HNP Retreat 4

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Welcome to the SAS Retreat Part III

Scenery: Blue Ridge Mountains

Atmosphere: Tranquil, picturesque and breath-taking

Objective: To create, with ease, an excellent end-product

The scene is set and the time has arrived for you to make it happen! We have consulted the best around the region and have taken all measures to ensure an atmosphere that will stimulate creativity and productivity.

You are here to work - every minute counts. Stay focus and commit to do your best and your objective will be met with ease, thereby, conquering the task ahead.

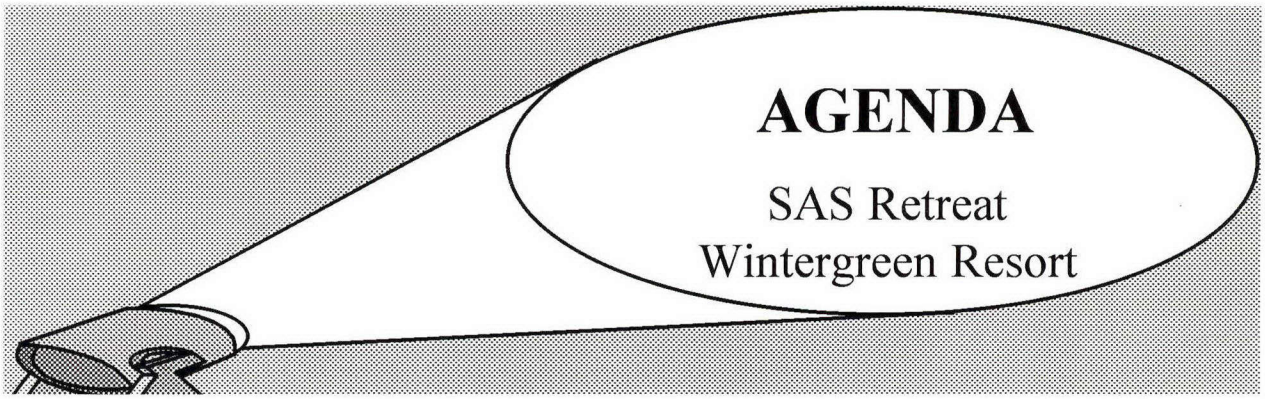
Again,

W E L C O M E !!

Sancta Watley
SAS Retreat Coordinator

HOUSE RULES

- Emergency messages will be accepted by Wintergreen conference services at **(804) 325-2200 ext. 9960** and delivered to the meeting room.
- Lodging and meals are covered on the master account, however any personal charges (e.g.. incidentals, etc..) must be paid with cash or credit cards.
- Tips are included in the total package price.
- Staff support will be available during the hours of **8:00am - 9:30pm**.
- All faxes and copies must be directed to Yvette Atkins or Sancta Watley
- It is advisable to make dinner reservations in order to expedite service.
- All individual accounts must be cleared upon check out.
- Please make arrangements for an early check-out at the front desk, if possible, before the final session.
- Please direct all concerns/problems or inquiries to Yvette or Sancta, your SAS Assistants.



Monday 2/10

Session 1	2:00pm	**Core Team Discussion on White Cover**

Tuesday 2/11

Session 2	9:00am	**continued**
Session 3	2:00pm	**continued**

Wednesday 2/12

Session 4	**WRITING ASSIGNMENTS**

Thursday 2/13

Session 5	9:00am	**Regional Discussion on White Cover**
Session 6	2:00pm	**continued**

Friday 2/14

Session 7	9:00am	**continued**

RESTAURANTS AT A GLANCE

Five full-service restaurants:

- Cooper's Vantage (casual dining)
- The Copper Mine (continental cuisine)
- The Garden Terrace (casual dining)
- The Rodes Farm Inn (country, family style meals)
- The Verandah (continental cuisine)

Three lounges:

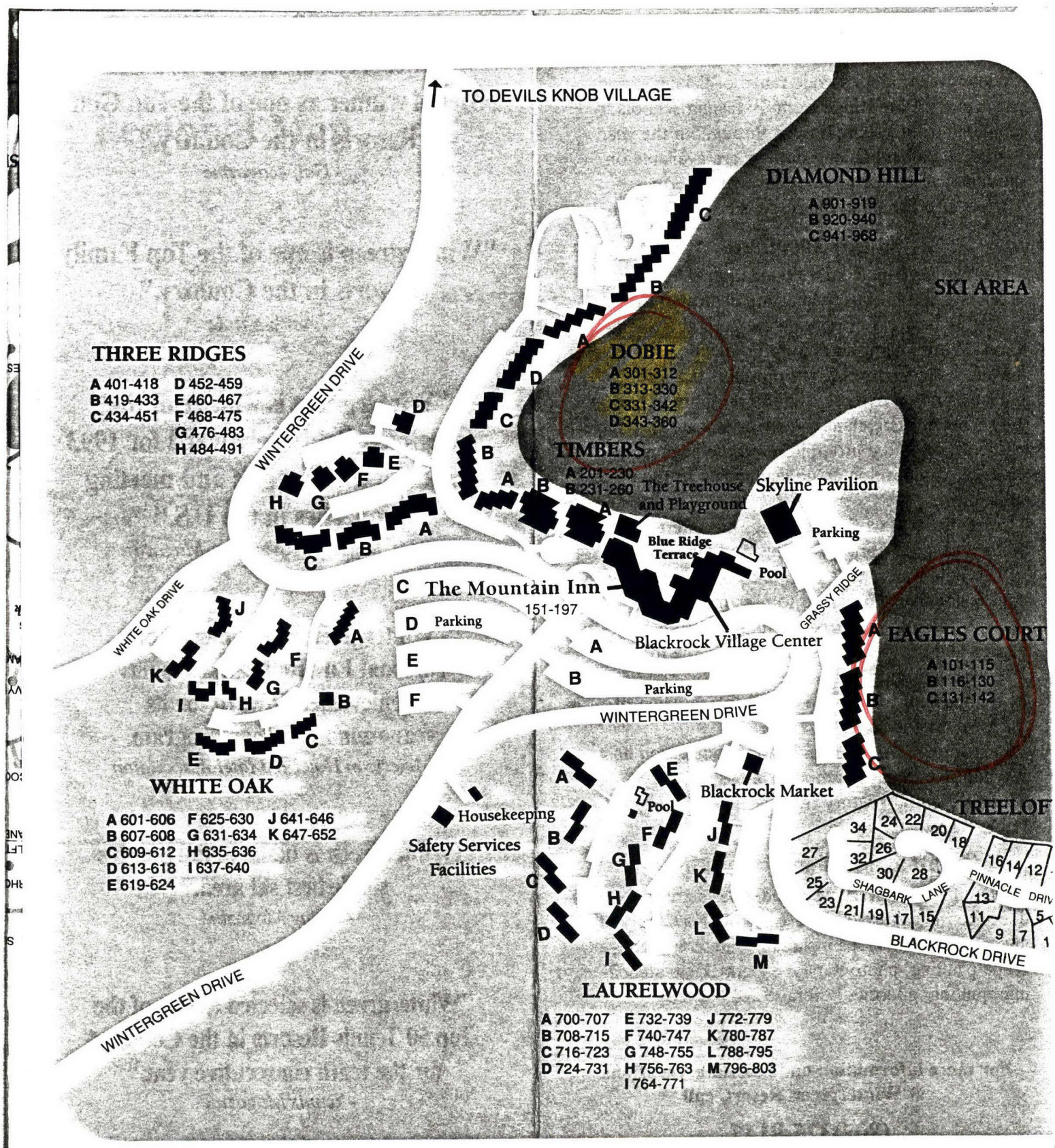
- Cooper's Vantage Lounge (live entertainment)
- The Garden Terrace Lounge
- The Copper Mine Lounge
- The Gristmill Cappuccino Bar

Seasonal Restaurant:

- Prvors Cafeteria (ski season)

ROOMING LIST

	Name of persons per bedroom	Arrival	Departure	Location	Unit No.	Extension
1.	Richard & Zuzana Feachem	Sat. 2/8/97	Thur. 2/13/97	Eagles Court	120	7120
2.	Alexander Preker	Sun. 2/9.97	Fri. 2/14/97	Dobie	335	7335
3.	Sancta Watley	Sun. 2/9/97	Fri. 2/14.97	Timbers	253 114	7253
4.	Yvette Atkins	Sun. 2/9/97	Fri. 2/14/97	Inn	170	7170
5.	Said Saidi	Sun. 2/9/97	Wed. 2/12/97	Inn	164	7164
6.	Dean Jamison	Mon. 2/10/97	Wed. 2/12/97	Timbers	247	7247
7.	George Schieber	Mon. 2/10/97	Fri. 2/14/97	Timbers	217	7217
8.	Prabhat Jha	Mon. 2/10/97	Fri. 2/14/97	Timbers	207	7207
9.	Mariam Claeson	Mon. 2/10/97	Mon. 2/17/97	The Ridge	1420	1420
10.	William Mc Greevey	Mon. 2/10/97	Fri. 2/14/97	Timbers	223	7223
11.	Ed Bos	Mon. 2/10/97	Fri. 2/14/97	Timbers	241	7241
12.	Vivian Hon	Mon. 2/10/97	Fri. 2/14/97	Timbers	249	7249
13.	Akiko Maeda	Mon. 2/10/97	Fri. 2/14/97	Timbers	243	7243
14.	Judith McGuire	Mon. 2/10/97	Fri. 2/14/97	Eagles Court	125	7125
15.	Anne Tinker	Mon. 2/10/97	Fri./ 2/14/97	Eagles Court	102	7102
16.	Susan and June Sebastian	Tues. 2/11/97	Thur. 2/13/97	Timbers	224	7224
17.	Tom Merrick	Mon. 2/10/97	Wed. 2/12/97	Timbers	238	7238
18.	Davidson Gwatkin	Mon. 2/10/97	Wed. 2/12/97	Timbers	206	7206
19.	Ed Elmendorf	Wed. 2/12/97	Fri. 2/14/97	Timbers	244	7244
20.	Verdon Staines	Wed. 2/12/97	Fri. 2/14/97	Timbers	246	7246
21.	Xavier Coll	Wed. 2/12/97	Fri. 2/14/97	Timbers	247	7247
22.	Daniel Cotlear	Wed. 2/12/97	Fri. 2/14/97	Timbers	238	7238
23.	Sandy Lieberman	Wed. 2/12/97	Fri. 2/14/97	Timbers	256	7256
24.	Gail Richardson	Wed. 2/12/97	Fri. 2/14/97	Inn	220	7220
25.	Regina Bendokat	Wed. 2/12/97	Fri. 2/14/97	Timbers	226	7226
26.	Salim Habayeb	Wed. 2/12/97	Fri. 2/14/97	Timbers	242	7242


TO DEVILS KNOB VILLAGE
DIAMOND HILL
A 901-919
B 920-940
C 941-968
SKI AREA
THREE RIDGES
A 401-418 D 452-459
B 419-433 E 460-467
C 434-451 F 468-475
G 476-483
H 484-491
WINTERGREEN DRIVE
DOBIE
A 301-312
B 313-330
C 331-342
D 343-360
TIMBERS
A 201-230
B 231-260
The Treehouse and Playground
Skyline Pavilion
Parking
Blue Ridge Terrace
Pool
C The Mountain Inn
151-197
D Parking
E
F
A
B
Parking
Blackrock Village Center
GRASSY RIDGE
EAGLES COURT
A 101-115
B 116-130
C 131-142
WINTERGREEN DRIVE
WHITE OAK DRIVE
WHITE OAK
A 601-606 F 625-630 J 641-646
B 607-608 G 631-634 K 647-652
C 609-612 H 635-636
D 613-618 I 637-640
E 619-624
Housekeeping
Safety Services
Facilities
Pool
Blackrock Market
TREELOF
SHAGBARK LANE
PINNACLE DRIV
BLACKROCK DRIVE
WINTERGREEN DRIVE
LAURELWOOD
A 700-707 E 732-739 J 772-779
B 708-715 F 740-747 K 780-787
C 716-723 G 748-755 L 788-795
D 724-731 H 756-763 M 796-803
I 764-771

Ken Idd

→ Alex

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

DATE: 12-Feb-1997 06:15pm

TO: Richard Feachem (RICHARD FEACHEM)

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

EXT.: 38729

SUBJECT: **RE: Travel to Wintergreen, Va, March 20-24**

Richard,

All this time at retreats -- TWO now at Wintergreen and one at Harper's Ferry last summer -- could come to the attention of someone who might ask some probing questions about how much it all costs.

Could an estimate of the total cost for these retreats please be sent to me. Better to know in advance than to get caught unawares. Especially as we are emphasizing how poor we are as a Network and a support unit.

Also, could someone (Khanh?) update me on the HNP Group's spending/budget for this fiscal year. We will not be able to overrun in any Group. If we get any more money -- and that is a big if -- then we really owe it to the Network to use it for actions in the Regions.

By the way, if you went to Coolfont instead of Wintergreen in March, you could use up the money that Diana committed to them last year for a Departmental retreat -- and that we never used. That would save a lot of money.

CC: Helen Saxenian (HELEN SAXENIAN)
CC: Lac Khanh Truong (LAC KHANH TRUONG)
CC: Diana Walker (DIANA WALKER)

→ Good idea

Alex, please follow-up.

→ 2

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

DATE: 03-Feb-1997 03:42pm

TO: See Distribution Below

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: "Dirty" White Cover Draft of SAS and Meeting on Thursday

I am circulating this afternoon the dirty White Cover draft of the SAS. Although this document is already very rich in material, I would like to emphasize that it is still about 2 weeks from the more polished White Cover which we will distribute prior to the Bank-wide White Cover review meeting later in February. The purpose of asking you to have a brief look at this draft for discussion on Thursday is to allow you to provide me with some preliminary inputs which can be taken into consideration during next weeks regional consultations and redrafting.

The most useful feedback on Thursday will be if your were able to give a quick first impression of the overall thrust of the document (main story line and some of the central messages) based on a very broad brush read the current version. I would strongly discourage anyone from spending a lot of time preparing detailed editorial comments at this time, although such feedback would be appreciated at the White Cover and Yellow Cover Review stages.

As agreed at the time of the regional meetings in January, I have made failing government health services a consistent theme throughout the document. The SAS argues that although governments have and will continue to have both a legitimate and essential role in the health sector the time has come to get serious about addressing the unacceptable poor performance of central government-run health care delivery systems.

The solution proposed, which is consistent with many other Bank documents, is to get central governments out of the business of providing direct services to the population by:

. supporting the creation of a better facilitating environment for local communities, NGOs and the private sector to become much more active in service provision (a more aggressive "third wave" privatization strategy); and

. strengthening other areas of government involvement in the health sector providing information, providing public goods (such as public health activities), regulating other activities (especially countering the effects of market

failure but without crowding out the private sector), organizing financing (mandates or direct public financing such as social insurance) and protecting the poor (mainly through targeted subsidies although occasionally this may also involve limited public production).

The paper goes on to argue that, although in the past there has been a lot of discussion about such a strategy, this is not fully reflected in the current Bank portfolio or proposed pipeline for the next three years. Very few project directly support setting up a private sector "friendly" environment (if anything, many of our project are even hostile to the private sector and surprisingly (at least I was surprised), contrary to common belief, the relative share of the portfolio devoted to capacity building has dropped by nearly 50 percent during the past three years.

Although it is possible that the latter observation reflects how we analyzed the portfolio (some capacity building activities activities are now hidden in the new broader reform projects, we need to do some more analysis before I would be able to confirm this).

The following provides a roadmap for the document which you will receive. It is in four separate Sections:

Section I - Sector Background and Future Development Challenges

Section II - Reform in the Role of the State and Future Global Policy Directions

Section III - Rationale for Bank Involvement and a Review of the HNP Portfolio

Section IV - Proposed Assistance Strategy

The annexes are not included at this time but I will bring a draft sample of some of the sections on Thursday for you to have a quick look at.

Proposed Agenda for Thursday's meeting

On Thursday, I suggest we:

. Agree on the general thrust of the document;

. Decide on concrete modification which could usefully be done next week with inputs from the regions before going public with the White Cover; and

. Discuss additional background work which may need to be initiated before moving to a Yellow Cover version in March.

DISTRIBUTION:

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TO:	BARBARA K. HERZ Rm: T 8-045	(BARBARA HERZ @A1@WBHQB)
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TO:	SANCTA WATLEY	(SANCTA WATLEY @A1@WBHQB)
TO:	YVETTE ATKINS	(YVETTE ATKINS @A1@WBHQB)
TO:	LAURA SHRESTHA	(LAURA SHRESTHA @A1@WBHQB)

WHITE COVER

Sector Assistance Strategy (SAS)
Health, Nutrition and Population (HNP) Sector

Section I

Sector Background and Development Challenges

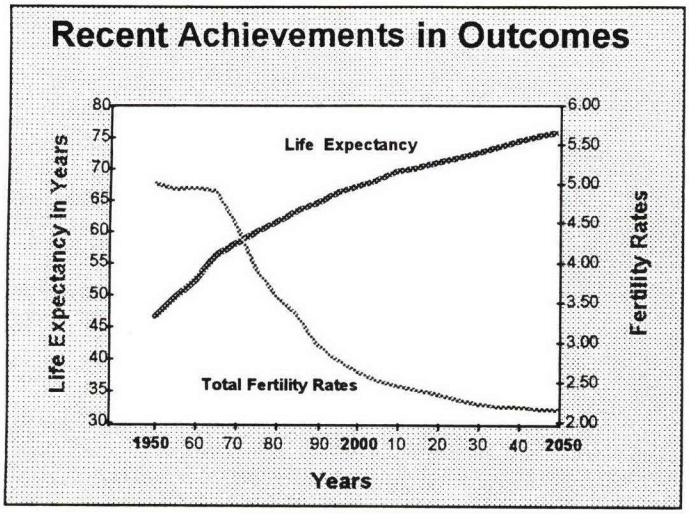
HNP Family
Human Development (HD) Network
World Bank

January 31, 1997

SECTION I: SECTOR BACKGROUND AND DEVELOPMENT CHALLENGES

IMPRESSIVE RECENT GAINS IN OUTCOMES

Advances that have occurred in health, nutrition and population outcomes during the past few decades are impressive. For example, as we approach the turn of the second millennium, it is remarkable to realize that over half of the gains in life expectancy of the past two thousand years occurred during this century, while fertility rates dropped significantly (see Figure *** below).



As described by the World Health Organization (WHO) in its *1996 World Health Report*, hundreds of millions of people in developing countries are on the threshold of a new era in which they will be safe from some of the world's most threatening diseases.

The *1996 State of the World's Children*, by the United Nations Children's Fund's (UNICEF), gives vivid examples of how recent changes in knowledge and policies have dramatically changed the quality of children's lives. The proportion of children who now die before reaching age 5 is less than half the level in 1960. There has been a 20 percent reduction in child malnutrition rates. Immunization saves an estimated 3 million children's lives from the six major childhood diseases annually. Better control of diarrhea saves over one million a year.

The number of children born per women of childbearing age is a third below what it was in 1960. Population growth rates are slowing. Improvements in access to family planning, such as the increase in contraceptive use from 10 percent of married couples in the mid-1960s to 53 percent in 1990, have facilitated this trend.

The Origins of Good Health and Illness

Several factors influence the great variability in health status which is observed across population groups:

- economic status and poverty;
- education, especially of women;
- cultural and social behavior; and
- health care and medical interventions.

Progress in understanding the interconnections between these determinants of good health and illness has made a major contribution to recent improvements observed in health, nutrition and population outcomes.

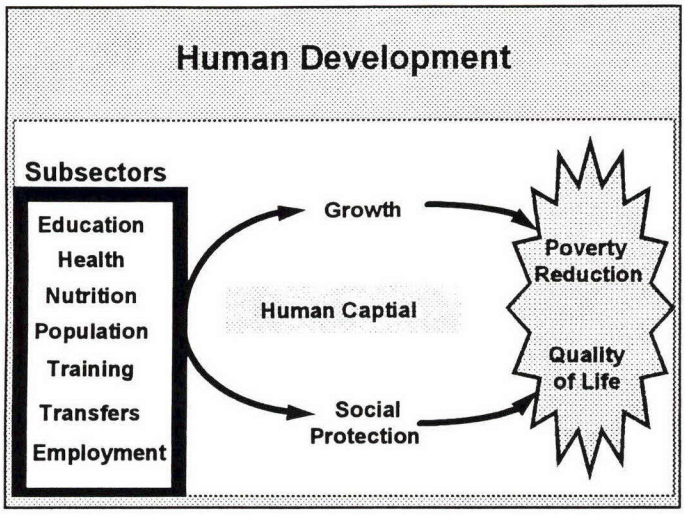
Income levels and reductions in poverty — with their consequences for adequate food, better housing and access to clean water, satisfactory sanitation, primary education and basic health care — remain the most powerful determinants of good health.

Likewise, education — especially in the case of women — operates through multiple channels. Educated individuals lead healthier lifestyles, learn to make a more efficient use of scarce resources such as food and health care, and avoid excessive exposure to the health risks caused by tobacco, alcohol and illicit drugs.

Finally, public policies that promote healthy environments and lifestyles, and the use of effective health care also contribute to better outcomes. People fall ill and die at all levels of income and education. It is health services that have to prevent or deal with the consequences even when the underlying causes lie elsewhere.

Impact on Income, Poverty and Quality of Life

Effective programs for infectious disease control, nutrition and reproductive health enhance workforce productivity, reduce disease-related poverty, improve children's learning in school and contribute to overall quality of life. These arguments for investing in health, nutrition and population are well known (see Figure ***):

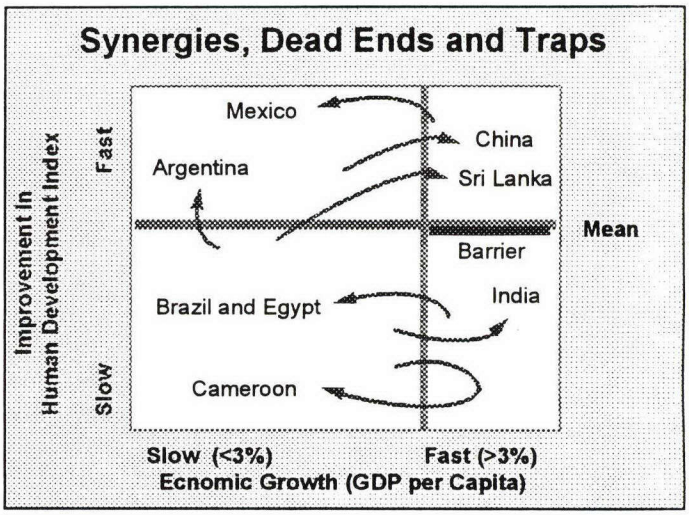


Through a 30 year review of economic growth patterns, *1996 Human Development Report* by the United Nations Development Program (UNDP), demonstrates how no country has ever achieved sustainable growth without improving human development in parallel to economic development.

So far, only those countries which simultaneously crossed a critical threshold in human development were also able to sustain economic growth. All countries that underwent periods of rapid economic growth without parallel improvements in human development ended up slipping back to lower growth rates.[1]

Economic growth must be associated with reductions in income differentials and investments in health, education, the status of women, social protection, the environment and labor markets to secure sustained economic growth.

Without investments in the social sectors, the usual links between economic growth and human development fail — in some countries, despite significant economic growth, little human development or poverty alleviation will occur; in other countries, achievements in human development will not reap the expected benefits in terms of economic growth (see Figure *** below).



In addition to concerns about quality of life and poverty, there are also compelling fiscal reasons for government and Bank involvement in the HNP sector.

The health sector consumes about US$1.7 trillion or 8 percent of world income, making it one of the largest industries in the global economy. Ensuring value for money spent on health care has significant implications for the entire economy.

Well regulated community-based services can stimulate private sector development and improve equity in access to health services. Well designed national health insurance programs have re-distributional effects in addition to the social protection they provide.

Effective cost-containment programs in the HNP sector contribute not only to a more efficient use of scarce resources, but also to better fiscal control over public expenditure. Likewise, excessive or inappropriate spending has an enormous potential negative impact on overall economic growth and resources available for education and other social programs that contribute significantly to economic growth, poverty reduction and the quality of peoples lives.

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[1] The Human Development Index used for this analysis is a composite indicator which combines achievements in human development under three dimensions — life expectancy, educational attainment, and income levels.

FUTURE CHALLENGES AND OPPORTUNITIES

To preserve past gains and address future threats to health in an effective way, policy-makers in developing countries face a number of difficult challenges caused by the continually changing external environment, patterns of illness and effectiveness of health care interventions. The following have significant future policy implications:

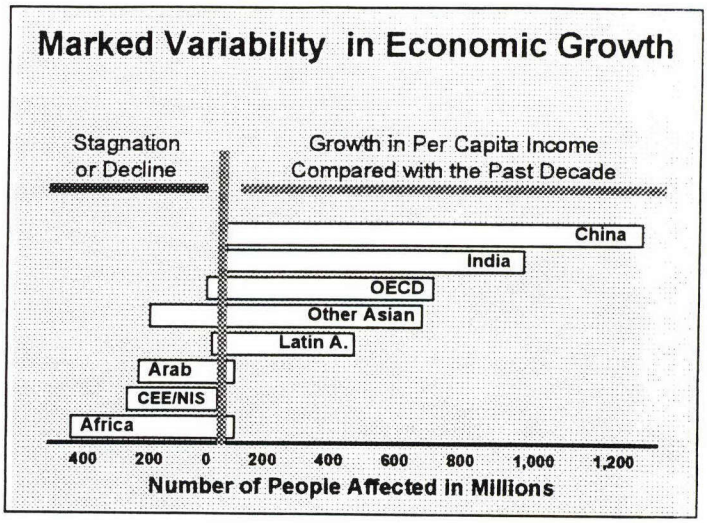
- continued poverty and malnutrition;
- other global trends and transitions;
- changing patterns of global disease burden;
- marked variability in the performance and cost of health care delivery systems.

Continued Poverty and Malnutrition

Although the world is richer today than it has ever been before, and basic levels of education have improved significantly, the world has become increasingly polarized in terms of economic development during the past thirty years.

In some countries, the economic growth that has occurred since 1980 (affecting 1.5 billion people, or more than a quarter of the world's population, in 15 countries) surpasses anything seen since the start of the industrial revolution two centuries ago. The OECD, China, India and other Asian countries have benefited from this trend.

But, another 1.6 billion people in 100 other countries experienced the effects of unprecedented economic stagnation and decline that, in some cases, far exceeded in duration and depth the Great Depression of the 1930's of the industrialized world. People in Sub-Sahara Africa, many Arab States, and Eastern Europe suffered the effects of this trend. In 70 of these countries, average income today is less than it was in 1980 and in 43 countries it is less than it was in 1970). These differences in economic growth are seen in Figure *** below.



Based on past trends, global production will triple by about 2030. Once again, although there will be a significant overall increase in resources available to human development (including health, nutrition and population programs), the benefits will not be shared equally. Projecting current trends indicates that:

- Per Capita income in the OECD could increase to nearly US$40,000;
- Some East Asia countries could catch up to OECD levels by 2030, China by 2040 and India by 2090; but
- Per Capita income in Sub-Sahara Africa could drop to below US$325.

The implications of this variability in economic growth are enormous in terms of the number of people who will continue to live in extreme poverty and the resources which will be available to health, nutrition and population programs. In the case of low-income countries, or those that anticipate future economic stagnation, improving outcomes at low cost will be critical. And in the case of middle-income countries, or those that anticipate future growth, protecting past gains will be equally important.

Nutrition Status in Zimbabwe:
A Sentinel Beacon for Poverty and Health

Nutrition status has in the past provided a powerful sentinel beacon for poverty, potential educational status and multi-sectoral causality of poor health in Zimbabwe — remaining healthy or reaching a high educational attainment was difficult for those who were malnourished.

This synergistic relationship between malnutrition and childhood infections is well known. Diseases caused by intestinal parasites or infections adversely affect nutrition and malnutrition increases the risk of diseases. Poor nutrition correlates with cognitive dysfunction in children, poor reproductive health, productivity and chronic adult diseases.

The Zimbabwe Second Family Health Project is an excellent example of how a well designed program can intervene in this process, even under difficult circumstances. The principal nutrition components of this program include community-based growth monitoring activities, promotion of correct breast feeding practices, iodine deficiency control, and school health and nutrition activities. In addition, there is a supplementary feeding component for periods of drought.

Zimbabwe is fortunate to have a rich network of community groups which have proven to be an invaluable mechanism for delivering many of the nutrition activities in terms of information and education. On the more formal side, "baby-friendly" hospitals are promoting good breast feeding practices, following guidelines for weaning foods and monitoring the Code of Marketing for Breastmilk Substitutes.

The Zimbabwe experience has provided many valuable lessons. To improve nutrition requires addressing poverty, getting fiscal and agricultural policies right, improving attention to food (production, pricing, subsidies, processing, trade, etc.), and increasing education, physical exercise and appropriate reproductive health, in addition to providing effective health services.

Other Global Trends and Transitions

A number of other global trends will have a significant impact on health, nutrition and fertility during the next few years. These include:

- demographic and health transitions;
- social transformations and political turmoil;
- technological advances and global integration.

Demographic and Health Transitions

Many of the changes in disease patterns which have been observed during the past century in developing countries relate to changes in health status **(health transition)** as population groups move from high mortality and fertility to low mortality and fertility. The four main engines of the health transition are: (a) a **demographic transition** as populations get older; (b) age-specific risk factors; (c) behavior patterns as individuals choose smaller family size; and (d) access to health services (improved maternal and child health services, and contraceptive choice).

These demographic and health transitions will have a profound impact on health and population outcomes during the next few decades. The health transition will lead to a rise in non-communicable diseases — such as heart disease, cancer, neuro-psychiatric illness, and injuries — and a fall in communicable disease and maternal and perinatal conditions.

Even when fertility declines to replacement levels (close to two children per family), population growth will not immediately drop to zero. Instead, birth rates will continue to outstrip deaths for several decades because of the young population age structure that has resulted from past high fertility rates (***demographic momentum***).

Due to a combination of factors — continued demand for large families, unwanted fertility and demographic momentum — the world's population could double during the next century (increasing from 5.3 billion people in 1990 to over 10 billion by 2100). Almost all of this population growth will occur in developing countries.

The net impact of the demographic and the health transition varies by country. In many countries, especially in the Africa region, a combination of demographic momentum and poor health service access suggest that the high burdens from communicable, maternal and perinatal diseases will continue into the future. Some countries, such as India, have concurrent high burdens from both communicable and non-communicable diseases, or what is termed a *health polarization*.

Social Transformations and Political Turmoil

Finding more effective ways to influence individual and household behavior in a way that leads to healthier lifestyles is an urgent priority for policy-makers in most developing countries. Since many of the behavior changes that have an impact on health, nutrition and fertility happen slowly (in some cases spanning several generations), commitment to clear medium-term policies is an essential prerequisite for improved outcomes.

In many developing countries such policy continuity is often lacking. This is especially true in countries undergoing political and economic turmoil or war. The following examples illustrate this point.

The non violent social transformations that have occurred recently in the transition economies have unleashed an unprecedented wave of changes that have a significant impact on health, nutrition and fertility patterns. In the countries such as Poland, the Czech Republic and Hungary, where economic recovery has begun to occur, health status has improved. In the countries that have experienced a more dramatic economic decline, such as Russia and Asian Republics, reversing the associated downward trends in life-expectancy and infant mortality will not be easy.

Likewise, violent conflicts continue to pose a threat to health, nutrition and population outcomes throughout the world. Since 1945, there have been 149 wars, killing more than 23 million people, maiming countless others and leaving one out of 17 people in developing countries homeless or displaced. On an average yearly basis, the number of deaths due to war since World War II has been more than double the number of deaths in the 19th century and more than seven times the number in the 18th century (UNICEF 1996).

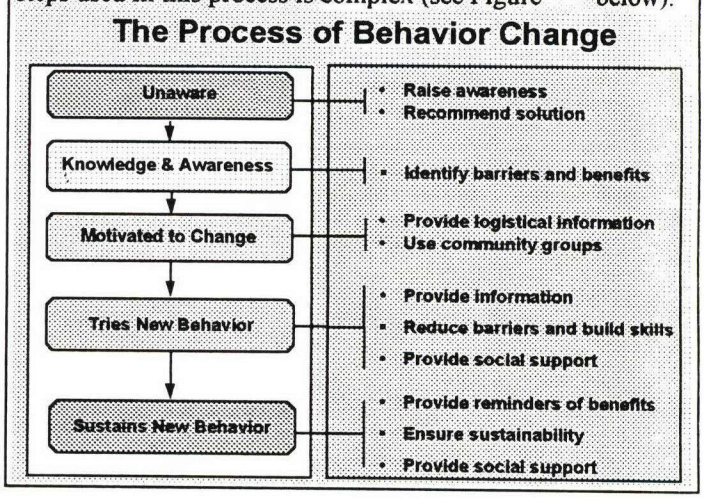
But wars are not the only violent killer. Entire generations have grown up in an environment of brutal internal conflicts due to ethnic strife and genocide. At the end of 1996, Angola has been involved in turmoil for over 30 years, Afghanistan for 18 years, Sri Lanka for 12 years, Somalia for 8 years and Bosnia and Herzegovina for 5 years.

Taking Prevention Seriously in Africa

Many of the most cost-effective public health interventions in Africa — promoting healthier lifestyles, reproductive health and preventing communicable diseases — require behavioral changes, time and complex public and private partnerships across many sectors to work.

For example, through meetings, dramas and informal networks, communities in Botswana, Malawi, South Africa, Tanzania, Zambia and Zimbabwe are teaching the population the use of condoms and quick reporting of sexually transmitted diseases to prevent the spread of many infections (pelvic inflammatory disease, HIV/AIDS and other sexually transmitted diseases) and debilitating conditions (e.g., unwanted and complicated pregnancies, dysfunction and pain, abortions, genital mutilation, etc.)

Various Ministries in Mozambique, Kenya and Uganda are working closely with UNICEF and the Bank in initiating a multi-channeled communication program to promote positive messages about female children. Avoiding alcohol, HIV/AIDS, and the complications of female genital mutilation, and staying in school, are the subjects of stories played on TV, over the radio, on video, and in plays. The steps used in this process is complex (see Figure *** below).



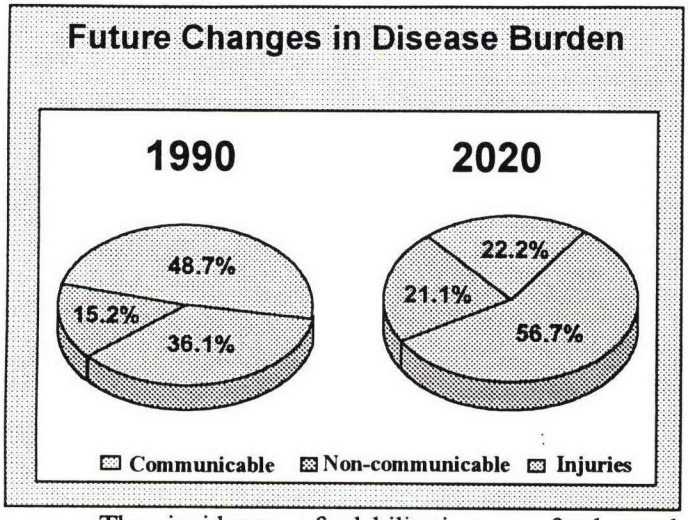
Technological advances and global integration

Fortunately, recent progress (social and natural sciences), and globalization of information, provides a hope that some of the above potentially negative trends will be offset by new and more effective approaches to health, nutrition and population problems which will benefit vulnerable groups in developing countries. To achieve this, health systems must be adapted to the continually changing environment and disease patterns.

Changing Patterns of Global Disease Burden

The *1993 World Development Report: Investing in Health* developed a new method to estimate the global burden of disease in terms of loss of healthy life from about 100 of the most common diseases and injuries.[2] Of the total disease burden in the world, 93 percent is concentrated in developing countries, with nearly 60 percent in Sub-Sahara Africa, India and China alone.

During the next three decades, health patterns, and needed policy responses, will change profoundly. The total global disease burden due to non communicable diseases is estimated to increase from 36.1 percent in 1990 to 56.7 percent in 2020, while that for infectious diseases will drop from 48.7 percent to 22.2 percent during the same time period (see Figure *** below).



The incidence of debilitating or fatal road accidents and self destructive behavior — such as gender-based violence, other interpersonal conflicts, and suicide — continues to rise. Road accidents could become the third biggest cause of disability and death by the year 2020 (comprising 5 percent of the burden of disease).

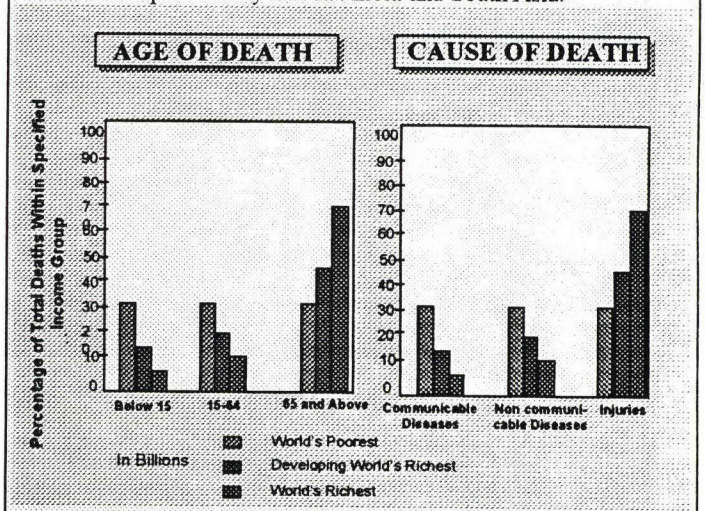
The 1996 *Report of the Ad Hoc Committee on Health Research* by WHO highlights three major challenges which result from changing disease patterns:

- The continued threats to maternal and child health from unwanted pregnancies, unsafe childbirth, low birth weight, malnutrition and childhood illnesses;
- The threat of drug resistance (e.g., tuberculosis, malaria, etc.) and new infections (HIV/AIDS); and
- The emerging epidemic of non-communicable diseases and injuries from increased exposure to risk factors such as tobacco, unsafe roads, violence, etc.

Health of the World's Poorest Billion

When and how do the world's poorest billion die compared with the richest billion? They die ***younger*** and more often from ***infectious diseases*** (see figure *** below).

It is the world's poor who will suffer the most from all diseases, but especially from the old enemies of communicable, maternal and perinatal diseases. Despite major progress in creating access to cost-effective interventions, these diseases still kill more than 12 million children and more than 0.5 million women a year. This remains particularly true in Africa and South Asia.



But poverty also impacts at other stages of the life cycle and from other diseases. For example, people in poor states in India have nearly 50 percent higher probability of death between ages 15 to 60 than those from richer states, often from non communicable disease such as hearth attacks. The current tobacco epidemic is a major contributing factor.

The recent period of economic stagnation and decline in Africa and some other parts of the developing world — and the stubborn persistence of poverty in other regions such as Latin America — has emphasized the fact that poor people remain particularly vulnerable to ill health during periods of economic difficulty and the need to ensure that vulnerable groups have access to basic health services.

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2 The disability-adjusted life years (DALYs) indicator combines healthy life years lost because of premature mortality with those lost as a result of disability.

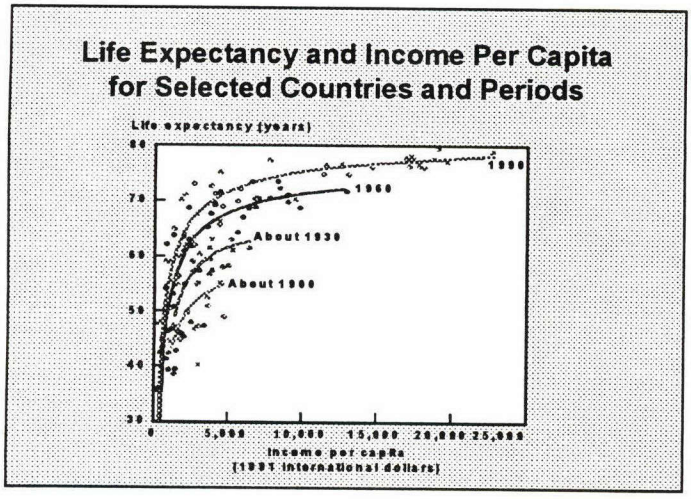
Variability in Performance

The ultimate test of the performance of health, nutrition and population policies, and health care systems, is outcomes at a given level of inputs in terms of costs. Highly performing systems have good outcomes at low cost. Under performing systems have poor outcomes at high cost.

At the same time, the rising cost of health care systems have serious associated fiscal consequences. Several other factors relating to the internal performance of health systems must, therefore, also be examined when trying to assess if a country is getting good value for money spent on health. These include: equity; efficiency and sustainability of financing; equity in access to basic health services; cost-effectiveness of interventions; efficiency of health care delivery systems; and quality and consumer satisfaction.

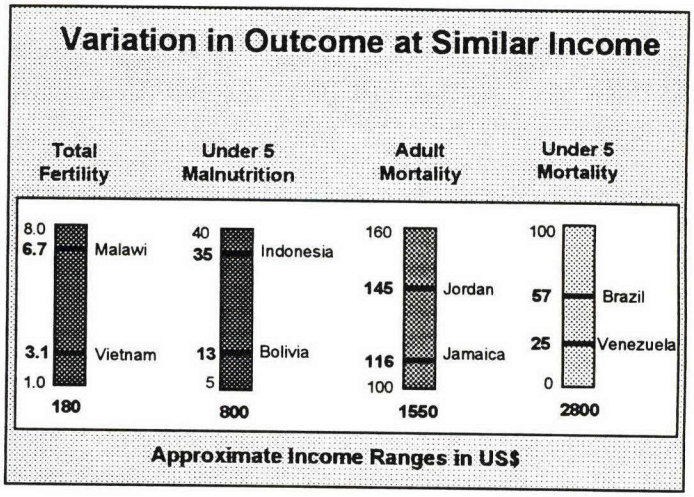
Performance in Terms of Outcomes

In terms of outcomes, people are much better off today than they ever were before. It is true that poverty reduction and basic educational attainment continue to be important. But the generation and use of knowledge about illness and the effectiveness of interventions have also contributed significantly to recent gains in health, nutrition and population outcomes. Citizens of a low- to middle-income country today can expect to live almost a quarter of a century longer, and be healthier during that time, than they would have at similar income and education levels a hundred years ago (see figure ***



Despite these improvements over time, policymakers in many developing countries face some difficult challenges. Even at similar levels of income, education and income distribution, outcomes vary significantly, indicating that factors other than broad socio-economic determinants play a significant role.

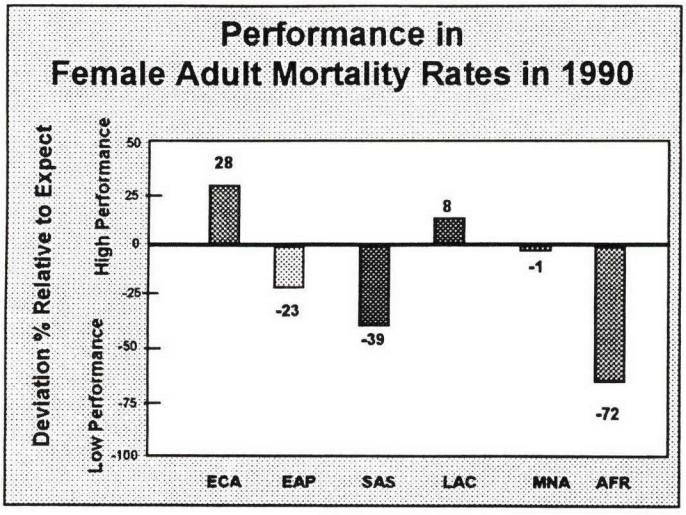
For example, at very low income levels (approximately US$180 per capita), Vietnam performs much better than Malawi in terms of total fertility rates (see Figure *** below); at somewhat higher but still low income levels (approximately US$800 per capita) Bolivia performs much better than Indonesia in terms of under-5 malnutrition; Jamaica outperforms Jordan in adult mortality at lower middle-income levels (approximately US$1,550 per capita); and Venezuela outperforms Brazil significantly in under-5 mortality at middle-income levels (approximately US$2,600 per capita).



For the purpose of this report, a new methodology was developed to assess the performance of a country's health, nutrition and population policies, and basic health care delivery systems, by "factoring out" the effects of broad socio-economic determinants, such as capita national income, primary education levels for women and income differentials (Gini coefficients), that are outside direct influence by HNP interventions.

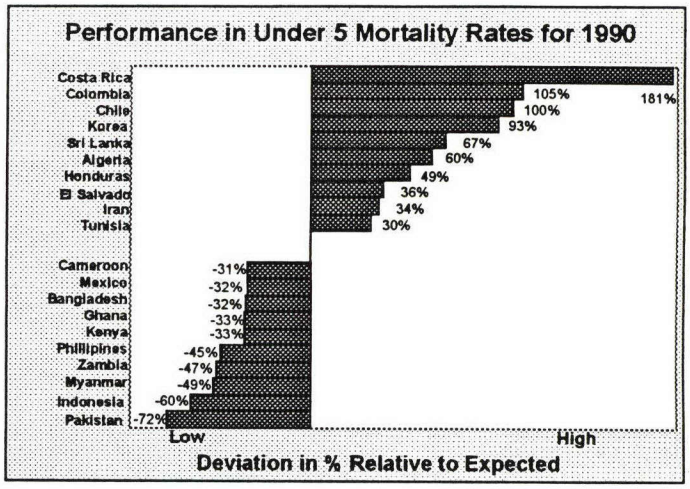
Using this approach, changes in the performance (improvements or deteriorations) of a country's broad HNP policies, and health care delivery system, can be tracked both over time in terms of a number of key outcome measures and relative to other countries.

For example, in terms of adult female mortality rates, the Sub-Sahara Africa region did much more poorly than one would have expected, even after appropriate adjustments are made for its low income levels, poor female educational attainment and income differentials (see Figure *** below).[3] Likewise, although South Asia and much of East Asia have outperformed the rest of the world during the past two decades in terms of economic growth, adult women have not benefited in relative terms from this growth in terms of expected health outcomes.

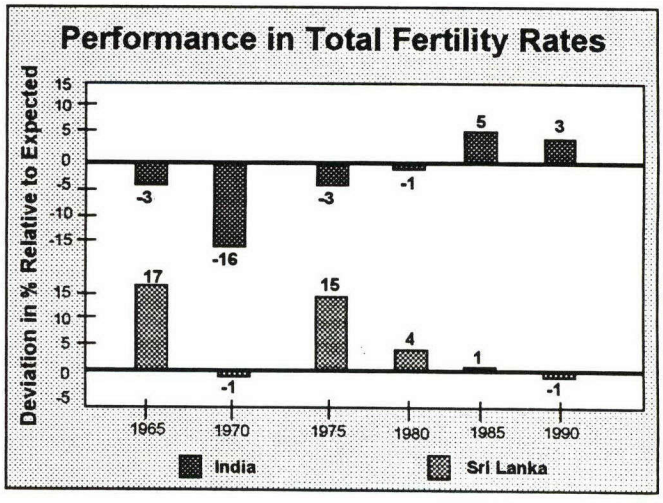


But regional averages hide some significant differences among countries within regions and from one region to another. Ranking the top ten and lowest ten countries in terms of their expected performance in under-5 mortality during the past 30 years, reveals some surprises (see Figure *** below). For example, Costa Rica, Columbia, Chile, South Korea and Sri Lanka come out at the top, while Pakistan, Indonesia, Myanmar, Zambia and the Philippines come out at the bottom.

By disaggregating the performance of individual countries into 5 year intervals during the past 30 years, Annex *** demonstrates how some countries have improved dramatically while others have deteriorated relative to what would be expected during this time period. Understanding the policies and interplay of other factors that contributed to this variability provides policymakers with an indication of where target interventions are likely to have the greatest payoff in terms of improving outcomes.



For example, in India total fertility rates lagged significantly behind the expected levels during the 1960s, only to improve significantly during the 1970s and 1980s. During the same time period its neighbor, Sri Lanka, enjoyed much attention for its above average performance during much of the 1960s and 1970s. Having gone through the demographic transition, its performance is now in the range of what would be expected for its level of income and educational attainment.



[3] Annex *** provides a league table of countries ranked according to their systems performance during the 1960 to 1990 time period in terms of life expectancy, adult male mortality, adult female mortality, under-5 malnutrition and total fertility rates. Comparisons in performance are made on a country by country basis over time, among countries and between regions.

Internal Performance of Health Systems

Developing countries are also getting much better value for money today than ever before in terms of the internal performance of their health systems. A hundred years ago not only was knowledge about effective cures for most illnesses still very limited but there was no scientific basis for assessing other dimensions of the performance of health systems. Despite these improvements, some countries perform extremely poorly and some very significant difference exist in:

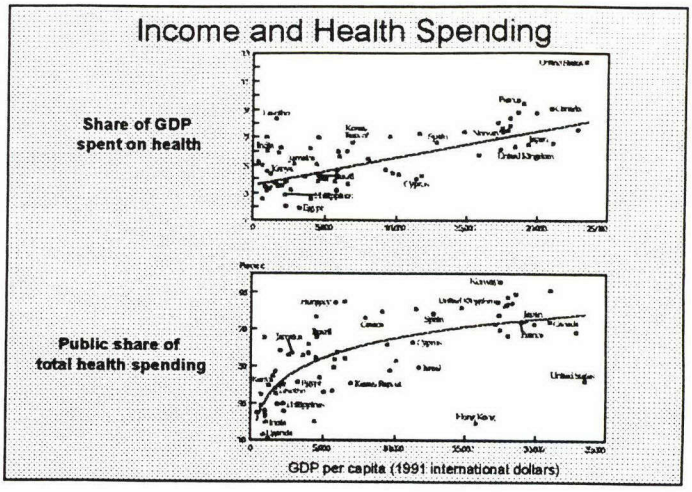
- equity, efficiency and sustainability in financing;
- equity in access to basic health services;
- cost-effectiveness, efficiency and quality;
- consumer choice and satisfaction.

Equity, Efficiency and Sustainability. In 1990 (update), total global health expenditure (public and private) was about * US$1,700 billion *, or 8 percent of total world production globally. The OECD alone spent nearly 40 percent more on health than the combined GDP of East Asia, South Asia and Sub-Sahara Africa.

Although developing countries accounted for only 10 percent (or US$170 billion) of this spending, at 4 percent of GDP, the potential impact of these resources is still substantial if used in an effective, equitable and efficient manner. At the current global annual growth rate for GDP of 3.5 percent, health care expenditure will increase at about US$60 billion a year worldwide or US$6 billion a year in developing countries. In contrast, a hundred years ago, developing countries had no formal system to finance the primitive care available to them.

Yet, over 900 million are still without adequate access to basis care and there are good reasons to believe that a significant amount of the available resources will be wasted on ineffective care.

Currently, health expenditures in developing countries range from a minimum of about US$6 per capita in some African countries to a maximum of over US$900 per capita in some Latin American countries (excluding the OECD where the maximum is US$3,817 per capita for the US). Significant difference also exists in terms the public share of total health expenditure (see Figure *** below).



The highest spenders are not always the best performers. By comparing spending with the earlier analysis of outcome performance, it is interesting to note that Sub-Sahara Africa and South Asia spend less than other regions and performed significantly worse as well in terms of both outcomes and available health resources (doctors and beds). OECD countries spend more and perform better. But among the mid-range regions there are some significant differences, with Europe and the Central Asia region performing significantly better than East Asia, Latin America and the Middle-East. (see Figure *** below).

	Per Capita Expenditure (US$)			Relative Performance						Health Service Infrastructure	
	Average	Minimum	Maximum	Under 5 Mortality Rate	Total Fertility Rate	Male Adult Mortality	Female Adult Mortality	Male Life Expectancy	Female Life Expectancy	Number of MDs	Number of Beds
AFR	82	6	390	-5.8	-0.4	-104.0	-72.2	-11.8	-12.5	0.1	1.3
ECA	299	66	892		1.0	15.9	28.2	2.4	5.3	3.5	10.2
EAP	257	44	686	5.3	0.1	-18.5	-22.6	1.1	1.3	0.4	2.4
LAC	371	34	920	-3.3	-0.4	18.7	8.4	2.2	2.3	1.1	3.8
MNA	307	126	665	-3.0	-0.8	16.0	-0.7	0.6	0.6	1.0	2.2
SAS	55	30	94	0.4	0.1	-14.3	-39.3	-4.0	-7.7	0.1	0.7
OECD	1,772	759	3,817	19.8	0.6	48.8	39.4	7.6	9.5	2.7	8.6

Mobilizing sufficient resources to secure sustainability and in and efficient manner will continue to be a major challenge in the Sub-Sahara Africa and South Asia regions, where formal labor market participation

rates are low and government revenues sometimes comprise less than 10 percent of GDP. Many of these countries will have to continue to rely on informal risk-pooling mechanisms, community based financing schemes and NGOs as their only source of health funding even for the poor.

In many middle-income countries, higher formal labor market participation rates allow more a more efficient and equitable risk pooling through social insurance and general revenues. In these countries, expanding coverage to rural communities and the informal sector continues to be a major priority. So does avoiding excessive labor costs and an expenditure "spill over" to the public sector from the observed cost explosive in the private sector (see Table *** below). As East Asia moves slowly from a rural agricultural society to a more urban-based industrial society, countries in that region will be faced with this problem which is already experienced in Eastern Europe and Central Asia, Latin America and the Middle East.

Table

Income elasticities of per capita health expenditure

Income Groups (US$ per capita)		*Income elasticity, η **		
		Total	*Public*	*Private*
Low	(less than US$765)	1.15	1.07	0.74
Middle	(US$766-9,385)	1.25	1.07	1.54
High	(more than US$9386)	1.52	1.58	0.94

* Income elasticities greater than 1 indicates that expenditure in the health sector is rising at a rate greater than inflation.

Cost-Effectiveness, Efficiency and Quality

As medical interventions and health systems become more complex and expensive, a difficult challenge — especially in very low income countries — is avoiding waste and choosing the most cost effective interventions available.[4] Although spending and physical access may have improved, the health services provided by the public sector in many developing countries are in a deep state of deep crisis due to the inefficient and ineffective use of scarce resources and poor quality of care provided. In the private sector, the lack of proper quality assurance often leads to high cost but ineffective care and abuse.

Improving Efficiency in Jordan

Jordan's health sector performs well in terms of access and health outcomes. Its indicators are the best in the region and rank high among middle income countries.

But the system is expensive and inefficient in terms of resources spent for the outcomes achieved. At 7.9 percent of GDP, health care expenditure in Jordan is well above most middle-income countries and even some industrialized countries that perform even better in terms of health indicators, nutrition status and fertility.

While Jordan provides coverage for its poor and disabled, the splintered financing system leaves an estimated 20 percent of the population without formal coverage and is difficult to control in terms of global health expenditure.

Significant inefficiencies in the delivery system are created by excess capacity (the hospital occupancy rate is only 69 percent in the public sector and less than 50 percent in the private sector). A centralized allocation process results in limited incentives for efficient delivery of services. Lack of standard treatment protocols results in excessive use of expensive drugs, with over 25 percent of total resources spent on pharmaceuticals.

The government is currently looking at ways to address these problems through a standardization of insurance coverage, improved regulation of the private sector and a well defined benefit package of cost effective care.

Among the most cost-effective public health interventions and essential clinical services in low and mid-income countries are the management of the sick child, immunization, prenatal and delivery care, family planning, AIDS prevention, treatment of other sexually transmitted diseases, short-course chemotherapy for tuberculosis, school health programs and tobacco and alcohol programs (see Figure *** below). There is often a tension between cost-effectiveness and consumer choice, as individuals frequently do not choose the most cost-effective treatment, especially when treatment is free.

[4] The HNP sector benefits from the availability of powerful and cost-effective interventions that have already experienced major successes (e.g. the eradication of smallpox).

Understanding Underutilization of Government-Run Health Services in East Asia

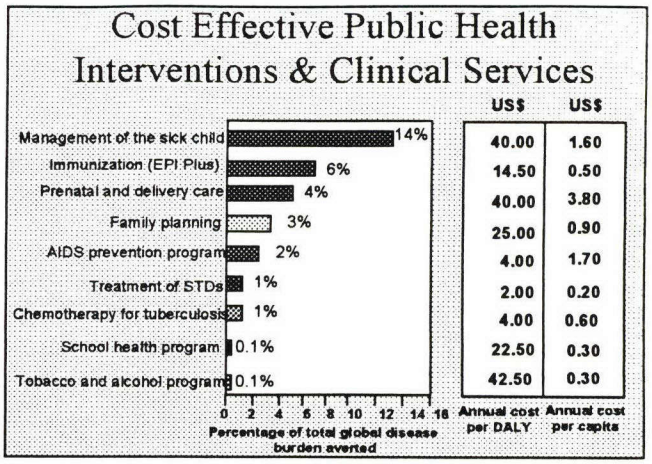
Utilization rates and other measures of service performance have been disappointing in government-run primary care facilities in East Asia and other regions.

Typically only a quarter of the Indonesians interviewed in national surveys in the 1990s visited government service points when ill, while the proportion going to private providers continues to rise and exceeds the share going to public facilities. Difficulties reaching government centers due to distance or lack of transportation, direct charges, absences of appropriate staff and lack of appropriate drugs all contribute to preventing people from using the government system.

Even when program expansions mitigated many of these factors, the lack of effective and quality of care continued to negatively influence health seeking behavior. Quality pertains not only to the availability of skilled staff, medicines and so forth, but to the nature of client-provider interactions, and the effectiveness of examinations, diagnoses and other uses of staff time.

In Viet Nam, lack the authority and policy tools, seriously handicap any attempt to improve service quality. Facility managers and their immediate supervisors have only circumscribed responsibility for work processes and outcomes, and for the activities and productivity of staff. Constructive managerial involvement is inhibited by a checklist approach to supervision; by the requirement that workers, who are often assigned dozens of tasks, report to several supervisors; by a lack of awareness of clients' needs and concerns; by the practice of assigning fixed numbers of staff to facilities irrespective of utilization levels; by the absence of usable monitoring and evaluation data; by over-reliance on quantitative targets; by the distractions introduced by opportunities to engage in private practice; and by a performance review system which gives little weight to output indicators, service costs or impacts.

Solutions to many of these problems are available through better public sector management interventions. For example, Malaysia, has been able to address many of such indications of "government failure" by delegating authority for decision making and problem solving facility managers and their supervisors who have requisite resources. They have also been able to establish strong quality assurance mechanisms. But even with such measures, greater private sector participation will be essential to improve the range of available services and consumer choice.



Consumer Choice and Satisfaction. One of the effects of the globalization of knowledge and access to the media is an increase in expectation about quality, choice and consumer satisfaction.

With rare exceptions, most people who seek medical help expect to be better off in terms of relief of pain and disability, avoidance of impairment or death and return to normal activities. Competent treatment at a reasonable cost, with a minimal risk of getting hurt or worse off in the process, is an important part of most people's expectation when they see a doctor or other health care provider. So are other factors such as travel and waiting time, availability of drugs and supplies and hours of service.

However, since fear is such a central element of illness, trust is often one of the most critical factors which determines the degree of patient satisfaction with a health care system. Poor bedside manners, which erodes such trust, are easy to acquire in settings of extreme resource constraints and the excess demand which characterize most developing countries.

White Cover

Sector Assistance Strategy (SAS)
Health, Nutrition and Population (HNP) Sector

Section II

Reform in the Role of the State and New Global Policy Directions

HNP Family
Human Development (HD) Network
World Bank

January 31, 1997

SECTION II: REFORM IN THE ROLE OF THE STATE AND NEW GLOBAL POLICY DIRECTIONS

A major conclusion drawn from the detailed country by country analysis described in Section I on variability in performance of health systems is that:

- the underlying threats to good health, nutrition and population outcomes are known and affordable solutions are frequently available; but

- because of the weak implementation capacity of many public agencies or market imperfections in the private sector, recommended policies often fail.

REFORM IN ROLE OF STATE AND PRIVATE SECTOR

Given this background, it is not surprising that governments almost everywhere are trying to develop new strategies in the HNP sector and reform their failing public and private health care systems in response to: (a) the challenge of improving outcomes; (b) generalized dissatisfaction with the poor performance and quality of existing services; and (c) a continued fiscal threat from increasing costs.

Why do Governments Intervene in the HNP Sector?

Throughout most of history, people used private doctors and hospitals when they were ill and private teachers and private schools to get an education. In low income countries, where public revenues may comprise as little as 10 percent or less of GDP, the private sector still plays a major role in the health, nutrition and population.

It is only during the 20th century — initially in the industrialized world and later in developing countries — that governments have become central to health care and other social services, in extreme cases excluding the private sector altogether. It is easy to identify three reasons for this striking increase in government activity:

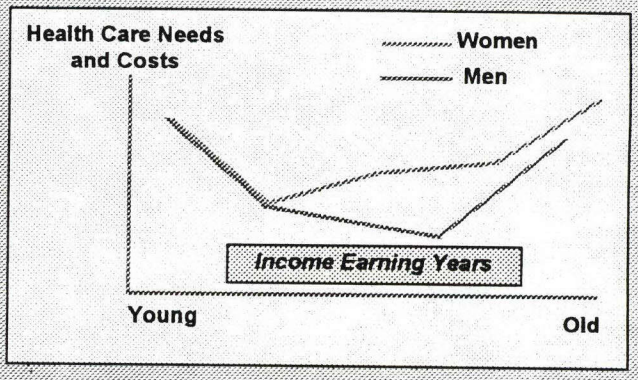
- to correct for market failure (efficiency);
- to protect the poor (equity); and
- to satisfy a political ideology (social choice).

Tension Between the Need for Social Protection and Private Financing in Africa, South Asia and Middle East

Why has collective financing, such as health insurance (public or private) and government revenues, evolved to play such an important role in the financing of the health care throughout the world rather than direct charges?

It is during childhood, childbearing and old age — when they are the least productive economically — that people make most use of health care. Sharing of risks across population groups and across the lifecycle is, therefore, a fundamental aspect of social protection in the HNP sector.

Changes in Needs and Ability to Pay Across Lifecycle



Yet, similar to 19th century Europe, direct out-of-pocket health expenditure and private financing is a distinctive feature in many of the industrializing economies in East Asia and Latin America, as well as in many of the world's poorest countries in Africa, South Asia, and the Middle-East.

In some countries household payments account for as much as 80 percent of total health expenditures because of:

- nontrivial user fees charged in public facilities;
- high copayments required in health insurance schemes;
- use of private health services (hospitals, clinics, diagnostics, medicines, and providers).

Finding better ways to take advantages of the substantial resources that can be mobilized through private channels, while at the same time ensuring social protection for vulnerable groups and an efficient use of resources, is a pressing priority in many developing countries.

Market Failure. Some health services need to be provided, subsidized or financed directly by the government because the sum of benefits to society as a whole is greater than the benefits to the individual. This would include clean water, sanitation services, vector control, immunization programs, family planning services, infectious disease control programs (e.g. control of tuberculosis, malaria, sexually transmitted diseases, HIV/AIDS etc.) and control of tobacco and use of illicit drugs. Individuals, if left to their own devices, will only spend up to the point at which their private (marginal) benefits equals cost. Society under consumes.

Other health services can be provided efficiently through the private sector, providing effective arrangements are made to finance them collectively and steps taken to offset other market imperfections.

Private health insurance is an area of particularly pronounced market failure. Why do countries not use private markets to pool risks in health in the same way that this is done in the case of car insurance, funded pensions systems or other forms of insurance? In pooling health care risks across the lifecycle and across population groups, some particular problems are encountered which almost always requires significant government intervention, usually in the form of direct public financing or government mandated insurance.

At the risk of a gross oversimplification of insurance market failure, the central problem stems from a tension between: (a) subscribers who dislike paying money for something from which they will not benefit, leading many to use services which they do not really need (moral hazard) or hiding information about their pre-existing health conditions (adverse selection); and (b) private insurers who try to maximize their profit by selecting only those who are healthiest (risk selection or cream skimming) or limiting their liability (benefit caps).

As a result of these factors, although most people are sufficiently risk averse that they would be willing to pay small amounts of money to protect themselves against later substantial losses if they become sick, empirical evidence shows that in an unregulated market (without significant state intervention) the chronically sick and poor ultimately get eliminated from most private heath insurance systems.

Protecting the Poor. Although it is possible to make a profit from pregnant women, children, the elderly and the poor, most democratic societies do not find this a politically viable public policy. Even in the absence of public goods or market failure arguments, many governments also get involved in health care to provide protection for such vulnerable groups, even when the private sector, non governmental organizations and local communities already could play a more significant role.

Continued Role of the State in the Transition Economies

The main instruments used by governments to influence public policy in the HNP sector include:

- ***information*** to influence consumer behavior (dangers of smoking or HIV/AIDS);
- ***regulations*** to influence private sector activities (accreditation and safety standards, mandates, etc.);
- ***financing*** to pay for services or influence prices (national health insurance, tax credits, direct taxes, etc.);
- ***production*** to provide some services directly (public health, rural health clinics, catastrophic care, etc.); and
- ***income transfers*** to empower poor individual with same choice and purchase power as the rich.

The key strategic policy shift which has occurred during the transition in Russia, the Baltics and Eastern Europe is a significant devolution in social assets to lower levels of government, privatization of many ambulatory services and increase in the use of social insurance and direct charges to finance clinical care.

The central governments in these countries, as elsewhere in the world, are getting out of the business of ***producing*** health services. Instead they are strengthening their role in the provision of information, maintaining public health programs, regulating the private sector and ensuring that adequate financing mechanisms are available to secure universal assess to a full range of basic clinical care.

Political Ideology. Unfortunately, in many countries governments get involved in the HNP sector for political reasons rather than to provide public goods, correct for market failure or protect the poor. And, too often they indirectly subsidize the rich through public production. The resulting unbalanced investments, lack of sustainability, disregard for quality of care and disrespect for individual choice contribute significantly to a discrediting of many of the more positive aspects of such government involvement.

Failing Government Health Services

Just like markets may fail to be efficient, so governments have not been a panaceas in the HNP sector. The justification for and good performance in some activities should not provide a smokescreen to hide the equally dismal track record observed in other areas.

In many developing countries, the direct ownership and provision of health services by central governments is pervasive. The health and education sectors often employ as much as two-thirds of public sector workers. Improved public management, such as better governance, sustainable financing of recurrent expenditures, staff training, devolution of responsibility to lower levels of government and better quality control, can improve some of these problems, but not all.

Despite years of extensive government supervision, many public services continue to perform exceedingly poorly. In many cases they do not provide the access, levels of effectiveness, efficient allocation of resources and quality of services expected. Even in the poorest of countries, patients are increasingly turning to private providers in the hope of receiving better care.

"Third Wave" Privatization as an Alternative

Getting governments "out of the business" of direct service delivery would be one way to improve their performance in the HNP sector. In recent years, an increasing number of developing countries — not just in the transition economies — are undertaking a significant privatization of their social programs as a key component of their efforts to restructure and modernize the state.

The governments of these countries are re-defining the role of the state from a direct producer of goods and services to a more indirect role — facilitator in the financing, the creation of an enabling environment and the supervision of private sector activities, NGOs and local communities in areas where governments have failed.

The *initial wave* of privatization concentrates on commercial companies. Success in this area leads to a *second wave* — privatization of infrastructure and facilities which, although previously thought impossible, has been equally successful in many developing counties.

Finally, the confidence gained in these two areas is beginning to pave the way for a "***third wave***" — a continuation of the privatization process — which focuses on private management and investment in the social sectors such as health, education and pensions.

Whereas most privatization occurs spontaneously in response to demand, third wave privatization is deliberate and premeditated. This allows governments to design and implement sector-wide policies which enhance private sector involvement in areas where remedies are desired to counter known public sector deficiencies such as improving productivity, management efficiency, consumer responsiveness, quality assurance, etc.

Middle-of-the-Road Divestiture of Social Assets in Costa Rica, Columbia and Eastern Europe

While her neighbors were engulfed in civil wars over the past decades, Costa Rica kept busy building a welfare state. The results are impressive: Literacy (95 percent) and life expectancy (76 years) compare more with Europe's than that of Central America.

But to maintain this welfare state implied also a huge state bureaucracy (over 10 percent of the 3.4 million Costa Ricans work in the public sector). Public spending is at unsustainable levels (internal debt is at 40 percent of GDP). The social security system, which provides over 75 percent of health care, suffers from long waiting lists, inefficient use of resources, quality problems, and coverage gaps.

A new reform program has been introduced which includes a "Hospital Autonomy Plan". This plan is transforming the ownership and incentive system under which hospitals currently operate. Hospitals will be decentralized and, instead of historical budgets, managers will control their own income through contracts with the social insurance scheme and new user fees. They will hire their own staff, outsource services, and purchase equipment and supplies in response to assessments of local needs and client expectations.

By maintaining universal access and financing through social insurance, the Costa Rican reform, like those in Columbia and many of the transition economies of Europe and Central Asia, represents a middle position between the inequities of totally free market health care system and the underfunding and inefficiencies of centralized state-run health care systems. Regulations on licensing, accreditation and quality control establish new performance standards.

There are some significant constraints that need to be overcome before a third wave privatization can take place in the HNP sector:

- *ideological misgivings* about the need to protect vulnerable groups from "evils of the market" even though in most countries such groups are already exposed in an unregulated environment (e.g., unofficial user charges in public facilities, etc.);
- *political and vested interests* who would loose from a more open competitive environment (health care providers who supplement their incomes through tax free gratuities, bureaucrats with job security, etc.);
- *macro-economic instability and market-impeding policies* (e.g., currency instability, restrictions on the import of equipment or supplies, tariff structures, double taxation, etc.);
- *legal restrictions* (e.g., bans or private ownership, professional protectionism that blocks labor market entry (licensing of doctors and nurses), corruption in accreditation system;
- *excessive regulations* (e.g., complicated pricing policies, enrollment limits, restrictions on salaries and mobility, excessive monitoring requirements, etc.); and
- *crowding out* by simultaneous supply side government activities (e.g., government services targeted to the poor but which do not control demand from groups who have alternate financing mechanisms, etc.)

Like in the infrastructure sector, privatization in the HNP sector does not necessarily imply the outright sale of public assets — it can involve a variety of initiatives that allow greater private sector participation such as private co-financing, private management (contracting out) and private ownership (trusts).

Blind faith in the "invisible hand" of the market is, however, no more likely to resolve many of the complex problems that face the HNP sector than a naive belief in the economics government ownership and motivation of bureaucrats. Governments that have trouble controlling inefficiency and quality of care in the public sector are likely also to have trouble regulating such activities in the private sector. The third wave in privatization must, therefore, build on the experiences learned in other sectors and the HNP sector itself.

Four critical prerequisites for successful third wave privatization in the HNP sector include:

- *conducive institutional environment* and political support (legal and regulatory framework which fosters private sector activity and social acceptance);
- *full cost recovery* through multiple financing sources (social insurance, statutory subsidies for the poor, private insurance and user charges);
- *safety net* that provides protection from those that cannot take advantage of the private system without help (the preferable route is through voucher or subsidies to gain access to the private facilities rather than targeted parallel government services which have a long history of remaining underfinanced and providing low quality in developing countries); and
- *quality control* through an appropriate regulatory framework for monitoring of performance and safety.

Collapse and Rebuild in China

Beginning in 1979, the Chinese government introduced radically new economic policies that moved the country away from the previous centrally planned economy towards a more competitive market system. Over time, this change in economic polices has been accompanied by a gradual devolution of power from the central to provincial and lower levels of government which has had a profound effect on the health care system.

Within a very short period of time, private sector activities flourished throughout the country, ranging from individual practitioners, to private clinics and urban hospitals.

Unfortunately, the Chinese reforms suffered a serious setback when the social protection which was previously provided by the rural Cooperative Medial System collapsed. Most Chinese — some 800 million in rural areas and 100 million in urban areas — do not belong to an organized financing system to sharing risks across the population. As a result, a survey of those who had been referred to a hospital for care in 1992 indicated that 40.6 percent did not seek the recommended care on grounds of an inability to pay.

Chinese policy makers are now faced with the urgent need to build a new regulatory framework, financing system, safety net and quality control mechanism for the expanding private sector to underpinning its past social progress in terms of health outcomes and recent economic growth.

NEW GLOBAL POLICY DIRECTIONS

In many developing countries, reforms in the role of the state and private sector are a critical precondition for the successful implementation of many of the new global policy direction that have recently been proposed for the HNP sector. This section summarizes some of the most significant new initiatives.

Underlying Objectives

The policy objectives of most of the new interventions in the HNP sector can be grouped under three broad categories:

- to improve the quality of life through achievable gains in health, nutrition and population outcomes;
- to relieve poverty and improve productivity; and
- to control expenditures (public and private).

Major International HNP Policy Initiatives

Five notable recent global initiatives have been instrumental in defining the policy directions for improving health, nutrition and population outcomes. They include:

- UNFPA's initiative to improve *population and reproductive health* presented at the World Population Conference in Bucharest in 1974 and the more recent International Conference on Population and Development in Cairo in 1994;
- WHO's initiative to achieve *Health For All by the Year 2000 Strategy* presented at the Thirtieth World Health Assembly in 1977 and the upcoming revisiting of Alma Ata which took place in 1996;
- UNICEF's initiative to improve the *State of the World's Children* presented at the World Summit for Children in 1990;
- UNDP's initiative on *social spending* (the 20/20 initiative), which was presented at the Social Summit in Copenhagen in 1995; and
- FAO's initiative on *Renewing Global Commitment to Fight Hungary* presented at the World Food Summit in Rome in 1996.

Policy Directions

In the fluid environment which characterizes the world today, and our expanding knowledge about effective solutions to some of the serious threats to health, nutrition and population outcomes, policies in the HNP sector must be dynamic and responsive to the individual circumstances of each country.

Although a globally applied blueprint would almost certainly fail in most countries, there is good empirical evidence to support cost-effective and affordable interventions in the following areas:

Policies for Targeted Program Interventions

Disease Specific Policies

- Prevention and control of infectious diseases
  - e.g., childhood illnesses, diarrhea, malaria, tuberculosis, HIV/AIDS, other sexually transmitted diseases, etc.
- Prevention and control of non-communicable diseases
  - e.g., tobacco and alcohol control, unhealthy diets, and mental health problems, etc.;
- Prevention and control of injuries
  - e.g., car accidents, domestic violence, suicides, etc.

Population/Reproductive Health Policies

- Development agendas that impact on populations
  - e.g. poverty reduction, education, etc.
- Completion of the demographic transition
  - e.g. lower fertility rates, delay reproduction, etc.
- Promotion of positive health practices
  - e.g. safe sex, delay marriage, birth spacing, education for girls, etc.
- Prevention of unwanted pregnancies
  - e.g. information, contraceptive choice, etc.
- Safe pregnancy, deliveries and motherhood
  - e.g. eliminate unsafe abortions, perinatal care, etc.
- Prevention of harmful practices
  - e.g. genital mutilation, discrimination, domestic violence, etc.

Nutrition Policies

- Micro-nutrient supplements
  - e.g. iodine, iron, etc.
- Nutrition counseling
  - e.g. growth promotion, prenatal, childhood, etc.
- Targeting of the poor through food transfer programs
  - e.g. social funds, etc.
- Nutritional safety nets
  - e.g. school nutrition programs, etc.
- Food production policies
  - e.g. rural and agricultural policies, etc.

Policies for Broader Systemic Interventions

Health Care Delivery Systems

- Equitable access to basic health services
  - e.g., broad risk pooling, entitlement to basic package of essential cost-effective services, etc.
- Efficient use of resources
  - e.g., increased competition among suppliers (also in private sector), referral systems, high technology review protocols, limited drug formulas, etc.
- Improve clinical effectiveness
  - e.g., training, peer reviews, clinical protocols on cost effectiveness, integrated clinical management (also in private sector), etc.
- Strengthen governance and institutional capacity
  - e.g., clear rules on responsibility and accountability (also in private sector), and management training, etc.
- Quality of care and choice
  - e.g., professional accreditation, continued medial education, peer reviews, decentralization, patient satisfaction surveys, quality control surveillance (also in private sector), diversification in supply, etc.

Health Care Financing

- Sustainable financing
  - e.g. full cost recovery through combination of social insurance, general revenues, private health insurance, user charges, etc.
- Expenditure controls
  - e.g. budget caps, limited benefit packages, regulation of private sector, etc.

Policies on Foundations for Research and Development

- New research
  - e.g., to deal with (i) childhood infections diseases and poor maternal and perinatal health, (ii) new microbial threats, (iii) emerging epidemics of non communicable diseases and injuries; and (iv) improving performance of health financing and services; and
- Stronger institutions for global health research

The Bangladesh Family Planning Program
A Surprising Success Story

Among the world's 20 poorest countries, only Bangladesh has experienced a significant, sustained fertility decline over the past two decades. In 1975, the country's total fertility rate was roughly seven births per woman; by 1995, the level had fallen to about 3.4 births per woman.

Such a dramatic fertility decline was not expected in Bangladesh. Conventional wisdom tells us that without certain pre-conditions--economic development, urbanization, improvements in the status of women, high literacy levels--there will be little demand for family size limitation and a family planning program will not succeed. Bangladesh, does not meet such requirements. Primarily an agricultural country with high population density, limited arable land, and few other natural resources, Bangladesh has 40 percent of the work force under or unemployed, and 45 percent of households below the poverty line. Social and health indicators, although improving slowly, are still quite poor.

Faced with unfavorable demographic trends and socio-economic conditions, from the outset the leadership of a new country that emerged 25 years ago has given highest priority to fertility reduction, principally through a national family planning program. The program has been successful in increasing the use of contraception from 3 percent in 1971 to about 45 percent in 1995. Two key lessons can be drawn from this experience:

- The critical importance of sustained political commitment at the highest levels of successive governments for implementation of effective national programs like family planning that have medium term objectives; and
- The necessity of adapting delivery of services to cultural realities. In Bangladesh, the family planning program was adapted to the patriarchal society, with its limited female mobility and low female literacy, by recruiting and training women providers.

New Directions in Population and Reproductive Health: The 1994 Cairo Conference

The 1994 *International Conference on Population and Development* (ICPD) in Cairo, has set the agenda for addressing population issues as we enter the twenty-first century. Several key changes in population dynamics and in the policy environment have produced an international consensus on the way forward in population and reproductive health.

Major development objectives expressed at the Conference are to:

- ***Bridge*** the gender gap in education;
- ***Promote*** equity for women;
- ***Reduce*** maternal mortality and morbidity;
- ***Increase*** child survival; and
- ***Provide*** universal access to reproductive health and family planning services

The ICPD approach does not abandon population but puts individual needs first by recommending that countries should:

- continue to assist the world's poorest countries as they complete the demographic transition (slowing population growth) during the next few years (high birth rates and very young populations make it more difficult to reduce poverty and pursue sustainable economic development);

- integrate population policies more effectively with core development agendas such as seeking better infant and child health, educating girls and empowering women (understanding the social, economic and political dimensions of urbanization, international migration and aging;

- provide the poor with access to high-quality and user-oriented (culturally sensitive) services that offer a range of choices in addressing population and reproductive health needs; and

- redefine the role of the state in population policies (selective investments in service-delivery infrastructure and institution building in very poor countries, while limiting activities to providing information and fostering a better function of the private sector in more advanced middle-income countries.

New Directions in Caring for the World's Children: The 1990 World Summit for Children

The 1990 the *World Summit for Children* set goals for reducing deaths, malnutrition, disease and disability among the children of developing world.

The end-of-century goals, agreed to by almost all the world's governments following the Summit can be summarized under ten priority points:

- A one-third reduction in 1990 under-five death rates (or to 70 per 1,000 live births, whichever is less).
- A halving of 1990 maternal mortality rates.
- A halving of 1990 rates of malnutrition among the world's under-fives (to include the elimination of micronutrient deficiencies, support for breastfeeding by all maternity units, and a reduction in the incidence of low birth weight to less than 10%).
- The achievement of 90% immunization among under-ones, the eradication of polio, the elimination of neonatal tetanus, a 90% reduction in measles cases, and a 95% reduction in measles deaths (compared to pre-immunization levels).
- A halving of child deaths caused by diarrheal disease.
- A one-third reduction in child deaths from acute respiratory infections.
- Basic education for all children and completion of primary education by at least 80% -girls as well as boys.
- Clean water and safe sanitation for all communities
- Acceptance in all countries of the Convention on the Rights of the Child, including improved protection for children in especially difficult circumstances.
- Universal access to high-quality family planning information and services in order to prevent pregnancies that are too early, too closely spaced, too late, or too many.

UNICEF has one of the most detailed programs for monitoring and tracking progress of any of the international organizations. Latest annual report — the *State of the World's Children 1997* — provides some striking illustrations of both successes and failures during this decade in achieving these goals.

New Direction in Health:
Update of the Health For All by the Year 2000 Initiative

The Global Strategy for **Health for All by the Year 2000**, founded on primary health care principles and adopted by the World Health Assembly in 1981, has provided a common policy framework for worldwide health action in the last two decades.

Adopting "health for all" (HFA) as a fundamental objective has committed governments to attain "as a *minimum* by *all* people in *all* countries, *at least* such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live" (*The World Health Report 1996; Fighting disease Fostering development*).

The **Health for All** goals in countries include:

- at least 5% of the gross national product spent on health; a reasonable percentage of the national health expenditure devoted to local health care (reasonable defined by country context);
- equitable distribution of resources, and;
- primary health care available to the whole population.

Primary health care targets by year 2000 include:

- access to safe water (85 percent);
- adequate sanitary facilities in the home (75 percent);
- immunization (90 percent);
- local health care (first level facilities) with at least 20 essential drugs (85 percent); and
- trained personnel for pregnancy, childbirth, and caring for children up to at least 1 year of age (100 percent).

In addition to disease specific mortality and morbidity targets, specified goals for the year 2000 are:

- Infant mortality rate less than 50 per 1000 live birth;
- Probability of dying before 5th birthday less than per 1000 live births; and
- Maternal mortality (per 100 000 live birth) to be reduced to 50 percent of 1990 level.

To assess the global progress in the attainment of HFA at the end of the decade, and to set a new direction in health, WHO is currently evaluating all the global targets (economic, demographic, social, nutritional, lifestyle, water supply and sanitation, human and financial resources, drugs, maternal and child health, family planning, life expectancy, mortality, morbidity and disability). The evaluation will contribute to a revised HFA policy, for action beyond 2000.

New Directions in Nutrition:
The 1996 World Food Summit

The 1996 *World Food Summit* in Rome emphasized the intersectoral nature of effective nutrition policies. Unlike other health problems, including maternal and reproductive health, problems in malnutrition are not well addressed through health services alone. Instead major reforms to address malnutrition need to focus on policies in five major intersectoral areas:

- ***Policy and institutional framework*** to support agricultural and rural development;
- ***New role of the state,*** with an emphasis away from heavy public intervention in the rural economy, towards providing the enabling, sound macro-economic, fiscal, and sectoral policy environments;
- ***Private sector involvement*** to mobilize the needed investment capital, production and services;
- ***Community and local government participation*** in designing and implementing nutrition policies rather than rely on central government; and
- ***Partnerships*** at all levels of involvement, ranging from central governments to local governments to community participation to the private sector.

Examples of two successful nutrition interventions include community nutrition and food fortification programs.

Community nutrition programs are carried out at the community and household level rather than at a clinic or school. They usually involve growth promotion and nutrition counseling (including breastfeeding promotion), basic health services (immunization, oral dehydration therapy), referral of sick children, and supportive services (childcare, small scale credit, food technology improvements, agricultural extension). Some successful programs also include targeted food supplements and family planning. Usually a community agent, responsible for reaching out to high risk populations, referring malnourished families to formal government services (health, social worker, etc.)

Food fortification to address micronutrient malnutrition has a long history in developed countries of effectiveness: salt iodination, fortification of flour with iron, rice with thiamin, dairy products with vitamins A and D, and water with fluoride have had dramatic impact. Newer ideas for fortification include fortifying sugar with vitamin A, rice with vitamin A and iron, fluoridation of salt, iodization of water, and double fortification of salt with iron and iodine. Fortification offers one of the best public health bargains: it is highly effective, at low cost (less than $0.50 per year) and paid for primarily by the consumer.

IMPLEMENTATION STRATEGIES

The 20th century has been a rich social laboratory for learning more about *how* to implement successful HNP sector reform strategies, in parallel to the continuously quest to expand knowledge about the origins of good and poor health, nutrition and population outcomes. A *strengthening of the appropriate role of the state and the creation of a more "private sector friendly" environment* underlies the following strategies:

Strategies to Focus Public Attention on Priorities

First, since three of the key determinants of improved health, nutrition and population outcomes (income levels, education, and income distribution) lie outside the traditional HNP sector, broad systemic approaches should be used to attack some of the most resilient problems which do not respond to sectoral policies alone. In this respect, governments should become much more aggressive in finding ways to put a greater focus on:

- Strategies that emphasize life-styles and the primacy of individuals/families over health rather than government health services and health care providers. Many of the activities which are associated with this strategy lie outside the HNP sector and often require close coordination with the macro- framework (e.g. health promotion and outreach activities that aim at changing life-styles, higher taxes on tobacco, removal of agricultural subsidies on foods that are known to have adverse health effects, major improved housing for the poor, population policies that are more linked to poverty reduction, empowerment of women through education, etc.)

- Strategies that emphasize an integrated approach to health, nutrition and population problems (e.g. sector wide-reforms in health sector, include health reforms in public financing and social insurance, integrated approaches to the management of the sick child, early childhood development approaches, health implications of activities in other sectors such as highways — industrial policies (environmental and safety consequences), energy (dams), etc.)

Strategies to Strengthen Institutional Capacity

Second, within the HNP sector itself, both national priorities and international trends have contributed to setting the agenda.

Although some countries still have problems with access to basic health services and, therefore, need capital investments to increase the capacity and the quality of existing services, in the vast majority of cases it is how recurrent expenditure is mobilized (source of financing) and allocated (spending patterns) that really matters.

By focusing too much on physical inputs (brick, mortar and equipment for clinics and hospitals), many developing countries are overlooking the importance of quality staff (salaries), drugs and supplies (consumables) and basic diagnostic services as critical elements in influencing the performance of health services. In this respect, governments need to develop more effective:

- Strategies that strengthen the capacity of both the public and private sectors in securing affordable, equitable and sustainable financing (e.g. programs which strengthen cost recovery through a combination of risk pooling and user charges). It is notable that few health care reforms deal explicitly with improving equity and access through better risk pooling although nearly 1 billion people in developing countries still do not have financing arrangements to secure adequate access to basic health services.

- Strategies that lead health care providers to seek cheap health gains first (allocative efficiency) by shifting a greater share of the recurrent budget to basic health services (e.g. country specific programs which emphasize cost-effectiveness analysis, clinical guidelines, high technology review panels, etc.). Many countries are still spending a large share of total health care expenditure on inefficient and ineffective interventions that benefit only a small part of the population.

- Strategies that lead to a better assessment of performance of HNP delivery systems (monitoring, tracking and evaluating the performance criteria described earlier — sustainable financing, equitable

access to basic services, cost-effectiveness of interventions, efficiency of health care delivery systems, and quality and consumer satisfaction). It is particularly notable that most countries do not have an adequate system for assessing the impact of spending in terms of the performance of their health systems.

Strategies to Foster Fiscal Responsibility

Third, in many countries a significant share of national product and public resources are spent on health care. This draws resources away from other public programs that have an impact on economic growth, poverty reduction and improving the quality of peoples lives. In this respect, governments need to focus on:

- Strategies that introduce effective global caps on public expenditure programs (especially in the case of countries that use performance-based provider payment systems) and full cost recovery for services (through broad based risk pooling arrangements, public subsidies and direct changes).

- Strategies that provide incentives for the private sector to play a more effective role, especially in the case of provision of services.

- Strategies that regulate the private sector, especially in the case of private health insurance which often puts a cost pressure on the public sector.

- Strategies that strengthen monitoring and tracking of health expenditure patterns, especially in the case of private sector activities which contribute significantly to overall cost in the health sector.

Strategies to Improve the Management of Change

The effective management of change and crisis is often critical to successful or failed attempts to introduce new and more effective policies. In this respect, governments need to develop:

- Contingency plans to deal with periodic crisis; and

- Procedures that allow them to adapt to change.

Building Capacity in the Maghreb

The role of ***knowledge broker*** is becoming increasingly important to the Bank. Countries require access to the practical experience and knowledge garnered by other countries which have undertaken stages of sector reform similar to those they are considering themselves. The Bank's involvement in the Maghreb Health Priorities Study —a multicountry exercise — illustrates this new trend.

The Maghreb Health Priorities Study, initiated in 1994, assisted Algeria, Morocco and Tunisia to develop the analytic capacity to address the epidemiologic transition. Its overall goal was to enable governments to acquire the information they need to respond to the challenges created by this transition.

Specific study objectives included: (a) identification of cost-effective interventions to pinpoint resource misallocation in the current situation, so that allocative efficiency could be improved; (b) strengthening capacity to set priorities by improving the ability to determine the burden of disease and to conduct cost-effectiveness analysis; and (c) providing a rational framework for resource allocation and external aid in the sector.

The study was the first regional study on burden of disease and cost-effectiveness for middle-income countries. It was carried out by multidisciplinary local teams within each of the Ministries of Health. These teams included epidemiologists, health economists, clinicians, demographers and health planners. The Bank contributed value to the exercise by identifying the skills our clients most needed to develop, and arranging for relevant state-of-the-art technical assistance in response. It *brokered* a transfer of experience and knowledge from the top practitioners in the world to professionals in Ministries of Health and Universities.

The study has improved the quality of national analysis on mortality, morbidity and costs in the Maghreb countries, enhancing their framework for current and future decision making, and fostering an intra-regional exchange of ideas on strategic development of the health sector.

White Cover

Sector Assistance Strategy (SAS)
Health, Nutrition and Population (HNP) Sector

Section III

Rational for Bank Involvement and a Review of the HNP Portfolio

HNP Family
Human Development (HD) Network
World Bank

January 31, 1997

SECTION III. RATIONAL FOR BANK INVOLVEMENT AND A REVIEW OF THE HNP PORTFOLIO

RATIONALE FOR BANK INVOLVEMENT

Investing in people is at the center of the Bank's development strategy as it moves into the 21st century, reflecting the fact that no country can secure sustainable economic growth, poverty reduction or basic quality of life without a healthy, well nourished, and educated population.

What Developing Countries Say they Want

Bank involvement in the HNP sector responds directly to client demand.

To change the deeply ingrained systemic problems in the HNP sector, most countries say they need assistance from the international community in the form of: (a) broad global perspective and intersectorial expertise; (b) long-term commitment since even small changes in outcome may take as long as 10 to 15 years to realize, extending well beyond the average length of a Minister's term in office; (c) financial resource requirements that outstrip country capacity; and (d) field presence with a deep understanding of local circumstances (economic, political, social and institutional factors).

Yet responding directly to client demand is not straight forward in the health, nutrition and population areas. First, it is necessary to reconcile the divergent views of the various interest groups — the "client" (MOH, MOF and MOW, etc.), "vested stakeholders" (local communities, health care providers, insurance companies, etc.), "beneficiaries" (the population, patients, etc.) and other "partners" (other UN agencies, international donors, NGOs, etc.)

Second, it is necessary to reconcile differences that often exist between perceived needs and concrete evidence about the cost effectiveness of specific interventions. Many countries have health, nutrition and fertility problems precisely because governments introduced the wrong policies during the past or because they were unable to harness in a constructive way the resources that are available in the private sector.

Finally, Bank credits and loans must eventually be repaid. Investments in the HNP sector through loans must be carefully balanced with the medium-term returns to such investments and the opportunity cost of not investing in other spheres of the economy that impact on health, nutrition and population outcomes.

Comparative Advantage (Who can do What?)

None of the international organizations can face the complex health care challenges described in Section I of this Report alone. Responding to the most pressing needs of developing countries will require the combined ingenuity and collaboration of all those who work in the international field.

The Bank works in close partnership with many other international organizations (WHO, UNICEF, UNFPA, UNFPA, UNDP, UNAIDS, FAO, ILO, etc.), regional banks (EU, EBRD, IDB, the two ADBs), bilateral and non-governmental organizations as well as the private sector. Each has its own comparative advantage in providing some financing, specialized expertise, commitment and field presence.

Who Can Do What?

	Expertise	Commit-ment	Finance	Field Presence
Households				
Communities				
Civil Society				
UN Agencies				
Bilaterals				
Regional Banks				
Private Sector				
Foundations				
Governments				
World Bank	++++++	++++++	++++++	++

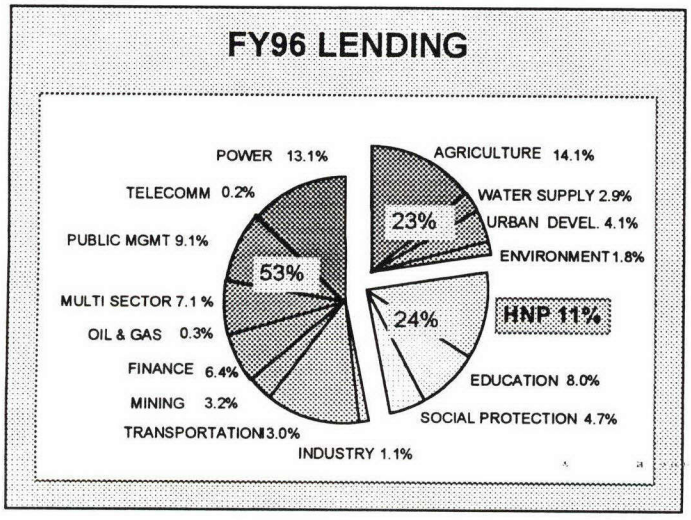
The Bank's major strength is its broad cross-sector strategic expertise, long-term commitment, ability to mobilize large financial resources (either directly or through partnerships), and growing field presence with a macro-level country focus.

BANK INVOLVEMENT IN HUMAN DEVELOPMENT

Since its creation at Bretton Woods in 1944, the Bank has been actively involved in supporting human development (HD), first through water and sanitation programs, agricultural projects, and various forms of rural and urban development projects.

Education sector lending began in the 1960s. Population, nutrition, and health activities began during the 1970s and 1980s. Since the mid-1980s, these activities have broadened to include employment funds, training programs, social transfers (pensions, safety nets, and other benefits), HIV/AIDS prevention and care and early childhood development.

During the past 10 years alone, annual lending directed towards the HD sectors (education, HNP and social protection) increased from about US$1.0 billion in 1986 to over US$5.0 billion in FY96 (from 8 to 24 percent of the US$21billion in new loans). The number of new projects increased from 29 to 69 per year or from 13 to 27 percent of total new Bank projects during the same timeperiod (see Figure *** below).



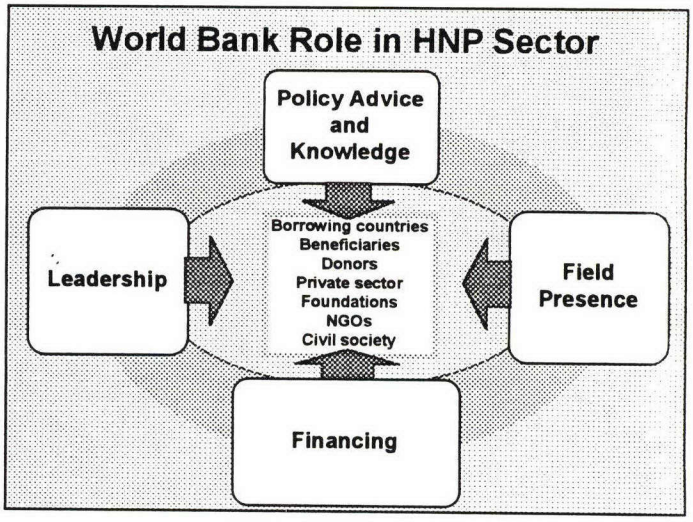
By FY99, the share of loans directed to the HNP sector will increase from its current 40 to 44 percent of the total human development portfolio value; social protection will increase from 12 to 18 percent; and education will drop from 47 to 39 percent.

In addition to these direct human development activities, the 23 percent of total Bank lending which is devoted to the agricultural, environmental and rural/urban development sectors continues to have an indirect impact on nutrition and population outcomes. Likewise, many of the Bank's macro-economic activities, private sector development and financial sector reforms, which aim at improving growth or creating employment, also have indirect effects on human development.

No other organization has a sufficiently broad mandate to touch simultaneously on all of these areas that are needed to create the facilitating environment to improve health, nutrition and population outcomes.

THE HNP SECTOR

The Bank's role in the HNP sector includes the following functions: (a) policy advice and repository of knowledge; (b) leadership (coordinator, catalyst and long term commitment); (c) financing (direct loans, grants and mobilization of resources through other donors); and (d) field presence (see Figure *** below)



Policy Advice and Knowledge

Although the Bank may be best known for its loans and financial support to developing countries, it has contributed significantly to national and international debates on health, nutrition and population policy through three different non lending channels:

- policy analysis and research;
- country specific sector work and dialogue; and
- training

Policy Analysis and Reseach

Several noteworthy early policy papers in the HNP sector included: (a) the *1970 Sectoral Programs and Policies Paper* which included recommendations on population planning; (b) the *1973 Sector Program Paper* on Bank nutrition activities; and (c) the *1975 Health Sector Policy Paper.*

Although the *1975 Health Sector Policy Paper* recommended that the Bank should not lend directly to basic health services, it provided the basis for a Board decision to allow lending for health as "components" of other projects to increase awareness of potentially negative health consequences. This early policy paper raised several issues that are still relevant today, including:

- an argument that health programs should not be isolated efforts, but be a part of broader socio-economic development programs designed to reduce mortality and fertility;
- a concern about the feasibility of low-cost health care systems and the lack of *political will* to introduce significant reform, including the inefficient and inequitable government spending on hospitals and highly trained staff; and
- a recommendation to increase access to primary health care through community level involvement.

The *1980 Health Sector Policy Paper* was the first attempt to set out a solid rationale for free-standing Bank investments in the health sector, drawing links between health sector activities, poverty alleviation and family planning. This paper included recommendations to expand access to basic health care systems through development of infrastructure, training of staff, supply of inputs such as drugs and consumables and provision of maternal and child health care, family planning and disease control.

It was the highly influential *1980 World Development Report on Poverty* which secured a solid place for the social sectors as one critical leg of a three-pronged strategy for poverty alleviation. By defining the social sectors in an overall macro-economic context, this document gave the health sector, along with education and social protection, a central place in the Country Assistance Strategy (CASs).

It is interesting to note that most of the past major policy documents included a concern about the appropriate role of governments, the private sector, market failure, equity and efficiency. The *1984 World Development Report: Population and Development* emphasized the central role of government action in reducing mortality and fertility. This Report also stressed that — to have an impact on medium term objectives such as improved health, nutrition population outcomes — countries need to develop a **social contract** that extends beyond the horizons of individual governments or stakeholder interests.

The 1987 policy study, *Financing Health Services in Developing Countries: An Agenda for Reform*, tackled the policy themes of inefficient and inequitable public spending in the health sector and the ongoing problem of financing recurrent costs. In the face of the slow economic growth and budget deficits which marked the 1980s, the paper recommended:

- the use of charges at government health facilities, especially in the case of drugs and curative care;
- a strengthening of insurance and other prepayment mechanisms to help mobilize additional resources and protect individuals and households against the financial risk of illness;
- more effective use of non governmental services, including NGOs and the private sector; and
- decentralized planning, budgeting and purchasing of government health services.

The forthcoming *Proceedings to the 1997 International Conference on Innovations in Health Financing* will provide a major follow-up to the 1987 policy study on health care financing policy options, focusing on the challenge of mobilizing resources in an affordable, efficient and equitable way, especially in very low income countries.

The theme of the role of governments repeated itself in the Bank's seminal piece on the HNP sector, the 1993 *World Development Report 1993: Investing in Health.*[1] This report has already had an immense impact

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1 The 1992 WDR on *Development and the Environment*, the 1996 WDR on *From Plan to Market* (transition

on shaping national and international debates on health policy priorities in many middle- to low-income countries as well as set priorities for the Bank's work. Its key recommendations were that:

- the public sector should finance (or mandate finance of) well-defined packages of essential public health and clinical services.[2]
- government finance should be reduced (and ultimately ended) for services of lower cost-effectiveness (often in tertiary hospitals);
- governments should encourage potential suppliers (both public and private) to compete both in delivering clinical services (and inputs to services) whether those services are publicly or privately financed; and
- gains in scientific knowledge have underpinned huge health gains of this century and, since scientific knowledge is an international public good, collaborative financing for appropriate research and development should be a high priority for the international community.

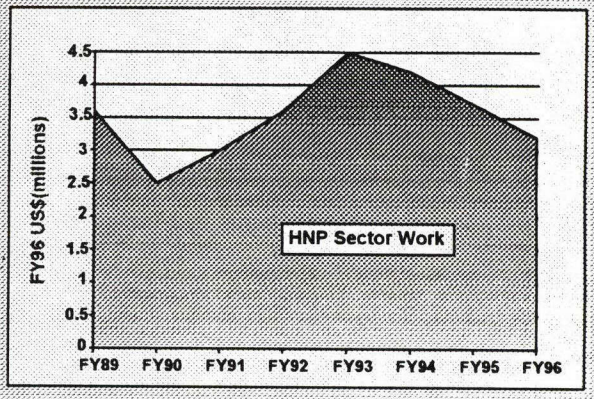
In addition to these major policy papers, the Bank has published several hundred technical notes and working papers (including background and discussion papers). Several notable examples of recent publications include: OED's recent *Evaluating Health Projects: Lessons from the Literature*, 1996; *Better Health in Africa -- Experience and Lessons Learned*, 1994; *Population and Development: Implications for the World Bank*, 1994; *New Agenda for Women's Health and Nutrition*, 1994; *Enriching Lives: Overcoming Vitamin and Mineral Malnutrition in Developing Countries*, 1994.

Research. The Bank also carries out additional research and analysis that addresses key health needs and concerns common to many developing countries. Through the Ad Hoc Committee on International Health Research and Development, the Bank is currently working to develop new strategies in international collaboration to address neglected research priorities in old and new infectious diseases, non-communicable diseases, and health policy. In recent years, health-sector reform has been at the center of much of the Bank's project and sector work in both middle- and low-income countries.

Recent Decline in Attention to Sector Work

Whereas resources devoted to sector work increased significantly during first part of the past decade (from FY89-93), there has been a significant deterioration since FY93. By the end of FY96, total resources devoted to sector work had dropped to below the FY89 levels (see Figure *** below).

Decrease in Budget for Sector Work



A recent Bank study by the Policy Research Department — *Foreign Aid's Impact on Public Spending*, 1996 — found that most of the foreign aid received by the health sector substitutes for government spending. There was no net increase in the total resources to the sector.

The policy impact of the sector work, is the real source of aid effectiveness. Cutting sector work, cuts the effectiveness of HNP lending.

Country Specific Sector Work and Dialogue

Country-based analytic studies — economic and sector work (ESW) — on specific topics such as population and reproductive health, nutrition, financing,

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economies) and the 1997 WDR on *The Role of the State in a Changing World* also deal with issues that have significant implications for the HNP sector.

2 Minimum essential packages could cover cost-effective interventions addressing a large fraction of the overall disease burden in low-income countries. In middle- to high income countries, the experience in many countries suggests that, in order to contain costs and reach vulnerable groups, countries may wish to consider more comprehensively defined essential packages.

health care delivery systems and health manpower are an important complement to cross cutting publications.

Country policy studies educate Bank staff about health issues and investment needs in client countries. They stimulate analysis, debate and consensus-building among national decision makers. Examples of countries for which such studies have recently been published include Chile, China, Kyrgyz Republic, India, Malawi, Mexico, Poland, Tunisia. A major country report on health care financing will soon be published for Jordan.

In addition to the 163 formal sector studies and 225 Staff Appraisal Reports (SARs) which were completed and published by the end of FY96, there have been literally thousands of shorter background working documents and country strategy papers on selected topics. Often Country Assistance Strategies (CASs), Country Economic Memoranda (CEMs), and other documents that deal with sectors of the economy that have a connection to health, nutrition or population policies, have sections on the HNP sector.

Another important venue for policy advice is the country dialogue that accompanies preparation of, or follow up to, a major sector study or lending operation.

This is not restricted to the HNP sector. The country dialogue that accompanies broad macro-economic operations (e.g., IMF standby operation or a Bank adjustment loans) is often a critical entry point for subsequent lending activities in the HNP sector and may provide a unique opportunity to address stubborn cross sectoral problems.

During the past decade, 105 adjustment operations have had some health, nutrition and/or population content. These have tried to address difficult cross-cutting issues such as civil service reform, sustainable rural development, decentralization, food policies, protection of social expenditure, cost containment and tax policy. A narrow sectoral approach is not effective in these areas.

Training

Training also provides a strong vehicle for policy dialogue. Since the beginning of the Bank's involvement in the HNP sector, the Economic Development Institute (EDI) of the Bank has taken a lead responsibility for providing training and senior policy seminars on issues relating to health, nutrition and population policy. Reflecting the evolution in operational work, the emphasis of EDI seminars during recent years has been on health policy, health sector development and sustainable financing.

A large proportion of EDI's policy and management training seminars are held in individual countries. These usually focus on identifying common issues and sharing country experiences in implementing reforms. Seminars that aim at providing a global perspective are often Washington-based.

An example of a recent regional policy seminar is the 10 country meeting of southern African countries which was held in Johannesburg in the spring of 1996. It focused on policy options in health care financing. An example of a major global initiative is the joint EDI-HDD flagship course on *Health Sector Reform and Sustainable Financing.* This course will feature an intensive 6 week training program in Washington as well as delivery of locally adapted training modules in six regional partner institutes.

International Leadership

*** More in this section ***

The Bank also participates actively in international *fora*, including major conferences and scientific meetings.

The Bank sponsors the Task Force for Child Survival and the Global Micronutrient and Safe Motherhood Initiatives. The Bank was a key participant in the 1990 UNICEF-led World Summit on Children in New York, the 1995 World Conference for Wormen on gender issues in Beijing, and the 1996 International AIDS Conference in Vancouver. It was host for the 1991 International meeting of Partners for Safe Motherhood in Washington and for the 1996 International Conference on Early Childhood Development in Atlanta.

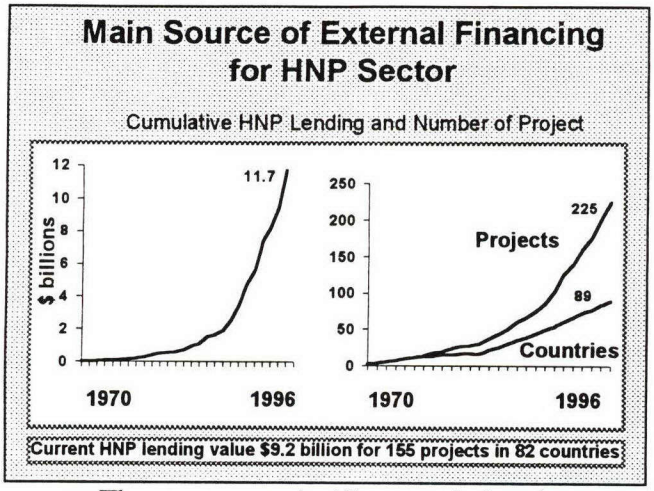
Assisting developing countries secure sustainable financing for the HNP sector without major macro-economic distortions is another area receiving increasing attention. In collaboration with WHO and other international organizations, the Bank was the host for

1997 International Conference on Innovations in Health Financing, the first major conference of this kind to focus exclusively on a full range of financing mechanisms.

Financing (Loans, Credits and Grants)

Since the Bank's first loan of US$2.0 million, dedicated to family planning activities in Jamaica in 1970, its activities in the HNP sector have grown to the point where it is now the single largest external financier of HNP activities in low- to middle-income countries (see Figure *** below).[3]

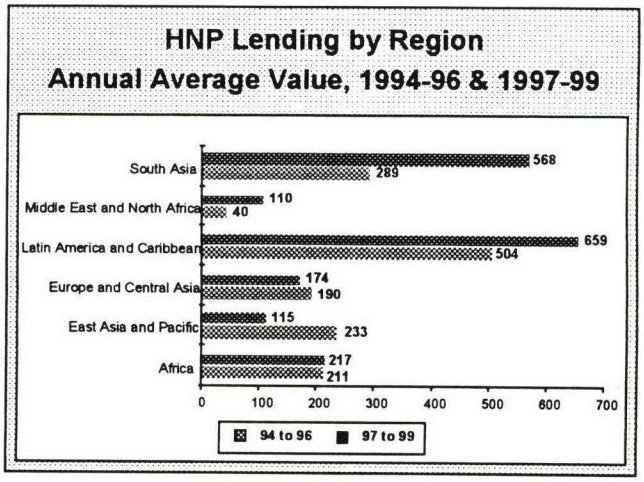
By the end of FY96, the HNP portfolio had a cumulative value of over US$11.7 billion with 225 projects in 89 countries (155 active projects valued at US$9.2 billion in 82 countries and 70 completed projects valued at US$2.5 billion).



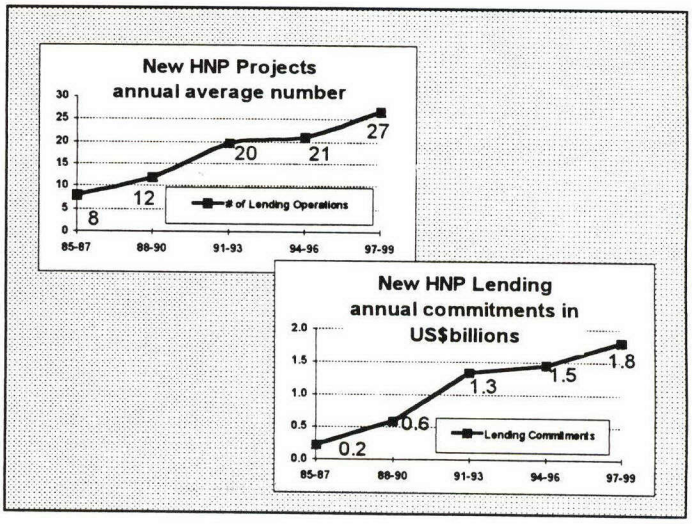
There are some significant variations in past total lending and the future pipeline at the regional level.

Today, 73 percent of total HNP projects and total commitments are in AFR, LAC and SAS regions (see Figure *** below). The SAS region has been particularly active both in terms of total projects (7 completed, 12 active and 7 in pipeline completed projects) and in terms of the pipeline (US$3.4 billion). The entry of the ECA region in the early 1990s led to a transient rapid rise in both total commitment and the size of the ECA pipeline. This growth has now slowed down compared with the continued rapid growth in the SAS and LAC regions.

Total commitments in the EAP region are expected to fall during the next three years, reflecting in part changes in demand for Bank financing as this region moves from IDA credits to IBRD loans. This will have significant implications for the HNP sector, given that the EAP region still has a large share of the world's poor and unhealthy populations.



The average annual value of new loans to the HNP sector during the period from FY94 to FY96 was US$1.5 billion (6.7 percent of total Bank lending). Based on the current pipeline (through FY2000), the cumulative portfolio value will increase to over US$17.6 billion (see Figure *** below).



[3] In 1976 the first nutrition loan went to Brazil, and in 1981 Tunisia was the first country to borrow for a project to expand access to basic health services.

Evolution in the Lending Portfolio

During the course of the Bank's involvement in the HNP sector, the portfolio has changed significantly in terms of the sub-sectors involved and scope of activities.

Increase in Number of Sub-sectors. The Bank's initial activities in population, which started in the 1970s, expanded rapidly to include nutrition in 1976, health services in 1983, HIV/AIDS in 1986 and early childhood development (ECD) in 1990. Free-standing population and nutrition projects are most prevalent in the SAS and AFR regions, although also found to a lesser extent in EAP, LAC and MNA regions.

The early focus of work in the HNP sector was mainly to secure adequate access to basic population, nutrition and health care services. This focus on basic programs has continued into the 1990s, with a recent emphasis on addressing infectious diseases such as tuberculosis, malaria and control of the HIV/AIDS epidemic (over 75 percent of total lending is still targeted to basic services).

By the end of FY96, the composition of the portfolio continues to emphasize basic health services, including reproductive heath (see Figure *** below):

Shift in Composition of Portfolio

	Relative Share of Total Portfolio in % Total Value	
	1986-91	1991-95
Disease Control	13.1	13.1
Nutrition	7.5	9.7
Population and RH	32.7	23.4
Supply Inputs	6.7	7.7
Basic Health Services	20.0	20.4
Reconstruction	0.0	0.5
Capacity Building	16.5	8.8
Sector Wide Reforms	3.6	16.4

Although the relative share of total lending to population, reproductive heath and capacity building activities may appear to have decreased over time, a significant part is now included under basic health projects and sector wide reforms.

Similarly, although there were only 10 projects with nutrition content in FY96 the relative share of lending has remained nearly constant. Also this does not reflect overall Bank interventions in nutrition, which are often dealt with through agricultural projects, education projects and other composite projects.

OED reviews of the Bank's early experience in the HNP sector, during the 1970s and early 1980s, seems to indicate that the move from having these activities included as subcomponents under broader operations, free-standing operations led to an increase in development. The impact of the recent trend towards inclusion of targeted program interventions under broader sector-wide reforms needs to be tracked carefully.

Broadening in Scope of Activities. During the 1990s, the Bank has increasingly turned its attention to a broad restructuring of the HNP sector in both low- and middle-income countries. This new emphasis reflects a view that more radical systemic reforms are needed to secure improved value for money (cost effectiveness of interventions), sustainability and cost controls.

In terms of the scope of interventions, one can identify three broad categories of activities in the HNP sector which require different approaches:

- **Specific targeted program interventions** (disease control programs, population and reproductive health programs, nutrition programs and specific supply inputs such as pharmaceuticals medical supplies, "brick and mortar" and narrow training programs).

  These interventions promote discrete improvements in health gain through tuberculosis control, immunization programs, nutritional supplements, provision of essential drugs, etc. Some of the most effective Bank interventions have been such targeted program interventions.

- **Broad underlying systemic reforms** (basic services, emergency reconstruction, institution capacity building and sector-wide systemic reforms)

  These interventions attempt to restructure the service delivery system and financing, including creating a "private sector friendly" environment. They address

issues of governance, capacity building, resource allocation, payment systems, capital stock, and recurrent costs. These operations have macro-economic implications for public sector employment, labor markets and private sector development (see Figure *** below).

- **Intersectoral and fiscal interventions**. Whereas ten years ago it was rare to see the health sector mentioned in a structural adjustment loan, this is no longer the case.

  With the increased awareness that even poor countries spend a large share of their gross domestic product and public revenues on health care, it is now common to see cost containment and efficiency gains in the health sector as conditionalities of a public sector adjustment loans (PSALs or SECALs).

Shift in Scope of Interventions

REGION	BROAD SYSTEMIC	% of Total	TARGETED	% of Total	COMPOSITE	% of Total	OVERALL TOTAL
AFR	31	58.5	21	39.6	1	1.9	53
EAP	9	40.9	12	54.5	1	4.5	22
ECA	11	78.6	0	0.0	3	21.4	14
LAC	12	38.7	11	35.5	8	25.8	31
MNA	8	61.5	4	30.8	1	7.7	13
SAS	4	18.2	18	81.8	0	0.0	22
FY96	75	48.4	66	42.6	14	9.0	155
FY91	30	32.3	33	35.5	30	32.3	93
FY86	1	2.7	19	51.4	17	45.9	37
FY81	0	0.0	18	100.0	0	0.0	18

Almost without remark, HNP lending has shifted from brick and mortar to technical assistance and software. As a result, whereas HNP projects disbursed only 14 percent on technical assistance and 29 percent on equipment prior to FY92, this has increased to reach 17 percent on technical assistance and 50 percent on equipment during the FY92-96 period. In FY96, disbursements on technical assistance reached 21 percent of total disbursements. Disbursements on civil works has decreased during this period.

These broader reform projects often address systemic distortions in the HNP sector. Early experience indicates that these type of activities are risky in terms of the needed political processes and institutional changes. Furthermore, implementing multiple decentralized technical assistance or training components is very labor intensive on supervision time. The expected benefits must, therefore, be carefully balanced with the greater risk that this type of operation entails.

Sector-Wide Reforms in Mexico

One of the reasons why sector-wide investment approaches are so attractive is that they avoid the need to prespecify in detail matters which cannot and should not be prespecified in detail - the evolution of a health sector reform.

Whereas the typical "blueprint" investment approach may be suitable for "brick and mortar" projects, investments that deal with complex institutional change need to address both technical issues and the fluid political environment in which they are being implemented.

The Mexican Basic Health II Project is a good example of this approach. This project included US$335 million in loan funds which will be disbursed against specific annual investment plans in 18 of the country's poorest states. The investment plans follow a menu of predefined cost effective interventions for the uninsured poor. States choose from this menu according to their needs. Strict criteria for selecting investment areas and for evaluating individual proposals are applied. These criteria introduce incentives to increase efficiency, quality and link resource to performance.

The backbone of the approach are annual evaluations of subprojects, that are based on a combination of policy, process and outcome indicators. Project control mechanisms include physical inventory surveys before receipt of new equipment and annual audits by external auditors. Overall project progress is assessed in annual Bank-Government review meetings. This annual review assesses the performance in the past year, draws from lessons learned and approves the next annual investment plan.

This approach is in stark contrast to the traditional blueprint concept, where obstacles during implementation or a change in course make it necessary to amend the Loan Agreement, at a high transaction costs for Bank and client.

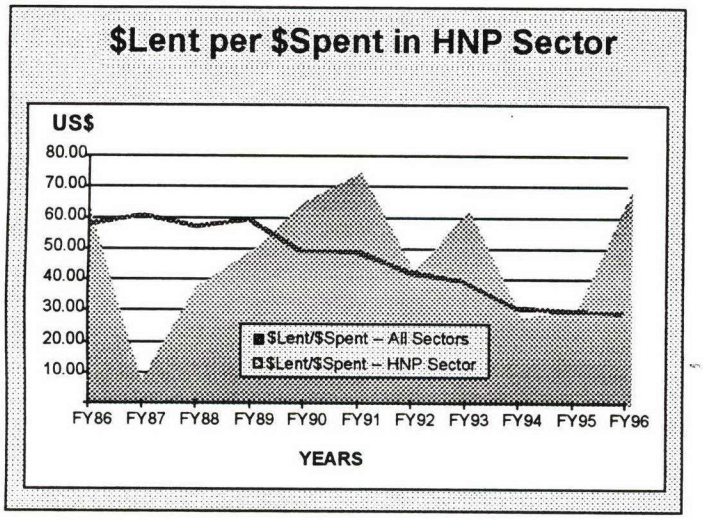
While it is too early to draw on any evaluation results for this concept, the project has already obtained high grades from the client. The flexible design made it possible to reach loan effectiveness in record time (compared to the average in the Mexican portfolio) and first results on the ground can already be demonstrated after only 8 months.

Fluctuations in Portfolio Performance

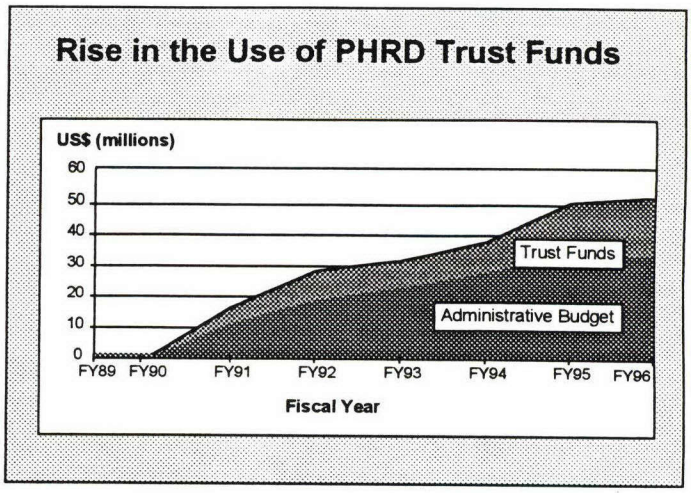
The size of HNP loans has increased from an average of US$12.5 million per loan in FY81 to US$102.3 million in FY96 (Bank average is US$84 million per loan).

While the average size of HNP operations has increased, the resources used to prepare and supervise them has decreased significantly. Several indicators are useful in assessing the performance of the HNP portfolio. Tracking the dollars lent per dollars spent over time is one way to assess overall efficiency in lending.[4] During FY96, the HNP and education sectors used 15 percent less resources to prepare projects (US$308,800 compared with US$366,000 Bank-wide) and supervise projects (US$49,700 annually per project compared with US$64,400 Bank-wide).

In terms of "dollars lent per dollars spent" it is interesting to note that the HNP sector has been a high performer. While performance by the Bank as a whole plunged by 50 percent from FY86 to FY96, although erratic, lending per dollar inputs in the HNP sector rose from US$35 to US$70 during the same timeperiod (see Figure *** below).



Although strictly speaking most trust funds are available only for project preparation, they have allowed managers to free up Bank resources for sector work and project implementation. Today, trust funds comprise almost a third of the total administrative budget in the HNP sector (see Figure *** below). Once again the HNP sector has been more successful than the Bank average in mobilizing such external budgetary resources.



Finally, the 60 percent "drop rate" for the HNP sector is much lower than Bank-wide average of 110 percent (a little over one project dropped per project approved). In FY96, the average Bank-wide cost per dropped project was US$113,300, while for HNP dropped projects was US$96,900. Since dropped projects add to overall costs, the low drop rate in the HNP sector contributes to its low administrative cost.

Drop Rate in HNP Sector

Sector	Dropped Projects FY92-FY96	Approved Projects FY93-FY96	Drop Rate
Human Development (including HNP)	147	231	0.6
Public Sector Management	55	86	0.6
HNP	62	84	0.7
Education	74	107	0.7
Environment	24	33	0.7
Energy	98	87	1.1
ALL SECTORS	460	628	1.1
Infrastructure & Urban Dev.	256	202	1.3
Agriculture	244	127	1.9
Industry and Finance	156	76	2.1

Drop Rate = (number of dropped projects)/(number of approved projects)

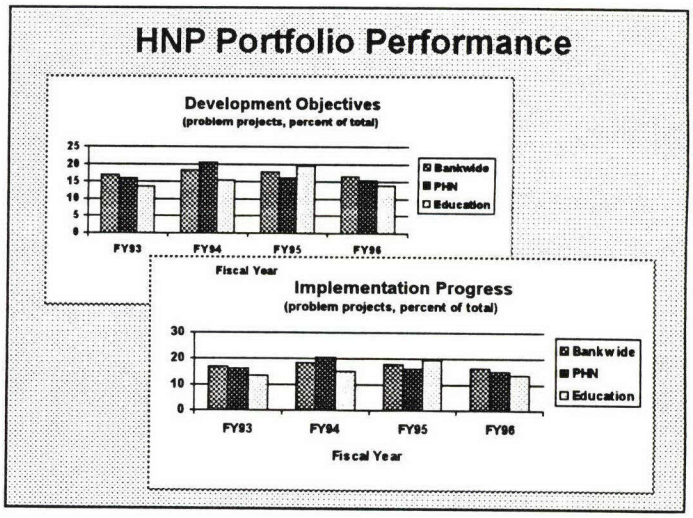
4 For the purpose of this analysis: ($Lent per $Spent) = (the Bank's administrative budget + consultant trust funds + Japan Grant trust funds)/(total commitments).

Although this overall efficiency in lending to health, nutrition and population activities indicates high staff performance in the HNP sector, several recent trends give reason to be concerned that further budget cuts could lead to a break point where quality of the product could be compromised. These trends include:

- The HNP portfolio is aging (based on the experience of other sectors, problems tend to increase with the average age of the portfolio);
- Pressure to contain public spending throughout the world is putting a strain on the health sector in many countries with availability of counterpart funding becoming a problem in many projects (salaries, supplies, and maintenance account for a larger share public-sector budgets in the HNP and education than in other sectors of the economy);
- Partly in response to such budgetary problems the HNP portfolio has been shifting from the more traditional "blueprint" projects to broader systemic reforms such as financing reforms and decentralization (but the implementation capacity of many developing countries to manage complex reforms is often low);
- The use of trust funds has allowed a disproportionate amount of resources to be available for project preparation, with a resulting increase in complex project designs (some of the resulting "complex" project are difficult to implement without parallel increases in supervision resources); and
- Most of the emphasis in performance monitoring has been on implementation progress (indicators to monitor, track and evaluate progress of development objectives are still in an embryonic stage of development).

As a result of these factors, although historically HNP projects performed slightly better than Bank-wide averages in terms of achieving both development objective and implementation progress, this performance appears to be deteriorating recently (see Figure *** below).

A project-by-project analysis of the current portfolio by the Bank's Quality Assurance Group and a 15 year historical review of the Bank's involvement in the HNP sector by Operations Evaluation Department (OED) has revealed a number of common issues. These include problems associated with implementation of projects in federated states; problems associated with country setting, including civil unrest; problems associated with inadequate institutional capacity by countries to manage projects, particularly those with more complex designs; and problems relating to procurement, disbursement lags, and availability of counterpart funds. In many cases more than one of these issues is involved, and it is often.



Efforts to address these problems in the HNP portfolio are well under way. They seek to strengthen both quality at entry by preparing better projects and review of supervision efforts. Regional managers and staff have established a number of initiatives, including a focus on HNP projects in Country Project Performance Reviews, with time-bound targets for portfolio cleanup, increasing resources for supervision, better project staff continuity, and in some cases moving staff to regional offices to bring the Bank closer to the client.

*Special Grants (*** more on OCP, TDR, HRP***)*

In addition to loans, the Bank co-funds 20 global and regional health programs through a Special Grants Program which supports activities that could not easily be undertaken at an individual country level. Typically, the Bank provides 10 to 15 percent of the total costs.

The longest standing and best known activity is the highly successful Onchocerciasis Control Program. At less than US$1.0 per person per year, the impact of this program has been immense: 30 million people protected from riverblindness; 9 million newborns since

the program began safe from risk of the disease; and 1.5 million afflicted people cured.

Other Special Grants address the AIDS epidemic, micronutrient deficiency, population, safe motherhood, female genital mutilation, tropical diseases, vaccination programs, and research on a variety of other health policy-related topics.

Catalyst in Setting Up Donor Consortia

Bank credits and lending, in addition to enhancing sector investments directly, also help to mobilize domestic and other donor resources.

For example, the Bangladesh Fourth Population Project (FY92) includes IDA financing of US$180 million, which is complemented by US$165.1 million from the government, and US$256.3 million from a consortium of 11 donor organizations. Thus the project mobilizes 3.3 times as much resources as the IDA credit.

Another example is the Zimbabwe Second Family Health Project. In this case, the IBRD financing of US$25.0 million was matched by US$52.7 million from the government, and US$36.6 million from a consortia of 5 donors.

The Budapest Regional Hub Approach

In 1995, the Central and Southern Europe Human Resources Division took steps to increase client responsiveness through creation of a Regional Hub in Budapest. Of the 31 higher professional staff in the Division, 10 are locally appointed staff in the seven Resident Missions, and 5 are HQ-based assigned to the field.

Results during the past two years have been impressive. By shifting 90 percent of supervision responsibility to the field (under a HQ-accountable Portfolio Manager), disbursements increased by 25 percent and development objective ratings improved significantly.

The function of the Budapest HUB, and other field offices, has been greatly facilitated by a quantum leap in the communications links with Washington. By using real-time satellite-based electronic mail and video teleconferencing systems, staff in many field offices are now able to participate as a team directly in key HQ-based activities and visa versa.

Supervision by a team of local staff and HQ-based staff stationed in the field can be both cost-effective and of high quality providing HQ support is maintained in providing a full range of strong technical expertise.

Increasing Field Presence

Many HNP Managers are exploring different ways to increase their field presence both to improve client responsiveness and implementation effectiveness.

One approach has been to step up the amount of operational and professional contact time between Bank staff and client countries through an increased field presence. If properly done, it is felt that such a shift to the field has the following benefits: better understanding of the country context; more sensitivity to client needs; greater opportunity to engage in policy dialogue; and close working relationship during supervision.

The India Resident Mission Approach

In India and a number of other countries — e.g., Bangladesh, Brazil, Indonesia, Ivory Coast, Mali, Mauritania, Mozambique, Senegal, South Africa, Tanzania and Uganda — skilled staff from HQ have been moved to the field to bring the Bank closer to the client.

The India Department has maintained at least one HQ-appointed Human Development staff member in the New Delhi mission since 1987. Additional local HNP professional staff have been recruited since 1989, bringing the total number of HNP staff in the field to five (four local staff and one HQ-based HNP professional).

The New Delhi-based HNP team now manages most of the nutrition work program, and provides support for population and reproductive health tasks. Project supervision has benefited by being scheduled when needed, and often by one state at a time. Task management of new operations from the field has improved client ownership and participatory project development. Likewise, sector work, — e.g., the review of the Family Welfare Program — has benefited from an in increase in the ownership fostered by continuous interaction with field-based staff.

A notable feature of the India model is that all procurement, accounting and auditing work on the HNP portfolio (19 projects) is handled out of the resident mission. Another notable feature of the India model is that the HNP team reports, and is accountable to, the New Delhi Resident Mission rather than the HQ-based HNP network.

LESSONS LEARNED

The high priority now assigned to the social sectors (by the Bank, its borrowers, and partners), the recent rapid growth in social sector lending, the squeeze of budgetary stringency, and fluctuations in project performance ratings as the sector is maturing — all underscore the need to strive continuously for better results and quality.

Extensive recent reviews of portfolio performance by the Quality Assurance Group, the OED and various country and regional implementation reviews have taught us a lot about how to improve quality at entry, implementation and sustainability of interventions in the HNP sector. Many of the following observations, which were made in the report on *Getting Results in the Social Sectors* issued early in 1996, are now in the process of being translated into action on the ground.

One set of observations emphasizes the need to ensure quality at entry (quality analysis and project preparation) by strengthening:

- **participatory approaches** that engage clients, beneficiaries, and other stakeholders in building strong local ownership and commitment;
- **sectoral analysis** to secure a solid knowledge about the issues and options being addressed, linking these to the macro- context of the country in question;
- **economic analysis** to inform choices among options, taking into account their costs and impacts;
- **institutional analysis** to ensure that a realistic assessment has been made of the country's policy making and implementation capacity;
- **sustainability analysis** -- including assessment of institutional issues, financial viability, and risks -- to check that the proposed project can be sustained;
- **project design and the focus of objectives** by concentrating on achievable and outcome-oriented goals and activities; and
- **monitoring and evaluation** to keep projects on track and to draw out lessons from experience to guide further efforts.

A second set of observations emphasizes the need to focus on lending policies and procedures to:

- facilitate easier and faster ways to test out project ideas on a small scale **(pilot operations)**, so that lessons can be learned and incorporated more fully before going to larger scale;
- encourage **a process approach rather than a blueprint approach**, so that projects that need to focus a *change process* -- such as a health reform -- are not committed to every expenditure in advance;
- accommodate the **highly decentralized nature of the social sectors**, where numerous factors are involved, right down to community level (e.g., education systems);
- modify how the financing of **recurrent costs** is treated, in cases where this would better serve the objectives of ensuring sustainability and supporting development in the poorest countries; and
- extend recent innovations in the application of **procurement** rules to accommodate the special features of social sector operations.

Finally, a third set of observations stresses the importance of staffing and organizational issues such as:

- the strengthening of professional excellence, a key priority, requires building up -- through **expanded training, improved incentives and high-quality recruitment** -- greater technical expertise and skills competencies in the sector;
- for **managers and reviewers** -- HR division chiefs, operations advisors, procurement advisors, and country directors -- to become more familiar with the HNP sector;
- using a **strategic approach** to analyzing and dealing with cross cutting issues; and
- using staff more efficiently by improving **professional network and sharing knowledge** more effectively across operational units.

Few of these recommendations would require changes in current policies or procedures, although some would entail changes in how some rules are interpreted and applied. All are, in essence, a call to take an idea that has already worked successfully in some cases and extend it widely -- i.e., make best practice into universal practice.

White Cover

Sector Assistance Strategy (SAS)
Health, Nutrition and Population (HNP) Sector

Section IV

Proposed Assistance Strategy

HNP Family
Human Development (HD) Network
World Bank

January 31, 1996

SECTION III. PROPOSED ASSISTANCE STRATEGY

OBJECTIVES OF BANK'S FUTURE STRATEGY

The objectives of Bank's future strategy in the HNP sector are to continue supporting low and middle-income countries in their efforts to:

- improve the quality of life through achievable gains in health, nutrition and population outcomes;
- contribute to the reduction of poverty and improvement in productivity; and
- control expenditures (public and private) in the HNP sector though more equitable, effective, efficient and quality financing and delivery systems.

PLAN OF ACTION

The SAS concludes that — in order to achieve these objectives — countries must re-define the role of governments and private involvement in the HNP sector.

It is not enough to merely continue investing additional resources in failing public services. Central governments must move away from direct provision of clinical services, while strengthening their role in other areas (proving public goods, information, regulation, protecting the poor and mandating/securing broad based risk pooling) and creating a more "friendly" environment for local communities, NGOs and the private sector to fill this role.

To assist countries implement this strategy, the Bank needs to adjust its activities in the HNP sector in five different areas:

- Engage clients and other stakeholders more fully in adapting and implementing the strategy at the country level through the sector work and country dialogue.
- Focus the HNP product mix to support this strategy (using a fuller range of IBRD, IDA, IFC and MIGA mechanisms and adjusting the portfolio, administrative budget and staffing patterns to anticipated future demand for support in this direction).
- Adapt the HNP Family's management, knowledge base, staff development policies, quality assurance and business processes to the needs of this strategy.
- Monitor and track performance in achieving the development objective described for the sector, as well as the recommended focus on a new balance between the role of the state and private sector.
- Provide leadership for, or support to, a few major international initiatives in the HNP sector which offer the greatest potential of having a significant impact globally in implementing this strategy.

Sector Work and Country Dialogue

Implementing the new HNP strategy is likely to have a development timeframe of 10 to 15 years, exceeding the life-cycle of most projects (5-8 years), individual staff assignments (3-5 years) and governments' term in office (1-3 years). It is, therefore, crucial that the Bank work closely with different government departments in elaborating country-specific strategies through country dialogue, sector work and training.

The SAS recommends:

(a) Making the CAS country-compact a key instrument for delivering this message by; (i) ensuring the strategy is consistently included in the CAS, or justification provided when this is not appropriate;[1] and (ii) allocating adequate staff time to work on the CAS and other macro policy-based work such as joint Bank-IMF-Borrower Policy Framework Papers (PFPs), CEMs, public

[1] The Country Assistance Strategies should be reviewed for: (i) the strategic policy framework they present in support of a shift in central government involvement in HNP service delivery systems, balanced by strengthening in other critical areas and establishment of a facilitating environment for the private sector; (ii) a minimal set of indicators to track progress over time (trends in public and private expenditure, human resources and capital stock); and (iii) a pipeline of lending and non lending services which support this strategy.

expenditure reviews, social insurance reforms, education projects, agriculture projects etc. [define benchmark].

(b) Including the strategy in: (i) sector work; (ii) regional, sub-regional and country-based initiatives; (ii) client-oriented training such as the "EDI/HD Flagship Course on Health Sector Reform and Sustainable Financing" [define benchmark]; and

(c) Bringing the Bank much closer to the client through its field presence by: (i) expanding regional offices like the Budapest Human Resources Hub; or (ii) increasing HNP staff in local resident missions [define benchmarks].

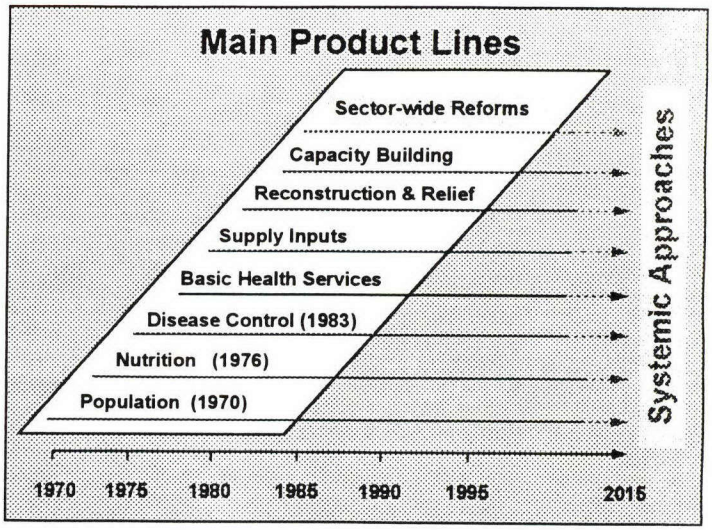
Product Selectivity and Impact

Demand for Bank financial assistance in the HNP sector is likely to continue outstripping available financial and staff resources.

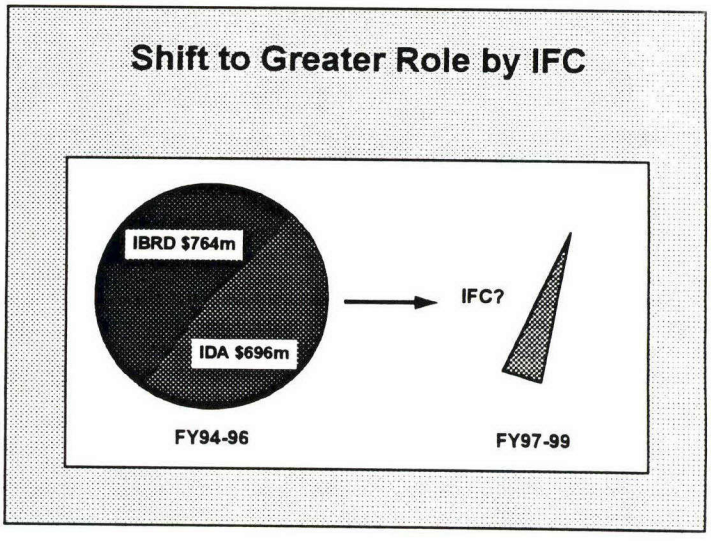
In deciding where to intervene and where to leave things to others or the private sector, there are few "off-the-shelf" solutions or "easy fixes" — blueprints do not work in addressing social problems or the challenges faced in the HNP sector. As described earlier, affordability, effectiveness and public sector rationale are likely to remain the best guiding principles, with each case treated on its own merits.

Although focused interventions in health, nutrition and population are likely to continue to be at the core of the Bank's involvement in the HNP sector in terms of total lending volume, the SAS recommends:

(a) Increasing selectivity in defining the HNP product line through: (i) more emphasis on a few critical activities that will facilitate a re-definition of the role of the state and private sector as describe earlier; and (ii) mechanisms that allow clients to apply for financial support from the Bank for a select group of "certified" programs that would be fully developed and implemented by other agencies or the private sector [define benchmarks]; and



(b) Exploring a more comprehensive range of IBRD, IDA, IFC and MIGA mechanisms, with: (i) IBRD and IDA funds reserved for areas of significant public sector rationale (major externalities, market failure and potentially negative fiscal or distributional consequences) such as health care financing, civil service and community-based reforms; and (ii) a shift towards IFC financing or MIGA guarantees, especially in the case of input-oriented operations in the service delivery system, such as hospitals and the production of drugs and supplies, which could be competently done by the private sector within the context of a proper regulatory framework [define benchmark].



Management of Bank's HNP Sector

The underpinnings for a new management of the HNP Family has already been initiated by the Bank's change management process and establishment of the new HD Network, HD Council and HNP Sector Board and Regional Sector Heads. The previous hierarchical structure in the Bank has been replaced by a horizontal, matrix structure that is more typical of corporations that deal with human capital, such as management consultants. This organizational framework allows for a more flexible and task-oriented approach to meeting client needs.

Keeping current in a sector where total global knowledge doubles in less than 10 years requires a substantial commitment and investment. Finding effective ways to deal with information overload will be essential in allowing staff, client countries and other international partners to take full advantage of the valuable resources that already exist as well as in keeping abreast with new developments.

It is also obvious that the rapid growth in the HNP portfolio cannot continue indefinitely without parallel adjustments in staffing and budget resources. With nearly 30 percent of HNP staff being long-term consultants, over 25 percent being newly transferred to the sector and another 25 percent being newly recruited to the Bank, staff development must continue to be a priority area.[2] The new HD Network has already begun addressing some of the associated staff development challenges through improved recruitment and exit policies, better staff training opportunities and higher HNP sector professional standards.

Another high priority area is to develop a more solid conceptual framework for: assessing what constitutes quality at entry (good economic analysis does not correlate strongly with project success in the HNP sector, and the tools for evaluating institutional capacity and political dimensions are not well developed); influencing negative external factors during implementation (maintaining political commitment from one government to another and overcoming institutional resistance); and monitoring and evaluating impact.

A final major challenge for the new HNP family is how to deal effectively with the transition costs associated with change (up-front sunk costs, teething problems and staff dislocations). Avoiding unnecessary staff dislocations is especially critical in the HNP sector where a detailed knowledge of the local context and continuity in the work program plays such a critical role in successful portfolio management.

The SAS recommends:

(a) Developing a *User-friendly Knowledge Management System* which will provide staff with ready access to a variety of resources, including: (i) a HNP help desk; (ii) an on-line database of policy papers, best practice papers, electronic forums, terms-of-reference, profiles of staff and consultants, and links to external resources; and (iii) a core HNP statistical database for expenditure and financing trends, currently not available through other agencies (with a focus on tracking private sector activities more closely) and a clearing house function for other health, nutrition and population data which are available through other agencies [define benchmarks].

(b) Implementing a new *HNP Staff Development Program* which will include: (i) a new skills mix consistent with anticipated expansion in the lending pipeline and shift in the product line to focus on private sector development, private sector regulation, sustainable sector financing, local capacity building, quality assurance and cross-cutting systemic reforms; (ii) a detailed staff training program which will place a greater emphasis on leadership and client related competencies (dissemination skills, advocacy and communications skills), in addition to technical skills (private sector development, public sector regulations, public health, nutrition, population science, health systems management, financing and health economics); (iii) new standards for assessing technical and other competencies which

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[2] Less than 20 percent of HNP staff have more than 5 years of sector experience. Some more experienced staff have become "de-skilled" over time. Many of the new staff are not yet fully skilled at using a full range of the Bank's instruments and dealing with its clients. And, while most HNP staff have impressive technical training and work histories, some require strengthening in management, communication or interpersonal skills.

will be required for entry to, maintenance in and promotion within the HNP family of the HD Network; and (iv) recruitment policies for the HNP sector which will emphasis the skills needed to deliver and manage a more focused portfolio [define benchmarks].

(c) Adapting *Business Processes* to the HNP sector by: (i) adjusting the administrative budget and staff (core Bank budget and trust funds) to place a greater focus on sector work; and (ii) using a wider range of instruments (including sector wide approach and use of dedicated technical assistance loans) and procurement procedures; and (iii) building better communication strategies into the policy dialogue and project cycle [define benchmarks].

(d) Improving *Portfolio Performance* by: (i) implementing current recommendations from the Quality Assurance Group (QAG) and translating *Getting Results in the Social Sector* into action plans; (ii) developing new analytical instruments; and (iii) initiating a more thorough analysis of monitoring and evaluation techniques, with an emphasis on the special requirements of assessing reforms, improving performance in service delivery systems through the private sector (while maintaining equity, efficiency, effectiveness, quality and choice dimensions) and financing [define benchmarks].

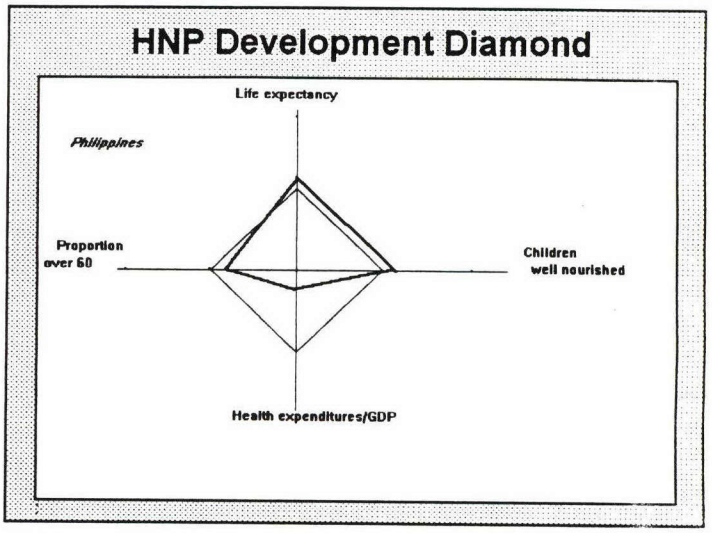
(e) Managing the *Change Process* by: (i) focusing on people and the work environment rather than structural changes and processes; (ii) making the system as transparent as possible; (iii) holding focus groups (the HNP family has already had a series of such meetings with valuable inputs from staff); and (iv) developing a set of indicators to measure the change process [define benchmarks].

Monitoring and Evaluation

To allow clients countries and Bank staff to monitor and track performance in achieving the stated development objectives for the HNP sector, a set of polygon charts ("Development Diamonds") that have been constructed from several basic indicators. These give an easy to understand "snapshot" of the performance or risk of a given country relative to the average for low- and middle income countries. For overall performance of the HNP sector, nutrition status, life expectancy, age structure, and HNP expenditure have been selected.

The following HNP Development Diamond for the Philippines is an example of country whose HNP characteristics are:

- below average HNP expenditure;
- better than average mortality;
- better than average nutrition status; and
- younger than average age structure.



More specific indicators for creating similar polygons to provide quick information on key HNP indicators are included in Annex ***. These include a health status diamond (under-five mortality, male and female adult mortality, over 60 mortality), a nutrition status diamond (low birth weight, stunting in children, obesity, and anemia), a population/reproductive health diamond (population growth rate, maternal mortality, adolescent fertility, unattended births).

New epidemics and other priority areas can be tracked through indicators such as HIV/AIDS prevalence rates, annual tobacco consumption, and remaining diseases such as TB. Finally, the performance of health systems will be tracked through indicators such as HNP expenditure/GDP level (level of resource mobilization), public/total health expenditure ratios (degree of risk pooling and equity in coverage), access to basic health services and immunization rates (success in providing cost-

effective basic health services) and health expenditure elasticity (efficiency of cost containment measures).

The SAS recommends:

(a) Tracking the impact of policy advice and lending over time through a set of standard performance indicators such as these development diamonds [define benchmarks];

(b) Assessing perceptions about need, demand and client satisfaction from a wider audience than is currently the practice through survey techniques [define benchmarks]; and

(c) Developing new instruments for assessing the performance of health care delivery systems (equity, effectiveness, efficiency, quality and choice) both in the public and private sectors [define benchmarks]; and

(d) Evaluating the effectiveness with which the Bank is communicating HNP strategies in client countries and with other partners through survey techniques [define benchmarks];

New Global Leadership

Although the Bank is the leading international agency in providing assistance to the HNP sector in developing countries, prominent in international policy debates and a major repository of intellectual capital, it could significantly improve its leadership role internationally in the HNP sector:

The SAS recommends that the priority areas be consistent with the new direction of the Banks involvement in the HNP sector. This would include:

(a) Ways to create a better facilitating environment for greater non governmental involvement in health care delivery systems; and

(b) Areas with significant market failure where the Bank's comparative advantage relative to other organization make it ideally suited to assume a leadership position such as such as: (a) supporting countries in securing more sustainable and equitable financing for the HNP sector and containing costs; (b) spearheading major international initiatives in addressing the unfinished agenda in immunization and re-emerging infectious diseases (such as malaria or the growing epidemic of tobacco abuse); (c) taking a proactive role in reforming and expanding international research and development (R&D) related to the HNP sector; and (d) participating in a major capital-intensive post conflict reconstruction program.

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Lieberman

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

DATE: 15-Feb-1997 09:39am

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

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

EXT.: 82539

SUBJECT: special initiatives

Alex,

Some notes follow in a few minutes on the topics allocated to me. But first I wanted to mention a topic I had hoped to see discussed but which I intentionally did not raise because we were very usefully occupied with the main story line and Chap.4. This topic concerns the limited number of special themes, health problems and initiatives we want to recommend via the SAS. When we discussed the GTB at the Health Board last month, it was agreed that the SAS process was the arena in which to talk through which of the several actual or potential Bank commitmenst in the health field should get priority. When and How do you see this happening? Obviously, I would like the opportunity to make the case for a stronger Bank commitment to and involvement in GTB. There are several reasons for this apart from the intrinsic merits of confronting a worrisome disease threat. These reasons include the good fit between fighting TB and the emerging story line of the SAS which emphasizes faltering government services, the continuing poverty angle, the need to enhance system performance and to figure out appropriate role for central and local governments and various non-government players and so forth. A second key rationale is the good relations we have with GTB and the open door this provides. Please advise how you want to play this. SL

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

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

DATE: 15-Feb-1997 10:02am

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

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

EXT.: 82539

SUBJECT: some paras.

Alex,

here are some paras on a few topics. I hope that Ed, Bill and Xavier will chime in if they feel so moved.

QA: the sense of the discussion was that there are a variety of QA mechanisms which are available; some older ones like peer reviewing are in disrepute while some new ones, e.g., QAG, have their own characteristics and disadvantages including relying on a possibly outdated approach and being very costly. Improving staff skills ect. itself should raise quality. Nevertheless there will need to be useful QA procedures. These should be based and operated at the regional level. What role for the HNP Board and Network--this is something that needs further attention. The SAS could ask the Board to do this.

decentralization: the sense was that this is a growing trend with each region trying out different approaches with somewhat different objectives. There was growing appreciation of the value of transferring many procurement functions to resdient missions (RMs) along with the traditional representation and liason roles. I noted that EAP we will likely to looking to RMs to be home base for carefully selected teams whose mandate includes not only lending dev. and spn but increasingly the provision of just in time, catalytic advice to clients who are looking not for knowldeg/best practice but help in working through difficult trade-offs. I suspect this function overlaps a lot with the need for/abilty of the Bank to pursue sector-wide approaches. Some cautions were voiced. Would the wrong people get sent and who would manage the health team--it could be a disinterested resrep or p tussle with HQ. Then there is the high costs likely leading to more local hiring at lower rates. But this could lead to some disengagement with the health family Bank-wide unless care was taken. I believe these concerns while valid can be handled. Finally, the usefulness of hubs was questioned on costs grounds.

partnerships: There were various thoughts to pass on re this topic. First, the SAS should not assert the Bank's global leadership--let's adopt a humble pose. references, examples re IFC would be useful. The way that WHO is treated also matters. There are some positive examples--GTB, TDR etc. Same for bilaterals and there could be good boxes (Ghana, Bangladesh)

shoiwng bilaterals in a positive light. IADB got some favorbale mention but ADB and AfrDB definitely did not. The value of hosting good secondees from outside was recognized and the usefulness of selective placement of good Bank staff in the UN (GBT) was noted in discussion.

There needs to be a review and prioritiziation of Bank involvement in key international initaitives. Where should be invest our time and talent? This still needs discussing.

hope I got it all, SL

CC: A. EDWARD ELMENDORF (A. EDWARD ELMENDORF@A1@WBWASH)
CC: Xavier Coll (XAVIER COLL@A1@WBHQB)
CC: William McGreevey (WILLIAM MCGREEVEY@A1@WBHQB)

Lending

The SAS recommends the following approaches and actions to increase the impact of :the Bank's lending for PHN.

First, lending in the sector will increasingly be carried out within a sector wide framework. This implies that the preparation of Bank-financed operations will require improved analysis aimed at ensuring a better link with the overall policy in the country's health sector, increased attention to the appropriateness of the sector's expenditure levels and to allocative efficiency both of public and private financing. The objective is to assure that the Bank's PHN lending portfolio in any given country is consistent with and contributes to increased allocative efficiency in the sector. A related objective is to provide a sound framework for bilateral and other multilateral support to the sector.

The introduction of a sector-wide approach to does not necessarily require new lending instruments. Current instruments, such as investment lending, can effectively contribute to this approach through enhancements of the quality and scope of the economic analysis carried out during preparation, the introduction of loan conditionality linking investments to improvements in sector policy and overall allocative efficiency (e.g., linking investments in civil works or equipment to measurable improvements in the levels and composition of recurrent expenditures), and, through cofinancing arrangements with bilateral and other multilateral sources of external financing.

In addition, the sector will expand its use of other lending mechanisms. Investment operations can have an increased impact if associated with a combination of sector adjustment operations, and broader adjustment and public sector reform projects. . For instance, sector investment programs, such as the ones that are currently used in the Africa Region and Pakistan, can have a great impact in those countries that require greater adjustment of the levels and composition of expenditures and a more consistent approach for external aid and financing. The sector should also be more actively involved in participating in the design and implementation of adjustment lending. For example, the preparati on of a provincial reform project in Argentina primarily involves actions to ensure the reform and adjustment of the health and education sectors in four northern provinces. As the health sector is increasingly recognized as one of the biggest public sector employers and responsible for a large (and, in most cases, increasing) share of public sector expenditure, the introduction of health sector conditionality in SALs should be substantially increased.

New Financial Instruments: One of the SAS main messages is the failure of the public sector to deliver quality health services efficiently. As this is recognized, the need to improve the role of the non-government sector becomes a priority. the implementation of this objective is currently limited by the lack of the Bank's financial instruments to support private sector activities and investments. While the IFC is unlikely to increased its lending levels to private sector initiatives (e.g., pharmaceuticals, for-profit hospitals), there is still a need for the Bank's more active involvement in the development of non-government

initiatives. The SAS proposes, for example, the creation of an IDA window of financing that will provide (grant?) funding to support such initiatives (*to be developed)*

Financing of recurrent expenditures. The current limitations on the Bank's financing of recurrent expenditures has a negative effect on the design and implementation of HNP operations. There is a widespread agreement in the sector that budgetary support of some resurrent costs (e.g., medical supplies, food) should be considered as investment costs and funed under loan or credit proceeds.

Box on Argentina and Brazil

Private Sector Delivery

In Brazil, most health care services are delivered by rpivate providerswho compete for patients. Service provision is organized under the Unified Health System (SUS) which integrates the public network with the private philantropic and for-profit networks from which the Government purchases services. These serrvices represent about 70 percent of total health services provided in Brazil. The balance of 30 percent is supplied by the private for-profit network that does not contract with the Government and serves patients who are privately insured or pay out-of-pocket. Patients are free to choose between public and private providers contracted by the SUS. In 1994, the private sector accounted for 79 percent of hospital beds in the SUS, 83 percent of publicly funded hospital admissions, and 87 percent of hospital reimbursements. The private sector also accounted for 43 percent of publicly-funded ambulatory procedures and 73 percent of all reimbursements.

The potential benefits of a system characterized by public financing of "competing" private providers are limited by the inadequacies of the contracting mechanims. Providers are reimbursed of production (DRGs): Current reimbursement rates are far out-of-line with the average costs of services, causing lack of investments and maintenance of facilities, shortages of essential inputs and leading to poor qulaity of care and to fraud. A recent study estimates that reimbursements cover no more than 40 to 50 percent of real costs. Furthermore, the deterioration of prices has been uneven across procedures and diagnosis. This distortion affects the reimbursement of essential clinical and public health services, while less cost-effective tertiary care has been realtively more protected. In addition, it provides a perverse cross-subsidy since the upper middle class use costly tertiary care dsiproportinately.

The Brazil case underscores that the benefits of the financer provider split can only be attained if transaction mechanims and payment modalities are celarly defined, sound and transparent.

Linking Investments to Institutional Change

In Argentina, the Bank is financing the establishment of a basis for a broad reform of public hospitals. The Government of Argentina is supporting the transformation of public hoshospitals into self-governing trusts. This model is based on the separation of the health financing and and health delivery functions of the public sector. Self-governing trusts are granted the capacity to charge and collect from third-party payers (i.e., national and provincial social insurance funds and private insurance). These funds stay at the hospital level to finance investments and recurrent costs such as supplies and performance-based salary complements. The rpject is supporting organiational, management and financial tools into hsopitals to facilitate their transformation. It is also financing selective investments in physical plant and equipment.

Investments are linked to management improvemenst and will be carried out in two phases. Hospitals are eligible fro financing under the first phase (up to 40 percent of total investment costs) subject to the preparaton of a satsifactory investment plan. The reamining financing for investments relate to the progress in implementation of institutional development activities including the definition of cost centers, a new orgazational structure, and a retructured staffing plan. Some provincial .....

Satffing

MODALITIES: Knowledge is a Product

In HNP, knowledge is a product: BM

- Indonesia, Chile borrow to get Bank sector work and advice;
- Gulf states pay for Bank reports

Beyond knowledge, the Bank and its staff provide catalytic advice, i.e., fundamental policy guidance that no individual consultant can offer. Communications skills and a team approach are essential to this service.

creation of HelpDesk and Web site by HDDHE is an input to knowledge building.

mcg.

23 Feb Sun DCA 8
SMF 12 15

25 Tues SMF 11:30
26 Wed PEK 21 30

2 Mar Sun PEK 1745
BKK BKK 2155
3 " DAC 12 15
Sheraton
13 " DAC 13 25
BKK 16 40
14 Mar FRI BKK 00 30
LHR 6 20
23 Mar Sun LHR 12 15
IAD 15 35

- missing much of BANGLA mission
- George's seminar
- Logan / Alex day seminar

Xavier

Instruments for the World Bank to achieve the HNP mission

1. With the articulation of a Bank strategy for HNP, the Bank intends to provide a more consistent, less idiosyncratic approach to country assistance than in the past, while still encouraging innovation. The main tools to achieve the Bank HNP mission are:

a. Policy advice, advocacy, and sharing of international experience
b. Lending
c. Analysis and research

Policy Advice, Sharing Experience, and Advocacy

2. The underlying notion is that the Bank will be primarily concerned with helping countries to develop their own policies and implementation strategies to deal with HNP issues most pertinent to them. The area where our policy advice is most pertinent is in the design of overall systems and strategies for HNP, helping to define priorities, assisting relevant agencies to assign roles and responsibilities, and monitoring progress. Where there is demand and staff or consultants have particular expertise, we should advise on more specific program content. A major role of the Bank is to facilitate the processes of policy development, program design, monitoring and evaluating system performance, and to bring in appropriate actors in these processes. We have a particular role in linking sector issues to other policy areas within a country, and synthesizing and disseminating world experience on systemic HNP strengthening or reform. The specific mechanisms for providing advice include: Technical assistance, ESW, seminars, study tours, PERs, IDF grants, and others.

3. We also plan to take on a greater advocacy role for HNP issues, promoting dialogue within sector Ministries and central Ministries of Finance and Planning, and in engaging civil society in larger public debate on key issues. This will entail better communications strategies and use of media.

Lending

4. Based on the HNP SAS intentions, Bank lending and supervision in all countries should be consistently predicated on the analysis of sector-wide policy and operational framework, and assessment and plan for the capacity, and agreement on overall expenditures on HNP, covering public, aid, and private financing. Other characteristics of HNP lending are:

- a broad group of country stakeholders (not simply Ministries of Health) should be involved in developing and monitoring lending
- the need to accept a range of loan options from simple starter loans to complex reform loans, or loan programs with multiple projects
- Where appropriate, sector-wide or cross-sectoral lending should be used as a means to support system strengthening and sector reforms (though this may be possible or appropriate in only a few countries)

- We will need to have time-slice lending available for projects and programs with longer time frames (e.g. 20 years), particularly in very low income countries
- IDA funds should be considered for grants, particularly to non-government entities
- A specific rationale for targeted projects should be given when they are not part of a system wide program
- Within the context of agreed expenditure programs, recurrent cost expenditure should be explicitly allowed, along with 100% Bank financing where needed
- Selective Regional or global lending or grants should be considered to support high priority, cross-country initiatives. Selection should be based on making a business case for Bank involvement or leadership in these areas (such criteria could include trans-national nature of the issue, potential for economies of scale, multi-national demand, opportunity to develop new tools through a multi-national approach, etc.)

Research and Analysis

5. Research and analytic priorities should be explicitly related to our HNP mission and operations. The comparative advantage of the Bank is in areas of cross-country, cross-sectoral, economic, and expenditure issues, more broadly to promote evidence-based HNP policy. As a general rule, the Bank should focus on framing technical research questions, assessing and disseminating results, rather than conducting the research. We should, however, have strong in-house evaluation and expenditure analytic capability. We should promote international research consortia, and work with other partners in promoting research, taking on leadership in coordinating or promoting the research agenda on larger, international issues.

Mission Objectives
Talen

Section III relates to WB mission
The overriding mission of the Bank is reducing poverty and an essential element is improving human capital. See Section III White draft. Add: with low population growth.

Failure of HNP programs, public programs
Not reaching the poor
Not adequately addressing their problems
Not attracting them to such services
Not enough resources
Poorly allocated
Not efficiently spent not adequately targeted tot he poor
Poor quality
Participatory approaches
Failed to provide means to reduce fertility
failed to include other sectors in promoting demand.

Rapid population growth is associated with poverty at the macro-level
High fertility rates are concentrated in the poor and are associated with high maternal and child mortality and low status of women at the household level.
In the poorest developing countries, primarily in Africa and South Asia, rapid population growth seriously jeopardizes human and economic growth
The number of reproductive age women chase doubled generating serious population growth momentum, which makes fertility reduction even more imperative

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Reproductive health service be widely accessible
Improve status of women, increase girls schooling, reduce maternal and child health mortality,
Provide means for women to prevent unwanted pregnancy
Recognition of the demographic momentum and the need to address it and to make efforts to delay child bearing and increase the spacing of children

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Nutrition
Inadequate purchasing power
Disease
anti-nutritional behavior

Address above through safety nets & nutrition education
community-based behavior-based community programs
Improve food policies
Coordination with improved general sectoral services

Assist in providing basic core packages of cost-effective services to the poor
(publicly financed and not necessarily publicly provided)

Resource Mobilization

RE. Richard's Outline

III. ENHANCING OUTCOMES

HNP outcomes should be an overriding consideration in planning, designing and implementing and evaluating.

Governments failed to provide enough attention to outcomes in past interventions.

Concurrently, the Bank will need to assist Governments in shifting their focus from supply driven approach to outcome driven as well as client-driven approach.

Mention that we need to go beyond health services, selectively and where relevant.

Key investments in other sectors could have major consequences on health.

David Peters

HNP Sector Assistance Strategy Meeting with Regional Representatives - February 13-14, 1997

Meeting Notes

Attending: Alex Preker, Richard Feachem, Prabhat Jha, Mariam Claeson, Bill McGreevey, Ed Bos, Vivian Hon, Akiko Maeda, Judith McGuire, Anne Tinker, Ed Elmendorf, David Peters, Verdon Staines, Xavier Coll, Daniel Cotlear, Sandy Lieberman, Gail Richardson, Regina Bendokat, Salim Habayeb,

1. Following work by the core HNP SAS team on the initial three sections of the SAS document, regional representatives joined the SAS team to provide guidance on Section IV of the document: "The Proposed Assistance Strategy", and to review the conceptual basis for the statistical annex. The following framework was adopted for the proposed Bank strategy (written reports were prepared for each of the three domains):

A. The Mission for Bank involvement in HNP
   i. Poverty reduction/alleviation
   ii. Resource mobilization and cost-containment
   iii. Enhancing HNP outcomes and system performance

B. Instruments for Bank intervention in HNP
   i. Policy advice, advocacy, and sharing of international experience
   ii. Lending
   iii. Analysis and research

C. Modalities for enhancing our effectiveness
   i. staff skills mix
   ii. lending instruments
   iii. use of Bank budget
   iv. knowledge management and application
   v. decentralization
   vi. building partnerships
   vii. quality assurance

2. The team also discussed other concerns with the strategy. The main message of the document is not simply that public HNP systems are failing, and therefore should be put out of business. Rather there are failures of public and private sectors and of aid, requiring more fundamental and selective approaches in the changing the roles and effectiveness of various actors involved with HNP issues. The group cautioned against restricting HNP to a narrow view of a health sector (and health services), but to take a more broad view of HNP perspectives. Similarly, it was suggested that more attention is needed to bring out the Bank's relationships with Government, HNP interest groups, partner agencies, beneficiaries, and civil society, in order to be more specific about our strategic approaches with different groups and in different contexts.

3. The discussion on the statistical annex reached the following conclusions...

Tom

(4)

Despite its rapid expansion, the performance of the HNP portfolio has kept pace with the Bank-wide average, with approximately one-in-five projects in HNP being classed in the "problem" category for implementation progress and development objectives combined in the FY 1996 Annual Reviews of Portfolio Performance. Nonetheless, there are reasons for concern about performance trends in this sector: chart

- The social sectors face a number of challenges not found in traditional lending areas (for example, industry and infrastructure). The benefits are often difficult to quantify, and often appear years after specific projects investments have been made. Many more factors outside the scope of projects influence the outcomes, including a range of individual behaviors. The Bank and IDA often support the social sectors in settings where they would not invest in other sectors. While the needs often justify taking these risks, the standards and tools for assessing and managing risks in these settings may not be adequate.

- Delivering social services involves more people and institutions at various levels of government than do investments in other sectors. The success of social sector investments hinges to a greater extent on "people" factors: motivation, incentive systems and politics. For example, there is often great political resistance to privatizing social services because of the impact on public-sector employment.

- Recurrent costs – salaries, supplies, and maintenance – account for a larger share of public expenditures in the social sectors than in other sectors where the Bank lends. Availability of counterpart funding is often an issue, particularly when there is pressure to contain public spending.

- Over the last decade, the composition of the HNP portfolio has been shifting from more traditional "blueprint" projects that built infrastructure for service delivery toward inputs for which borrower implementation capacity is often weak: for example, to procure pharmaceuticals, to manage behavior-change communications and training, and to design and implement sector policy and reform. Problems emerge when Bank processes and borrower capacity (in procurement, for example) have not kept up with these changes.

- Most of the emphasis in performance monitoring has been on implementation progress, with less attention to development impact. Because both the shift in composition and the increase in lending has occurred since the late-1980s, there has been less chance to assess their development impact of these shifts, and there are few indicators available to measure them.

- Because few problems are identified in the first year or two of project effectiveness, problems tend to increase as the average age of the portfolio rises. While most HNP projects are younger, its older projects have not aged well. The problem share is 50 percent in HNP for projects with nine or more years of effectiveness, compared to a Bank-wide average of 17 percent. In many of these cases, HNP portfolio managers have been slow to restructure or cancel projects.

- Growing concern about performance issues Bank-wide prompted the Quality Assurance Group to focus on potential as well as actual problem projects. When potential problem projects are added to the list of actual problems in the HNP portfolio, a third of all active projects fall into the problem category.

Project-by-project analysis of HNP problem projects revealed a number of problem issues that showed up consistently in the list of actual and potential problem projects. These included problems associated with implementation of projects in federated states and other decentralized setting; other problems associated with country setting, including civil unrest; problems associated with inadequate capacity to manage projects, particularly those with more complex designs; and issues relating to procurement, disbursement lags, and availability of counterpart funds. In many cases more than one of these issues was involved, and it was often difficult to separate the symptoms from the causes of problem issues.

Efforts to address problem issues in the HNP portfolio have sought to strengthen the review and supervision process. Regional managers and staff have established a number of initiatives, including a focus on HNP projects in Country Project Performance Reviews, with time-bound targets for portfolio cleanup, increased resources for supervision, better project staff continuity, and moving staff to regional offices to increase project oversight. Recent actions to restructure all or part of problem projects and cancel components or whole projects have helped to reduce the problem project ratio in the HNP portfolio, especially among the older projects.

In their responses to problem issues, regional managers and staff reported that they were getting conflicting signals – they were being urged to allocate more resources to implementation at the same time that they were being asked to cut back substantially on administrative costs. Some of these cuts have come at the expense of "upstream" activities such as sector work and development of project designs better suited to the changing nature of HNP lending, and which could potentially avoid many of the problems that plague current portfolio.[1] One of the questions raised in addressing portfolio quality is how, in a resource-constrained environment, to address existing problem issues through more intensive supervision while taking action to avoid future problems through appropriate "upstream" investments in country-level sector strategies and in the development and application of tools and staff capacity in economic and institutional analyses during preparation. How we use scarce staff resources is as important as the amount of those resources, and there is growing evidence from recent experience that portfolio performance would improve if those resources were better deployed in upstream activities.

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1 As noted on page 30, there has been a 50 percent decline from FY1986 to FY1996 in the ratio of spending for project preparation in the HNP per dollar lent. The decline would have been even greater without trust funds such as the Japan Grant Facility. While this may have represented an increase in efficiency, it occurred while projects were becoming more complex and involved increased reliance on long term consultants who were less expeienced than regular Staff but could be paid from trust fund accounts.

David
& Watkins

SUGGESTED OPENING PASSAGE

The World's Health: Important and Improving -- for Most

1. Health is central to development , both in its own right, and as a contributor to economic progress. In itself, good health is as fully important as adequate income for adequate human well-being. In addition, it represents a central component of human capital, increasingly recognized as being fully as important as labor or physical capital for economic growth.

2. For most of the world's population, advances that have occurred in health, nutrition, and population during the past few decades are impressive. For example, as we approach the turn of the second (third?) millenium, it is remarkable to realize that over half of the gains in life expectancy of the past two thousand years occurred during this century; while in the last fifty (?) years, fertility rates have dropped by more than half (?)

3. As described by the World Health Organization (WHO) in its *1996 World Health Report*, hundreds of millions of people in developing countries are on the threshhold of a new era in which they will be safe from the some of the world's most threatening diseases. UNICEF's *1996 State of the World's Children* gives vivid examples of the progress that has occurred. The proportion of children dying before reaching age 5 is less than half the level in 1960. There has been a 20 percent reduction in child malnutrition. Immunization saves an estimated 3 million children's lives annually; better control over diarrhea saves over a million more.

4. However, over a billion of the world's people have participated only partially, if at all, in these gains. According to Bank estimates, 1.3 billion people -- over (nearly?) one-quarter -- of the global population continues to live in absolute poverty, earning less than $1.00 per day. These people have been growing in number, and are expected to continue doing so -- to 1.x billion by 2020.

5. Health conditions among these people are grim. On average, they live 20(?) years less than do people in the richest quarter of the world's population. Their children die more than twice (?) as frequently and more than 20(?) time as likely to be severely malnourished. Their fertility is over three (?) times as high.

The Origins of Good Health and Illness

6. Several factors influence the great variability in health status which is observed across population groups...

NOTES

The text presented on the preceding page was drafted by Dave Gwatkin on the basis of ideas provided by Prabhat Jha. The ideas are:

-- Beginning with a clear statement of the importance of health, both for its own sake and as a contributor to economic development. The objective is indicate a strong concern for human well-being at the outset, tohelp counter the objection to the earlier draft as inadequately concerned about this. This statement appears as paragraph one.

-- Including statistics about people in poverty, in order to provide a basis for and lead into the SAS recommendations concerned with the health of the poor. These statisitcs are in paragraphs four and five.

Mariam

Inputs for Section II

1. Poverty reduction

Although progress has been made in reaching consensus around new more effective and efficient HNP policy directions , discussed below, the world's poorest populations still live under the shadow of a group of old enemies that kill more than 12 million children and over half a million women a year. Often vulnerable groups -- urban and rural poor -- do not have access to the most cost-effective preventive and curative interventions. And, where there is access to health services, utilization might still be low due to poor quality of services as well as other factors that influence care seeking behaviors and demand (e.g. perception, knowledge, gender and cultural determinants).

Poverty increases people's vulnerability to most diseases, but its link with communicable diseases of childhood, malnutrition and poor reproductive health is particularly strong. Childhood infections, malnutrition and maternal perinatal conditions are borne almost exclusively by poor populations; they contribute to more than a third of the entire global disease burden, more than half of the disease burden in sub-Saharan Africa and almost half of it in India. Poverty is a predisposing factor and also a consequence of them. In spite of significant progress, hundreds of millions are trapped in a cycle of underdevelopment, prevented from reaching their potential in school, in the workplace, in the household and thus in the economy.

Reducing poverty related health and nutrition problems will require -- in addition to enhanced preventive and clinical services -- that these services, whether provided through private or public channels, reach the poor who need them most. Especially important in this regard will be measures to ensure that the 1.3 billion people whom the Bank has identified as living in absolute poverty, with incomes less than one dollar per day, are effectively served. Experiences in many fields show that it is possible to improve on the present situation through careful targeting. Approaches that can be used to reach this objectives are a focus on:

- poor individuals or households;
- poor regions;
- health problems or diseases that are major problems to the poor;
- service providers from which the poor frequently receive care.

[Inputs from regions : Box xxx on targeting, describing each of these approaches "how to" -- applying means test to identify the neediest and providing free or subsidized services to those qualifying/ vouchers/ regional focus within countries/ targeting MCH/skills training of front-line health workers etc. -- using country examples: China, Indonesia...]

These targeting strategies are not mutually exclusive, neither the complete solution to reaching and involving the poor. Exploring other proactive approaches to educate, inform and empower the poor to make effective use of available services and to initiate behavioral changes are necessary for long-term major health improvement.

2. Resource mobilization and cost containment
Fiscal issues

3. Global policy direction

Health policies vary greatly across countries but a few broad themes related to outcomes, strategic shifts, quality and participation have evolved. Five recent global initiatives have been instrumental in defining current policy directions for improving health, nutrition and population outcomes; these initiatives on Population and Development, Health for All, the World Summit for Children, Reviewing Global Commitment to Fight Hunger and the Social Summit are described in Annex xxx.

1. Enhancing outcomes

Some key elements of global HNP policy are reduction of the major disease burden, commitment to common goals, setting priorities and specifying targets, and evaluating outcomes. In recent years, attention has focused on putting interventions together into packages; grouping services to make the best use of the clients' time, treating an individual instead of the individual's diagnosis, bringing treatment together with prevention and reducing the costs of providing services by sharing resources (e.g. immunization and integrated management of childhood illness). The synergetic effect on outcomes that can be achieved through coordinated health, nutrition and education interventions are also at the center of recent health and development efforts.

A major conclusion in Section I regarding performance of health systems is that:
- the underlying threat to good health, nutrition and population outcomes are known and that affordable solutions are available, but
- because of the weak implementation capacity of many public health agencies or market imperfections in the private sector, recommended policies often fail.

The HNP strategies that are known to influence premature mortality at different stages of the life-cycle are shown in the box below:

[BOX

Low cost prevention and treatment

Childhood and early adulthood age 0 - 34	Vaccination, RCH, education of girls, safe water, HIV prevention, school health/deworming , nutrition program, TB/malaria treatment, injury control and low-cost secondary treatment
Middle age 35 - 65	Control of tobacco, prevention of high blood pressure, cholesterol and diabetes; TB/malaria treatment; low-cost secondary treatment

End BOX]

[Jordan, country example of a "package" of interventions that would impact the major disease burden and reduce costs/rationalize health services/shift current dependency on tertiary care etc., recommending health promotion and essential clinical services]

Health policymakers and managers have increasingly acknowledged that a focus on health outcomes is one of the guiding principles to prioritize health spending. One of the instruments is DALY's and cost-effectiveness analysis; this has been applied in 30 countries to date. Countries continue its strive to achieve their child mortality goals established at the 1990 World Summit on Children and WHO is currently collaborating with countries in evaluating progress towards Health for All targets by the year 2000. The commitment to monitoring outcomes and evaluating impact is still limited by lack of reliable data and incomplete information on health outcomes and spending in public and private sectors. For example, over 40 % of developing countries lack data on private health expenditures.

2. Shifting HNP policies and strategies

I. Addressing the unfinished agenda. Among the most cost-effective approaches that address a third of the global disease burden -- more than half of the burden of disease in sub-Sahara and around half of it in

India -- caused by communicable diseases in childhood, malnutrition and poor reproductive health are: immunization, integrated management of childhood illness (IMCI), prenatal and delivery care, and family planning.

[Figure page 19; Investing in Health R&D]

The state of the art and new directions in addressing the unfinished agenda are summarized as follows:

Immunization is a highly cost-effective package of vaccines. The objectives of the Expanded Program of Immunization are to achieve 90% immunization coverage in children under age one, eradicate polio, eliminate neonatal tetanus and reduce measles. In spite of major achievements in reaching the mid-decade goals and the eradication of polio from the Americas, national immunization coverage's are leveling off in some countries and falling in others (e.g. China). The global challenge is sustaining and increasing immunization coverages.

[Country Box on immunization]

The new approach to Integrated Management of Childhood Illness (IMCI) has recently been developed and is ready for implementation. The increased effectiveness has been achieved by new treatment protocols that deal with all major causes of death (diarrhea, pneumonia, malnutrition, measles and malaria) in a more holistic way. It recognizes that most children have more than one problem and thereby reduces missed diagnosis. IMCI combines prevention (feeding advice, immunization and vitamin A) with cure, reduces the dependency on a wide variety of drugs to a short list of essential drugs, helps the health worker (doctor, nurse and other health workers) to make a more accurate diagnosis and referral decisions based on signs and symptoms and emphasizes interpersonal communications skills in the interaction between the health provider and caregiver. Efficiency gains have been made by the development of one integrated skills training course replacing multiple disease specific training courses, and by an adaptation process that each country will follow to adapt generic policies and the state of the art to local conditions, disease patterns and cultural contexts.

The new Reproductive health approach are based on the recommendations of the 1994 International Conference on Population and Development (ICPD). It combines concerns for rapid population growth and the need to improve individual and family welfare -- recognizing the interactive effects between population growth and girl's education, the status of women and overall poverty reduction. Good reproductive health slows down population growth as well as reduces a significant burden of mortality and morbidity, especially of mothers and their infants. Three major reproductive health goals follow from this approach:
- a satisfying and safe sex life free of diseases, discrimination, coercion and violence;
- freedom to control the timing and frequency of reproduction; and
- a healthy maternal and infant outcome among those planning a family.

The most cost-effective services in a long list of reproductive essential services are: family planning services, prenatal cares, safe delivery and postpartum care, and the prevention and treatment of STDs.

In nutrition, as a result of implementation experiences and R&D breakthroughs, nutrition policies now focus on a few feasible and cost-effective interventions, **including micronutrient supplementation and deworming of school children.** Future directions include determining the best mix of nutrition interventions to improve the nutritional status of the poor, and a research focus on improved weaning practices, including locally appropriate weaning foods. Research of the effects of malnutrition on learning and work productive have shifted the focus on nutrition policy from welfare to development; effective nutrition policies also require broader multisectoral approaches.

II. Re-emerging and emerging communicable diseases
Increasing human mobility and spreading antimicrobial resistance contribute to the unpredictable threats of tuberculosis, malaria and HIV-- without respect for national borders. In response, prevention and treatment policies have changed. **Best practice for tuberculosis** is to use direct observed treatment (DOT) with a cost-effective drug combination in order to improve cure rates and reduce spread of infection. **Malaria control** now relies on a combination of approaches such as insecticide treated mosquito nets and treatment and less on household spraying. Research on the effectiveness of bed-nets have shown a reduction in under-five mortality of 20% in Africa. Finally, **treatment of Sexually Transmitted Diseases** (STDs) contribute to reduction in the incidence of HIV infections. STD treatment provides a cost-effective tool to the struggle against the HIV/AIDS pandemic as well as in the reduction of other STDs and is increasingly incorporated into reproductive health services.

III. Non-Communicable Diseases (NCDs) and injury control. Projections of the global disease burden shown in Section 1 indicate that middle-income and low-income countries are likely to see a shift towards an increase in the relative burden of NCDs in the population. As populations age and exposures to risk factors, such as tobacco and alcohol, increase, NCDs and injuries, mainly cardiovascular diseases, mental illness, cancers and road accidents become more prominent. Control of cardiovascular disease relies largely on prevention, including control of tobacco use [See Box xxx Taxation: A Powerful Tobacco Control Policy], and on low cost treatment.

[Box on Taxation]

3. Improving health care systems performance

While health care absorbs a very substantial 8% of the entire world's output, millions of people -- mostly poor , as discussed in the poverty section above --still lack access to quality health services. Governments in rich and poor countries struggle to meet a rising demand for services while facing spiraling costs. It has been estimated that an increase of just 10% in the efficiency of service delivery could reduce the overall burden of disease by 10% too. Countries are using precious public funds to finance inappropriate and cost-ineffective services, excessive tertiary care and inadequate remuneration schemes. Many countries are pressing ahead with health system reform without knowing how to best provide equitable, efficient and high quality services at low. At a time of rapidly changing demographic and epidemiological conditions and with an urgent need to improve health systems performance, there is an increasing recognition that more information is needed to understand what people need and want -- the demand side of service delivery -- and how to best organize and deliver services.

The results of productive investment in health; a virtuous cycle, compared to unproductive health spending: a vicious cycle, is illustrated in Figure xxx below [page 79 Investing in R&D].

4. Increasing knowledge through a new Research and Development agenda

The stage has been set for a new global R&D agenda through the Ad Hoc Committee on Health Research Relating to Future Intervention Options. Priority research topics have been identified in 1996: how to better deal with childhood infectious diseases and poor maternal and perinatal health, new microbial threats, NCDs and ineffective health systems.
[Box on R&D priorities]

Claeson

Section II

GLOBAL POLICY FRAMEWORK AND DIRECTIONS

In recent decades, major advances have been made in defining cost-effective approaches and more efficient implementation strategies to adress the major global disease burden and foster development. Although progress has been made in reaching concensus around new more effective and efficient HNP policy directions, the world's poorest populations still live under the shadow of a group of old enemies, still killing more than 12 million children and almost half a million women a year. Vulnerable groups - urban and rural poor - still do not have access to available cost-effective preventive and curative interventions. Countries in all regions, throughout the income spectrum, continue to provide inefficient and wasteful health care services where great gains could be made.

The situation and the state of the art

More than a third of the entire global disease burden, more than half of the disease burden in sub-Saharan Africa and almost half of it in India, is caused by a few communicable diseases of childhood, malnutrition and poor reproductive health. Poverty increases people's vulnerability to most diseases, but its link with this group of conditions is particularly strong: childhood infections, malnutrition, and maternal perinatal conditions are borne almost exclusively by poor populations. Poverty is a predisposing factor and it is also a consequence of them. In spite of significant progress, hundreds of millions are trapped in a cycle of underdevelopment, prevented from reaching their potential in school, in the workplace, in the household and thus in the economy.

In addition to the unfinished agenda, emerging and re-emerging diseases such as malaria, tubercuclosis and HIV/AIDS affect all age groups, and non-communicable diseases, notably tobacco, contribute at an increasing rate to the global burden of diseases, as discussed in Section I.

There are effective means to avoid or control these problems such as childhood immunization, integrated management of childhood illness, reproductive health interventions, TB and malaria control and micronutrient supplementation. The current challenge is to make vaccines , effective drugs and algorithms for safe pregnancy and TB treatment, information that influence healthy behaviors, and other means available to those who most need them.

In view of existing cost-effective health interventions, and in spite of major commitments to new global and national strategies (Ref box on major "events", Cairo, World Summit,HFA etc), a few trends can explain the persistence of these problem and lay the foundation for a strong Bank presence, new Bank strategies, and research and development agenda:

- governments have failed to invest in the health of poor people by providing essential, responsive and equitable health services;
- the pharmaceutical industry has too few incentives to develop promising new candidate vaccines, drugs or other products for their need;
- existing interventions fall short of their potential because of lack of knowledge of how to best use them.

Objectives and future achievements

The underpinning objectives of a strong HNP strategy for the next decade are improvements in the quality of life, poverty relief and increased productivity, and control of public and private expenditures. This can be achieved by addressing a high burden of diseases, predominantly among the poor segment of the population, through a small number of cost-effective interventions as outlined above. The financial and political implications as described in Chapter IV.

The main achievements that can be made in the next decade by moving in the direction of a basic services policy approach are:

- a significant reduction in the major disease burden. Defining useful, measurable and country relevant indicators that can help monitor progress towards well established national or decentralized targets are discussed in Annex xxx.

- cost-effective interventions and identification of more efficient and equitable delivery mechanisms that will increase access and utilization by the population most in need.

- externalities, including population growth reduction, quality of life/ well being and increased productivity.

Among the essential public health and clinical services, are some new approaches that would help achieve these goals. The new approaches to reproductive health and childhood illness, described in [Box XXX, in Sector 4] illustrate recent adoptions of new innovations.

The Bank can make a significant difference in transferring global policy to country reality -- in a time when the global community is re-examining global policy direction -- by focusing resources in the HNP sector on cost-effective interventions that would impact health status and help break the cycle of poverty.

[Box summarizing all major policy "events"]

[Boxes illustrating new cost-effective approaches]

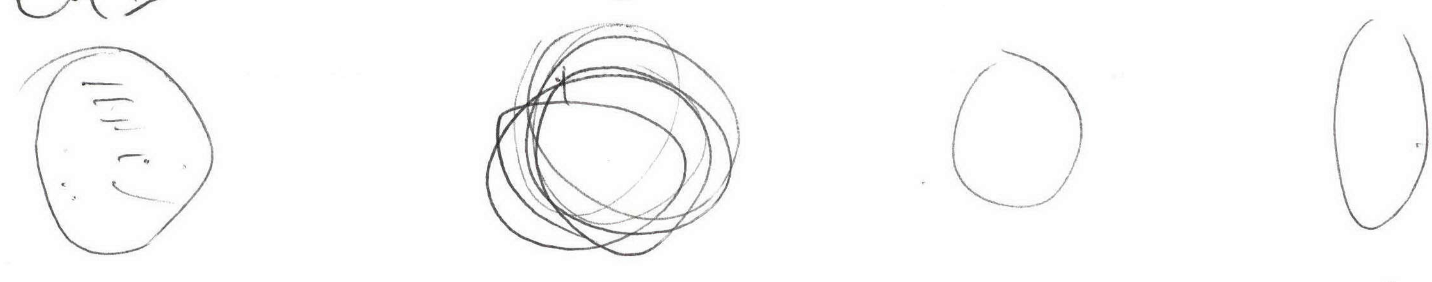
- Poverty ✓
- Fiscal [illegible] C. Mob of F
  - HQ [illegible]
- ~~Polic~~ Performance
  ~~Impact~~ Performance
  - Outcome [illegible]
  - Effic[illegible]
  - Quality

General Perf

Outcome

Outcome
Effic
Access
Quality

Ch I Ch 2 Ch 3 Ch 4



Alex — possible box for Ch. 4 in edited down form. Judy

Nutrition: The challenge

It is worthwhile noting several differences which make nutrition distinct from health with respect to both issues and remedies. The first major difference is that food, the basic foundation for nutrition, is largely procured in the private for-profit sector. Food is a wage-good for families. Even subsistence food producers are net food purchasers on the market. The poor spend 80% of more of their income on food and often the resulting diet is deficient in critical nutrients and inappropriate for young children. The major nutritional source for infants, breastmilk, is produced very efficiently and cheaply at home but the commercial market (albeit at non-competitive prices) threatens to reduce this most important foodstuff. In nutrition, unlike health, the problem is less the proper public/private mix in delivering the goods and more providing to the poor access to food available exclusively on private markets.

In nutrition, as in health, poverty is the driving force behind addressing the problem. In the case of nutrition, excellent evidence exists on the vicious cycle of poverty and malnutrition. Malnourished people have lower productivity and poorer school performance and these factors reduce the income and food purchasing power of families. Historical analysis of nutrition and economics suggests that improved nutrition explains over half of both mortality reductions and about 30% of GNP growth in Western Europe over the last century.

Unlike health systems which have broader societal goals for health, nutrition tends to focus primarily on the poor. This is not to say that society wide interventions -- food fortification, for instance, or counseling against high fat diets -- is not effective and critical to overcoming malnutrition. Unlike in health, there is no nutrition system which the average citizen counts on having available when his or her nutritional status takes a turn for the worse. Au contraire, they usually count on private food (and drug) industry to provide quick and easy albeit bogus nutritional solutions (witness the billion dollar nutritional supplements industry in developed countries)

Like health also, fiscal expenditures done in the name of nutrition, can consume enormous portions of the national budget. Food subsidies in Egypt, Morocco, and much of Eastern Europe have consumed 5% or more of GDP. There are additional economic costs of price controls, rationing, and import/export controls that are expensive to the economy but never appear on the budget. Thus, like health, the fiscal issues in nutrition are paramount. Generally, if all producer and consumer subsidies, food distribution programs, and food-based income transfers are taken into account, there is enough money being spent on nutrition but it is just not allocating them efficiently to address problem. In Feeding Latin America's Children it was found that aggregate expenditures on feeding programs alone, if reprogrammed, would be more than adequate to provide an effective nutrition program to the poorest children.

Policy issues in food and nutrition, as in health, are critical. The gamut of policies, however, spans a broader spectrum from social safety nets, microcredit, agricultural policies, trade policies, and education to general poverty alleviation. The multiplicity of actors and institutional budgets means that the gamut is never considered as a whole hence it is difficult to examine allocative efficiency, for instance. Instead, each component is dealt with piecemeal. A comprehensive food and nutrition policy is critical to bring together the disparate pieces, to prioritize actions and bring coherence, at least in targeting and the composition of the package of goods and services for the poor.

Impressive Gains? While infant mortality rates, life expectancy, and school enrollments have been improving in developing countries, rates of malnutrition have stagnated, very much in parallel with poverty rates. It appears that health and education services are not enough to address malnutrition. (graph from powerpoint). Saving lives may even have a perverse effect on prevalence on malnutrition since children who previously would have died, are subsisting on a suboptimal diet.

Origins of good nutrition: At the World Summit for Children (1990) and later at the International Conference on Nutrition (1992) and the World Food Summit (1996), a consensus developed around the three-part causality of -- and solution to -- malnutrition: food, disease, and behavior. In addition

quantitative goals were agreed upon: reduction by one-half in undernutrition, reduction of low birthweight to 10% of live births, virtual elimination of iodine and vitamin A deficiencies and reduction of iron deficiency by one-third.

To address the "food" leg of the stool requires attention to income and to food availability (production, trade, and aid; calories as well as micronutrients), access (prices, seasonality, markets, food distribution programs) and utilization (demand, tastes, intrahousehold allocation). The disease leg will be addressed through preventive as well as curative health services (immunization, diarrheal control and treatment, treatment of the sick child, micronutrient supplements) but also through water and sanitation and behavioral change. The behavior leg -- breastfeeding, proactive feeding of the young child, dietary management of diarrhea, healthy dietary choices, work and leisure energy expenditure patterns, food processing and preservation, and food beliefs and practices -- are largely dealt with through nutrition social marketing and interpersonal counseling.

With respect to technical efficiency, the cheap and easy solutions are not so clear cut for nutrition as they are for the infectious diseases. This is probably due to the tight relationship between poverty, food purchasing power, and nutrition. While much remains to be learned about the most effective way to deliver services, it appears that community based, behavioral-change-based, nutrition programs are the most effective in addressing undernutrition in a sustainable manner. These have been carried out by a wide variety of public, NGO, and contracted institutions. Targeting of nutrition messages and attention is generally done within the community based on growth monitoring. These are sometimes accompanied with highly targeted food supplementation or income transfer programs but the long-term sustainability of food supplementation is questionable. More often than not, community nutrition programs have some food production component, an income generation or credit component , and a child care component along with basic health services.

Addressing micronutrient malnutrition cost-effectively generally entails highly targeted micronutrient supplements, certainly for iron, and, where food processing industries exist, food fortification. Dietary modifications without fortification are probably only appropriate for vitamin A deficiency since locally produced foods are rich in vitamin A.

To sum up, addressing malnutrition requires a similar strategy but different tactics than those proposed for health. The problem has proved itself more resistant to change, more imbedded in poverty, and less amenable to technological solutions. A combination of policy reform, reallocation of resources, and adaptation of successful experiences is the agenda for the future in nutrition.

for section II NCDs BOX

Draft

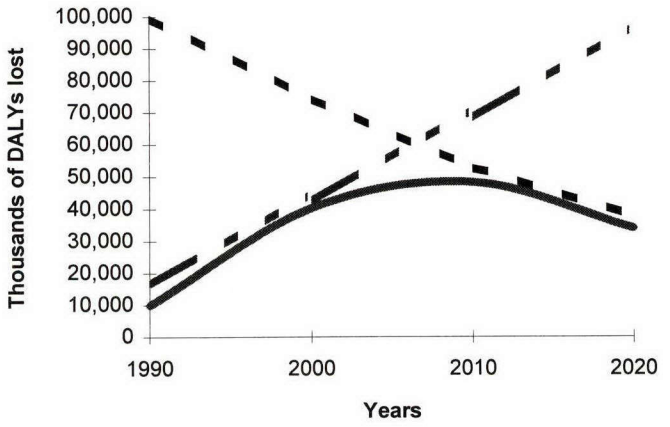
Taxation: A Powerful Tobacco Control Policy

Tobacco consumption is a growing concern because: (a) annual deaths worldwide from tobacco will increase from 3 million in 1990 to about 10 million by 2025, of which 70 percent will be in developing countries, and which will exceed deaths from HIV, tuberculosis, and complications of childbirth combined; (b) half of tobacco deaths occur in productive middle age (35-69), with an average loss of 20 to 25 years of life; (c) tobacco consumption is most common in the poor; and (e) tobacco use leads to diseases which are expensive to treat, and which compete for public resources that would otherwise be spent on control of priority childhood and maternal diseases (figure *** below).

Taxation has decreased consumption of OECD countries, while it has increased revenue.

Tobacco price increases through taxation is one of the most powerful tobacco control measures, and can also generate revenues. In China, a recently-proposed 10 percent tax increase would decrease smoking by 5 percent and increase public revenues by 5 percent. The extra revenue would cover more than a third of the increment for basic health services for China's poorest 100 million habitants. Taxation and ensuring high tobacco prices can compliment other methods of tobacco control, such as serious and prominent health warnings as in Thailand; complete bans on advertising and promotion of all tobacco-associated products or trademarks as in Turkey and Slovenia; focused mass media education messages; and capacity to monitor tobacco burdens and control responses and to lobby for control (Sancta to fix figure).

Trends in DALYs lost (in 1000s) worldwide, 1990 to 2020



Almost 90 percent in demographically developing countries.

76 percent in demographically developing countries.

Prabhat

Strategic Policy Options for the Sector Assistance Strategy

Prabhat Jha, HDD

1. Tobacco control policy in developing countries

There are only two large and growing causes of death worldwide: infection with human immunodeficiency virus (HIV) and tobacco use. Currently tobacco use causes about three million deaths worldwide annually, of which around one-half to one million are in developing countries. On current smoking patterns, by the year 2025, tobacco-attributable deaths will increase to ten million annually, with seventy percent of these in developing countries. Many of these deaths are in productive middle age (35-69) with an average loss of twenty to twenty-five years of life. By 2025, premature deaths from tobacco use are likely to exceed deaths from HIV, tuberculosis and complications of childbirth combined. In developing countries, the largest epidemic of tobacco deaths is likely to arise in China, South Asia, East Asia and the Former Soviet States (Murray and Lopez, 1996). Smokers do not know the full risks of tobacco use, and do not assume the full social costs associated with smoking. Thus, there is a strong argument for public policies to intervene to reduce tobacco consumption.

The World Bank is well positioned to facilitate global tobacco control by not only providing a health standpoint, but also from taxation, revenue generation, environmental impacts, and other perspectives of tobacco control traditionally outside the health sector. Tobacco is one of the few areas of health in which the World Bank has a formal policy. Adopted in 1992, World Bank policy does not support tobacco production and encourages tobacco control. World Bank lending and policy dialogue on tobacco control have only recently increased but the amount and completeness of these remains below that required to deal with the great epidemic of tobacco. A recent World Bank-sponsored conference called "Avoiding the Epidemic of Non-Communicable Disease" endorsed the use strategic and comprehensive approaches to tobacco control. The key elements of effective tobacco control are: (a) high prices, above the rate of inflation; (b) serious and prominent health warnings, as in Canada and Thailand; (c) complete bans on advertising and promotion of all tobacco-associated products or trademarks; (d) focused health education messages; (e) capacity to monitor tobacco burdens and control responses and to lobby for control. Combinations of the above have helped reduce tobacco consumption by about 40% in OECD countries (B J Addiction reference). Unfortunately tobacco control is not effectively applied in most developing countries, because of ignorance about the risks, opposition from the tobacco industry, and lack of awareness by policy makers about the effectiveness, and cost-effectiveness of tobacco control. Some countries have begun effective tobacco control: Turkey and Slovenia recently passed complete bans on advertising and promotion. Egypt and Nepal earmark tobacco tax revenue for health care services and for insurance premiums, China is considering an increase in increase in taxes (see box).

Box XXX: Tobacco control in China

In China, of the 200 million males under age 20 currently alive, approximately 50 million may die from smoking, with mean years of life lost of around 20. Cigarette smoking in China shows disturbing trends for increased smoking. A recent estimate showed a high percentage of males smoked. A high number of smokers believed smoking was harmful (88%) but far less wished to quit (14%). Current smoking spent an average of 60% of household and 17% of household income, comparable to expenditures on health (Need to confirm this). Preliminary efforts to control tobacco in China have such as reducing tar content in cigarettes and banning foreign advertisement. In China tobacco taxation has been a major source of revenues for many years. In 1983, nearly 15 percent of government revenue came from the cigarette tax. The percentage was a much lower 9 percent by 1992, suggesting that there is room to increase the tax.. China currently imposes about a 40 percent effective tax rate on cigarettes, and its conventional sales tax rate is 67. A recent World Bank report on health finance in China suggested that a 10 percent additional tax on tobacco could generate an additional 5.1 billion RMB yuan (calculated in 1995 prices) or a 5 percent increase in public revenues, while consumption would drop by 5 percent. The extra revenue would cover more than a third of the additional resources needed to provide basic health services for the country's poorest 100 million habitants.

Box on Tobacco and Poverty

Non-cigarette tobacco use is common in many parts of South Asia and Africa, and its heaviest burdens are remain in the poor. In India, most tobacco use is from bidis or locally manufactured tobacco products. The use of bidis and other non-cigarette forms of tobacco is highest among rural poor women. The health impact of these non-cigarettes is not well studied, but there is some suggestion of a link to high rates of respiratory disease among such women, compounded by the use of indoor cooking oil. Given that the use of manufactured cigarettes strongly correlates with rising income, an important tobacco control strategy for such areas involves: (a) better information on the health hazards of non-cigarette tobacco products; and (b) avoidance of switch to manufactured cigarettes as income rises. In mature tobacco epidemics, the largest burden of ill health does fall upon the poor. Data from household surveys in Poland and other countries suggest that spending on tobacco products has a real cost in lower use of essential food items and health services, with such costs being higher in lower versus higher income groups.

2. Not subsidizing meat or saturated fat production: A World Bank Policy?

(Alex: Judy has comments on this, and we will revise before Wintergreen)

Non-communicable diseases loom, such as cardiovascular disease and cancer, loom as major health problems in most middle income and several low-income countries for several reasons, including their rates of increase, their potential economic costs, and because they disproportionately affect the poor. Aggressive policies to minimize their increase must begin now including preventing increases in saturated fat intake, a key cause of coronary heart disease and certain types of cancer. As income grows, saturated fat intake from meat and dairy products also increase, particularly if public subsidies support meat and dairy producers. In former socialist economies, increases in coronary heart mortality rates from 1961 to 1985 were associated with increases in both animal and vegetable fats with increases in fat as a percentage of total calories (Epstein, 1989). In the former USSR, relative saturated fat intake rose 50 percent between 1970 and 1985, and increases have also occurred in China.

The proper public policy response, including for the Bank is not to subsidize meat or saturated fat production, including: (a) the market price of these products should take into account their economic costs on health; (b) such subsidies favor rich versus poor groups: in Hungary and in Mexico the upper quintiles of income consume more meat products. (c) supporting grain-fed livestock has negative environmental impact (Goodland, 1996); (d) subsidies are an inefficient method of targeting, even to desirable increases in vulnerable groups, such as poor children; and (d) reductions in subsidies may have health impacts. For example, mortality from coronary heart disease fell by more than one third in Polish men and women from 1991 to 1993, largely because of declines in intake of saturated fat and increases in intake of vegetable sources of fat. These diet changes were because the government ended subsidies for meat and dairy products, chiefly butter subsidies (Zatonski, in press). In Estonia, body mass index, blood pressure, cholesterol and saturated fat intake markedly fell over a 8 year period in the late 1980s to 1990s (Volozh, 1996), because of lower subsidies to producers of saturated fat products. In addition to not subsidizing meat or dairy products, other public policies could include pricing dairy products on their protein, rather than fat content, as done in Finland, and food labeling of fat and other ingredients.

These policy changes entail no delivery of health services. They need to take into account the overall nutritional profile of a country, and the balance of risk from increased coronary heart disease and cancer and potential benefits such as reducing malnutrition in children. Bank lending for agricultural grain production has fallen over the last X years; it should not be replaced by increasing lending for meat or saturated fat production.

3. Better epidemiological information

Despite health consuming 8 percent of the world's wealth, there is an enormous gap in information on health status and outcomes of various health systems. Such information is important to monitor the performance of health systems. Recent indirect estimates such as DALYs do not fulfill these information gaps: despite internal validity, they may not be precise for any particular country. While DALYs may establish priorities, they are not feasible methods to monitor long-term performance of a health system unless the underlying data on mortality and morbidity are improved. The three inter-related components of measuring health status in various countries are vital registration of the entire or a random population, cause-of-death studies and epidemiological studies. These are particularly needed in regions with the poorest health status, but with currently poor coverage of vital registration and cause-of-deaths. Indirect disability estimates may be added to these estimates to help derive DALYs.

Vital registration covers the occurrence of all births, deaths and in some cases expands to marriages, divorces and other social events. Vital registration has existed as early as 3000 BC in China, reflecting its social value. Currently, most Established Market Economies and former socialists' economies have high coverage of population size, births and deaths although recent monitoring in Former Socialist Economies countries falls behind. These areas currently account for the estimated X percent of all deaths in the world. In contrast, most of the other regions in the world have neither high census coverage of population, or monitoring of deaths or births. China has about 18 percent of global mortality and its sample vital registration covers about 100 million people in rural and urban settings. India, which has about 16 percent of global mortality, has no complete vital registration system, although a Sample Registration System collects vital statistics on a sample of the population in each state. Vital registration for most Middle Eastern Countries, Other Asia Islands and Africa is generally lacking. These contribute approximately X, X and X percent of global mortality (figures pending Alex).

Several options exist for vital registration, of which the key goal should be complete coverage of all deaths, classified by at least age and sex. The priority countries are those which currently lack vital registration. For vital registration, creation of appropriate sampling frames would need to consider geographic, ethnic and rural and urban differences. Possible options for such include voters' lists, or sampling frames from Demographic Household Surveys, or satellite photos of households (Refs.). Newer methods for vital registration such as capture-recapture methodology, originally developed for wildlife estimates, are likely highly applicable to developing countries.

Cause-of-death studies, which provide the underlying reason for death, exist currently only for Established Market Economies and Former Socialist Economies, and to a lesser extent for Latin America. In China, cause-of-death data come from a follow up of 1 million deaths to determine causes of death, and from the district surveillance points' system (DSP), comprising about 100 communities in urban and rural settings. In India, cause-of-death data arise from a verbal autopsy method for 0.5 percent of rural deaths in India. Both the Chinese and Indian systems suffer methodological problems: the Chinese system may underestimate deaths by about 30 percent, especially in rural areas; and the Indian system has up to 25 percent of deaths classified as senile or ill-defined (Ref.). Several complementary options for cause-of-death studies exist, including:

(a) community-based random samples are those such as the Indian Rural Causes of Death Survey; (b) sentinel sites such as the DSP in China, or the longitudinal mortality surveys in Matlab area of Bangladesh (ref.); expanded verbal autopsy methods, including establishing validity and reliability for adult deaths.

Analytic epidemiological studies comprising retrospective case-control or prospective studies provide estimates of the magnitude of risk, and enable identification of key risk factors which may be reduced through policy or service interventions. Such studies can also examine the performance of the health system, and determine the impact of health system on outcomes, such as mortality and morbidity.

The three above types of studies are typically are long-term costs born by Governments for vital data collection, because they generate information that is largely a public good, and because they represent 'operating' costs of any health system. The Bank has a role in supporting these efforts as part of long-term institutional development. In many countries, central statistical organizations exist and collect other data such as on agricultural and industrial sectors. Unfortunately, central statistical organizations are often ignored in short-term development projects. Approximate costs of these types of studies in low and middle-income countries are provided in table 1.

Table X: Summary of vital registration, cause-of-death and analytic studies.

Study	Low-income countries	Middle-income countries
Vital Registration		
Sample size /duration	Stratified sample, 5% to 10% / permanent, repeated every 3-5 years	Complete coverage / permanent, repeated every 3-5 years
Data	Live births, deaths, marriages, sex	Live births, deaths, marriages, other social events, by sex
Investment costs /annual operational costs	$2-5 per capita / $1 per capital	$2-5 per capita / $1 per capital
Cause-of-death studies		
Sample size /duration	Community-based random samples: 5% to 10%/ repeated every 5 years Sentinel sites: select geographic areas/permanent with annual data collection	Community-based random samples: 5% to 10%/ repeated every 5 years Sentinel sites: select geographic areas/annual data collection:
Data	Cause of death by age, sex, ICD codes	Cause of death by age, sex, ICD codes
Investment costs /annual operational costs	Pending	Pending
Analytic studies: Incident case-control studies		
Sample size /duration	1000 cases and 1000 controls for each disease/ 2 years	1000 cases and 1000 controls for each disease/ 2 years
Data	Detailed questionnaire plus biological samples	Detailed questionnaire plus biological samples
Investment costs /annual operational costs	$50 per patient	$50 to $75 per patient
Analytic studies: Household case-control studies		
Sample size /duration	50,000 deaths from 100,000 households/ 2 years	100,000 deaths from 200,000 households/ 3 years
Data	Limited questionnaire data and cause-of-death	Limited questionnaire data and cause-of-death
Investment costs /annual operational costs	$5 per death including minimal operational costs	$5 to $10 per death including minimal operational costs
Analytic studies: Prospective studies		
Sample size /duration	100,000 persons/ followed for 15+ years by linking to vital registration	200,000 persons/ followed for 15+ years by linking to vital registration
Data	brief questionnaire and physical measures	brief questionnaire and physical measures plus optional biological samples
Investment costs /annual operational costs	$2 -5 per person including minimal operational costs	$10 to $15 per person including minimal operational costs

These costs compare favorably to other Bank-financed costs, such as Demographic House Surveys, Living Standards Measurement Survey, and others studies. DHS is about $50/per person. LSMS is about 5 times more expensive.

4. Technology Assessment

Technology, including information technology may be partly responsible for the health gains in developed and developing countries, even after taking into account income growth. However, developing countries require affordable technologies appropriate for control strategies. Considerable need exists for applying appropriate technologies to areas of population science, epidemiology and clinical care. However, Western-based clinical care technologies in developing countries have increased rapidly in many urban settings, often spurred by inappropriate government incentives. Appropriate technological assessment requires considerable intergovernmental and inter-sectoral coordination. Among the issues are definition of the users of technology assessment, the types of technologies assessed (drugs, devices, medical or surgical procedures, support systems, organization and administrative systems), level of use (prevention, diagnosis, treatment or rehabilitation), properties of the technology, including safety, efficacy and effectiveness, cost-effectiveness, and methods of technology assessment, and pricing of technologies. Experience from OECD countries suggests technology assessment methods vary (Banta, 1991). In the OECD, technology assessment linked to payment systems and global capitation of hospital budgets appeared to have more impact on controlling technological growth than did methods such as best practice approaches, clinical guidelines and consensus reviews (ISHTAC reference). In developing countries, similar detailed studies would help formulate policy in the broad areas of population-sciences for CVD control and low-cost individual treatment. Examples of the former include assessment of information, media campaigns, remote diagnostic systems and links to insurance and legal systems. Examples of the latter include angioplasty, diabetes treatments and surgical and diagnostic procedures for stroke. Several countries have established technology assessment units (obtain summary from ISHTAC).

5. Appropriate decentralization of disease control programs: The India example

Pending discussion with South Asia Dept.

Human development indicators in India are weak, a large percentage of the rural poor are affected by communicable and maternal diseases, and access to quality health services and primary education is poor. India accounts for 21 percent of global DALYs, a quarter of global maternal deaths, and a quarter of global deaths in children under age five. The under-five mortality rate in India is 21 percent, and the probability of death between age fifteen and sixty is 31 percent. In contrast, the under-five mortality rate is 4 percent in Sri Lanka and the probability of death between age fifteen and sixty is 18 percent. India spends six percent of its gross domestic product (GDP) on health care (equal to US thirteen per capita in 1990), more than Nepal, Bangladesh, Burma, China, Indonesia and Sri Lanka. The percentage of public health spending on primary care (0.6 percent of GDP or approximately one dollar per capita) is lower than in any of these countries, however. States spend nearly three-quarters of all public funds, but spending in poor states is low in absolute amounts. Eighty percent of all health spending is done by the private sector, mainly as regressive and often cost-ineffective out-of-pocket spending on curative services.

The Bank and GOI's substantive strategy involves continuing to focus on key endemic diseases, especially those strongly associated with poverty. The GOI has modernized paradigms for several disease control programs, such as adopting directly observed multiple drug therapy for tuberculosis and dropping fertility targets. The institutional strategy largely involves strengthening specific centrally sponsored programs and upgrading primary health centers and first-referral hospitals at the state level.

The strong federal structure in India has important implications for health services. Often national programs lead most of the spending on any one specific disease, such as malaria. It could be argued that it is important to decentralize the management and delivery of disease control, putting responsibility in the hands of primary health care staff. The Bank and GOI strategy have very carefully selected decentralization however for several reasons: (a) experience from other countries warrants caution in decentralization; and (b) decentralization of national control programs have, in many countries, resulted in loss of key distinguishing features: their unity of purpose, dedicated staff, commitment to getting results in the field, and ability to adapt to changing epidemiological conditions on the ground. Thus the approach in India is not to decentralize everything, as some national-level functions and capacities are essential for an effective disease control program. These functions include (but are not limited to) such important aspects as: (a) providing strategic direction; (b) policy-making and resource allocation at the national level; (c) providing oversight over decentralized and devolved functions; (d) setting standards, norms and indicators for monitoring operational activities; (e) providing technical back-stopping of operational levels; and (f) evaluating and validating program activities including operational research undertaken at or by the operational levels.

6. **Avoidance of death in middle, but not old age.**

First, death in middle-age is very avoidable while death in old age is unavoidable (and in many developing countries, attempts to avoid deaths in old age are not culturally acceptable). In the 1880s, 50% of UK residents would have died before age 40 and 77% before age 70. By 1980, only 3% of UK residents died before age 40, but 30% died before age 70. In both time periods, nearly all died before age 100. Epidemiology shows us that death in middle-age need not be common anywhere, and that much of the avoidable risk of death in middle age is driven by CVD. Developing countries achieve health gains more rapidly now than they did in the past because of information and technology. Thus, it is possible that developing countries may more rapidly avoid middle-age deaths, especially as more CVD burdens fall more upon middle age in developing countries than they do in Established Market Economies countries.

Second, the middle-aged populations will increase in absolute terms markedly in developing countries over the next three decades. Thus even modest reductions in the relative risk of premature CVD death or disability may avoid large numbers of deaths. Similarly, middle age is usually, the most economically productive age, from major gains in production and earnings, investment and consumption and contribution to household health (Over, 1994).

(figure: absolute increase in billions in population aged 30-69 and 70+ by region)

Third, recent epidemiological studies suggest that the relative risks from common exposures such as smoking, blood pressure and cholesterol are more extreme in middle than in old age (Collaborative group, Parrish, 1994). Thus the avoidance or reduction of this risk factors yields large benefits to this age group. However, absolute gains are still higher in old age, due to a higher baseline probability of death.

Fourth, reductions in risk factors in middle-age have benefits accruing to older ages. For example, quitting smoking at young middle-age results in the probability of death returning to non-smoker levels throughout remaining life. *For example, blood pressure elevation in women prior to menopause versus after menopause? ref.: Barrett-Conner, 1994).* However, blood pressure reduction may have postponed congestive heart failure to older ages, with resultant higher costs (ref.). Most clinical treatments such as aspirin and beta-blockers are effective in middle-age and offer larger absolute benefit in old age.

Finally, the impact of public health strategies to reduce the causes of incidence of CVD may be more reliably monitored by examining deaths in middle, versus old age. The impact of clinical treatments on case-fatality rate is also more reliably measured in middle age (Doll and Peto, 1981; Lopez, 1989).

7. **Essential Vascular Package of aspirin, beta-blockers, and possibly cholesterol-lowering statins for adults with cardiovascular disease**

A wealth of randomized evidence indicates that potentially low-cost interventions are effective clinical treatments for established vascular patients. Aspirin, beta-blockers and cholesterol-lowering statin drugs reduce the probability of death or major vascular event in patients with established coronary heart disease (ref. APT, Yusuf, WESCOPS, 4S). Aspirin provides a broad range of benefit, including in post-stroke or transient coronary attack, MI, or acute MI. Emerging evidence suggest a clear benefit of aspirin in acute stroke. Systematic overviews of aspirin and beta-blockers suggest benefit and high safety in wide range of patients, including middle and old age, women and other groups (APT, Collins, 1991). Such evidence for cholesterol-lowering statin drugs has only recently emerged, and a collaborative overview of their results should by the end of the decade, produce such results.

A large impact on the population may only happen if these drugs are widely accessible, and of low-cost. While cholesterol-lowering statin drugs in the ESTABLISHED MARKET ECONOMIES countries as expensive, and thus their cost-effectiveness is relatively unfavorable compared to aspirin or beta-blockers (reference). However, such statins are less expensive in relative terms in developing countries, and most of their patents will expire within five years. Thus, there is reasonable scope for introducing these core interventions as an "Essential Vascular Package" or EVP. The number of people who could benefit from such an essential vascular package is large (table XXX). The delivery of the EVP relies upon self-presentation and does not involve screening costs. Thus, the potential cost-effectiveness of the EVP is very high. Packaging these drugs into single once-a-day formulations, as done for multi-drug treatment of tuberculosis, could do much to improve compliance.

The goals of the EVP would be: (a) to have near universal access to these three interventions; (b) to chose generic, low-cost versions of these drugs, rather than higher-cost second or third generation products; (c) and to price such a package so that it would be attractive for clinical and patient to use them. The first goal may be achieved by inclusion of the EVP in a publicly financed essential package of clinical services that are universally available, and in insurance treatment lists. Physician education and patient awareness efforts would also be needed. The second and third goals may be addressed by pricing reimbursements of treatments to the lowest cost basis of the EVP.

The EVP would need to be tested for acceptability, use and other parameters of diffusion into practice as discussed for the algorithms. Such testing could be as randomized trials to assess the package, versus standard clinical care.

Costs: For aspirin plus beta-blocker about 1 cent a day, plus investment costs of development of package, marketing etc. We need estimated generic costs for statin drugs. These costs would still be far below what is required to market a third generation anti-hypertensive. Costs do not take into account packaging these three or two drugs into a single, once-a-day formulation.

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

DATE: 23-Jan-1997 02:58pm

TO: Olusoji Adeyi (OLUSOJI ADEYI @A1@WBHQB)

FROM: Prabhat Jha, HDDHE (PRABHAT JHA)

EXT.: 87384

SUBJECT: **RE: The long-term effects of cardiovascualr disease prevention: the Stanford Five-City Project**

Soji

Thanks for pointing out this article. We have reviewed the lessons from community-based large DEMONSTRATION studies, like Stanford and North Karelia as part of the Hungary HSMP Mid-term review. As you know, the HSMP contained a similar Primary Prevention component, based in Kalosca.

The key lessons are:

1. Demonstrations projects for mass education of adults do not meaningfully reduce risk factors: In North Karelia, Stanford, Minnesota and elsewhere the change in risk factors has been about the same as in control areas, or in the whole population.

2. The review of the Kalosca project is equally unfavorable. Our review is attached. Thus such demonstration projects are likely NOT cost-effective programs that the Bank should support.

3. Demonstration projects can help create policies and disseminate interventions. The best example is North Karelia, where the study was able to help convince the Finnish Parliament to price milk and dairy products on protein and not fat content, thus lowering intake of saturated fat that causes heart disease and some cancers.

4. Although we need more analysis of it, I think the preferred strategy is NATIONAL POLICY-BASED strategy involving four elements:

A. Tobacco control with: (a) high prices, above the rate of inflation; (b) serious and prominent health warnings, as in Canada and Thailand; (c) complete bans on advertising and promotion of all tobacco-associated products or trademarks as done in Turkey and Slovenia, and more recently in Belgium (attached); (d) focused mass media education messages; (e) and capacity to monitor tobacco burdens and control responses and to lobby for control.

B. Not subsidizing meat or saturated fat production in countries with prevalent heart disease for the following reasons: (a) the market price of these products should take into account their economic costs on health; (b) such subsidies favor rich versus poor groups: in Hungary and in Mexico the upper quintiles of income consume more meat products. (c) supporting grain-fed livestock has negative environmental impact (Goodland, 1996); (d) subsidies are an inefficient method of targeting, even to desirable increases in vulnerable groups, such as poor children; and (d) reductions in subsidies may have health impacts. For example, mortality from coronary heart disease fell by more than one third in Polish men and women from 1991 to 1993, largely because of declines in intake of saturated fat and increases in intake of vegetable sources of fat. These diet changes were because the government ended subsidies for meat and dairy products, chiefly butter subsidies (Zatonski, in press). In Estonia, body mass index, blood pressure, cholesterol and saturated fat intake markedly fell over a 8 year period in the late 1980s to 1990s (Volozh, 1996), because of lower subsidies to producers of saturated fat products.

C. Providing low-cost clinical treatments with aspirin, beta-blockers and diuretics to patients with EXISTING heart disease. Such treatments cost about $1 to 5 per month, and reduce mortality after a major vascular event from 20 to 25 percent.

D. Appropriate Research and Development on epidemiological and health service monitoring, developing and testing treatment algorithms, etc. Some of this mentioned in the MTR for Hungary, if you are interested.

I hope that ECA will push some of these topics in the SAS and in its work programs as proper things the Bank should finance or encourage. I also hope that ECA would perhaps consider getting such analytic work done for the region. I would happy to be involved in such efforts.

Best regards,

Prabhat

CC:	CHRIS LOVELACE	(CHRIS LOVELACE)
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Differences between NCDs and Communicable, maternal and perinatal diseases (CMP)

Variable	NCD	CMP
Underling process	Chronic, cumulative exposure leading to clinical event	Acute, time-limited infection (e.g. ARI) or increased risk period (eg. childbirth)
Probability of developing clinical event if underlying cause present	Low (e.g. atherosclerosis)	High (e.g. measles)
Efficacy of interventions		
Secondary curative	Significant but small effect sizes (20-30%, e.g. aspirin)	Significant with larger effect sizes, often curative (100% e.g. antibiotic)
Primary preventive	Significant but small (e.g.stop smoking)	Not as effective as cure
Prevention with vaccines	Not yet available	Available for several diseases
Cost of treatments	Variable	Variable

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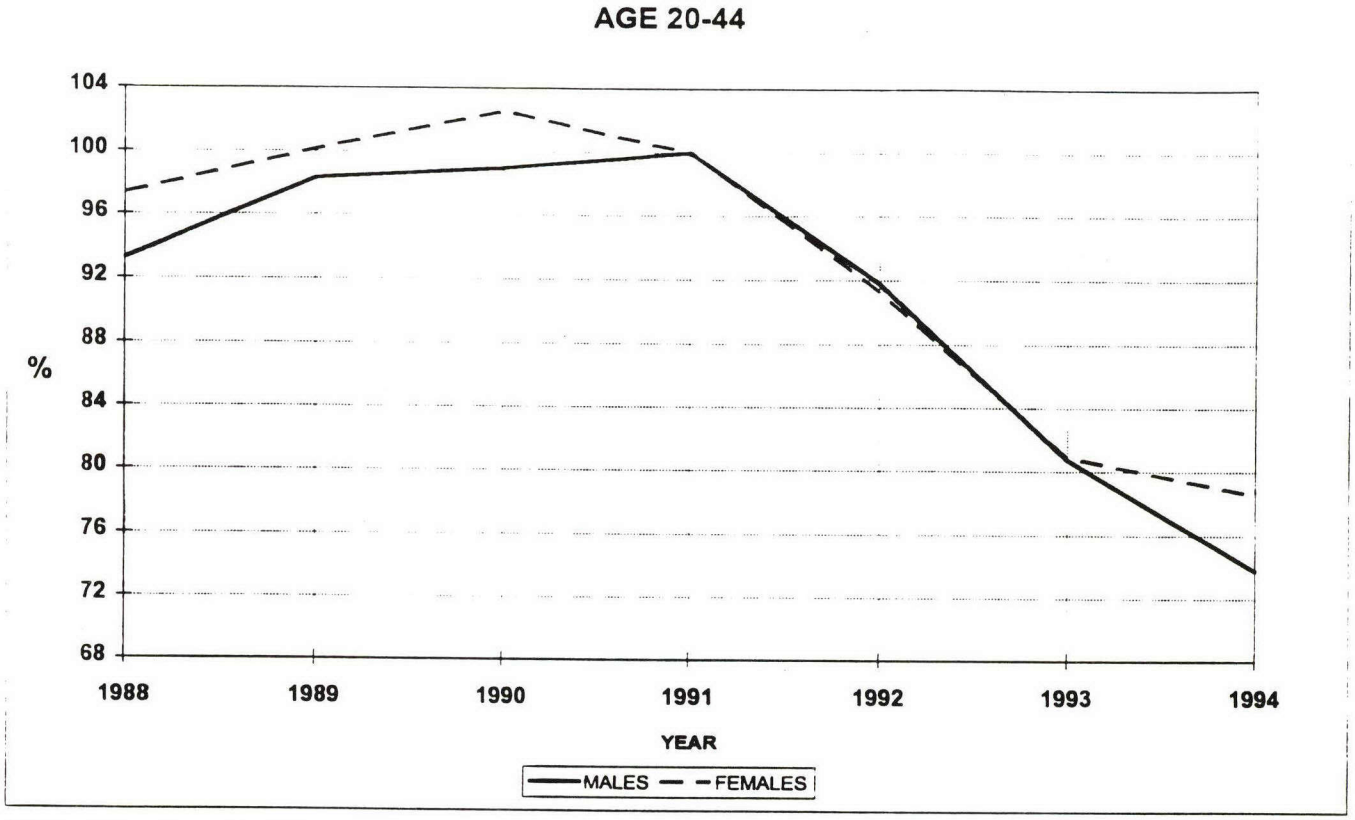
TABLE 1. STATUS OF CAUSE-OF-DEATH REPORTING TO WHO, BY REGION, 1985-1989

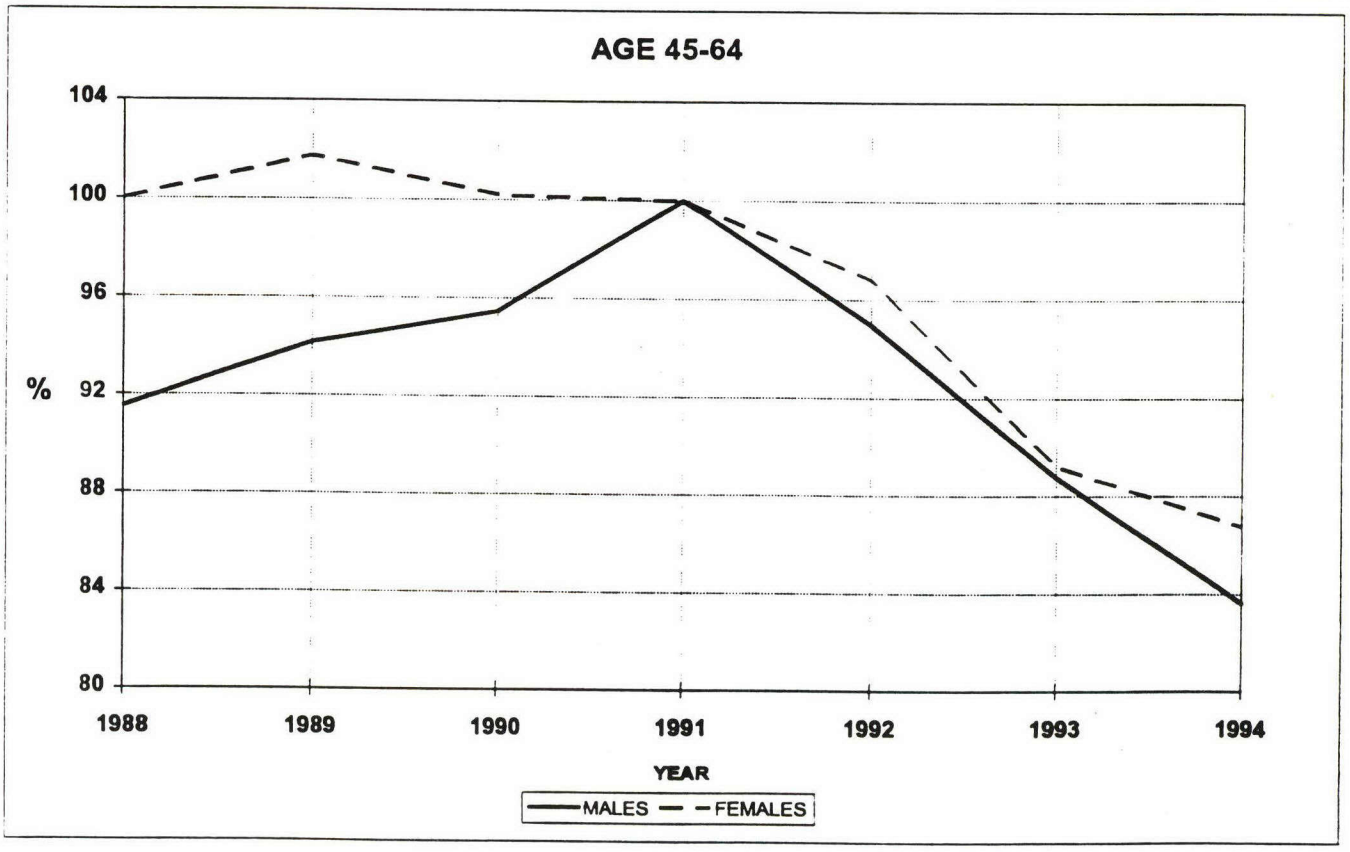
TABLEAU 1. RELEVÉ DES CAUSES DE DÉCÈS DÉCLARÉS À L'OMS, PAR RÉGION, 1985-1989

Who Region — Région OMS	Number of countries/areas reporting mortality data for at least 1 year between 1985 and 1989 • Nombre de pays/territoires ayant fourni des données de mortalité pour une année au moins entre 1985 et 1989 •	Estimated population covered by cause-of-death statistics Nombre estimatif de personnes couvertes par les statistiques sur les causes de décès	Percentage of regional population for which cause-of-death statistics are available to WHO Pourcentage de la population régionale pour laquelle l'OMS dispose de statistiques sur les causes de décès
		(000)	*(%)*
Africa — Afrique	3	1 250	0.25
Americas — Amériques	30	572 900	80
South-East Asia — Asie du Sud-Est .	2	47 500	4
Europe	30	790 500	94
Eastern Mediterranean — Méditerranée orientale	5	59 400	16
Western Pacific — Pacifique occidental	8	337 000	23
World — Monde	**78**	**1 808 550**	**35**

• For a list of country-years of mortality data available at WHO, see Annex I of the *World health statistics annual* (latest available edition) (*5*) — Pour la liste des données de mortalité, par pays et par année, voir l'annexe I de l'*Annuaire de statistiques sanitaires mondiales* (dernière édition parue) (*5*).

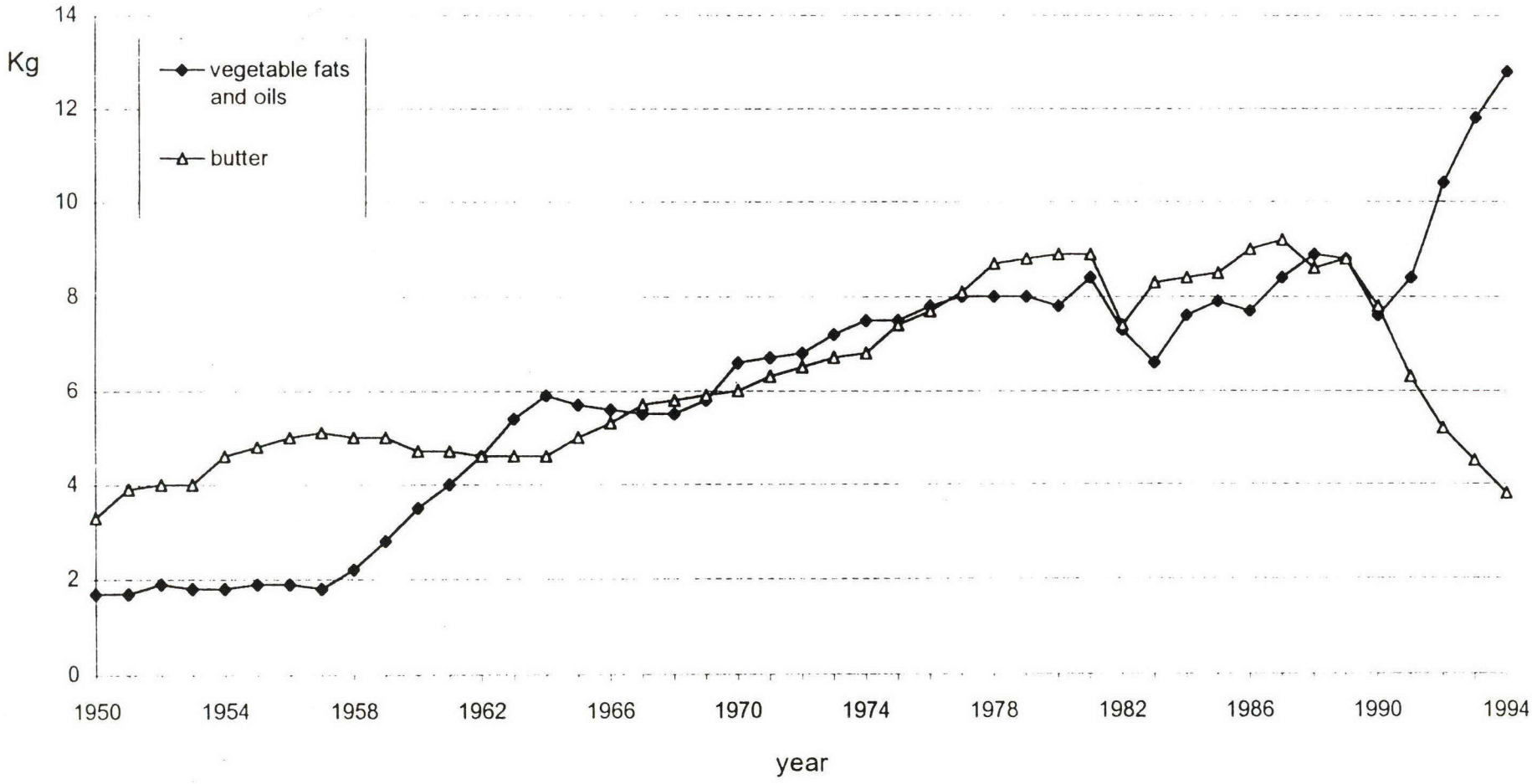
CHANGES IN STANDARDIZED MORTALITY RATES FOR CARDIOVASCULAR DISEASES (EXPRESSED AS A PECENTAGE, 1991=100%), POLAND 1988-1994





W.ZATONSKI, CENTER OF ONCOLOGY, WARSAW 1995

CONSUMPTION OF FAT IN POLAND, 1950-1994
(in kg per capita)



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Source: Sekuła W. i in. Food consumption in Poland converted into energy and nutrients, 1950-1993, IŻŻ, 1994

stanzdro\food\TLUSZCZ.XLS butter&vegfat

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Estimated deaths (in thousands) by cause and region in 1990 and percentage of world totals

Cause	CHI		EME		FSE		IND		LAC		MEC		OAI		SSA		World	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Causes	8,885	18%	7,121	14%	3,762	8%	9,371	19%	2,992	6%	4,384	9%	5,519	11%	7,937	16%	49,971	100%
Communicable, maternal & perinatal	1,342	8%	438	3%	134	1%	4,060	24%	966	6%	2,026	12%	2,307	14%	5,415	32%	16,690	100%
Injuries	1,024	24%	445	11%	362	9%	611	14%	293	7%	392	9%	477	11%	624	15%	4,227	100%
Noncommunicable	6,519	22%	6,238	21%	3,264	11%	4,700	16%	1,733	6%	1,967	7%	2,736	9%	1,899	7%	29,055	100%
Neoplasms	1,408	23%	1,763	29%	666	11%	776	13%	341	6%	327	5%	541	9%	305	5%	6,129	100%
Cardiovascular diseases	**2,566**	**18%**	**3,174**	**22%**	**2,151**	**15%**	**2,386**	**17%**	**787**	**5%**	**992**	**7%**	**1,352**	**9%**	**934**	**7%**	**14,345**	**100%**
Other	2,545	30%	1,301	15%	447	5%	1,539	18%	605	7%	647	8%	843	10%	660	8%	8,581	100%

Disability-adjusted life years (DALYs, in hundreds of thousands) by cause and region and percentage of world totals.

Cause	CHI		EME		FSE		IND		LAC		MEC		OAI		SSA		World	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Causes	201.267	15%	93.9187	7%	57.7792	4%	292.646	21%	102.892	8%	144.246	11%	176.423	13%	292.632	21%	1361.8	100%
Communicable, maternal & perinatal	50.8682	8%	9.10803	1%	5.02021	1%	148.277	24%	43.4147	7%	73.614	12%	85.6538	14%	208.744	33%	624.7	100%
Injuries	33.624	21%	11.0965	7%	9.63518	6%	26.7269	16%	15.4469	9%	18.7905	12%	20.0088	12%	27.3329	17%	162.662	100%
Noncommunicable	116.774	20%	73.7142	13%	43.1238	8%	117.642	20%	44.0304	8%	51.842	9%	70.7602	12%	56.5542	10%	574.442	100%
Neoplasms	18.9515	23%	18.2991	22%	8.77165	11%	12.842	15%	5.53449	7%	5.25519	6%	8.35174	10%	4.95868	6%	82.9643	100%
Cardiovascular diseases	**28.3692**	**19%**	**22.058**	**15%**	**17.06**	**12%**	**28.5919**	**19%**	**9.53827**	**6%**	**12.7825**	**9%**	**17.2675**	**12%**	**12.2523**	**8%**	**147.92**	**100%**
Other	69.4537	20%	33.3571	10%	17.2922	5%	76.2085	22%	28.9577	8%	33.8043	10%	45.141	13%	39.3432	11%	343.558	100%

CHI = China

EME = Established market economies

FSE = formerly socialist economies of Europe

IND = India

LAC = Latin America and the Caribbean

MEC = Middle Eastern crescent

OAI = Other Asia and islands

SSA = Sub-Saharan Africa

Estimated deaths (in thousands) by cause and region in 1990.

Cause	CHI		EME		FSE		IND		LAC		MEC		OAI		SSA		World	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Causes	8,885	100%	7,121	100%	3,762	100%	9,371	100%	2,992	100%	4,384	100%	5,519	100%	7,937	100%	49,971	100%
Communicable, maternal & perinatal	1,342	15%	438	6%	134	4%	4,060	43%	966	32%	2,026	46%	2,307	42%	5,415	68%	16,690	33%
Injuries	1,024	12%	445	6%	362	10%	611	7%	293	10%	392	9%	477	9%	624	8%	4,227	8%
Noncommunicable	6,519	73%	6,238	88%	3,264	87%	4,700	50%	1,733	58%	1,967	45%	2,736	50%	1,899	24%	29,055	58%
Neoplasms	1,408	16%	1,763	25%	666	18%	776	8%	341	11%	327	7%	541	10%	305	4%	6,129	12%
Cardiovascular diseases	**2,566**	**29%**	**3,174**	**45%**	**2,151**	**57%**	**2,386**	**25%**	**787**	**26%**	**992**	**23%**	**1,352**	**24%**	**934**	**12%**	**14,345**	**29%**
Other	2,545	29%	1,301	18%	447	12%	1,539	16%	605	20%	647	15%	843	15%	660	8%	8,581	17%

Disability-adjusted life years (DALYs, in hundreds of thousands) by cause and region.

Cause	CHI		EME		FSE		IND		LAC		MEC		OAI		SSA		World	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
All Causes	201.267	100%	93.9187	100%	57.7792	100%	292.646	100%	102.892	100%	144.246	100%	176.423	100%	292.632	100%	1361.8	100%
Communicable, maternal & perinatal	50.8682	25%	9.10803	10%	5.02021	9%	148.277	51%	43.4147	42%	73.614	51%	85.6538	49%	208.744	71%	624.7	46%
Injuries	33.624	17%	11.0965	12%	9.63518	17%	26.7269	9%	15.4469	15%	18.7905	13%	20.0088	11%	27.3329	9%	162.662	12%
Noncommunicable	116.774	58%	73.7142	78%	43.1238	75%	117.642	40%	44.0304	43%	51.842	36%	70.7602	40%	56.5542	19%	574.442	42%
Neoplasms	18.9515	9%	18.2991	19%	8.77165	15%	12.842	4%	5.53449	5%	5.25519	4%	8.35174	5%	4.95868	2%	82.9643	6%
Cardiovascular diseases	**28.3692**	**14%**	**22.058**	**23%**	**17.06**	**30%**	**28.5919**	**10%**	**9.53827**	**9%**	**12.7825**	**9%**	**17.2675**	**10%**	**12.2523**	**4%**	**147.92**	**11%**
Other	69.4537	35%	33.3571	36%	17.2922	30%	76.2085	26%	28.9577	28%	33.8043	23%	45.141	26%	39.3432	13%	343.558	25%

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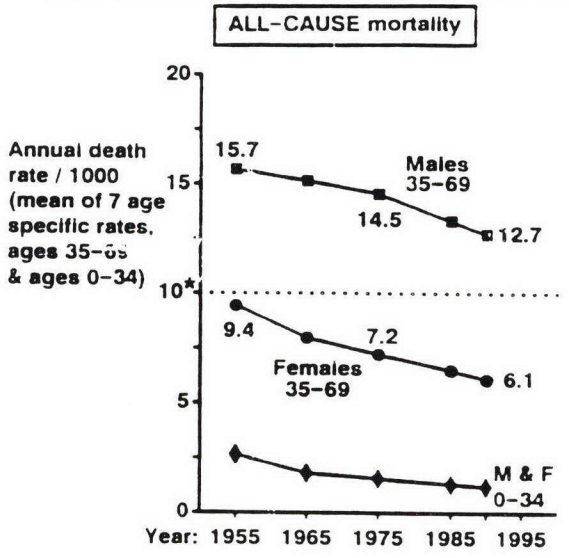
SSA = Sub-Saharan Africa

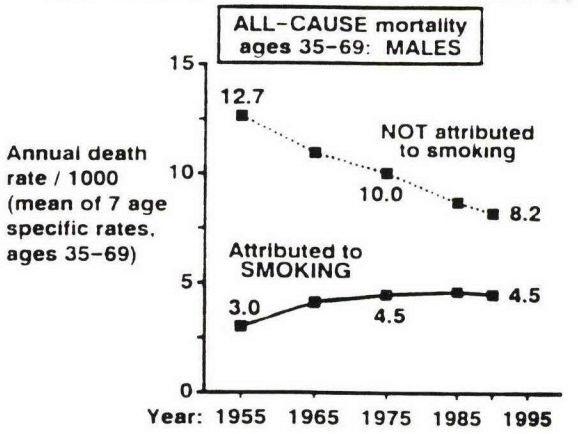
Figure 5.

ALL 'DEVELOPED' COUNTRIES: 1955–90

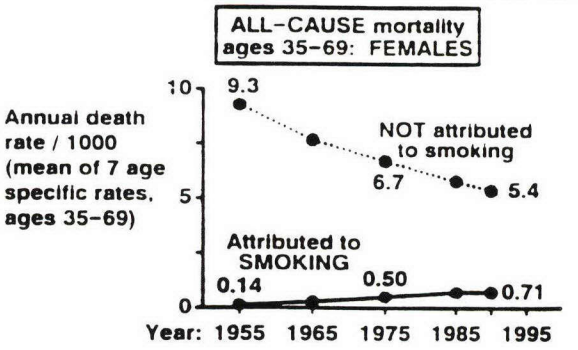


* An annual rate of 10 per 1000 implies that 30% of 35-year-olds will die before age 70

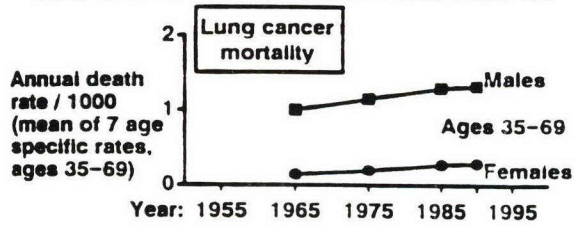
ALL 'DEVELOPED' COUNTRIES: 1955–90



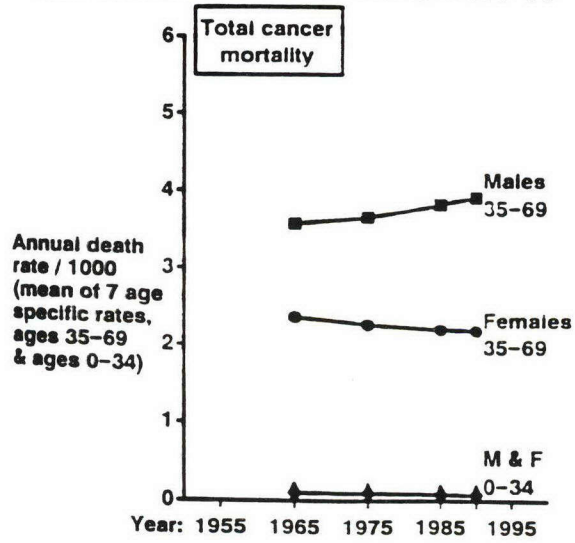
ALL 'DEVELOPED' COUNTRIES: 1955–90



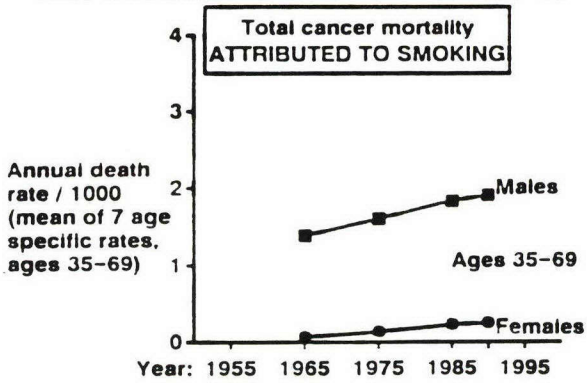
ALL 'DEVELOPED' COUNTRIES: 1965–90



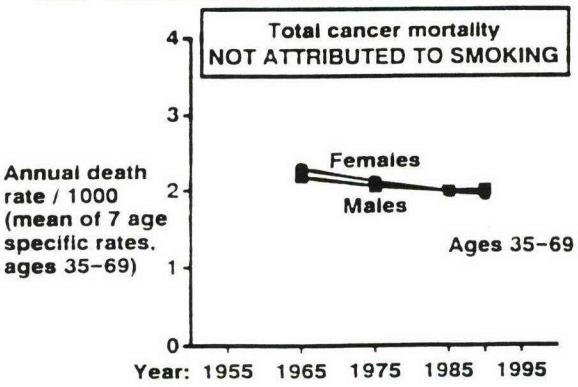
ALL 'DEVELOPED' COUNTRIES: 1965–90



ALL 'DEVELOPED' COUNTRIES: 1965–90



ALL 'DEVELOPED' COUNTRIES: 1965–90



Pase 5

Figure B

Fig. 58. Male mortality at ages 0–34 in 8 regions

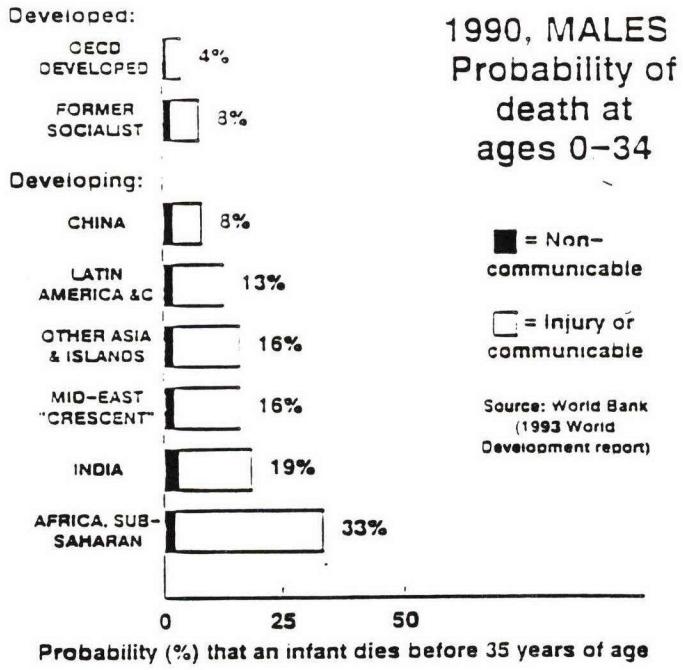


Fig. 59. Female mortality at ages 0–34 in 8 regions

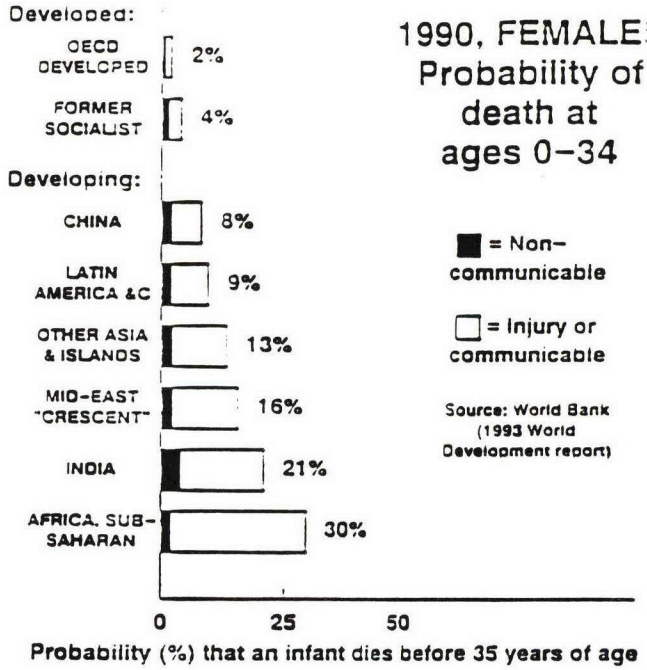


Fig. 60. Male mortality at ages 35–69 in 8 regions

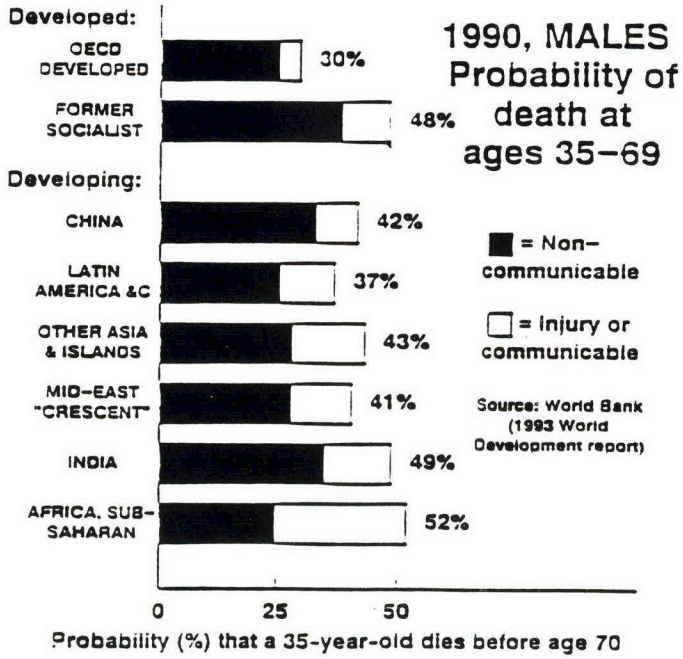


Fig. 61. Female mortality at ages 35–69 in 8 regions

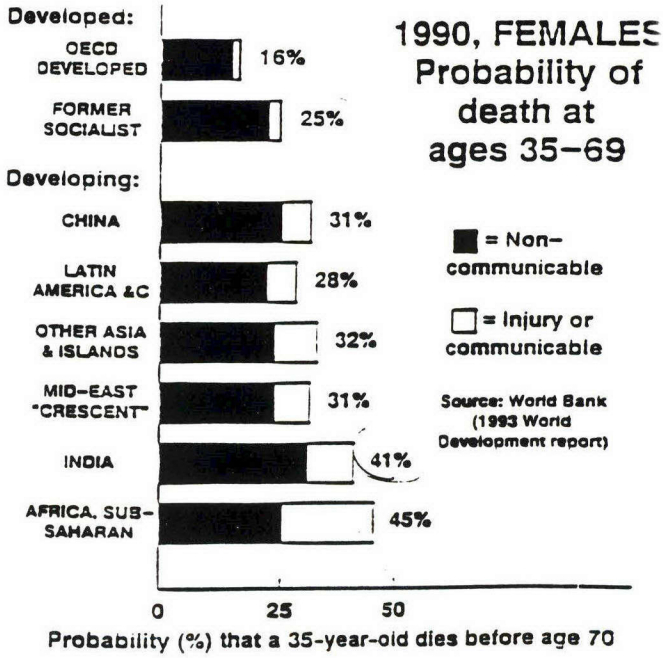


Figure 1

Fig. 58. Male mortality at ages 0–34 in 8 regions

Fig. 59. Female mortality at ages 0–34 in 8 regions

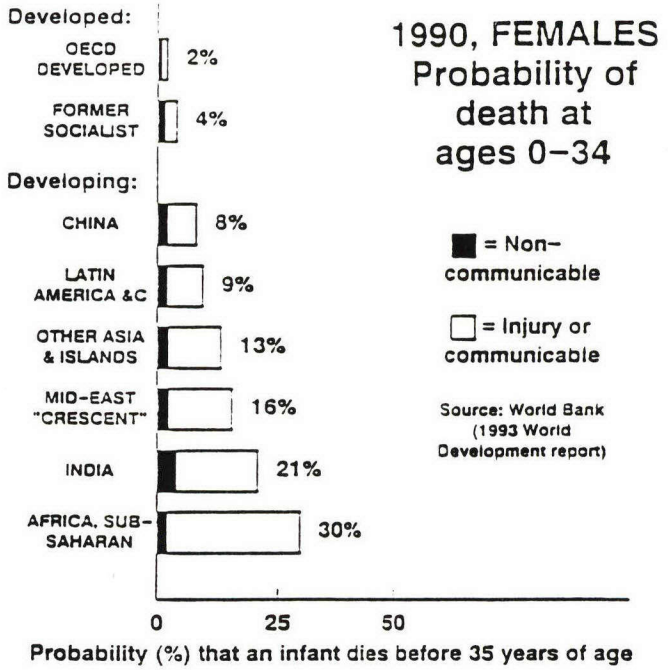


Fig. 60. Male mortality at ages 35–69 in 8 regions

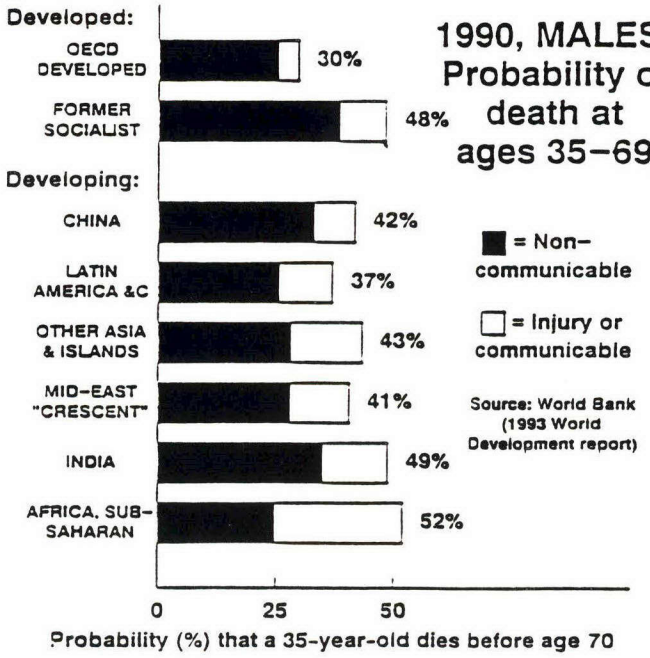
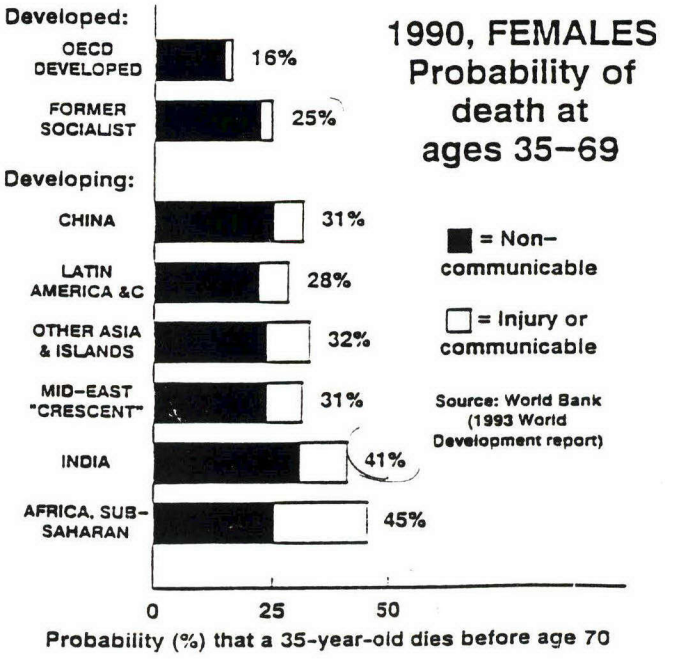


Fig. 61. Female mortality at ages 35–69 in 8 regions



Links of Effective Tobacco Control to Economic Development

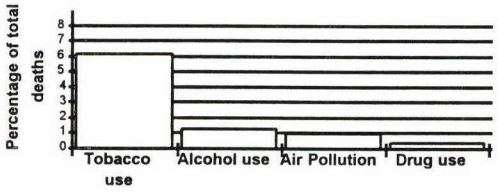
Dr. Prabhat Jha
Human Development Department
The World Bank

The views are those of the author and not the World Bank.

Outline of Presentation

- Shift in tobacco consumption to developing countries
- Profoundly negative economic impact from tobacco consumption
- Elements of effective tobacco control
- Cost-effectiveness of tobacco control
- Role of the World Bank, especially taxation

Percentage of worldwide deaths attributed to selected risk factors in 1990



Source: Murray and Lopez, 1996

Global Tobacco Consumption

Percentage of total world consumption

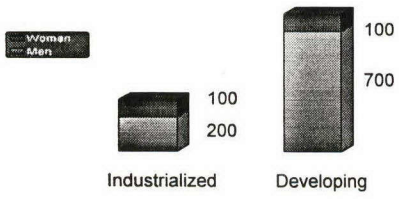
Year	Developing	Eastern Europe	Developed
1974-76	49	13	38
1984-86	61	12	27
2000	71	11	18

A 10% increase in per capita income implies increased consumption of:
7% in middle-income countries
13% in low-income countries

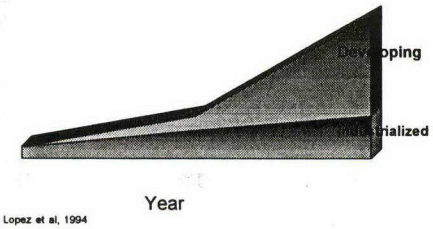
Sources, FAO, 1990; World Bank, 1994

Most Smokers Live in Developing Countries

Numbers in millions



Annual tobacco-attributable deaths



Source: Peto, Lopez et al, 1994

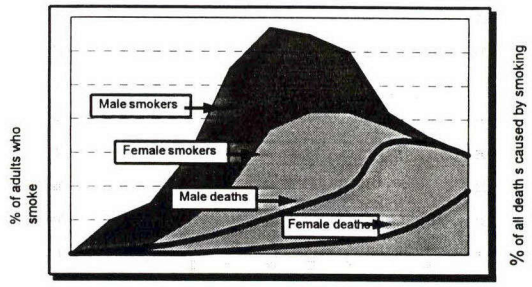
Global Annual Tobacco Deaths (in Millions)

Year	Developing	Developed
1995	0.5 to 1.0	2.0 to 2.5
2025	~7	3

The total in 2025 in developing countries exceeds deaths from AIDS, tuberculosis, and maternal deaths combined.

Source: Peto, Lopez, 1994; WDR, 1993

A Model of the Tobacco Epidemic



Source: Collishaw and Lopez, 1994

Lack of awareness of risks of tobacco use

Rankings of "good habits" by US adults

1.	Never drive after drinking	13.	Medical Advice on habits
2.	Air quality	14.	Dietary salt
3.	Water quality	15.	Get 7 - 8 hours sleep
4.	Domestic fire detectors	16.	Dietary fibre
5.	Body weight	17.	Seat belts
6.	Annual blood pressure	18.	Dietary fat
7.	Control stress	19.	Dietary calcium
8.	Vitamins and minerals	20.	Restrict sugar
9.	Exercise	21.	Daily breakfast
10.	NOT SMOKING	22.	Dietary cholesterol
11.	Have friends	23.	Restrict alcohol
12.	Good genes	24.	Avoid alcohol

Source: 1993 Harris poll of 1254 US adults asking what "helps people in general to live a long and healthy life" (1 = most, 24 = least perceived importance)

Economic Impact of Tobacco Use is Profoundly Negative

Net Benefits and Costs from a 1000 ton increase in tobacco consumption (in millions of 1990 US dollars)	
Consumer and producer benefits	2.6
Premature deaths	-13.2
Indirect morbidity costs	-11.0
Direct morbidity costs	-5.6
TOTAL	**-27.2**

Worldwide total loss from total consumption production exceeds 200 Billion US dollars, or 1% of global wealth

Source: World Bank, 1994, 1996

Economic Studies Show High Loss from Tobacco Use

	Percentage of GDP		
Region	Loss from tobacco use	Public health expenditures	Ratio
Canada	1.4	6.8	21%
USA	2.0	5.6	36%
Australia	1.4	5.4	26%

Source: Single et al, 1995

Tobacco Control is Cost-Effective

Cost-effectiveness studies		
Place	Intervention	Cost per life year saved (US dollars)
India	Encourage cessation and prevent or delay starters	70
Low-income country	Prevent new starters	20-40
Guinea, Africa	Encourage cessation and prevent or delay starters	40
US	Smoking cessation advice, middle age	600-1000
Low-income country	Childhood immunization	20-40
US	Pollution control at paper mills	80,000 to 1 million

Source: Jha et al, 1997; Jamison et al, 1994

Key components of effective tobacco control

- Serious health warnings
  - e.g. Thailand, Australia
- Complete ban on all advertising and promotion
- Price and taxation increases
- Tobacco or Health unit to monitor control
- *In OECD countries, the above combination reduced consumption by up to 40%*

Source: WHO, 1996

R&D Needs for Effective Tobacco Control

- **Reliable, local studies**
  - Mortality from prospective studies if smoking rising
  - Mortality from case-control studies if high smoking prevalence well established
  - Studies of smoking determinants
  - Economic and taxation studies

Source: Jha et al, 1997

Importance of Controlling Tobacco Promotion

Spending by US Cigarette Companies, in Billions of 1993 dollars.

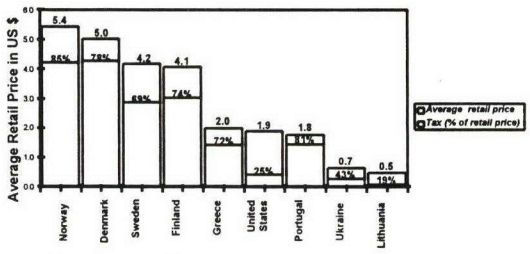
Year	Advertising	Promotion
1983	1.4	1.4
1993	0.75	5.5

Source: FTC, 1994

Rationale for Tobacco Taxation as Policy

1. **User fees that internalize the external costs of smoking.**
2. **Discourage new starters and current smokers from continuing.**
3. **Support health promotion, disease prevention, health insurance and research.**
4. **Efficient instrument with low administrative costs for collection of revenue.**
5. **In short to medium-term, raise revenues while decreasing consumption.**

Average Retail Price (in US $) for a Pack of 20 Cigarettes in Selected Countries, and their Percentage of Tax in 1995



Source: NSRA, 1995; Jha et al, 1997

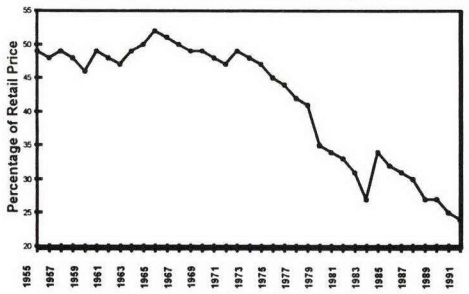
Annual revenues from taxes on tobacco products

Country	Percent of total tax revenues	US$ Million
Sri Lanka	10.6	214
Japan	9.3	24000
India	5.9	1700
Indonesia	5.5	1500
Ghana	3.8	30
Pakistan	3.8	340
Venezuela	3.7	320
Chile	3.6	350
Australia	2.0	2600
Turkey	1.9	1000
USA	1.5	12700
Lithuania	0.5	5
South Africa	0.1	450

Source: World Bank, 1996

Tobacco Taxation in the United States

Average Cigarette Tax as a Percentage of Retail Price



Source: Farquhar, 1993

Role of the World Bank

- Partner in economic development: money and ideas
- Policy of not lending for tobacco production, marketing, or processing and encouraging control
- Health system finance and reform are key issues

Previous World Bank Work on Tobacco Control

- World Bank policy of not supporting tobacco production and encouraging control-1992
- Preliminary economic analyses
- Tobacco control components in several Bank projects and studies

Planned World Bank Work on Tobacco Control

- More tobacco control elements in health and education projects and in country assistance and sector strategies
- Better links with WHO, International Tobacco Initiative and others
- Update economic analyses
- Create and distribute taxation strategies
- Regional control strategies

Proposed Tobacco Taxes in China

- Nearly 15 percent of government revenue in 1983
  - Fell to 9 percent by 1992
- World Bank report: A 10 percent additional tax on tobacco could:
  - Increase revenue by 5 percent
  - Decrease consumption by 5 percent
- Extra revenue could provide 1/3 of basic health services to China's poorest 100 million people.

Source: World Bank, 1996

Summary

- Tobacco consumption has profound negative health and economic impacts worldwide 1983.
- Tobacco control is effective and cost-effective.
- Active public policy for health promotion, legislation, and taxation can reduce health and economic burdens from tobacco.
- Considerable scope for regional taxation approaches exists in many areas of the world.

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Sick Individuals and Sick Populations

GEOFFREY ROSE

Rose G (Department of Epidemiology, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK). Sick individuals and sick populations. *International Journal of Epidemiology* 1985, **14**: 32–38.
Aetiology confronts two distinct issues: the determinants of individual cases, and the determinants of incidence rate. If exposure to a necessary agent is homogeneous within a population, then case/control and cohort methods will fail to detect it: they will only identify markers of susceptibility. The corresponding strategies in control are the 'high-risk' approach, which seeks to protect susceptible individuals, and the population approach, which seeks to control the causes of incidence. The two approaches are not usually in competition, but the prior concern should always be to discover and control the causes of incidence.

THE DETERMINANTS OF INDIVIDUAL CASES

In teaching epidemiology to medical students, I have often encouraged them to consider a question which I first heard enunciated by Roy Acheson: 'Why did *this* patient get *this* disease at *this* time?'. It is an excellent starting-point, because students and doctors feel a natural concern for the problems of the individual. Indeed, the central ethos of medicine is seen as an acceptance of responsibility for sick individuals.

It is an integral part of good doctoring to ask not only, 'What is the diagnosis, and what is the treatment?' but also, 'Why did this happen, and could it have been prevented?'. Such thinking shapes the approach to nearly all clinical and laboratory research into the causes and mechanisms of illness. Hypertension research, for example, is almost wholly preoccupied with the characteristics which distinguish individuals at the hypertensive and normotensive ends of the blood pressure distribution. Research into diabetes looks for genetic, nutritional and metabolic reasons to explain why some people get diabetes and others do not. The constant aim in such work is to answer Acheson's question, 'Why did *this* patient get this disease at this time?'.

The same concern has continued to shape the thinking of all of us who came to epidemiology from a background in clinical practice. The whole basis of the case-control method is to discover how sick and healthy individuals differ. Equally the basis of many cohort studies is the search for 'risk factors', which identify certain individuals as being more susceptible to disease; and from this we proceed to test whether these risk factors are also causes, capable of explaining why some individuals get sick while others remain healthy, and applicable as a guide to prevention.

To confine attention in this way to within-population comparisons has caused much confusion (particularly in the clinical world) in the definition of normality. Laboratory 'ranges of normal' are based on what is common within the local population. Individuals with 'normal blood pressure' are those who do not stand out from their local contemporaries; and so on. What is common is all right, we presume.

Applied to aetiology, the individual-centred approach leads to the use of relative risk as the basic representation of aetiological force: that is, 'the risk in exposed individuals relative to risk in non-exposed individuals'. Indeed, the concept of relative risk has almost excluded any other approach to quantifying causal importance. It may generally be the best measure of aetiological force, but it is no measure at all of aetiological outome or of public health importance.

Unfortunately this approach to the search for causes, and the measuring of their potency, has to assume a heterogeneity of exposure within the study population. If everyone smoked 20 cigarettes a day, then clinical, case-control and cohort studies alike would lead us to conclude that lung cancer was a genetic disease; and in one sense that would be true, since if everyone is exposed to the necessary agent, then the distribution of cases is wholly determined by individual susceptibility.

Within Scotland and other mountainous parts of Britain (Figure 1, left section)[1] there is no discernible relation between local cardiovascular death rates and the softness of the public water supply. The reason is apparent if one extends the enquiry to the whole of the

Department of Epidemiology, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK.
Based on a lecture to the Xth Scientific Meeting of the International Epidemiological Association, 27 August 1984, Vancouver.

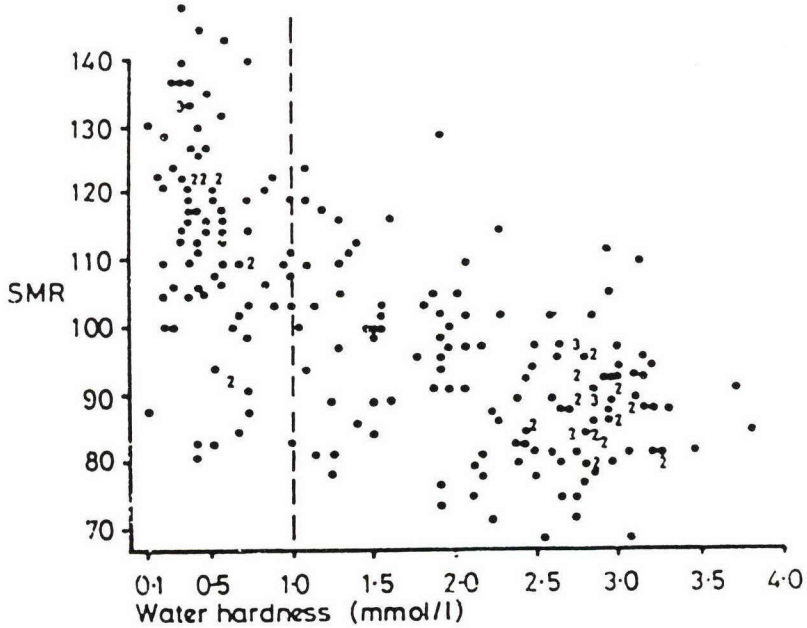

FIGURE 1 *Relation between water quality and cardiovascular mortality in towns of the UK.*[1]

UK. In Scotland, everyone's water is soft; and the possibly adverse effect becomes recognizable only when study is extended to other regions which have a much wider range of exposure ($r = -0.67$). Even more clearly, a case-control study of this question within Scotland would have been futile. Everyone is exposed, and other factors operate to determine the varying risk.

Epidemiology is often defined in terms of study of the determinants of the distribution of the disease; but we should not forget that the more widespread is a particular cause, the less it explains the distribution of cases. The hardest cause to identify is the one that is universally present, for then it has no influence on the distribution of disease.

THE DETERMINANTS OF POPULATION INCIDENCE RATE

I find it increasingly helpful to distinguish two kinds of aetiological question. The first seeks the causes of cases, and the second seeks the causes of incidence. 'Why do some individuals have hypertension?' is a quite different question from 'Why do some populations have much hypertension, whilst in others it is rare?'. The questions require different kinds of study, and they have different answers.

Figure 2 shows the systolic blood pressure distributions of middle-aged men in two populations—Kenyan nomads[2] and London civil servants.[3] The familiar question, 'Why do some individuals have higher blood

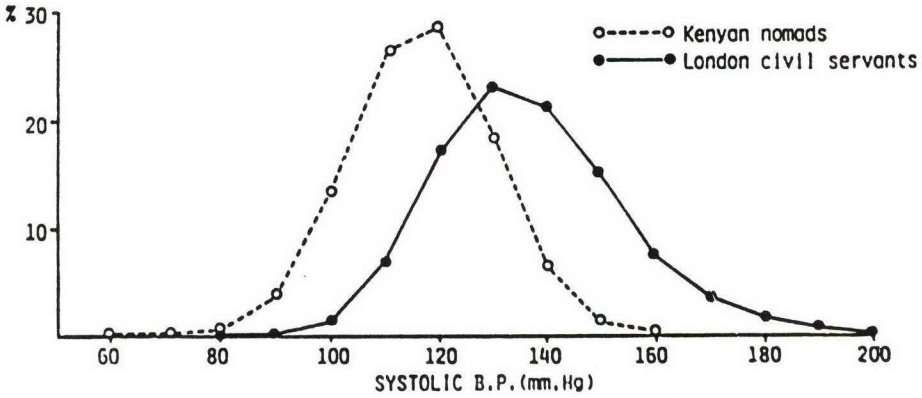

FIGURE 2 *Distributions of systolic blood pressure in middle-aged men in two populations.*[2,3]

pressure than others?' could be equally well asked in either of these settings, since in each the individual blood pressures vary (proportionately) to about the same extent; and the answers might well be much the same in each instance (that is, mainly genetic variation, with a lesser component from environmental and behavioural differences). We might achieve a complete understanding of why individuals vary, and yet quite miss the most important public health question, namely, 'Why is hypertension absent in the Kenyans and common in London?'. The answer to that question has to do with the determinants of the population mean; for what distinguishes the two groups is nothing to do with the characteristics of individuals, it is rather a shift of the whole distribution—a mass influence acting on the population as a whole. To find the determinants of prevalence and incidence rates, we need to study characteristics of populations, not characteristics of individuals.

A more extreme example is provided by the population distributions of serum cholesterol levels[4] in East Finland, where coronary heart disease is very common, and Japan, where the incidence rate is low: the two distributions barely overlap. Each country has men with relative hypercholesterolaemia (although their definitions of the range of 'normal' would no doubt disagree), and one could research into the genetic and other causes of these unusual individuals; but if we want to discover why Finland has such a high incidence of coronary heart disease we need to look for those characteristics of the national diet which have so elevated the whole cholesterol distribution. Within populations it has proved almost impossible to demonstrate any relation between an individual's diet and his serum cholesterol level; and the same applies to the relation of individual diet to blood pressure and to overweight. But at the level of populations it is a different story: it has proved easy to show strong associations between population mean values for saturated fat intake *versus* serum cholesterol level and coronary heart disease incidence, sodium intake *versus* blood pressure, or energy intake *versus* overweight. The determinants of incidence are not necessarily the same as the causes of cases.

HOW DO THE CAUSES OF CASES RELATE TO THE CAUSES OF INCIDENCE?

This is largely a matter of whether exposure varies similarly within a population and between populations (or over a period of time within the same population). Softness of water supply may be a determinant of cardiovascular mortality, but it is unlikely to be identifiable as a risk factor for individuals, because exposure tends to be locally uniform. Dietary fat is, I believe, the main determinant of a population's incidence rate for coronary heart disease; but it quite fails to identify high-risk individuals.

In the case of cigarettes and lung cancer it so happened that the study populations contained about equal numbers of smokers and non-smokers, and in such a situation case/control and cohort studies were able to identify what was also the main determinant of population differences and time trends.

There is a broad tendency for genetic factors to dominate individual susceptibility, but to explain rather little of population differences in incidence. Genetic heterogeneity, it seems, is mostly much greater within than between populations. This is the contrary situation to that seen for environmental factors. Thus migrants, whatever the colour of their skin, tend to acquire the disease rates of their country of adoption.

Most non-infectious diseases are still of largely unknown cause. If you take a textbook of medicine and look at the list of contents you will still find, despite all our aetiological research, that most are still of basically unknown aetiology. We know quite a lot about the personal characteristics of individuals who are susceptible to them; but for a remarkably large number of our major non-infectious diseases we still do not know the determinants of the incidence rate.

Over a period of time we find that most diseases are in a state of flux. For example, duodenal ulcer in Britain at the turn of the century was an uncommon condition affecting mainly young women. During the first half of the century the incidence rate rose steadily and it became very common, but now the disease seems to be disappearing; and yet we have no clues to the determinants of these striking changes in incidence rates. One could repeat that story for many conditions.

There is hardly a disease whose incidence rate does not vary widely, either over time or between populations at the same time. This means that these causes of incidence rate, unknown though they are, are not inevitable. It is possible to live without them, and if we knew what they were it might be possible to control them. But to identify the causal agent by the traditional case-control and cohort methods will be unsuccessful if there are not sufficient differences in exposure within the study population at the time of the study. In those circumstances all that these traditional methods do is to find markers of individual susceptibility. The clues must be sought from differences between populations or from changes within populations over time.

PREVENTION

These two approaches to aetiology—the individual and

the population-based—have their counterparts in prevention. In the first, preventive strategy seeks to identify high-risk susceptible individuals and to offer them some individual protection. In contrast, the 'population strategy' seeks to control the determinants of incidence in the population as a whole.

The 'High-Risk' Strategy

This is the traditional and natural medical approach to prevention. If a doctor accepts that he is responsible for an individual who is sick today, then it is a short step to accept responsibility also for the individual who may well be sick tomorrow. Thus screening is used to detect certain individuals who hitherto thought they were well but who must now understand that they are in effect patients. This is the process, for example, in the detection and treatment of symptomless hypertension, the transition from healthy subject to patient being ratified by the giving and receiving of tablets. (Anyone who takes medicines is by definition a patient.)

What the 'high-risk' strategy seeks to achieve is something like a truncation of the risk distribution. This general concept applies to all special preventive action in high-risk individuals—in at-risk pregnancies, in small babies, or in any other particularly susceptible group. It is a strategy with some clear and important advantages (Table 1).

TABLE 1 *Prevention by the 'high-risk strategy': advantages.*

1. Intervention appropriate to individual
2. Subject motivation
3. Physician motivation
4. Cost-effective use of resources
5. Benefit:risk ratio favourable

Its first advantage is that it leads to intervention which is appropriate to the individual. A smoker who has a cough or who is found to have impaired ventilatory function has a special reason for stopping smoking. The doctor will see it as making sense to advise salt restriction in a hypertensive. In such instances the intervention makes sense because that individual already has a problem which that particular measure may possibly ameliorate. If we consider screening a population to discover those with high serum cholesterol levels and advising them on dietary change, then that intervention is appropriate to those people in particular: they have a diet-related metabolic problem.

The 'high-risk' strategy produces interventions that are appropriate to the particular individuals advised to take them. Consequently it has the advantage of enhanced subject motivation. In our randomized controlled trial of smoking cessation in London civil servants we first screened some 20000 men and from them selected about 1500 who were smokers with, in addition, markers of specially high risk for cardio-respiratory disease. They were recalled and a random half received anti-smoking counselling. The results, in terms of smoking cessation, were excellent because those men knew they had a special reason to stop. They had been picked out from others in their offices because, although everyone knows that smoking is a bad thing, they had a special reason why it was particularly unwise for them.

There is, of course, another and less reputable reason why screening enhances subject motivation, and that is the mystique of a scientific investigation. A ventilatory function test is a powerful enhancer of motivation to stop smoking: an instrument which the subject does not quite understand, that looks rather impressive, has produced evidence that he is a special person with a special problem. The electrocardiogram is an even more powerful motivator, if you are unscrupulous enough to use it in prevention. A man may feel entirely well, but if those little squiggles on the paper tell the doctor that he has got trouble, then he must accept that he has now become a patient. That is a powerful persuader. (I suspect it is also a powerful cause of lying awake in the night and thinking about it.)

For rather similar reasons the 'high-risk' approach also motivates physicians. Doctors, quite rightly, are uncomfortable about intervening in a situation where their help was not asked for. Before imposing advice on somebody who was getting on all right without them, they like to feel that there is a proper and special justification in that particular case.

The 'high-risk' approach offers a more cost-effective use of limited resources. One of the things we have learned in health education at the individual level is that once-only advice is a waste of time. To get results we may need a considerable investment of counselling time and follow-up. It is costly in use of time and effort and resources, and therefore it is more effective to concentrate limited medical services and time where the need—and therefore also the benefit—is likely to be greatest.

A final advantage of the 'high-risk' approach is that it offers a more favourable ratio of benefits to risks. If intervention must carry some adverse effects or costs, and if the risk and cost are much the same for everybody, then the ratio of the costs to the benefits will be more favourable where the benefits are larger.

Unfortunately the 'high-risk' strategy of prevention also has some serious disadvantages and limitations (Table 2).

TABLE 2 *Prevention by the 'high-risk strategy': disadvantages.*

1. Difficulties and costs of screening
2. Palliative and temporary—not radical
3. Limited potential for (a) individual
(b) population
4. Behaviourally inappropriate

The first centres around the difficulties and costs of screening. Supposing that we were to embark, as some had advocated, on a policy of screening for high cholesterol levels and giving dietary advice to those individuals at special risk. The disease process we are trying to prevent (atherosclerosis and its complications) begins early in life, so we should have to initiate screening perhaps at the age of ten. However, the abnormality we seek to detect is not a stable lifetime characteristic, so we must advocate repeated screening at suitable intervals.

In all screening one meets problems with uptake, and the tendency for the response to be greater amongst those sections of the population who are often least at risk of the disease. Often there is an even greater problem: screening detects certain individuals who will receive special advice, but at the same time it cannot help also discovering much larger numbers of 'borderliners', that is, people whose results mark them as at increased risk but for whom we do not have an appropriate treatment to reduce their risk.

The second disadvantage of the 'high-risk' strategy is that it is palliative and temporary, not radical. It does not seek to alter the underlying causes of the disease but to identify individuals who are particularly susceptible to those causes. Presumably in every generation there will be such susceptibles; and if prevention and control efforts were confined to these high-risk individuals, then that approach would need to be sustained year after year and generation after generation. It does not deal with the root of the problem, but seeks to protect those who are vulnerable to it; and they will always be around.

The potential for this approach is limited—sometimes more than we could have expected—both for the individual and for the population. There are two reasons for this. The first is that our power to predict future disease is usually very weak. Most individuals with risk factors will remain well, at least for some years; contrariwise, unexpected illness may happen to someone who has just received an 'all clear' report from a screening examination. One of the limitations of the relative risk statistic is that it gives no idea of the absolute level of danger. Thus the Framingham Study has impressed us all with its powerful discrimination between high and low risk groups. but when we see (Figure 4)[5] the degree of overlap in serum cholesterol level between future cases and those who remained healthy, it is not surprising that an individual's future is so often misassessed.

Often the best predictor of future major disease is the presence of existing minor disease. A low ventilatory function today is the best predictor of its future rate of decline. A high blood pressure today is the best predictor of its future rate of rise. Early coronary heart disease is better than all the conventional risk factors as

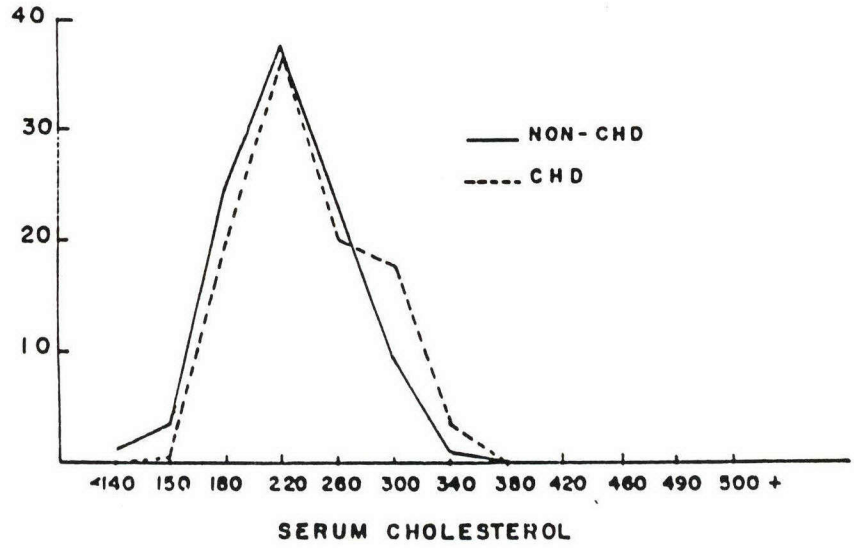

FIGURE 3 *Percentage distribution of serum cholesterol levels (mg/dl) in men aged 50–62 who did or did not subsequently develop coronary heart disease (Framingham Study[5]).*

a predictor of future fatal disease. However, even if screening includes such tests for early disease, our experience in the Heart Disease Prevention Project (Table 3)[6] still points to a very weak ability to predict the future of any particular individual.

TABLE 3 *Five-year incidence of myocardial infarction in the UK Heart Disease Prevention Project.*

Entry characteristic	% of men	% of MI cases	MI incidence rate %
Risk factors alone	15	32	7
'Ischaemia'	16	41	11
'Ischaemia' + risk factors	2	12	22
All men	100	100	4

This point came home to me only recently. I have long congratulated myself on my low levels of coronary risk factors, and I joked to my friends that if I were to die suddenly, I should be very surprised. I even speculated on what other disease—perhaps colon cancer—would be the commonest cause of death for a man in the lowest group of cardiovascular risk. The painful truth is that for such an individual in a Western population the commonest cause of death—by far—is coronary heart disease! Everyone, in fact, is a high-risk individual for this uniquely mass disease.

There is another, related reason why the predictive basis of the 'high-risk' strategy of prevention is weak. It is well illustrated by some data from Alberman[7] which relate the occurrence of Down's syndrome births to maternal age (Table 4). Mothers under 30 years are individually at minimal risk; but because they are so numerous, they generate half the cases. High-risk individuals aged 40 and above generate only 13% of the cases.

The lesson from this example is that *a large number of people at a small risk may give rise to more cases of disease than the small number who are at a high risk.*

TABLE 4 *Incidence of Down's syndrome according to maternal age.*[7]

Maternal age (years)	Risk of Down's syndrome per 1000 births	Total births in age group (as % of all ages)	% of total Down's syndrome occurring in age group
< 30	0.7	78	51
30–34	1.3	16	20
35–39	3.7	5	16
40–44	13.1	0.95	11
> 45	34.6	0.05	2
All ages	1.5	100	100

This situation seems to be common, and it limits the utility of the 'high-risk' approach to prevention.

A further disadvantage of the 'high-risk' strategy is that it is behaviourally inappropriate. Eating, smoking, exercise and all our other life-style characteristics are constrained by social norms. If we try to eat differently from our friends it will not only be inconvenient, but we risk being regarded as cranks or hypochondriacs. If a man's work environment encourages heavy drinking, then advice that he is damaging his liver is unlikely to have any effect. No-one who has attempted any sort of health education effort in individuals needs to be told that it is difficult for such people to step out of line with their peers. This is what the 'high-risk' preventive strategy requires them to do.

The Population Strategy

This is the attempt to control the determinants of incidence, to lower the mean level of risk factors, to shift the whole distribution of exposure in a favourable direction. In its traditional 'public health' form it has involved mass environmental control methods; in its modern form it is attempting (less successfully) to alter some of society's norms of behaviour.

The advantages are powerful (Table 5). The first is

TABLE 5 *Prevention by the 'population strategy': advantages.*

1. Radical
2. Large potential for population
3. Behaviourally appropriate

that it is radical. It attempts to remove the underlying causes that make the disease common. It has a large potential—often larger than one would have expected—for the population as a whole. From Framingham data one can compute that a 10 mm Hg lowering of the blood pressure distribution as a whole would correspond to about a 30% reduction in the total attributable mortality.

The approach is behaviourally appropriate. If non-smoking eventually becomes 'normal', then it will be much less necessary to keep on persuading individuals. Once a social norm of behaviour has become accepted and (as in the case of diet) once the supply industries have adapted themselves to the new pattern, then the maintenance of that situation no longer requires effort from individuals. The health education phase aimed at changing individuals is, we hope, a temporary necessity, pending changes in the norms of what is socially acceptable.

Unfortunately the population strategy of prevention has also some weighty drawbacks (Table 6). It offers

TABLE 6 *Prevention by the 'population strategy': disadvantages.*

1. Small benefit to individual ('Prevention Paradox')
2. Poor motivation of subject
3. Poor motivation of physician
4. Benefit:risk ratio worrisome

only a small benefit to each individual, since most of them were going to be all right anyway, at least for many years. This leads to the *Prevention Paradox*:[8] 'A preventive measure which brings much benefit to the population offers little to each participating individual'. This has been the history of public health--of immunization, the wearing of seat belts and now the attempt to change various life-style characteristics. Of enormous potential importance to the population as a whole, these measures offer very little—particularly in the short term—to each individual; and thus there is poor motivation of the subject. We should not be surprised that health education tends to be relatively ineffective for individuals and in the short term. Mostly people act for substantial and immediate rewards, and the medical motivation for health education is inherently weak. Their health next year is not likely to be much better if they accept our advice or if they reject it. Much more powerful as motivators for health education are the social rewards of enhanced self-esteem and social approval.

There is also in the population approach only poor motivation of physicians. Many medical practitioners who embarked with enthusiasm on anti-smoking education have become disheartened because their success rate was no more than 5 or 10%: in clinical practice one's expectation of results is higher. Grateful patients are few in preventive medicine, where success is marked by a non-event. The skills of behavioural advice are different and unfamiliar, and professional esteem is lowered by a lack of skill. Harder to overcome than any of these, however, is the enormous difficulty for medical personnel to see health as a population issue and not merely as a problem for individuals.

In mass prevention each individual has usually only a small expectation of benefit, and this small benefit can easily be outweighed by a small risk.[8] This happened in the World Health Organization clofibrate trial,[9] where a cholesterol-lowering drug seems to have killed more than it saved, even though the fatal complication rate was only about 1/1000/year. Such low-order risks, which can be vitally important to the balance sheet of mass preventive plans, may be hard or impossible to detect. This makes it important to distinguish two approaches. The first is the restoration of biological normality by the removal of an abnormal exposure (eg, stopping smoking, controlling air pollution, moderating some of our recently-acquired dietary deviations); here there can be some presumption of safety. This is not true for the other kind of preventive approach, which leaves intact the underlying causes of incidence and seeks instead to interpose some new, supposedly protective intervention (eg, immunization, drugs, jogging). Here the onus is on the activists to produce adequate evidence of safety.

CONCLUSIONS

Case-centred epidemiology identifies individual susceptibility, but it may fail to identify the underlying causes of incidence. The 'high-risk' strategy of prevention is an interim expedient, needed in order to protect susceptible individuals, but only for so long as the underlying causes of incidence remain unknown or uncontrollable; if causes can be removed, susceptibility ceases to matter.

Realistically, many diseases will long continue to call for both approaches, and fortunately competition between them is usually unecessary. Nevertheless, the priority of concern should always be the discovery and control of the causes of incidence.

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Control of Non-Communicable Diseases in South Asia

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Summary of Burdens and Consequences of NCDs

- High and rising burdens
- High impact during productive middle age
- Negative equity implications
- Negative micro-level economic impacts
- Negative long-term macro-economic impacts
- Current inefficient allocation on NCD control

The Health Transition

Changes in health status of populations as they move from high mortality and fertility to low mortality and fertility.

Three engines:

- demographic (populations get older)
  - Not modifiable
- risk factors (age-specific rates change)
  - Modifiable
- health service (access to and use of preventive and curative services)
  - Modifiable

Impact of the Health Transition on Disease Burdens

- Rising
  - Non-communicable diseases (NCDs)
    - Cardiovascular, cancer and neuro-psychiatric
  - Injuries
- Falling
  - Communicable, maternal and reproductive
    - Still a high burden

Vocabulary

- The NCDs include
  - Cardiovascular disease (CVD), mainly ischemic heart disease and stroke
  - Diabetes (associated with CVD)
  - Cancers (tobacco-attributable and others)
  - Neuro-psychiatric diseases (not extensively discussed here)

Major NCDs

(and their percentage of total deaths in India in 1990)

- Cardiovascular Disease (24%)
  - Ischemic heart disease (13%)
    - occurs at younger ages than in OECD countries
    - apparent genetic pre-disposition and link to body shape and diabetes
  - Stroke (5%)
    - relationship with blood pressure is stronger than in western countries
    - high burdens in women
    - serious underreporting, especially in rural areas

Major NCDs

(and their percentage of total deaths in India in 1990)

- Cancers (5%)
  - Tobacco Associated (2%)
    - mainly oral and mouth
    - influence of chewed tobacco PLUS manufactured cigarettes
    - rising sharply
  - Cervical cancer (0.5%)
    - much more common in poor women, especially in rural areas
    - women present for treatment at advanced stage of disease

Demographics in South Asia in 1990

	Deaths: 13 million/year		**Births: 38 million/year**
Age at death	Millions of Annual Deaths, 1990	Mean YLL	Millions of Annual Deaths, Future
Childhood/early adulthood* 0-34	5	60-65	4**
Middle Age 35-69	4	20-25	12***
Old Age 70+	4	5-10	22

*mostly at ages 0-4
**rapidly failing
***increasing

Death in Middle Age is Avoidable

Deaths in UK

	1880s	1980s
Dead < 40	50%	3%
Dead < 70	75%	30%
Dead < 100	100%	100%

Death in Middle Age is Avoidable

- Epidemiological studies
  - Between populations
  - Over time
- Outcomes and Wealth: Improving with time
  - Chile's per capita income in 1990 was about $5,000, the same as that for the US in 1900, but life expectancy in Chile was about 25 years more

Aging is not a Factor in Avoiding Deaths in Middle Age

Differences in death rates between a 70+ year old and a 30-44 year old man in India and Established Market Economies (EME)				
Cause	Ratios of Rates: India to EME		Absolute differences 70+ to 30-44	
	Age 70+	Age 30-44	India	EME
Lung Cancer	**0.3**	**0.3**	**140**	**490**
IHD	**1.0**	**1.1**	**1880**	**1930**
Stroke	**1.7**	**1.5**	**1560**	**900**

Death rates per 100,000; Source: Jha et al, forthcoming

Avoidance of Death in Middle Age

More NCD deaths in South Asia occurs in middle age than in OECD countries, where they occur largely in old age.

Age at Death*	Percentage of deaths		Mean YLL
	South Asia	OECD	
<35	**20**	**3**	**60-65**
35-69	**45**	**23**	**20-25**
70+	**35**	**74**	**5-10**

*neonatal exceptions at 1990 death rates

Economic Impact of NCDs

- Inadequate spending on prevention
  - India: of all primary care spending, 85% is for curative, 15% for preventive.
    - This balance is not appropriate for NCD
  - Inappropriate government incentives: e.g. technologies
- Reduces resources for unfinished agenda

Summary of Burdens and Consequences of NCDs

- High and rising burdens
- High impact upon productive middle ages
- Negative equity implications
- Negative micro-level economic impacts
- Negative long-term macro-economic impacts
- Current inefficient allocation on NCD control

What to do?

- Priority remains the unfinished agenda of communicable, maternal and perinatal diseases
- We need to incrementally address new agenda of NCDs and injuries

Global Strategies for Avoidance of Premature Death

Absolute death rates are falling at all ages, more so at ages 0-4
Relative increases occur in numbers of deaths at older ages

Low cost prevention and treatment exist for both age groups:

Childhood and early adulthood age 0-34	Vaccination, MCH, education of girls, safe water, HIV avoidance, TB
Middle Age age 35-69	Control of tobacco use, blood pressure, cholesterol, and diabetes; treat TB; immunize against HBV; provide accessible, low-cost secondary treatment

Differences between NCDs and Communicable, maternal and perinatal diseases (CMP)

Variable	NCD	CMP
Underling process	Chronic, cumulative exposure leading to clinical event	Acute, time-limited infection (e.g. ARI) or increased risk period (eg. childbirth)
Probability of developing clinical event if underlying cause present	Low (e.g. atherosclerosis)	High (e.g. measles)
Efficacy of interventions		
Secondary curative	Significant but small effect sizes (20-30%, e.g. aspirin)	Significant with larger effect sizes, often curative (100% e.g. antibiotic)
Primary preventive	Significant but small (e.g.stop smoking)	Not as effective as cure
Prevention with vaccines	Not yet available	Available for several diseases
Cost of treatments	Variable	Variable

Appropriate Strategies for Controlling NCDs

- Focus on middle age
- Focus on reducing risk factors and providing low-cost, accessible treatments
- Small reductions in risk in large populations are worthwhile
- Increase knowledge of disease causes
- Develop low-cost interventions
- Use existing tools from industrialized countries effectively

Why Middle Age as a Focus for Developing Countries?

- Absolute increases in population will be large (in millions from 1985 to 2015)
  - **Age group** **15-59** **60+**
  - Developed 59 44
  - Developing 1786 216
- Avoidable death and disability
- Benefits should extend to older ages
- Measurable outcomes

The Role of the World Bank

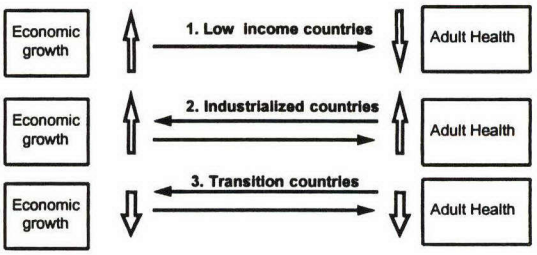
- Help fill policy vacuum for adult health
- More emphasis on tobacco control within Bank operations
- Specific operations with borrowing countries for NCD control
  - risk factor reduction
  - low-cost treatments
  - targeted service delivery to aid the poor
  - create policies and support R&D

Aid Disbursements for Diseases in Relation to Burden

Disease	% of disability adjusted life years (DALY)	Funds in US $million	$ per DALY
Communicable, maternal and perinatal	50	807	1.32
Non-communicable	38	74	0.16
Injuries	12	9	0.06

Source, Murray et al, 1994

Links to Economic Growth



Source: Modified from Catalonia Declaration, 1995

Strategies for the World Bank

- Low-income countries
  - ensure economic growth does not lead to increases in major risk factors
- Middle-income (transitional) countries
  - reduce health care expenditures with adequate investment in preventive and low-cost treatments for adult health
- Both types of countries
  - reduce inequalities

Examples of what to do

- Effective tobacco control: health promotion, education, legislation and taxation
- Low-cost secondary treatments for common diseases
- Build capacity for information, monitoring consequences, and implementing control of NCDs
- Build inter-sectoral collaboration for NCD control
  - e.g. agricultural policy for tobacco, pricing dairy products on protein and not fat content

Examples of inappropriate requests for Bank lending

- Bone marrow transplant program
- Trauma center
- High-technology CVD patient care center
- Stadiums for encouraging physical fitness
- Replace tobacco sponsorship for sports events
- Engineering low-fat cattle

Examples of Effective Responses in NCD Control

- Promote research and development
  - Economic and health services research
    - utilization, financing and insurance studies
    - quality of care in the private sector
    - improved health system data
  - Epidemiological: Focus on COMMON population-based risk factors that are MAJOR causes of disease
    - tobacco attributable mortality
    - case-control studies of risk factors
    - large-scale randomized trials to establish efficacy of treatments
    - limited occupational and environmental studies (only if MAJOR exposures are involved)

Examples of Effective Responses in NCD Control

- Policy Development
  - important prior to service delivery
  - focus on long-term sustainability and public-private cooperation e.g.,
    - Public Health Capacity Building Project in India
    - Hepatitis B vaccination in China
- Targeted Service delivery for the poor
  - surgical versus radiotherapy cancer control at district level
  - cervical cancer screening linked to STD control

Clinical Interventions for NCDs: Accessibility is Key

- Ischemic heart disease and stroke
  - Aspirin, low-cost diuretics and beta-blockers
  - Eventually cholesterol lowering agents
- Common Cancers
  - Surgery for breast, colon and cervical cancers
  - Tamoxifin for breast cancer
  - HB vaccine for liver cancer and perhaps HPV vaccine for cervical cancer

Summary: We Can Help Avoid the Epidemic of NCDs

- Raise awareness among governments, developmental agencies and individuals
- Planning: complete the unfinished agenda, and address the new agenda
  - Start with focus on tobacco control
- Coordination globally and regionally
  - Proposed Special Program on NCDs

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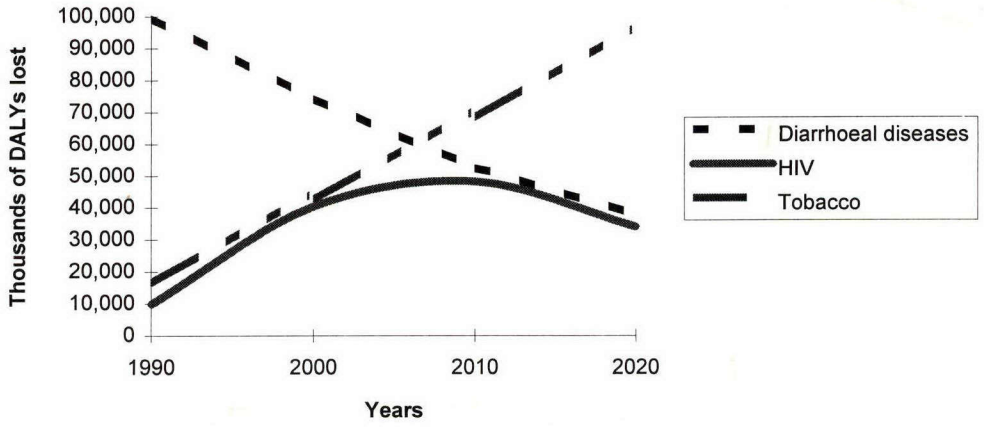
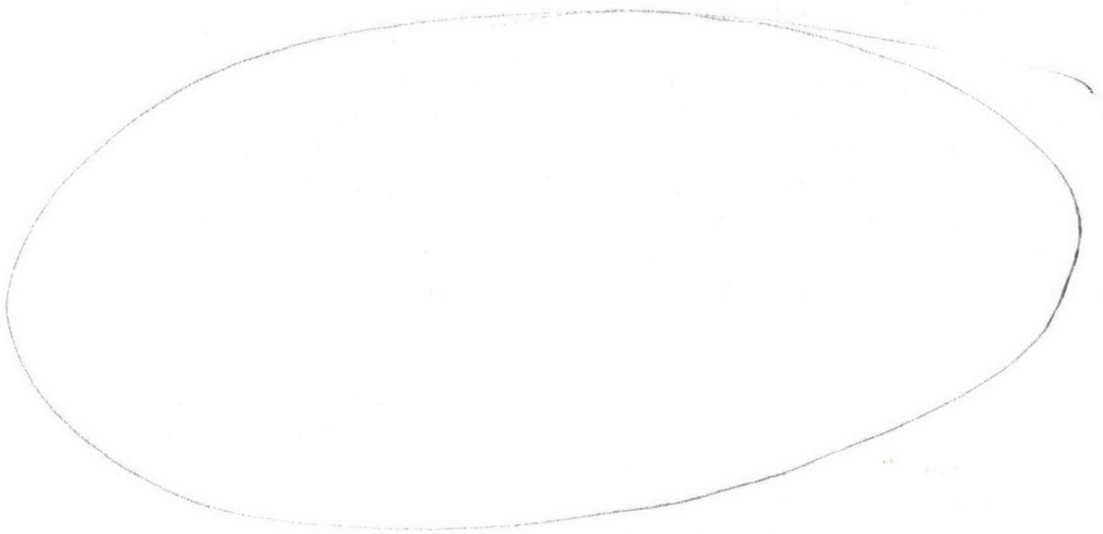
Taxation: A Powerful Tobacco Control Policy

Tobacco consumption is a growing concern because: (a) annual deaths worldwide from tobacco will increase from 3 million in 1990 to about 10 million by 2025, of which 70 percent will be in developing countries, and which will exceed deaths from HIV, tuberculosis, and complications of childbirth combined; (b) half of tobacco deaths occur in productive middle age (35-69), with an average loss of 20 to 25 years of life; (c) tobacco consumption is most common in the poor, and is rising fastest in low-income countries; and (e) tobacco use causes diseases which are expensive to treat, and which compete for public resources that could otherwise be spent on control of priority childhood and maternal diseases (figure *** below).

Tobacco price increases through taxation is one of the most powerful tobacco control measures, and can also generate revenues. In China, a recently-proposed 10 percent tax increase would decrease smoking by 5 percent and increase public revenues by 5 percent. The extra revenue would cover more than a third of the increment for basic health services for China's poorest 100 million habitants. High tobacco prices compliments other methods of tobacco control, such as serious and prominent health warnings as in Thailand; complete bans on advertising and promotion of all tobacco-associated products or trademarks as in Turkey and Slovenia; focused mass media education messages; and capacity to monitor tobacco burdens and control responses and to lobby for control (Sancta to fix figure).

Trends in DALYs lost (in 1000s) worldwide, 1990 to 2020





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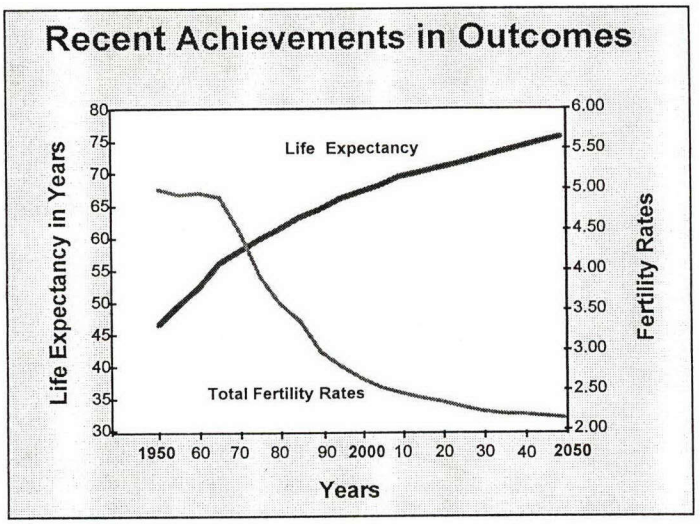
SECTION I: SECTOR BACKGROUND AND DEVELOPMENT CHALLENGES

IMPRESSIVE RECENT GAINS IN OUTCOMES

Advances that have occurred in health, outcomes during the past few decades are impressive. Life expectancy had increased more, and total fertility rates have fallen more, in the past 40 years than in the previous 4000 years. Further more, the year 2000 will mark the mid-point of a century of global transition from high mortality and fertility to low mortality and fertility (see Figure *** below). We live and work in a unique period of human history.



As described by the World Health Organization (WHO) in its *1996 World Health Report*, hundreds of millions of people in developing countries are on the threshold of a new era in which they will be safe from some of the world's most threatening diseases. The United Nations Children's Fund's *1996 State of the World's Children*, gives vivid examples of how recent changes in knowledge and policies have dramatically changed the quality of children's lives. The proportion of children who now die before reaching age 5 is less than half the level in 1960. There has been a 20 percent reduction in child malnutrition rates. Immunization saves approximately 3 million children from major childhood diseases annually. Better control of diarrhea saves over one million children a year.

The average number of children born per woman of childbearing age (the total fertility rate) was X in 1960 and is X today. Population growth rates are slowing. Improvements in access to family planning, together with rising incomes and education of girls and women, have facilitated this trend. Contraceptive use has risen from 10 percent of married couples in the mid-1960s to 55 percent in 1990. Developing countries are half way through the transition from high to low fertility; many have already reached replacement levels of two children per family.

The Origins of Good Health

Several factors influence the great variability in health status that is observed across population groups:

- economic status and poverty;
- education, especially of women;
- culture factors; and
- health care and medical interventions.

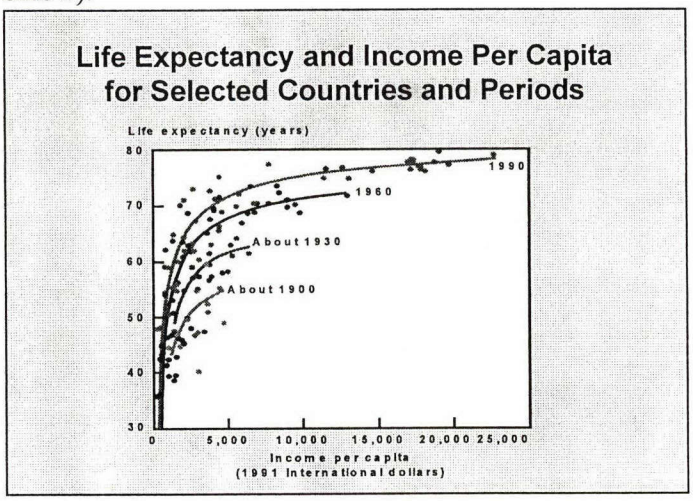
Income levels and reductions in poverty -- with their consequences for adequate food, better housing and access to clean water, satisfactory sanitation, primary education and basic health care -- remain the most powerful determinants of good health.

Likewise, education -- especially in the case of women -- operates through behavior and other channels. Educated individuals more readily adopt healthier lifestyles, learn to make a more efficient use of scarce resources such as food and health care, and avoid harmful risks caused by tobacco, alcohol and illicit drugs.

Culture and behavior also exert powerful influences on health. Most significant are societal norms regarding childbirth and child care, the status and abuse of women, personal hygiene and sexual behavior. All of these are deeply rooted in culture and society and change very slowly.

Finally, people fall ill and die prematurely in all societies and at all levels of income and education. It is health services that must provide specific intervention and treatment. Access to powerful interventions and use of scientific knowledge in everyday behavior have

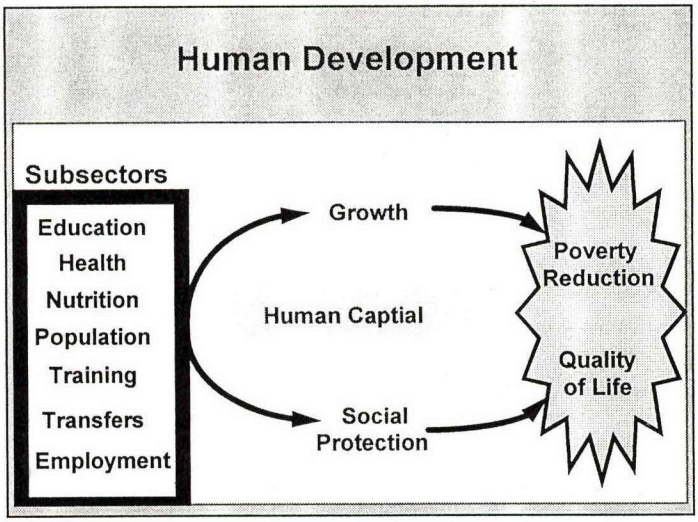
yielded health gains above that expected by income along. Thus citizens of low- and middle-income countries today live almost 25 years longer than they would have at a similar income in 1990 (Figure *** below).



Links with Quality of Life, Poverty and Growth

Good health is a goal in itself because it contributes to overall quality of life. Good health also contributes to human capital, which is increasingly recognized as important to economic growth as labor or physical capital. Effective programs for disease control, nutrition and reproductive health reduce disease-related poverty, enhance work force productivity, improve children's learning in school and contribute to overall quality of life (see Figure ***): For example iron supplementation of women workers in Sri Lanka and China increases worker output, and treatment of intestinal worm infection improves childhood schooling.

Despite impressive gains in health, over a billion of the world's people have benefited only partially, if at all in these gains. According to Bank estimates, 1.3 billion -- nearly one-quarter -- of the world's people continue to live in absolute poverty, earning less than 1 dollar per day. These people are growing in number, and are expected to reach X billion by 2020. Health conditions among the poor are grim. In comparison to the richest billion in the world, the poor live, on average, 20? years less, and their children die more than twice as frequently and 20 are times more commonly malnourished.

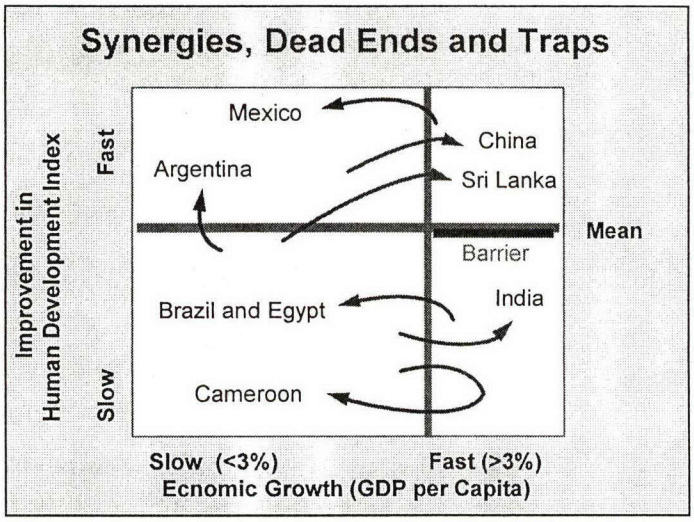


Health of the World's Poorest Billion

It is the world's poor who will suffer the most from all diseases, but especially from the old enemies of communicable, maternal and perinatal diseases. Despite major progress in creating access to cost-effective interventions, these diseases still kill more than 12 million children and more than 0.5 million women a year. This remains particularly true in Africa and South Asia. Poverty also impacts at other stages of the life cycle and from other diseases. For example, males in poor states in India have nearly 50 percent higher probability of death between ages 15 to 60 than those from richer states, usually from non communicable disease such as heart attacks.

The recent period of economic stagnation and decline in Africa and some other parts of the developing world — and the stubborn persistence of poverty in other regions such as Latin America — has emphasized the fact that poor people remain particularly vulnerable to ill health during periods of economic difficulty and the need to ensure that vulnerable groups have access to basic health services.

Sustainable economic development appears to require substantial investment in overall human development. A 30 year review by the United Nations Development Program, demonstrates that only those countries, such as China, and Sri Lanka that simultaneously crossed a critical threshold in human development were able to sustain economic growth. In contrast, countries, such as Cameroon, Mexico and Egypt that underwent periods of rapid economic growth without parallel improvements in human development ended up slipping back to lower growth rates (Figure ***).



Fiscal Concerns Of The Health Sector

In addition to concerns about quality of life and poverty, there are also compelling fiscal reasons for government and Bank involvement in the health, nutrition, and population (HNP).

The health sector consumes about US$1.7 trillion or 8 percent of world income, and US$ 60 billion or 5 percent of developing country income, making it a large industry in most countries. The OECD alone spent nearly 40 percent more on health than the combined GDP of East Asia, South Asia and Sub-Sahara Africa. Ensuring value for money spent on health care has significant implications for the entire economy.

Well-regulated community-based services can stimulate private sector development and improve equity in access to health services. Well-designed national health insurance programs have re-distributional effects in addition to the social protection they provide.

Appropriate cost-containment programs in the HNP sector contribute not only to a more efficient use of scarce resources, but also to better fiscal control over public expenditure. Likewise, excessive or inappropriate spending has a negative impact on overall economic growth and on resources available for education and other social programs that contribute significantly to economic growth, poverty reduction and the quality of life.

Future Challenges and Opportunities

To preserve past gains and address future threats to health in an effective way, policy-makers in developing countries face a number of difficult challenges caused:

- continued poverty;
- social transformation and political turmoil
- health transitions and changing disease burden;
- variable performance of health care systems.

Continued Poverty

Although the world is richer today than it has ever been before, and basic levels of education have improved significantly, the world has become increasingly polarized in terms of economic development during the past thirty years. In some countries, the economic growth that has occurred since 1980 (affecting 1.5 billion people, or more than a quarter of the world's population, in 15 countries) surpasses anything seen since the start of the industrial revolution two centuries ago. The OECD countries, together with certain Asian and Latin American countries have led this trend.

But 1.6 billion people in 100 other countries experienced the effects of unprecedented economic stagnation and decline that, in some cases, far exceeded in duration and depth the Great Depression of the 1930's of the industrialized world. People in Sub-Sahara Africa, many Arab States, and Eastern Europe suffered the effects of this trend. In 70 of these countries, average income today is less than it was in 1980 and in 43 countries it is less than it was in 1970.

Global production is projected to triple by about 2030. Projections also suggest that some East Asian countries could catch up to OECD per capita income of around US 40,000 by 2030, China by 2040 and India by 2090. However per capita income in Sub-Sahara Africa could drop to below US$325.

Appropriate investments in HNP will continue to be important well into the future. This is because while economic growth may make available more

resources for human development (including health, nutrition and population programs), such growth is neither predicable or certain to benefit the poor equally. In addition, the absolute numbers of poor will rise.

Many low-income countries will continue to fall short of total health spending required for a basic set of preventative and curative services. For them, improving outcomes at low cost will be critical. For middle-income countries, or those that anticipate future growth, protecting past gains, and ensuring the efficient use of health sector resources will be equally important.

Nutrition Status in Zimbabwe:
A Sentinel Beacon for Poverty and Health

Nutrition status has in the past provided a powerful sentinel beacon for poverty, potential educational status and multi-sectoral causality of poor health in Zimbabwe — remaining healthy or reaching a high educational attainment was difficult for those who were malnourished.

This synergistic relationship between malnutrition and childhood infections is well known. Diseases caused by intestinal parasites or infections adversely affect nutrition and malnutrition increases the risk of diseases. Poor nutrition correlates with cognitive dysfunction in children, poor reproductive health, productivity and chronic adult diseases.

The Zimbabwe Second Family Health Project is an excellent example of how a well designed program can intervene in this process, even under difficult circumstances. The principal nutrition components of this program include community-based growth monitoring activities, promotion of correct breast feeding practices, iodine deficiency control, and school health and nutrition activities. In addition, there is a supplementary feeding component for periods of drought.

The Zimbabwe experience has provided many valuable lessons. To improve nutrition requires addressing poverty, getting fiscal and agricultural policies right, improving attention to food (production, pricing, subsidies, processing, trade, etc.), and increasing education, physical exercise and appropriate reproductive health, in addition to providing effective health services.

Social Transformation and Political Turmoil

Finding more effective means to influence individual and household behavior in a way that leads to healthier lifestyles is an urgent priority for policy-makers in most developing countries. Since many of the behavior changes that have an impact on health, nutrition and fertility happen slowly (in some cases spanning several generations), commitment to clear medium-term policies is an essential prerequisite for improved outcomes. In many developing countries such policy continuity is often lacking. This is especially true in countries undergoing political and economic turmoil or war. The following examples illustrate this point.

The non-violent social transformations that have occurred recently in the transition economies have unleashed an unprecedented wave of changes that have a significant impact on health, nutrition and fertility patterns. In the countries such as Poland, the Czech Republic and Hungary, where economic recovery has begun to occur, health status has improved. In the countries that have experienced a more dramatic economic decline, such as Russia and Central Asian Republics, reversing the associated deterioration in life-expectancy will not be easy.

The changing role of women in society also has several implications. More girls attend school, marry later and have smaller families. Women increasingly join the labor force. Thus life cycle approaches for women's health is required, placing more emphasis on childhood and adolescent exposure to unwanted pregnancy and sexually transmitted diseases, and -- as women are living longer -- on post-reproductive problems such as cervical cancer.

Taking Prevention Seriously in Africa

To be effective, several key interventions in Africa -- promoting healthier lifestyles, reproductive health and curing communicable diseases -- require behavioral changes, and public and private partnerships across many sectors.

For example, through meetings, dramas and informal networks, communities in Botswana, Malawi, South Africa, Tanzania, Zambia and Zimbabwe are teaching the population the use of condoms and quick reporting of sexually transmitted diseases to prevent their spread.

Various Ministries in Mozambique, Kenya and Uganda are working closely with UNICEF and the Bank in initiating a multi-channeled communication program to promote positive messages about female children. Avoiding

alcohol, HIV/AIDS, and the complications of female genital mutilation, and staying in school, are the subjects of stories played on TV, over the radio, on video, and in plays.

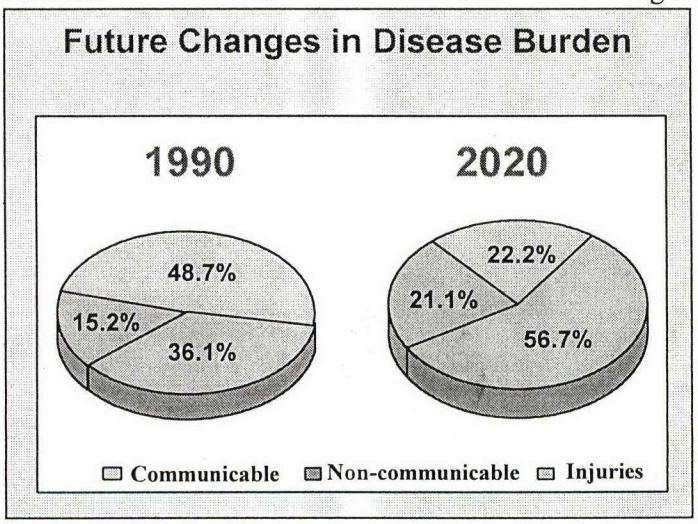
Health Transitions and Changing Disease Burden

Many of the changes in disease patterns that have been observed during the past century in developing countries relate to changes in health status **(health transition)** as population groups move from high mortality and fertility to low mortality and fertility. The four main engines of the health transition are: (a) a **demographic transition** to older populations; (b) changing risks of particular diseases in particular age groups, and changing behavior such as choosing smaller families; and (c) increasing access and use of HNP services.

Even when fertility declines to replacement levels (close to two children per family), population growth will not immediately drop to zero. Instead, birth rates will continue to outstrip deaths for several decades because of the young population age structure that has resulted from past high fertility rates (***demographic momentum***). Due to a combination of factors — continued demand for large families, unwanted fertility and demographic momentum — the world's population could double during the next century (increasing from 5.3 billion people in 1990 to over 10 billion by 2100). Almost all of this population growth will occur in developing countries.

These demographic and health transitions will have a profound impact on health and population outcomes during the next few decades. In particular, the health transition will be marked by a rise in the relative and absolute importance of non-communicable diseases - such as cardiovascular and neuro-psychiatric diseases, cancer and injuries- and a relative decline in communicable disease and maternal and perinatal ill health.[1] Road accidents could become the third biggest cause of disability and death by the year 2020 (comprising 5 percent of global disease burden).

The total global disease burden due to non communicable diseases is estimated to increase from 36 percent in 1990 to 57 percent in 2020, while that for infectious diseases will drop from 49 percent to 22 percent during the same time period (see Figure *** below[2]). Some of these diseases, especially communicable, maternal and perinatal diseases are more common in the poor, and thus their absolute burden will continue to be high.



The net impact of the demographic and the health transition varies by country. In many countries, especially in the Africa region, a combination of demographic momentum and poor health service access suggest that the high burdens from communicable, maternal and perinatal diseases will continue into the future. Some countries, such as India, have concurrent high burdens from both communicable and non-communicable diseases.

The 1996 *Report of the Ad Hoc Committee on Health Research* by WHO highlights three major challenges which result from changing disease patterns:

[1] There are two important caveats. First, although the numbers of cases and relative prominence of non-communicable diseases will rise, for most disease the age-specific incidence rates will fall. Second, although most communicable disease will fall, some will increase -- for example, HIV/AIDS, tuberculosis and malaria.

[2] The disability-adjusted life years (DALYs) was developed as part of the 1993 World Development Report. It combines healthy life years lost because of premature mortality with those lost as a result of illness and disability.

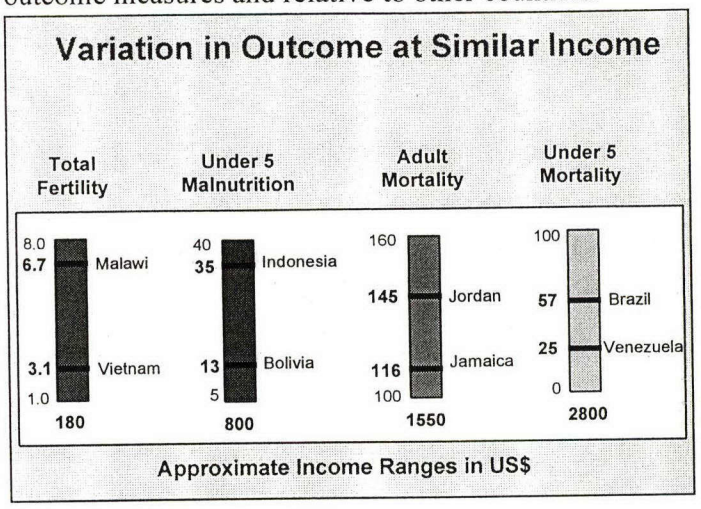
- The continued threats to maternal and child health from unwanted pregnancies, unsafe childbirth, low birth weight, malnutrition and childhood illnesses;
- The threat in existing infection (e.g., tuberculosis, malaria and food poisoning) and of new infections (HIV/AIDS, Ebola, prion disease); and
- The emerging epidemic of non-communicable diseases and injuries from increased exposure to risk factors such as tobacco, unsafe roads and violence.

Performance of Health Systems and Determinants of Performance

The major goals of a health system are to provide good health at affordable cost; increase equity and raise consumer satisfaction. Governments must examine proper roles for public and private sectors (Section II) in health delivery. Moreover, Governments have a proper role in some areas, such as public finance, regulation and inter-sectoral issues, but often fail in other areas, most often in service delivery. Thus, countries differ in health outcomes even at similar levels of income.

For example, at very low income levels (approximately US$ 180 per capita), Vietnam performs much better than Malawi in terms of total fertility rates (see Figure *** below); at somewhat higher but still low income levels (approximately US$800 per capita) Bolivia performs much better than Indonesia in terms of under-5 malnutrition; Jamaica outperforms Jordan in adult mortality at lower middle-income levels (approximately US$1,550 per capita); and Venezuela outperforms Brazil significantly in under-5 mortality at middle-income levels (approximately US$2,600 per capita).

For the purpose of this report, a new methodology was developed to assess the performance of a country's health, nutrition and population policies, and basic health care delivery systems, by "factoring out" the effects of broad socio-economic determinants, such as capita national income, primary education levels for women and income differentials (Gini coefficients), that are outside direct influence by HNP interventions. Using this approach, changes in the performance (improvements or deterioration's) of a country's broad HNP policies, and health care delivery system, can be tracked both over time in terms of a number of key outcome measures and relative to other countries.[3]



For example, in terms of adult female mortality rates, the top performing countries are ***. These are characterized by ***.

Similarly, examination of expected performance in under-5 mortality during the past 30 years, reveals some surprises (see Figure *** below). For example, Costa Rica, Columbia, Chile, South Korea and Sri Lanka come out at the top, while Pakistan, Indonesia, Myanmar, Zambia and the Philippines come out at the bottom.

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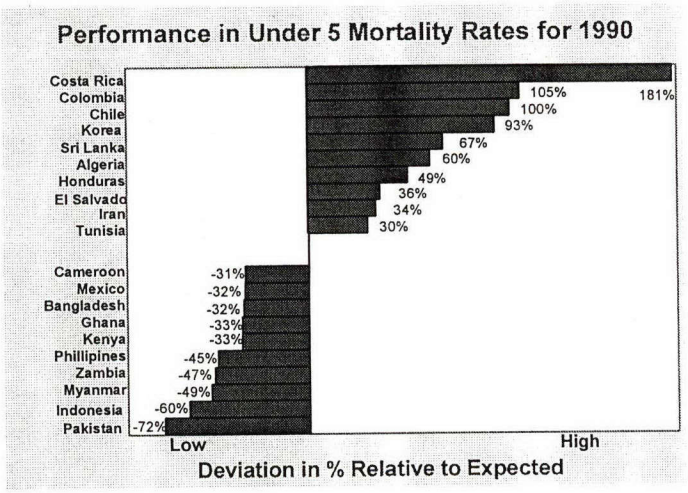
[3] Annex *** provides a league table of countries ranked according to their systems performance during the 1960 to 1990 time period in terms of life expectancy, adult male mortality, adult female mortality, under-5 malnutrition and total fertility rates. Comparisons in performance are made on a country by country basis over time, among countries and between regions.

	Per Capita Expenditure (US$)			Relative Performance						Health Service Infrastructure	
	Average	Minimum	Maximum	Under 5 Mortality Rate	Total Fertility Rate	Male Adult Mortality	Female Adult Mortality	Male Life Expectancy	Female Life Expectancy	Number of MDs	Number of Beds
AFR	82	6	390	-5.8	-0.4	-104.0	-72.2	-11.8	-12.5	0.1	1.3
ECA	299	66	892		1.0	15.9	28.2	2.4	5.3	3.5	10.2
EAP	257	44	686	5.3	0.1	-18.5	-22.6	1.1	1.3	0.4	2.4
LAC	371	34	920	-3.3	-0.4	18.7	8.4	2.2	2.3	1.1	3.8
MNA	307	126	665	-3.0	-0.8	16.0	-0.7	0.6	0.6	1.0	2.2
SAS	55	30	94	0.4	0.1	-14.3	-39.3	-4.0	-7.7	0.1	0.7
OECD	1,772	759	3,817	19.8	0.6	48.8	39.4	7.6	9.5	2.7	8.6



Understanding performance of system involves examining:

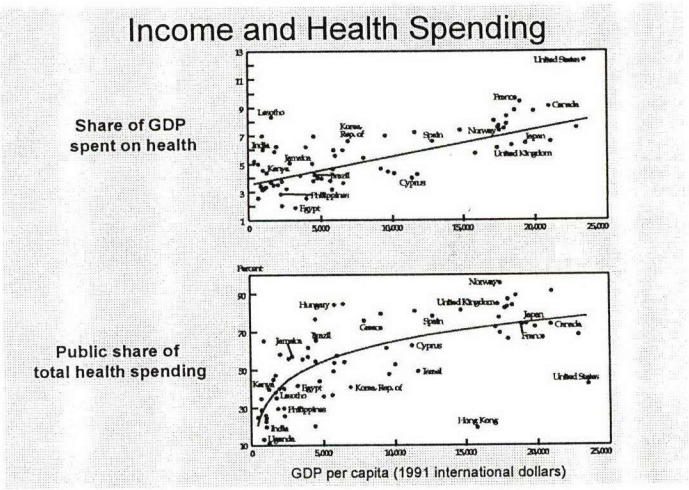
- levels of spending;
- cost-effectiveness of interventions;
- technical efficiency
- access and equity; and
- quality and community satisfaction.

Levels of Spending

In 1990 (update), developing countries accounted for about 13 percent, or about US$ 60 billion of the total global health expenditure (public and private) of about US 1,700 billion. Total spending rises as income rises (Figure ***). Moreover, public spending also rises as income rises. Currently abut 50 percent of total spending in developing countries is public, in contrast to 75 percent in developed countries.

At the current global annual growth rate for GDP of 3.5 percent, health care expenditure will increase at about US$60 billion a year worldwide or US$6 billion a year in developing countries.

There is tremendous range in health spending, but the highest spenders are not always the best performers. Some countries, notably in Sub-Saharan Africa spend much below that required to finance a basic package of preventive and curative services, either because they chose not to, or because of limited ability to raise public revenue. Other countries spend considerable sums, but do not get corresponding returns in gains in health status. Finally, as seen earlier, health outcomes are influenced not only by health systems but other than broad socio-economic determinants.



Mobilizing sufficient resources to secure sustainability and in and efficient manner will continue to be a major challenge in the Sub-Sahara Africa and South Asia regions, where formal labor market participation rates are low and government revenues sometimes comprise less than 10 percent of GDP. Many of these countries will have to continue to rely on informal risk-pooling mechanisms, community based financing schemes and NGOs as their only source of health funding even for the poor.

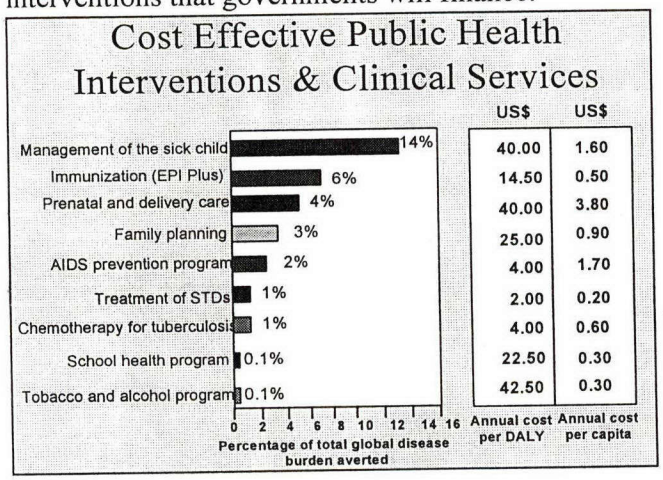
In many middle-income countries, higher formal labor market participation rates allow more a more efficient and equitable risk pooling through social insurance and general revenues. In these countries, expanding coverage to rural communities and the informal sector continues to be a major priority, along

with avoiding cost-explosion in public and private sectors. As East Asia moves slowly from a rural agricultural society to a more urban-based industrial society, countries in that region will be faced with this problem which is already experienced in Eastern Europe and Central Asia, Latin America and the Middle East.

Cost-Effectiveness of Interventions

Given limited resources, but high demand for health services, Governments have a responsibility to ensure value for money. The 1993 World Development Report, Investing in Health recommended that the governments prioritize public spending on interventions that address the largest burden of disease at the lowest cost possible, and that it use cost-effectiveness analysis. In addition to use for priority setting, cost-effectiveness can also inform consumers, providers and insurers about the costs and outcomes of various health interventions.

Fortunately for the HNP sector, some of the most powerful interventions are available at low cost (figure ***). These include treatment of sick children, immunization, and AIDS prevention. Such analysis needs to be local and about 30 countries worldwide have done such analysis to design the 'package' of interventions that governments will finance.



Technical Efficiency

In addition to choosing the right interventions that are most cost-effective, outcomes depend upon ensuring appropriate inputs into delivery of these services. For example, the integrated management of the sick child at primary-care level facilities helps improve quality of care of children, by combining preventive and curative services and lowering missed diagnosis. It also reduces inappropriate admission to hospitals.

Technical efficiency at hospital also involves correct inputs to ensure reasonable cost for the types of patients treated. Correct inputs include non-recurrent salary expenditures helps maintain adequate supply of drugs at district level facilities.

Improving Efficiency in Jordan

Jordan's health sector performs well in terms of access and health outcomes. Its indicators are the best in the region and rank high among middle income countries.

But the system is expensive and inefficient in terms of resources spent for the outcomes achieved. At 7.9 percent of GDP, health care expenditure in Jordan is well above most middle-income countries and even some industrialized countries that perform even better in terms of health indicators, nutrition status and fertility.

While Jordan provides coverage for its poor and disabled, the splintered financing system leaves an estimated 20 percent of the population without formal coverage and is difficult to control in terms of global health expenditure.

Significant inefficiencies in the delivery system are created by excess capacity (the hospital occupancy rate is only 69 percent in the public sector and less than 50 percent in the private sector). A centralized allocation process results in limited incentives for efficient delivery of services. Lack of standard treatment protocols results in excessive use of expensive drugs, with over 25 percent of total resources spent on pharmaceuticals.

The government is currently looking at ways to address these problems through a standardization of insurance coverage, improved regulation of the private sector and a well defined benefit package of cost effective care.

Access and Equity

Financial, physical and social access are needed to ensure that the poorest benefit from health systems. Financial access is most often limited by low household income: In India, the poorest quintile of households spend 3 times the proportion of household income than to rich households on malaria treatment. Physical

access typically involves facilities within walking distance. Social and gender access ***.

Quality and Community Satisfaction

Health systems in al countries increasingly recognize the importance of community involvement in health care delivery. Community awareness and involvement influences health behaviors and appropriate utilization of services, such as increasing immunization of children and increasing compliance for contraception or tuberculosis treatment.

On of the effects of globalization of knowledge and access to media is an increase in expected about quality, choice and consumer satisfaction. Most people who seek medical care expect quality services. Perceptions of quality stem from factors such as travel and waiting time, availability of drugs and supplies, hours of services and the manners and attitudes and inter-personal skills of health professionals. Thus it is not surprising that in many countries private providers are preferred over public facilities because of perceptions of quality and client orientation.

Understanding Underutilization of Government-Run Health Services in East Asia

Utilization rates and other measures of service performance have been disappointing in government-run primary care facilities in East Asia and other regions.

Typically only a quarter of the Indonesians interviewed in national surveys in the 1990s visited government service points when ill, while the proportion going to private providers continues to rise and exceeds the share going to public facilities. Difficulties reaching government centers due to distance or lack of transportation, direct charges, absences of appropriate staff and lack of appropriate drugs all contribute to preventing people from using the government system.

Even when program expansions mitigated many of these factors, the lack of effective and quality of care continued to negatively influence health seeking behavior. Quality pertains not only to the availability of skilled staff, medicines and so forth, but to the nature of client-provider interactions, and the effectiveness of examinations, diagnoses and other uses of staff time. In Viet Nam, lack the authority and policy tools, seriously handicap any attempt to improve service quality. Facility managers and their immediate supervisors have only circumscribed responsibility for work processes and outcomes, and for the activities and productivity of staff. Constructive managerial involvement is inhibited by a several factors. Solutions to many of these problems are available through better public sector management interventions. For example, Malaysia, has been able to address many of such indications of "government failure" by delegating authority for decision making and problem solving facility managers and their supervisors who have requisite resources. They have also been able to establish strong quality assurance mechanisms. But even with such measures, greater private sector participation will be essential to improve the range of available services and consumer choice

PENDING: IMPLICATIONS FOR HEALTH SYSTEMS

1. High spending does not necessarily secure good outcomes.
2. Many countries have such low levels of spending and limited ability to raise revenue that the cannot adequately provide a basic package of preventive and curative hearth services.
3. Poverty reduction through cost-effective interventions that reach the poor is an integral part of improving overall health status.
4. More health R&D is needed to understand health systems and HNP policies.
5. Performance varies considerably according to different factors.

Trends in DALYs lost due to selected diseases throughout the world, 1990 to 2020.

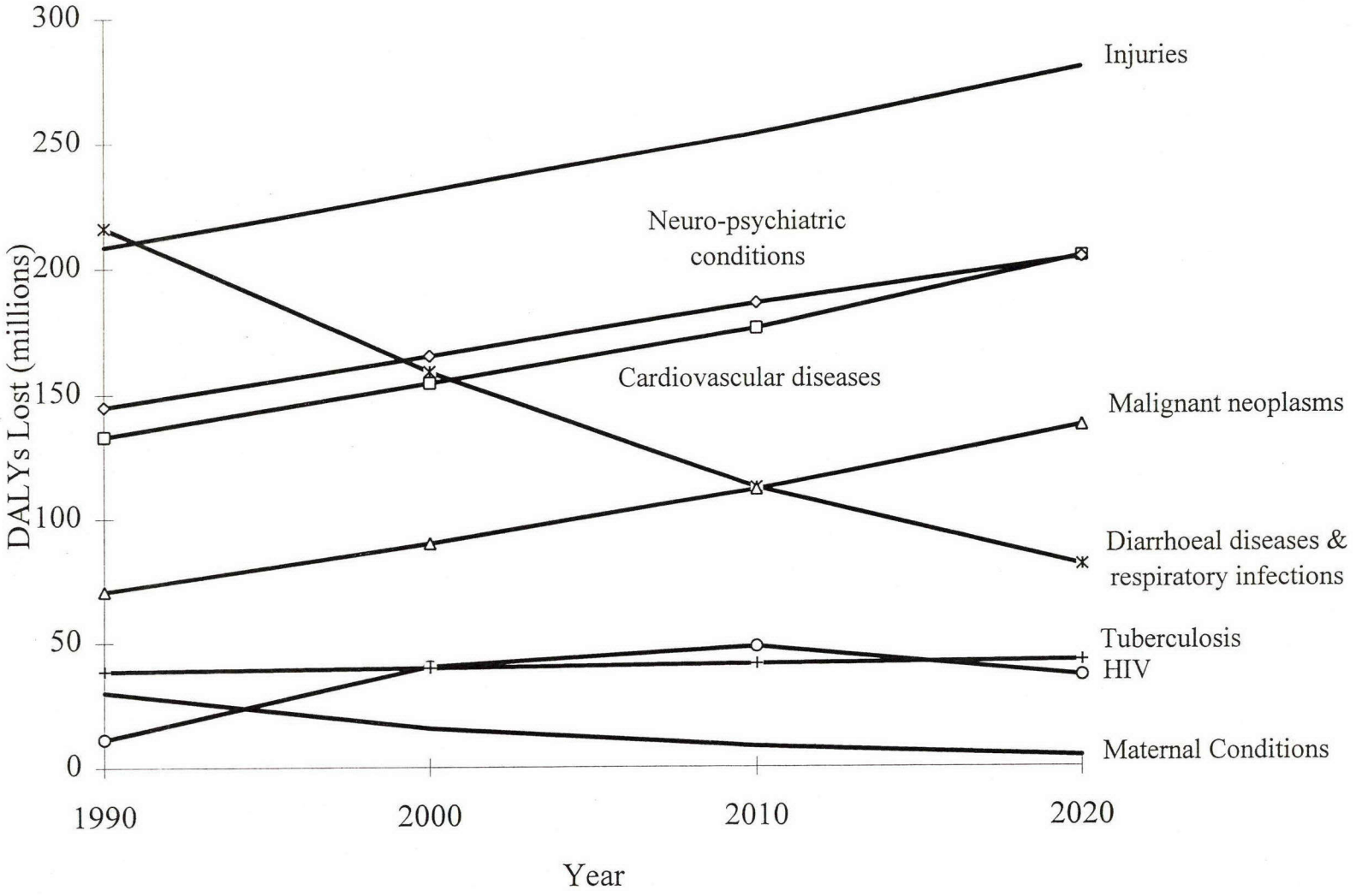
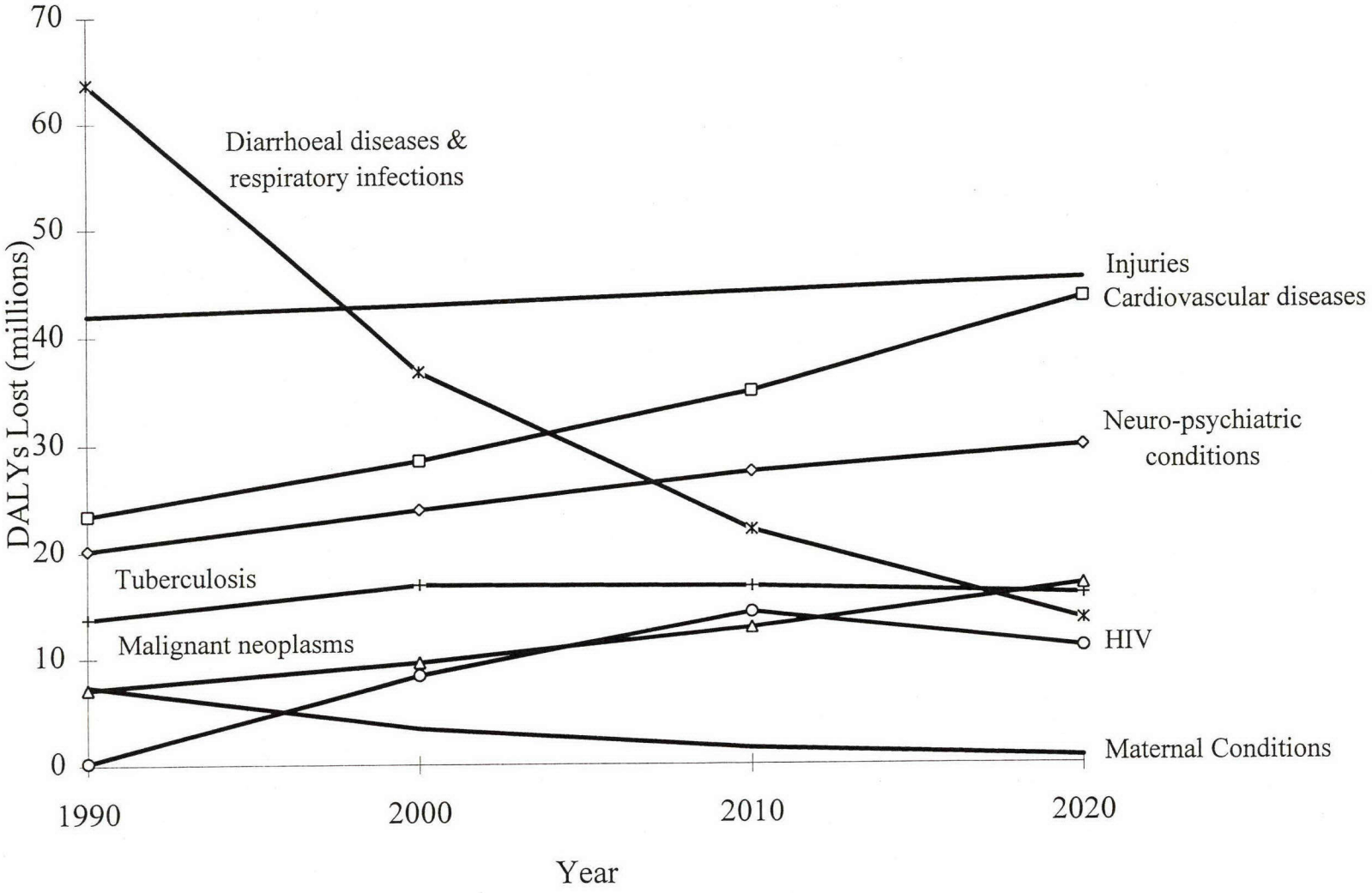
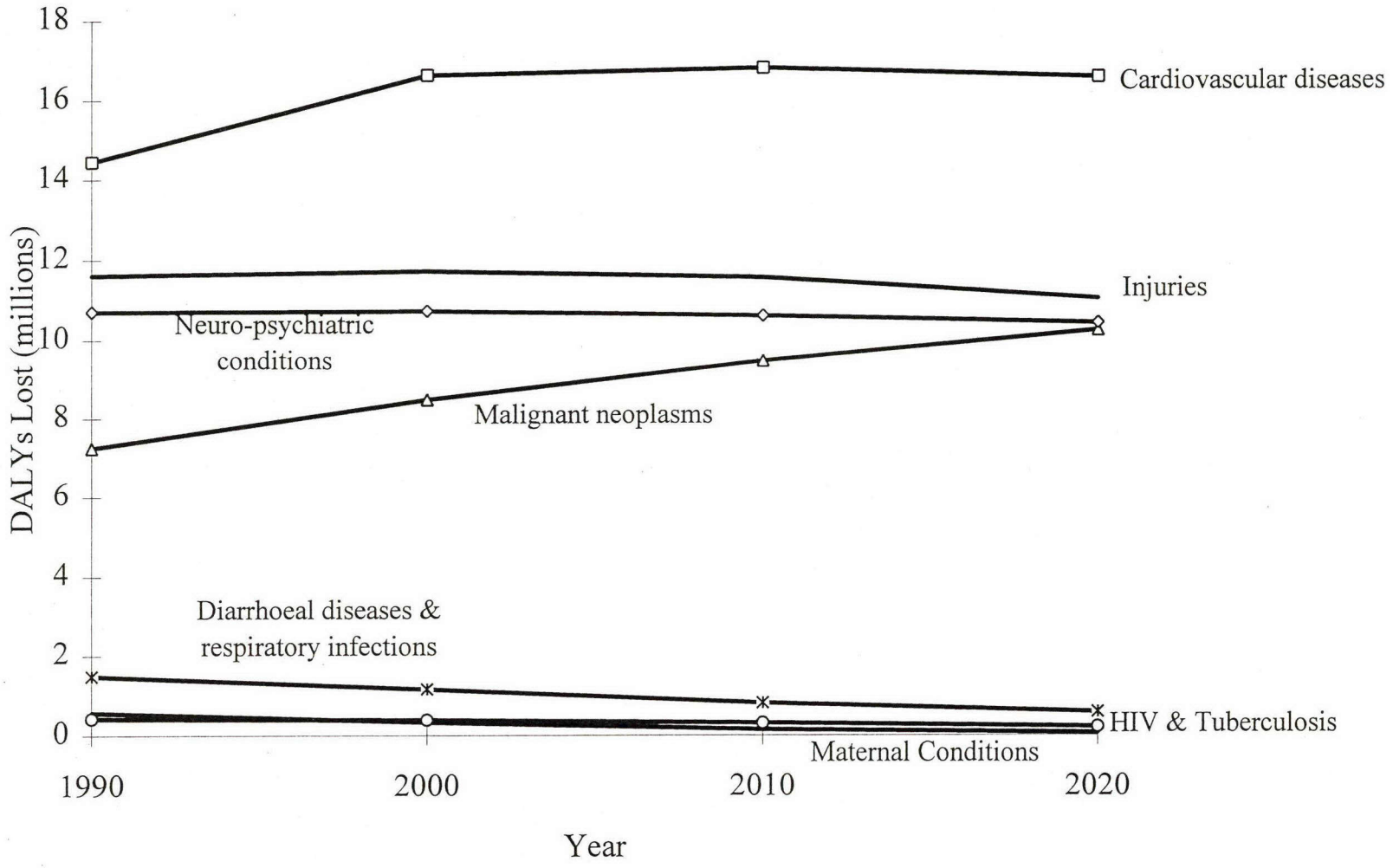


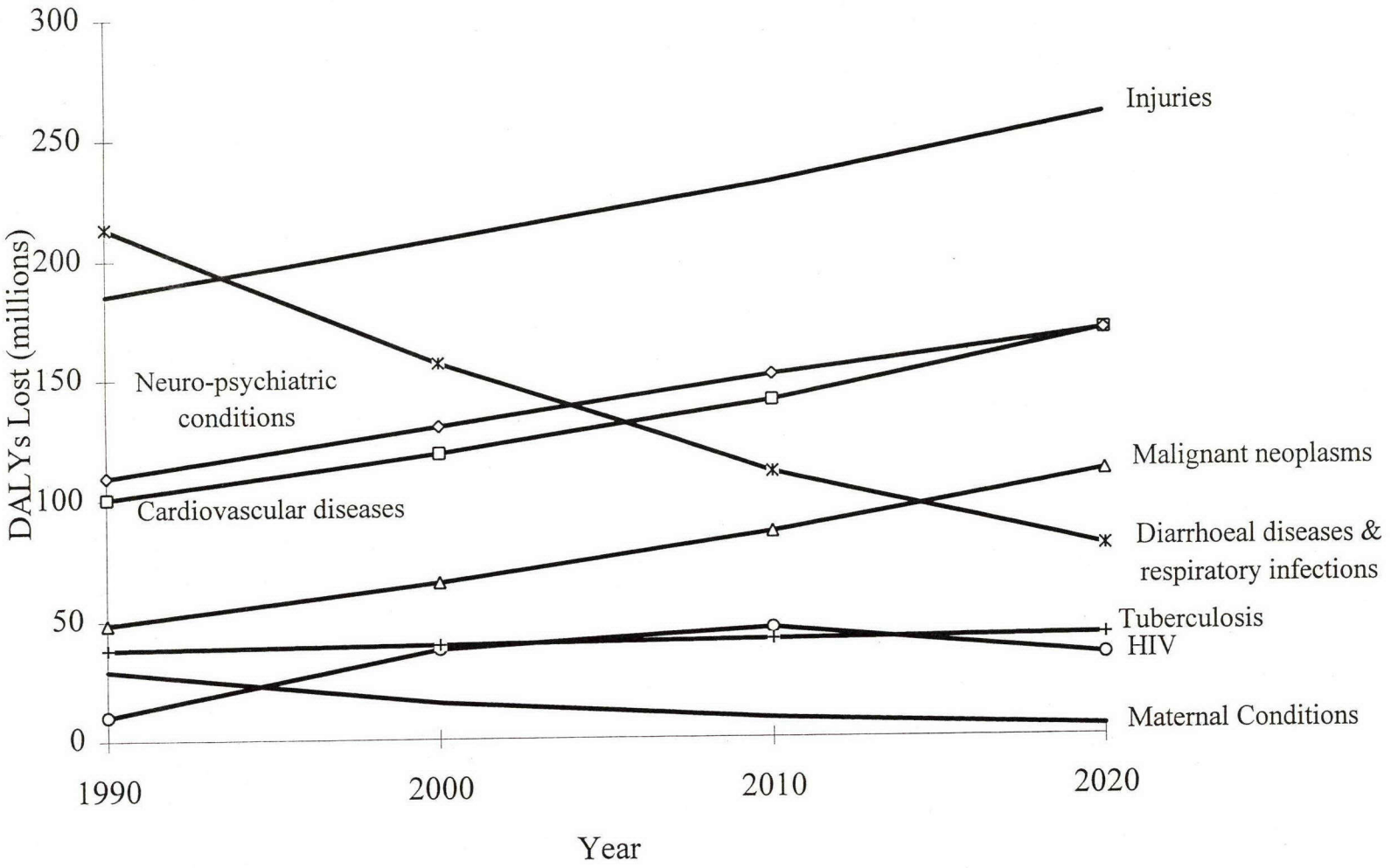
Figure 1. Trends in DALYs lost due to selected diseases in India, 1990 to 2020.



Trends in DALYs lost due to selected diseases in "formerly socialist economies of Europe", 1990 to 2020.



Trends in DALYs lost due to selected diseases in "demographically developing" countries, 1990 to 2020.



Tobacco.Doc

Revised tobacco box of policy for Section 2 and Section 4

Currently tobacco use causes about 3 million deaths worldwide annually, of which around 0.5 to 1 million are in developing countries. On current smoking patterns, by the year 2025, tobacco use will cause 10 million deaths annually, of which 7 million will be in developing countries, where deaths from tobacco are likely to exceed deaths from HIV, tuberculosis, and complications of childbirth combined. In mature epidemics, half of all chronic smokers die from their habit; with half of these deaths in productive middle age (35-69), with an average loss of 20 to 25 years of life.

Tobacco control is justified because smokers do not know all the risks of tobacco use and do not assume all its costs. In opinion polls, people rank tobacco use low as a health hazard. In OECD countries, economic losses from tobacco total between 1.2 and 2.0 percent of GDP, or about one-quarter to one-third of all public health expenditures. The Bank estimates global losses to be at least 200 billion dollars or about 1 percent of global GDP. Moreover, tobacco-related health treatment costs place demands upon limited resources, including those for priority childhood and maternal diseases.

Tobacco use is one of the few areas of health in which the Bank has a formal policy. Adopted by the Bank board in 1992, this policy does not support tobacco production or processing activities and encourages control programs. About 15 countries already borrow from the Bank for tobacco control, largely for health promotion.

The Bank needs to increase its discussion and financing of policy-based tobacco control strategies in borrowing countries, and advocate the following: (a) high tobacco prices, above the rate of inflation; (b) serious and prominent health warnings, as in Thailand; (c) complete bans on advertising and promotion of all tobacco-associated products or trademarks as in Turkey and Slovenia; (d) focused mass media education messages; and (e) capacity to monitor tobacco burdens and control responses and to lobby for control. This policy-based strategy is extremely powerful: In China, the Bank proposed a10 percent tax increase which would decrease smoking by 5 percent but increase public revenues by 5 percent. The extra revenue would cover more than a third of the increment for basic health services for China's poorest 100 million habitants.

Chapter 4. Outline

1. Statement on girls' education, poverty reduction, water supply and sanitation and other World Bank activity which contributes to improved health and nutrition and reduced fertility.

2. Statement on World Bank contribution through knowledge and through finance. Conclusion that knowledge is the main contribution everywhere and the essential prerequisite for successful financing. Conclusion that financing has subtle political economy value for middle-income clients and more obvious purchasing power value for low-income clients. Link last statement to evidence of declining ODA flows to the health sector and therefore increasing importance of Bank's rising health sector financing through IDA.

3. Statement of three foci of World Bank HNP sector attention in the coming decade - linked to our comparative advantage, client needs, and our need to not do everything everywhere.

    - Poverty alleviation through ensuring access to high quality preventative and basic curative services in HNP that address the needs of women, children and the poor.

- Resource Mobilization and cost containment through working with clients on the macro-policy environment relating to public and private expenditure on HNP. In middle-income clients, the focus is primarily on preventing uncontrolled rise in expenditures and insustainable demands for public expenditure. In low-income clients, the focus is on ensuring an adequate level of public investment and on getting better volume for money out of _____ expenditures.

- Assisting HNP policy formulation and sector reform through bringing international best practice and experience on issues such as:

  - the health workforce.

  - regulation, especially of the private sector.

  - divestment of public assets.

  -management of decentralization.

  - revenue generation for health.

  - provider payment.

- quality assurance.

- technology assessment.

- vertical integration, and

- pharmaceuticals.

4. For each of these three foci, provide a page of elaboration. For objective 1 (poverty alleviation) this would include specification of the universal package of cost-effective services with commentary about how to finance and provide them and past public failure in their provision. It will also include angles of regional or global objectives in this area, such as:

- childhood immunization

- malaria in Africa

- TB everywhere

- integrated management of the sick child,

- micronutrient deficiency, and

- reproductive health

to which the Bank might give elevated corporate priority and visibility.

5. A selection on knowledge capture and knowledge generation.

6. A lengthy section on implication for the Bank internal process:

- product innovation,

- ESW

- knowledge management,

- research,

- skills mix,

- links to IFC,

- partnerships,

- budgetary allocation,

- link to CAS

- need for selectivity and rules of engagement.

Mean tasks

Pusan 50

400gm

Self forgets.

George

Executive Summary

This paper focuses on the methods employed by governments to raise revenues to finance their health systems as well as some recent innovations for public and private sector management of such funds (e.g., managed competition, medical savings accounts, private insurance, community risk pooling schemes). In particular, this paper draws attention to the costs associated with public revenue generation--costs that are generally far in excess of the amounts of revenue raised. Such costs along with their distribution across population income groups are often overlooked in discussions of health care financing. The paper also discusses the rationales for public verses private finance, the criteria that should be used to evaluate alternative revenue sources, and the appropriate types of financing arrangements for developing countries given their underlying institutional characteristics. These special characteristics of developing countries often preclude use of the principle financing modalities and management arrangements employed in the developed countries. These issues are especially important for developing countries where low levels of income limit the scope for revenue raising. The paper concludes with a summary of the basic health financing issues in each of the developing regions of the world.

Financing issues must be discussed in the context of current disease burdens, health infrastructures, income levels, and expenditure patterns. Developing countries account for 86 percent of the world's population, 23 percent of world income, 93 percent of the world's disease burden, and 13 percent of global health spending. Developing countries spend 5 percent of their gross domestic products on health compared to over 8 percent in developed countries. In developed countries the public sector finances for over 75 percent of public spending compared to just over 50 percent in developing countries. These imbalances between expenditures and illness burdens will be exacerbated as a result of the changing composition of illness in developing countries toward expensive to treat non-communicable diseases and injuries, which will account for almost 80 percent of their disease burden in 2020 compared to just over 50 percent now.

Financing also must be discussed in the context of appropriate roles of the public and private sectors. Such roles are predicated on the basis of public goods theory and market failures. In particular, public health services should be financed publicly. Personal health services (i.e., services for which the benefit accrues to the individual) which also have collective benefits should be publicly subsidized. Personal health services with no collective benefits can be publicly or privately financed. Personal health services for vulnerable populations are generally financed publicly on equity grounds. Insurance reduces overall risks through the pooling of risks and is therefore a preferred method for financing health services. Health insurance for personal health services can be either publicly or privately financed. Inherent instabilities in insurance markets necessitate government regulation and, under certain circumstances, public financing.
Market failures create inefficiencies concerning individual out-of-pocket purchase of health services. Regulation and provision of information by government may in some cases be a viable alternative to public financing of personal health services.

Government revenues can be mobilized through various combinations of taxes, user charges, mandates, grant assistance and borrowing. However, the unique institutional features of developing countries limit the amounts of revenues that can be raised. In fact, relative to their GDPs, developing countries raise on the order of half the revenues of developed countries. More effective revenue generation is precluded by the inherently agrarian/rural nature of much economic activity, the small and transient nature of many formal urban sector firms, the openness of their economies, and inefficient tax administration.

Raising revenues imposes costs on countries and alternative revenue generation techniques should be evaluated on the basis of these economic efficiency costs, effects on the distribution of income, and administrative simplicity. The public revenue raising methods employed by developing countries generally result in high economic efficiency losses, inequity, and are administratively complex. While several of the more efficient and equitable methods used in the developed countries cannot be effectively implemented in developing countries (progressive personal income taxes), broad based taxes with little rate differentiation and few exemptions applied to commodities and/or entities which display little price responsiveness to such taxes would be preferable on equity and efficiency grounds to many of the taxes currently being used. User charges can also be employed to enhance public revenues where the services in question have individual as opposed to collective benefits, but such charges need to be carefully structured to balance efficiency, equity, and revenue generation objectives. User charges like mandates are a benefit 'tax', and therefore generally perform poorly on equity grounds.

The limited revenue raising potential of developing countries suggests that the public sector can only provide a limited amount of services. In very poor countries, this paucity of resources may preclude governments from even financing an essential package of basic health services. In such circumstances, it is critical for governments to maximize value for money. While governments may not be able to afford curative personal health services for the poor, they may be able to improve societal welfare by encouraging efficient risk pooling for privately financed curative services. In particular, since insurance reduces overall risks through the pooling of risks, developing country governments can improve the welfare of those able to afford privately financed curative services through regulation of private insurance markets and/or in the absence of such markets by organizing such markets so that those able to pay can purchase health insurance at an actuarially fair price.

Private financing accounts for almost half of all health expenditures in developing countries. Health services can be privately financed through private health insurance, direct out-of-pocket payments for services, charitable contributions, and grant assistance and borrowing. Inherent instabilities in private insurance markets caused by adverse selection and moral hazard deminimus necessitate regulation of private insurance to assure effective risk pooling, affordability, solvency, informed choice, and continuity of coverage. However, some argue that effective insurance arrangements require public financing.

Market failures in the service delivery system similarly suggest the need for regulation as unfettered competition in the market for health services does not lead to efficient consumption or provision.

A number of recent innovations including managed competition, medical savings accounts, and informal, generally rural, risk sharing arrangements provide the basis for more effective management of both publicly and privately financed funds through effective risk pooling and offsetting many of the inherent instabilities in standard insurance service delivery markets. Except for informal risk sharing schemes, applicability of these methods in developing countries requires certain functioning institutional arrangements such as financial markets, insurance purchasing cooperatives, etc.

The implications for health financing and overall health reform for the six developing regions of the world are also discussed. The unique socio-economic, cultural, geographic, and health systems features of the countries dictate their reform needs. Areas requiring reform include: financing and delivery of basic public health, reproductive health, nutrition, and female education; need for effective risk pooling for curative services; problems in public and private sector quality; improvements in access; improving the microeconomic and macroeconomic efficiency of the health systems; decentralization and effective management; and, the entire range of issues on the public-private mix in financing and delivery.

Summary:

- There are tradeoffs between equity and efficiency with all revenue raising efforts.
- Administrative capacity is a critical element in all revenue raising efforts.
- Since there are significant economic costs to all revenue raising efforts, it is incumbent upon governments to maximize the returns on the uses of such funds.
- The revenue raising capacities of government's increase significantly as incomes increase.
- The inherent structural characteristics of both work force and industry in lower income countries intrinsically limit the instruments available for governments to raise significant amounts of revenues.
- Broad based taxes with few loopholes placed on bases which display little behavioral responsiveness are preferred tax approaches for developing countries on equity and economic efficiency grounds.
- User charges properly designed and focusing on services with tangible benefits to the individual consumer and facility can lead to increased financing and better services, although user charges perform poorly on equity grounds unless they are applied to income elastic goods and services.
- Public health services need to be publicly financed or subsidized.
- Given the advantages of health insurance as a means of pooling risks as well as the random nature and potentially high costs of treating many illnesses, public and private insurance are preferred vehicles for financing personal health services.

- Given these advantages, their limited revenue raising capabilities, and the importance of private financing, governments in low income countries should consider supporting institutional capacity to assure availability of efficiently run, privately financed, health insurance.
- Informal risk pooling schemes, often sponsored by local governments and voluntary, appear to be viable mechanisms for pooling risks in poor rural areas.
- Recent innovations in managing health sector revenues such as managed competition and medical savings accounts may be appropriate mechanisms for promoting efficient use of resources from the demand side and can offset some of the inherent problems in insurance markets in those countries with the requisite administrative capacity and developed financial markets.
- High priority needs to be given to collecting information on public and private sources of revenues and expenditures for all geographic levels of the system. National Health Accounts are a sine qua non for effective policy-making.

Alex, Chapter 3, pp. 27ff.

Objective of this note: Make text and figures more compatible;
Make text flow with the argument of lending's major importance in a few very lowincome countries, as % of total resources)but minor importance in most (all) middle-income countries.

p. 27, 2nd para.

PROBLEM: The graph does not support its title. No data on "single largest external financier of HNP activities. To support that statement, need data on OTHER donor finance as well as Bank.

Have to change the statement or add a graph, or possibly just a footnote reference. But if you keep the statement, should name some other big donors.

I called Nandita and told her to prepare the data for all these graphs with 1996 prices.

I suggest adding some paragraphs on this page:

1. Donor assistance, including that from the Bank, may exceed governments' contribution to public health spending in many of the lowest-income countries, especially those in sub-Saharan Africa. Countries that finance more than [a third?, a half?] of public health spending by meansof donor assistance include [Chad, Mauritania, Cent African Repub???? need to check with Ok Pannenborg.] In most countries, however, Bank and donor assistance taken together finance but a small percentage of the public health budget: Less than half of 1 percent in Brazil and Poland[?], less than 1 percent in China, India, and Indonesia, and less than five percent in Bangladesh, Vietnam, and Pakistan. [These all need to be checked but are probably accurate.] These small shares emphasize this report's contention that amounts of lending are far less important in the Bank's HNP assistance strategy than is its role in inducing more efficient and equitable use of each country's own health spending resources.

2. Along the same lines, more detailed commentary on the regional distribution of HNP lending in the two trienial periods. Look how big LAC and SAS are. Why the fall-off in EAP?

In LAC regionit's mostly policy that counts. On a per capita basis, LAC would look even larger. Want to show that?

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

DATE: 05-Feb-1997 01:37pm EST

TO: See Distribution Below

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: SAS - Regional inputs for WC redrafting during Retreat next week

In preparation for the regional inputs for the SAS retreat next Thursday and Friday, you will be receiving a copy of the "Dirty" White Cover draft of the SAS (HNP Board Members have already have received their document).

Objective of Retreat
==========

The objective of the retreat next week is overhaul the draft White Cover so that we have a "cleaner" version ready by COB Friday, February 14.

Work plan
==========

To ensure we get the maximum out of the day and a half of regional meetings, I suggest you review the current draft document from the following perspectives:

- contents of storyline (get central message right)
- delivery of storyline (make story clear as possible)
- factual details (ensure data is correct)
- editorial (improve presentation and language)

Based on feedback I get from HNP Sector Board members this Thursday, I will be working on a redraft of the general document early next week. I would appreciate receiving by EMail before COB next Tuesday any general comments you think should be included in the initial redraft which I will distribute when you arrive on Wednesday evening (please be concrete about suggested improvements, cuts or additions).

On Thursday and Friday when you join us in Wintergreen, we will review the new working draft and try to give the document a greater regional flavor both through the case study boxes and other concrete examples in the text (each region currently has two Boxes based largely on the inputs you

gave me, although I have take some liberty in redrafting some of the text).

We need to decide as a group if these are the best case study examples and to strengthen the messages in the Boxes. I therefore suggest you have a particularly close look at the boxes which pertain to your region and make changes where appropriate.

During the regional discussions we should also try to go over some of the regional priorities that have emerged from the matrices. I have not included this in the current version of the WC SAS since the inputs I received, although very valuable in giving a sense of what you see as priorities, are quite varied in contents and presentation. I will circulate a set of these to everyone so that you can review these in advance.

Finally, during the regional discussions, I would like to go over the statistical annexes we are preparing. In each region we have identified priority countries according to different parameters:

- Performance in terms outcomes and resources
- Vulnerability in terms of income and education levels
- People affected in terms of populations covered
- Bank exposure in terms of size of lending portfolio

I will ask you to have a look at this during the retreat and subsequently have further discussions at the regional level about the priority countries identified.

Please bring any reference material you think will be useful and laptops for needed redrafting of text.

Sancta Watley and Yvette Atkins are fully in charge of logistics. Please address queries about travel, accommodations, downtime activities and any personal needs or special meal requirements to them.

I am looking forward to a productive couple of days with lots of stimulating discussions.

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TO: REGINA MARIA BENDOKAT (REGINA BENDOKAT @A1@WBHQB)
TO: SALIM J. HABAYEB (SALIM HABAYEB @A1@WBHQB)
CC: SANCTA WATLEY (SANCTA WATLEY @A1@WBHQB)

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

DATE: 04-Feb-1997 04:44pm EST

TO: See Distribution Below

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: Preparation for SAS Retreat

You will be receiving today a copy of the "Dirty" White Cover draft of the SAS. Many thanx for your valuable contributions - it has been a team effort although I take full responsibility for any misrepresentation that may have occurred during the drafting.

Objective of Retreat
==========

The objective of the retreat next week is to complete a thorough overhaul of the White Cover so that we have a "clean" version ready by COB Friday, February 14 (that includes a first crack at a clean version of the statistical annexes and accompanying text - take note Ed, Vivian, Akiko and George).

In other words, the retreat is not just to think about, discuss and critique the SAS but also roll up our sleeves and fix the things that need to be fixed (in addition to a little eating, sleeping, etc.)

Work plan
=========

To ensure we get the maximum out of the week, I suggest everyone prepare well in advance by doing the following:

1. Read the document and be prepared to give me a detailed marked up copy as well additional written inputs, redrafts, replacements, graphs etc, when you arrive at noon next Monday (anyone who would like to give me some of this material before Monday are encouraged to do so).

2. Since general and unfocused critique would NOT be helpful at this stage, I suggest we all review document from the following perspective:

- contents of storyline (get central message right)
- delivery of storyline (make story clear as possible)
- factual details (ensure data is correct)
- editorial (improve presentation and language)

3. If you think something could be improved, cut or added, please be concrete and come prepared with suggested alternative text (I am reserving most of the case study boxes for the regions but you should be prepared to help them with useful suggestions). Some of the thematic boxes need more work and throughout the document we need to add some "telling details" through references to actual country experience -- the current document is far too sterile in this respect.

4. Bring any reference material which you think will be needed while in Wintergreen (Ed, Vivian, Sancta and I are bringing desktops to be able to work on the document - we have arranged for everyone else to have laptops).

5. You will receive a schedule of proposed meetings but I want to keep a fairly flexible program so that we have lots of time to work and redraft some of the sections that need to be revised.

Bear in mind that we are aiming at a 30 page document and that the current version is 38 pages. There are parts that can easily be cut or moved into annexes, and the final version will have to be less dense and with fewer graphs and tables. This will reduce the length a bit, but trying to tell the full story in such short a document will require a trade-off between focus, superficiality and simply leaving some things out. So any suggestions for additions, should be accompanied by suggestions on what to cut.

Finally, Sancta and Yvette are fully in charge of logistics. Please address queries about travel, accommodations, downtime activities and any personal needs or special meal requirements to them.

I am looking forward to a productive few days with lots of stimulating discussions and a product we will be proud of at the end.

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TO: DAVIDSON R GWATKIN (DAVIDSON GWATKIN @A1@WBHQB)

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

DATE: 07-Feb-1997 02:51pm

TO: See Distribution Below

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER)

EXT.: 32327

SUBJECT: SAS Retreat Next Week

We had a good meeting with the HNP Sector Board yesterday (you will be receiving the minutes for the meeting during the next couple of days). There was general support for the overall thrust of the document. Yet we clearly still have a lot of work to do to get the message crisper and to make the case studies and document as a whole more "alive" through concrete examples.

The weakest part of the document is Section IV on future strategy. A suggestion was made yesterday that during the regional retreat next week, we should try to strengthen the messages in section IV, linking them more closely to the overall story line on government failure and the implementation strategies being tried at the regional level to address this problem.

There are already some good ideas about how we might do this in the matrices which each region prepared for me. Although most of the matrices are still fairly rough, I am going to circulate them to you in advance so that you have a chance to review them before next week.

I will also circulate the draft Sector Assistance Strategy for the ECA Region which I have just received. Although for Bank-wide SAS we are not asking each region to produce such a written document, several regions in addition to ECA are nevertheless working on their own regional papers. I have therefore asked ECA to share their preliminary draft with you as an illustration of how this whole exercise could be applied at the regional level.

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TO:	REGINA MARIA BENDOKAT	(REGINA BENDOKAT @A1@WBHQB)
TO:	SALIM J. HABAYEB	(SALIM HABAYEB @A1@WBHQB)

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TO:	JUDITH SNAVELY MCGUIRE	(JUDITH MCGUIRE @A1@WBHQB)
TO:	ANNE G. TINKER	(ANNE TINKER @A1@WBHQB)

Ed

Conclusions of Group 3: Modalities for Enhancing Bank Effectiveness

Staffing and Skills Mix

* HNP seems to be understaffed: 250 HL staff/LTC against 5,000 Bank total; growth over ten years - 6% of staff, 8% of loans and 13% of lending

* HNP requires (limited numbers of) very sr. staff, to engage substantial dialogue with government ministers, throughout the world - implies change in recruitment patterns and training; present pattern of large numbers of fairly sr. staff and relatively small numbers of more jr. staff is an inverted triangle - yet following the knowledge management institution model of consulting firms and law partnerships, the Bank should have limited numbers of 'sr partners' and more 'associates.'

* Technical standards for Bank work in HNP need to be raised, as Sector Board already working on; task team leader is different from task manager, and accountability of the task team needs to be underscored

* HNP should, selectively, rely increasingly on implementation teams to provide technical skills required on procurement, disbursement and related Bank lending policy and procedures, to participate as full members of task teams

* Training needs analyses required, for Bank to make required substantial investment in HNP staff training and development; modalities for staff training and development, and antecedent needs analysis, are not yet the subject of consensus - some favor traditional needs analysis, others favor Sector Board or a sub-committee of it reviewing batches of PMPs, meeting selected staff, to determine development needs; skills requirements for strengthening include both communications/advocacy/negotiations skills and technical skills

* Training and development needs do NOT vary substantially across regions, so a Bankwide program is feasible; and Bank should anticipate recruitment and development of staff for Bankwide work, rather than just in one region

* Ongoing changes processes, including LAC and Africa Region reorganizations, facilitate change in human resources for HNP in required directions

* While the education sector was recently in a position to make quantitative estimates of specific skills, HNP not ready/able to do this; this should form part of the future Sector Board activities

* Balance between Bank staff and long-term consultants needs to be revisited

* Continuity in assignment to operations and countries is critical in an environment of so many staff new to Bank or HNP work

* Actions set out above should facilitate 'mainstreaming' of HNP work in the Bank

A. Edward Elmendorf
February 13, 1997

Conclusions of Group 3: Modalities for Enhancing Bank Effectiveness

Lending Instruments[1]

* Move away from 'lending instruments' to 'financing instruments,' on the grounds that the instruments go beyond lending

* HNP staff must engage in Bank product work beyond HNP instruments themselves, in the interest of achieving HNP goals, by such actions as participation in SAL work, PFP work, civil service reform, active engagement in SASs and not just submission of papers for cut and pasting by macro staff

* Existing instruments are inadequate for fulfillment of HNP mission, at two levels: (a) financing activities at inter-country and global level, where major expansion of SGP-type activities is needed - there was a clear consensus that non-lending, inter-country regional activities are essential to the Bank's HNP mission; and (b) at country level, 'below' central governments in civil society, local government, traditional private sector, where procedural (Bank procurement and disbursement) and sometimes political (borrower objection to working with non-governmental parties) hurdles placed in the way by central governments inhibit reaching targets of Bank financing under newly and more broadly conceived HNP mission, especially attention to demand variables; the experiences in Tanzania with vouchers (C. Griffin) and Honduras with food stamps are the exception rather than the rule

* Creation of a new financing instrument to meet above need should be explored, possibly through an additional IDA window for grants at both inter-country and 'below-government' levels

* Sector-wide approaches should be the aim - but these approaches should be integrated at the level of country sector strategy rather than, generally, at the level of individual operations; sector wide approaches require linking work on development and introduction of new tools permitting integration of public and private expenditure, including creating and using using national health accounts

* Lending is often only incidental to work on HNP issues, as in Indonesia; this extends as far as non-lending, reimbursable TA in the middle east; borrowers count on Bank informal and official advice` under TA loans, investment loans, ESW and non-operational activities

A. Edward Elmendorf
February 13, 1997

[1] These comments are supplemental to those of Xavier Coll, rapporteur on this point.

SAS Chapter IV - Additional Comments[2]

* Quality control, in its many and varied dimensions, needs to be added to the list of 6 points

* Government failure is not a sufficient, or sufficiently nuanced message, for it can always by repaired by intervention - a rationale explaining government failures, and where they are, is needed - classic tools of public finance provide such a framework, within which government failure fits.

* Government failure needs to be admitted at same time as non-governmental failure

* Use notion of 'nongovernment' rather than 'private' on the grounds that the former expression is broader and suggestions something of the complexity of the 'private' sector.

A. Edward Elmendorf
February 13, 1997

[2] These comments include personal observations and additional views, of the Group, on issues in the list of 6 points prepared by Richard Feachem

New Directions in Health Development in India

India suffers from substantial gaps in the effectiveness, efficiency and quality of health services. Due to the strong private sector presence (4.7% of GDP), the Government is seizing the opportunity to promote selectivity and effectiveness in its own role, and to focus better on serving the poor. India has initiated a policy shift to (a) promote private-public partnership by encouraging further private expansion, while easing the public sector out of areas where it does not have a comparative advantage and tertiary care, and concurrently promoting private participation in preventive and promotive services; (b) reorient health care strategy taking into consideration need-based approaches, cost effectiveness, and staff incentives, improving the analytical capacity for planning and sectoral management; and (c) prioritize and improve state level expenditures, allocations and sustainability, strengthen peripheral financing arrangements, implement cost-recovery mechanisms, reform sectoral expenditures and enhance decentralized administration and governance under the Panchayati Raj System.

India has developed one of the largest HNP partnerships with the Bank, and has opened 3 windows of collaboration in the health sector, which emphasize capacity building:
(a) supporting public health programs and endemic disease control which have high social returns and positive externalities, while changing outdated technical paradigms and promoting appropriate technology in order to effectively reduce the burden of these diseases with substantial non-governmental sector involvement. This includes cataract blindness, leprosy, tuberculosis, malaria and STD/AIDS control; (b) strengthening district level systems in the states, improving their performance while pursuing these reform and decentralization policies; and (c) strengthening essential public health functions and regulatory mechanisms for consumer protection such as food and drug administration and quality control.

Throughout this partnership, the Bank has mobilized high technical expertise and collaboration from centers of excellence such as CDC, NIH, FDA, WHO, UNICEF and from bilaterals. Cocurrently, stakeholders analysis and broad-based participatory approches were promoted.

In the population and MCH sector, the government is supporting family welfare and fertility reduction interventions, safe motherhood & child survival, and is currently shifting towards a reproductive health approach focusing on the needs of women and on a demand approach rather than demographic targets. In nutrition, the Government is promoting integrated child development programs focusing on underprivileged communities.

To facilitate this partnership, the Bank has strengthened, and continues to strengthen, its field presence and HNP capacities. The appropriate mix of international staff and national staff brings added value to serve the clients. Most of the nutrition work program is based in New-Delhi. A notable feature is that procurement, disbursement and

auditing work of the HNP portfolio is handled out of the resident mission promoting prompt responses and facilitating program implementation processes.

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

DATE: 05-Feb-1997 01:37pm

TO: See Distribution Below

FROM: Alexander Preker, HDDHE (ALEXANDER PREKER@A1@WBWASH)

EXT.: 32327

SUBJECT: SAS - Regional inputs for WC redrafting during Retreat next week

In preparation for the regional inputs for the SAS retreat next Thursday and Friday, you will be receiving a copy of the "Dirty" White Cover draft of the SAS (HNP Board Members have already have received their document).

Objective of Retreat
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The objective of the retreat next week is overhaul the draft White Cover so that we have a "cleaner" version ready by COB Friday, February 14.

Work plan
=========

To ensure we get the maximum out of the day and a half of regional meetings, I suggest you review the current draft document from the following perspectives:

- contents of storyline (get central message right)
- delivery of storyline (make story clear as possible)
- factual details (ensure data is correct)
- editorial (improve presentation and language)

Based on feedback I get from HNP Sector Board members this Thursday, I will be working on a redraft of the general document early next week. I would appreciate receiving by EMail before COB next Tuesday any general comments you think should be included in the initial redraft which I will distribute when you arrive on Wednesday evening (please be concrete about suggested improvements, cuts or additions).

On Thursday and Friday when you join us in Wintergreen, we will review the new working draft and try to give the document a greater regional flavor both through the case study boxes and other concrete examples in the text (each region currently has two Boxes based largely on the inputs you gave me, although I have take some liberty in redrafting some of the text).

We need to decide as a group if these are the best case study examples and to strengthen the messages in the

Boxes. I therefore suggest you have a particularly close look at the boxes which pertain to your region and make changes where appropriate.

During the regional discussions we should also try to go over some of the regional priorities that have emerged from the matrices. I have not included this in the current version of the WC SAS since the inputs I received, although very valuable in giving a sense of what you see as priorities, are quite varied in contents and presentation. I will circulate a set of these to everyone so that you can review these in advance.

Finally, during the regional discussions, I would like to go over the statistical annexes we are preparing. In each region we have identified priority countries according to different parameters:

- Performance in terms outcomes and resources
- Vulnerability in terms of income and education levels
- People affected in terms of populations covered
- Bank exposure in terms of size of lending portfolio

I will ask you to have a look at this during the retreat and subsequently have further discussions at the regional level about the priority countries identified.

Please bring any reference material you think will be useful and laptops for needed redrafting of text.

Sancta Watley and Yvette Atkins are fully in charge of logistics. Please address queries about travel, accommodations, downtime activities and any personal needs or special meal requirements to them.

I am looking forward to a productive couple of days with lots of stimulating discussions.

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