentralized system. Finally, user charges may be a regressive policy for certain population groups, if means testing, etc. are not successfully employed. Perhaps you could mention that the objective of mobilizing resources through user charges and community financing schemes should not be at the expense of other objectives, such as equity and efficiency in the sector.

7) Under Evolution in the Lending Portfolio: specific, targeted interventions do not only focus on the poor. For instance, HIV/AIDS prevention programs usually target wider population groups.

8) Do we know why the Bank's lending is not reaching the intended target groups (poor and vulnerable)? How much is due to these groups not being appropriately targeted or effectively targeted? How much is due to the difficulty of means testing and implementing targeting programs? How much is related to systemic and

political reasons, or insufficient knowledge about the health-seeking behavior of beneficiaries?

9) I would be interested to see the results of Annex 3 if possible.

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CC: Anne Tinker (ANNE TINKER@A1@WBHQB)