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**Title**

Perspectives on Improving Health in Poor Countries: Qualitative Assessment of Multilateral Agency Views and Behavior

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*Disclaimer:* This paper was commissioned by Working Group 6 to gain a better sense of the views and opinions of selected staff of multi- and bilateral agencies on the prospects for development assistance in health. Its purpose is to provide an overview of the kinds of issues that those interviewed believe are relevant to considerations of the future of development assistance in health. The paper is not intended to convey official policies or positions of the concerned agencies, nor should its findings be interpreted as representative of staff opinion within the concerned agency.

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## Perspectives on Improving Health in Poor Countries

How do development professionals view the problems and prospects for combating major diseases and improving health status in developing nations? If financial constraints were lifted, what major obstacles to progress would remain? What broad strategies and approaches would be most promising?

This report explores these questions, based on interviews with twenty-six staff members of the World Bank, the Inter-American Development Bank (IDB), and the U.S. Agency for International Development (USAID). The interviews were conducted during May 2001. Sixteen of the discussions were with World Bank staff members, five with IDB, and five with USAID staff. Two additional people were consulted, affiliated respectively with Brookings and Apt Associates, with extensive knowledge of health sector reforms and assistance in particular countries or regions. Attachment 1 lists all those interviewed.

An effort was made to interview people from most major geographic divisions of the World Bank, including Africa (with special emphasis), Europe and Central Asia, Latin America, and South Asia. Respondents were also selected to represent varied responsibilities, including global finance and strategy, regional economic and programming responsibilities, more specific responsibilities for human resource development, and (in three cases) the health sector itself. In IDB, respondents from two of the three sub-regional divisions were interviewed, as well as two persons with region-wide responsibilities. In USAID, two of the respondents had global responsibilities; three were particularly concerned with Africa; and two of the five were specifically concerned with the health sector.

Most interviews lasted about an hour. Each interview started by noting current initiatives to greatly increase the financial resources available to combat diseases and improve health in developing nations. The rationales for increased funding were also noted, with special emphasis on the proposition that the burdens of disease, disability and early death are major obstacles to more rapid economic growth and reduced poverty. Each respondent was then asked to comment on the basic rationale, potential channels for effective use of increased resources, and obstacles to effective use (not only in developing countries but also in the respondent's own and other aid agencies). No standard list of questions was used; rather, the discussions varied according to each respondent's background and past and current responsibilities. Many of those interviewed had worked in more than one geographic region in their careers, and drew comparisons across regions or among countries at different levels of development. A few had moved from one aid agency to another, and offered comments on differences in approach. Respondents were assured that the report based on the interviews would not attribute specific views to individuals.

The report is organized in three sections. Section I conveys the main messages that emerge from the interviews taken as a whole. It is a synthetic summary of the major

points of substantial agreement, amplified in a few cases by an attempt to make explicit certain ideas that were largely implicit in the discussions. Section II reports the views of the respondents regarding major themes and issues. The section notes areas of strong consensus. It also flags issues where different people voiced divergent or conflicting views, and identifies some points on which respondents seemed to be uncertain or stated that knowledge is simply inadequate. The third and final section briefly surveys differences in responses among those with different geographic or functional responsibilities or from different agencies.

Several caveats are in order. While an attempt was made to interview agency staff representing a range of geographic and functional responsibilities, the set of interviews is not at all a systematic sample. The report is based on the expressed views of those interviewed, but no attempt was made to verify the factual accuracy of statements and perceptions. Moreover, in the short span of an hour, respondents did not have time to spell out their ideas in detail, or to fine-tune judgments. As already noted, Section I draws not only on ideas that were explicitly stated, but to some extent also on the unstated logic implicit in what was said. Some of those interviewed might disagree with the resulting interpretations.

## I. Main Messages

1. The proposition that *widespread poor health severely impedes development and poverty reduction* is generally accepted. More specifically, *much more aggressive measures are needed to contain and cope with the effects of the AIDs pandemic.*

2. Funding is not viewed as the most fundamental obstacle to improved health status. *Additional funds can improve health status quickly only to the extent that workable delivery systems are in place or can be rapidly created*. Most bilateral and multilateral aid agencies already give high priority to health (and education); many have increased their efforts in the health field in recent years. The World Bank and the IDB find that many health projects move slowly and pipelines are building up. Assuming that additional funds can be mobilized, the crucial questions concern delivery.

3. *Delivery requirements vary with different types of diseases and health problems.* For any specific disease (or disease cluster) or health challenge (such as reducing maternal mortality), the requirements for effective delivery reflect two sets of variables:

   a. The scope, technical complexity, and required duration of treatment and preventative measures.

   b. The degree of behavior change, by individuals and within local or larger societies, required to contain or eliminate the disease or problem.

Inoculating children is relatively simple, literally single-shot, and requires no on-going behavior change. AIDs, malaria, TB, maternal mortality, and many other problems pose far more complex technical and behavioral challenges, and require more durable and institutionalized delivery channels. Those channels can be more or less specialized, but if they are highly specialized, they must be coordinated with other agencies or actors addressing other dimensions of the problem.

4. *Feasible delivery mechanisms also vary with country circumstances,* including availability of skilled personnel, health infrastructure, transport and communication facilities, law and order, terrain and climate, and many other factors.

5. *Simple delivery systems to address specific diseases can be standardized,* that is, applied in almost identical form in varied country circumstances. (GAVI has standard guidelines for all eligible countries.). *Delivery systems that must bring about sustained behavior change must be adjusted to country contexts, and to differences among regions or groups within countries.*

6. Systems focused on specific diseases and health risks often (though not necessarily) have additional features that threaten their sustainability and/or incur undesirable side-effects:

a. They take the form of high-profile campaigns, setting targets to be accomplished in (often very ambitious) time periods;

b. They rely on earmarked funds, external and/or internal, that are explicitly or implicitly temporary;

c. They are externally prompted.

With very few exceptions, specialized campaigns have failed to provide for on-going financial support, nor have they been incorporated into or coordinated with more durable sector institutions. Their benefits, while often impressive, have usually proved temporary. In short, *vertical or categorical approaches, including campaigns or drives, may be useful in some circumstances, or for selected tasks (especially those that utilize simple delivery systems or one-shot opportunities). They cannot substitute for broader and more integrated health sector systems.*

7. *There are plenty of ideas, but very little consensus on how to accelerate the needed institutional development*. Views differ widely regarding the advantages and drawbacks of

- decentralization, and programs to strengthen state and local governments' capacities
- community participation or control
- the potential for voucher or subsidized pre-payment plans as a means of stimulating private supply of services
- the feasibility and effectiveness of substantially increasing salaries for doctors and other health specialists
- the potential for out-sourcing functions now largely or wholly in the public sector
- the possibility for rapidly training and deploying large numbers of paramedical personnel
- The pros and cons of various kinds of incentive funds to stimulate any of the above approaches

Clearly the feasibility and desirability of the various strategies vary among countries, reflecting factors such as size, extent and depth of poverty, sophistication of private

sector agents, and the capacities and commitment of existing public sector agencies. More developed countries, or regions within countries, have a wider range of options. But there is *very little systematic knowledge on what strategies and approaches work under varied circumstances.* Impatience and frustration with slow progress and lack of clear-cut courses of action for institution-building are major motivations for the tendency to push high-profile specialized campaigns.

8. *Improved health status depends not only on programs, policies, and progress within the health sector, but also – indeed, perhaps more -- on complementary programs, policies and progress in other sectors.* But organization and incentives within both aid agencies and the governments with which they work discourage cross- and multi-sector analysis, program design, and implementation. New programming approaches are addressing these problems, but there are intrinsic tensions between these approaches and sustained and adequate attention to development of needed human resources and institutional development within the health sector.

9 In any country, long-term specialized delivery systems and integrated public health and health care systems are embedded in broader governmental institutions. Government-wide formal and de facto or informal processes of budgeting, financial management, and procurement, and the regulatory framework for both public and private health sector activities powerfully affect the efficiency, equity, and quality of services delivered. *In the medium and long run, not only sector-wide but also broader government processes and quality must be strengthened in order to achieve better health sector performance*. Where specific short-term interventions can be reasonably effective in the existing governance context, they should be pursued – but in ways that do not undermine progress toward broader governance reforms that will benefit the health sector as a whole and other sectors as well. Extensive earmarking, for instance, can interfere with the evolution of well-designed government-wide budget and financial management processes and institutions.

9. Several conclusions follow.

a. *Uniform formulas and advice are suspect.*

b. *Specialized initiatives must be balanced with steady efforts to augment human capital and strengthen integrated health systems; time-limited campaigns must not preempt medium and longterm time frames.*

c. *Multiple and innovative approaches should be pursued.* The recent trend to break away from governments' and aid agencies' "public sector fixation" should be encouraged; a variety of non-governmental agents, actors, and networking approaches can and should be mobilized. These points are particularly crucial for combating AIDs.

d. *Much greater emphasis should be given to monitoring, evaluation, and comparative research on experience with different approaches, including serious efforts to understand the contextual factors that contribute to different outcomes from similar endeavors.* We cannot learn by doing, unless there is a concerted effort not only to do but also to learn. Resources for institutional evaluation and research are tightly limited even in the World Bank, which traditionally has placed a high priority on these activities. Yet research on improved delivery systems (for public health programs as well as curative

services) would not be costly, and might yield knowledge that is crucial to complement the gains from research in technical medical science.

10. Underlying the challenge of how to encourage better systemic performance in the health sector is another problem: political commitment. There is wide agreement that high-level government commitment is important (many would say indispensable) for institutional reforms to move forward. Indeed, strong commitment can overcome initial limitations on administrative and organizational capacity. Uganda, with strong leadership from the top, has made considerably greater progress in recent years than Kenya, despite the latter's better initial institutional and human resource base. But *little thought has been directed to how to promote commitment where it is weak.* Several of those interviewed did have suggestions on this issue: "quick wins" (that is, rapid and easily observed improvements in some specific health problem); pressure from below (through community-based development); incentive funds that link new resources to the challenge of competition. However, there has been almost no systematic examination of the question of how to promote increased political commitment.

## II. Development professionals' perspectives: themes and issues

### 1. Links between health status, growth, and poverty

Respondents agreed almost unanimously on the basic proposition that disease, disability, and early death severely impede economic growth and poverty reduction, and that prevailing development theories and practice have not given adequate attention to the improvement of health status. Two or three of those interviewed, however, expressed concerns that dramatic increases in emphasis and funding for health might detract from efforts in other sectors (whose progress is also needed to improve health outcomes), and might encourage health care systems that are over-designed and unsustainable in the medium term.

### 2. Obstacles to improved health status.

Almost all respondents identified four major obstacles to more rapid progress toward improved health status:

a. inadequate funding, in the poorest countries;
b. inadequate human resources, institutional development, and political commitment within countries;
c. lack of co-ordination and other shortcomings of external aid agencies (bilateral, multilateral, and non-governmental);
d. inadequate knowledge regarding how to encourage accelerated institutional development.

Among those interviewed, only one respondent regarded lack of finance as the most important impediment to improved health, and many explicitly stated that funding was not the main obstacle. Most emphasized lack of absorptive capacity (b, above) as the most important set of constraints. One person described sharply increased funds for health programs in most African nations as "pouring water on the desert." Several

remarked that many aid agencies have increased their allocations to the health sector in recent years. World Bank and IDB respondents noted that health sector projects often were delayed or difficult to implement, and pipelines tended to be large. One respondent added that many governments, even in middle-income countries, had difficulties spending their own funds (not aid) in the planned amounts and for the intended purposes. Another noted that many African governments allocate much less resources to health than to education or military expenditures, implying that commitment as well as poverty is at fault. A few remarked further that health outcomes vary considerably among countries spending roughly similar resources on health.

3. The central role of integrated health systems.

All respondents without exception emphasized the crucial role of a reasonably well developed and integrated health system capable of performing a range of public health functions as well as curative services. In other words, even those favoring vertical programs viewed them as supplements, not substitutes, for integrated systems. (The pros and cons of vertical or categorical approaches are discussed below). Most of those interviewed see as the crucial question how best to accelerate the development of more effective integrated public health and health care systems. But many agreed that past approaches to this task have been extremely slow and generally ineffective; entirely new approaches may be needed, especially in Africa.

4. Consensus on certain broad principles.

Several broad principles for strengthening health system capacities were mentioned by many of those interviewed, and seem to command broad agreement.

- Many stated that it is important to move away from the fixation (in aid agencies as well as client countries) that public health and curative services should be provided mainly through public sector agencies and programs.
- Most agreed that preventative and curative programs should be channeled through whatever agents were capable of contributing to delivery, including all levels of government, NGOs, private (for profit) agents, community groups.
- The roles of government accordingly need to be reoriented, with much less emphasis on direct provision and increased focus on analysis, planning, coordination, appropriate regulation, and equity (that is, encouraging and supporting special efforts to reach poorer or more vulnerable groups and regions).
- More broadly, there is a consensus that we have little systematic knowledge on what strategies and approaches for strengthening institutional capacities work under varied circumstances. Several World Bank respondents remarked that the Bank, and perhaps especially economists on its staff, have under-estimated the formidable problems of administration and perverse incentives that block institutional development in health and other social service sectors. (Those expressing this view are themselves economists.) It follows that multiple strategies should be pursued and innovations encouraged.

5. Disagreements and uncertainties regarding specific institution-building approaches.

Respondents suggested a number of more specific approaches that might be feasible and effective if more funding were available, but there was a good deal of disagreement about most of the proposed approaches.

- Probably the least controversial suggestion, made in varying forms by several of those interviewed, is to channel substantially increased funds to *strengthen the capacities of sub-national (provincial, district, municipal) governments.* In many countries, recent decentralization trends have shifted large segments of health services and facilities to state and local governments, which are usually ill-prepared for their new responsibilities. Help is usually welcome, even in middle-income countries like Argentina or Brazil. Moreover, strengthened local public health capacities generate public goods not only at local but also at national and international levels, since populations are increasingly mobile. Considerable resources could usefully be directed to training, advising, trouble-shooting, and improving support facilities and functions for state and local health services.
- Several respondents felt that additional resources might permit some countries to *rapidly expand existing programs of health paramedicals*. Brazil's experience with extending the model of home-visit nurses pioneered in Ceara was mentioned as one example. Another respondent mentioned Indonesia's effort during the l990s to train and deploy very large numbers of midwives.
- Closely linked with going to scale with paramedicals is a larger problem of inadequate salaries for health workers, both at semi-skilled and skilled levels, and the associated problem of out-migration of doctors and nurses. Several of those interviewed suggested that it might be possible to *subsidize wages* in some manner. Others, however, felt that such initiatives would be blocked by civil service regulations and/or union pressures from other categories of public sector workers. Three people suggested that these obstacles could be finessed if the health workers were community-based, rather than public sector employees: an example is Brazil's national social security system in health, which has encouraged the spread of community-based (and community-selected) health paramedics by offering increased wages. One person suggested that wage subsidies for medical personnel dealing mainly or exclusively with AIDs victims might be politically acceptable, as compensation for the risks entailed. One person speculated that even sizable salary increases would not induce many doctors to serve in rural areas. Others remarked that increased salaries would not guarantee more effective performance, although increases should reduce the incentive to moonlight.
- Several respondents noted that some Latin American countries have in place or are developing national health insurance systems that include subsidized components for the poor. It might be possible to extend the coverage of such systems (in effect, expanding effective demand for health services), *by channeling funds (on a declining basis over time) to the subsidized components of these insurance systems.* Such programs require workable arrangements for identifying those qualified for subsidized coverage: Brazil, Bolivia, Chile and Colombia were cited as counties that have or shortly will have such arrangements on a national or

somewhat smaller but substantial scale. This approach has the virtue of permitting poor people to choose their service suppliers, while encouraging suppliers other than the government to extend their coverage.

- An alternative suggested for countries with more extensive poverty and weaker public institutions might be *subsidies for NGOs to provide specified packages of basic health services*. In Guatemala, such a program reportedly expanded coverage from small beginnings to over three million people in the course of two decades.
- Another suggestion for poor countries (or, presumably, for poorer regions within middle income countries) is *pre-payment plans at least partially covering basic health services, supplemented with subsidies*. The insurance (or voucher) and prepayment plans have in common that users are free to choose the service provider of their choice, thereby also stimulating the supply of services. Other respondents are skeptical that such programs can be sustainable, arguing that programs have been successful for a few years in limited areas but then tend to run down. One person is convinced that quasi-insurance systems cannot work in heterogeneous societies such as those in most of Africa and South Asia, since the crucial ingredient of social trust is absent.
- Several of those interviewed argue, with varying intensity, in favor of programs to stimulate community demand and participation. A few respondents advocate widespread *programs based on community identification of priority needs*, perhaps along the lines of Social Funds. Such an approach can recruit and mobilize the substantial hidden talent and competences spread throughout poor societies, and can "suck down" funds to the level where they are needed. The advocates of community-driven development see the development of local and national government capacities as a crucial complement to local initiatives; in turn, local initiatives are crucial to create incentives for higher-level capacity to respond. Others seem to have in mind mobilization of community cooperation with programs or initiatives from higher levels of government, arguing that where widespread individual and/or community-level behavior changes are needed, community involvement is not merely desirable but imperative. Some sort of incentive fund might be used to encourage participation by communities. Several other respondents are skeptical about communities setting priorities, noting that they almost always favor curative over preventative services. A few note that community social and political structure is not necessarily more democratic or pro-poor than higher-level politics; indeed, village and neighborhood politics are often dominated by local notables or bosses pursuing their own agendas, or by specific clans, castes, or ethnic groups. And several emphasize that, whatever the potential of community participation may be, foreign aid agencies in general (and the World Bank in particular) are, in the words of one respondent, "wildly inappropriate" to try to directly encourage and support such an approach.
- Proponents of each of the approaches just reviewed often propose *incentive funds*, at the national (or perhaps provincial) or international level, as one mechanism for channeling funds to users. Incentive funds are widely viewed as a means, or perhaps the best means to put responsibility for design and action on those who will need to implement the measures, while removing the disincentive of

anticipated lack of financial support. However, several people note that incentive funds favor the better organized and more advanced over poorer units -- both within countries (among state and local governments, NGOs, or communities) and also at the global or regional levels (among countries).

6. Risks and advantages of vertical or categorical programs.

Most of those interviewed were quite critical of vertical or categorical programs, but a few held different views.

- Most agreed that such funds are likely to divert scarce country resources (above all, personnel) from other health-related uses, without considering the broader gains or losses to overall health status. That risk is greatest in the poorest countries, where skilled people are most scarce. The current polio drive in Nigeria was one of the examples cited. However, a few respondents remarked that in many countries health systems are so inefficient that diverting some resources to specialized campaigns probably increases productivity.
- Several felt that while functional or disease-specific campaigns are not inherently inconsistent with efforts to reform and improve integrated health systems, high-profile campaigns "parachuted" in from outside a country could interfere with efforts at systemic reform – efforts often painstakingly constructed through years of dialogue and effort.
- Several added that it is in theory possible that functional campaigns can jump-start or promote more integrated services, but there are few if any cases where this has happened.
- Most of those who addressed the issue did not feel that specialized drives were necessarily inconsistent with broader sector strategies and planning (for example, for countries that have developed SWAPs in the health sector, or well-articulated health components of a PRSP). But several argued strongly that when such drives are externally driven, they are inconsistent with recent emphasis on commitment, ownership, and putting client governments "in the driver's seat."
- Almost all those interviewed noted that, with virtually no exceptions, externally funded functionally specialized campaigns have not been successfully incorporated into country budgets in the past, and have died rapid or slow deaths after external funding was withdrawn. Examples include the Extended Program of Immunization and campaigns against malaria. Indeed, it was argued that in almost no case was an effort made to develop and put in place a plan for sustainable funding.
- Externally funded categorical programs also tend, some respondents suggest, to focus unduly on the purchase of commodities, probably because that permits rapid expenditures, while neglecting financial and other measures needed to secure personnel, administration, organization, and other components of the program itself..
- Even where one or two categorical programs make sense in view of the specific pattern of disease in a country and that country's (lack of)

institutional development, it is important not to launch too many. Multiple specialized systems make little sense even in middle-income countries, and are entirely beyond the human capital as well as financial means of poor countries.

Several of the people interviewed, however, argue that specialized drives can have important virtues.

- They can prompt high-level commitment, focus energies and stimulate cooperation from agencies or groups that ordinarily are not involved in health promotion efforts. For instance, the campaign against Chagas' disease in Bolivia has attracted the cooperation of the military.
- Specialized programs establish stronger incentives and clear accountability in much greater degree than integrated health services. Different diseases require different preventative and follow-up measures. When anti-malaria drives are folded into integrated health services, one respondent stated, the effort becomes much less effective.
- For politicians, such programs offer rapid and concrete results, while measures to build routine institutional capacity are often too slow and produce observable results too indirectly to provide a "popularity payoff."

While views ranged from vehemently opposed to supportive of vertical programs, the prevailing perspective seemed to be that vertical or categorical programs can be useful for selected goals (particularly where delivery was fairly simple), but face serious risks of proving unsustainable. Moreover, such programs often undermine integrated health services; this is particularly the case where there are multiple specialized programs and where integrated systems are weak.

These risks and drawbacks can be reduced by careful efforts to coordinate and integrate specialized programs into broader sector strategies, and to put the decision to initiate a program squarely in the hands of country leadership. GAVI's mode of operation and the criteria it has established for approving specific country proposals seek to follow these principles. GAVI funds are available for any country that submits a proposal meeting pre-established, clear criteria, but that country's government must take the initiative and responsibility for preparing and submitting the proposal. (Technical assistance is available to help governments prepare proposals, and is much in demand.)

However, several respondents note that effective efforts to contain or roll back most diseases other than those addressed through GAVI's program of inoculations for children require much more complex programs, including significant behavior change. This is certainly true for the three diseases currently proposed as the focus of the new Global Fund: AIDs, TB, and malaria. Standardized criteria for preparing and assessing country proposals, as used by GAVI, will not work for more complex interventions; proposals will have to be much more tailored to country circumstances. More or less inevitably, several respondents stated or implied, efforts (by governments or, possibly, non-government entities) to design proposals for new specialized funds must be developed through extensive dialogue between fund managers and country sponsors. In an ideal

world, this process need not dilute ownership and commitment. In the real world, it runs a real risk of so doing.

7. The broader governance context.

Some respondents went a step further, and noted that all health systems are embedded in broader governmental institutions. Formal and de facto or informal budgeting, financial management, procurement and other processes for the public sector as a whole, and the regulatory framework for both public and private health sector activities powerfully affect the efficiency, equity, and quality of services delivered. In the medium and long run, not only sector-wide but also broader government processes and quality must be strengthened in order to achieve better health sector performance.

8. Political commitment.

Many of those interviewed mentioned, or their views and examples implied the importance of high-level political commitment, as a necessary condition for improved performance and institutional development, in the health sector and government-wide. Three respondents noted that until quite recently (and in some respects even now) Uganda's public and private institutional and administrative capacities were less developed than Kenya's. Yet Uganda has moved much more rapidly than Kenya in the past half dozen years to improve both overall governance and performance in specific sectors including health. The contrast reflects top-level political commitment.

Such commitment may more often reflect broad circumstances and the flow of events in a country than more deliberate and focused persuasion, dialogue, or inducement. Guatemala's success in greatly extending access to basic health services, through government support for NGOs, was cited in two interviews. One of the respondents had a ready answer to the question of what had made this program possible: the internal peace accord and social covenants of the early l990s, which established both pre-conditions and benchmarks for subsequent progress; good communications between the central team of reformers and the Ministry of Health, and a sense of ownership on the part of the Ministry.

Despite the agreed importance of political commitment, most of those interviewed had little or nothing to say about how to promote it. One respondent noted that "quick wins", where feasible, were important to attract political support. Two others are convinced that political commitment up and down the line, from national to local leaders, must be generated mainly by citizen demands, that is, community empowerment and priority-setting. Still others think incentive funds supporting well-formulated proposals from municipal or state governments might harness political and geographic rivalries to serve constructive purposes – another channel for political commitment. Several of those interviewed stated or implied that improved data, analysis and research can play key roles in productive dialogue. In Uganda, research tracing actual funds allocated to specific schools demonstrated that only about 20% of the funds reached their authorized destinations. That fact catalyzed simple but effective reforms. In short, aid practicioners

do have a number of ideas regarding how to encourage political commitment. But the issue has received little focused or systematic analysis.

9. Inter-sector approaches and program (non-project) aid.

There is general consensus that improved health status depends not only, and perhaps not primarily, on measures in the health sector itself but also on development in other sectors. The AIDs pandemic, in particular, is viewed as a multi-sector challenge, in terms of measures needed to contain its spread and cope with its impacts.

There is also wide agreement that aid agencies in general (explicitly including those surveyed for this report) are not structured to encourage cross- or multi-sector analysis, programming, and implementation. Nor are client countries.

Many of the interviews included some discussion of recent innovations in strategy and programming approaches intended (among other goals) to encourage better multi-sector thinking and action.

- In principle, SWAPs in the health field can define the goals to be addressed in terms of improved health outcomes, and can consider complementarities and trade-offs between health sector programs and policies and relevant measures in other sectors. In practice, it was suggested, most SWAPs confine their attention to the health sector narrowly defined, and often do not even establish clear priorities within that sector. Two respondents felt that SWAPs in the health sector tend to emphasize process (procedures for co-ordination among donors; progress toward decentralization) and to neglect content.
- World Bank SECALs encourage analysis and dialogue regarding sector-wide problems, policies and processes; as with SWAPs, this might but usually does not lead on to consideration of cross-sector complementarities and trade-offs.
- Two IDB respondents mentioned Social Protection Loans as increasingly important vehicles for social sector funding. Such loans serve an important but limited purpose: they provide budget support during periods of macro-economic difficulties, linked to commitments by the recipient government to shield high-priority social programs from budget cuts or occasionally to expand specific measures to buffer the costs of austerity and structural adjustment for vulnerable groups. Social Protection Loans therefore are not vehicles for major new initiatives, nor are they well-suited to exercise leverage on general social sector policies. However, they can and do encourage efforts to identify short- and medium run priorities within and among social sectors.
- The Poverty Reduction Strategy Process (PRSP) is explicitly intended to encourage cross- and multi-sector analysis and identification of complementarities, trade-offs and priorities. In conjunction with implementing HPIC, PRSPs may pay particular attention to social sector goals and programs. A logical next step is the Poverty Reduction Structural Credit, a re-oriented Structural Adjustment Loan focused not on macro-economic

measures but on structural reforms, particularly in social sectors. The first of these is about to be approved by the World Bank for Uganda.

World Bank staff interviewed offered a wide range of views on the potential benefits and drawbacks of broad sector or economy-wide programming, supported by non-project aid. At one extreme, one respondent argued that most aid should be provided in this form, even to governments with weak analytic and administrative capacities. Carefully designed and closely audited project aid may give an external donor some influence over a small portion of a country's budget (though the fact that all aid is fungible makes that control partly or largely illusory). In contrast, budget support (provided against clear and consistent criteria) offers a possibility of influencing a much larger portion of the budget, while encouraging learning and commitment. Others took the more conventional position that government-wide budget support should be provided only for those governments capable of presenting a credible program and plan of action. Uganda demonstrates that that criteria can be met by low-income countries, but it is worth noting that the Poverty Reduction Structural Loan has been preceded by almost a decade of improvements to that government's budgeting process, and by half a dozen years of intensive efforts to improve data and analysis.

Still other World Bank respondents prefer a mix of program and project aid, consistent with the SWAP or PRSP where these exist. (USAID, operating within tight guidelines set by the U.S. Congress, represents the far end of the spectrum: the agency is permitted to provide aid for health objectives only in project form, and only for purposes that permit quantified annual indicators of progress.)

The principle advantage cited for working as much as possible through sector- or economy-wide program aid is that this encourages commitment, ownership, and accountability in client governments and societies. More specific advantages were also mentioned, such as encouraging communications between Ministry of Finance (or Economy) and operating ministries, and (in the case of HPIC countries) making the Ministry of Finance responsible for tracking social sector expenditures.

Respondents also saw problems and risks associated with sector- or economy-wide programming approaches and associated budget support.

- Non-project aid flows to Ministries of Finance and (unlike project aid) is not transmitted, as earmarked aid, to operating ministries, but instead merges with other revenues. The effect may be to divorce operating ministries from a sense of ownership of the policies and programs which were the basis for the assistance.
- Where project or sector-specific aid is greatly reduced or eliminated, the continuity of relations between sector specialists in aid agencies and client countries is likely to be disrupted. Where those relations have been productive, that can be a major loss. More generally, specialized staff , in aid agencies and client governments alike, regard non-project assistance as a threat to their control and influence.
- Non-project aid also poses fiduciary problems: new outcome-focused random audit procedures must be substituted for old audit arrangements that sought to

trace specific funds to specific uses. One respondent noted that the loss of fiduciary control may be more apparent than real. Project audits also are not foolproof: despite elaborate procedures, irregularities are frequent. Another person remarked that many governments lack capacity to track their own expenditures, even if they wished to do so.

- In all countries, rich and poor, the internal budget allocation process is inevitably and often intensely political. Therefore many aid agencies resist merging their funds with broader client revenues, because they feel that technocratic considerations will be given less priority and/or because their own political agendas will be submerged.

10. Supra-national programs

Current and potential new global initiatives relevant to health problems were not the focus of the interviews for this report. Nonetheless, several respondents noted that global programs to encourage medical research oriented to the problems of developing countries and to address pricing and trade problems regarding pharmaceuticals can make dramatic contributions.

Region-wide or sub-regional programs or facilities were mentioned in several of the interviews as helpful, or even imperative for improving health status. Strengthening such programs is one effective way to channel additional resources. In Central America, for example, one respondent stated that sub-regional arrangements and facilities for better surveillance are a vital aspect of improved health status. Integrated markets for procurement and allocation of costly pharmaceuticals might help to overcome disadvantages of small national markets, but would require complex coordination of standards and regulations.

Most regional or sub-regional arrangements are not particularly costly. Both World Bank and IDB respondents noted that the multilateral banks channel most loans to sovereign governments. However, much of the cost of supranational programs consists of facilities or personnel based in individual countries, and these can readily be funded. Both banks have also found additional ways to support useful supranational efforts.

11. Aid agencies' weaknesses

Each respondent was asked whether there are weaknesses in his or her own agency that hampered support for action to improve health status. .

- Several respondents in USAID, and a few in the World Bank state that fixation on measurable (and, for USAID, rapid) results is an obstacle to the kinds of long-run investments in improved human resources and institutional development crucial for sustainable progress.
- As noted earlier, incentives and structure in all three organizations discourage cross- and inter-sector analysis and programming. In the World Bank, the system of internal contracting introduced in the mid l990s has created "silos" of

specialists with strong incentives to concentrate on their own relatively narrow areas of concern. Recent trends toward increased use of sector- and economy-wide programming instruments may eventually help to counter such incentives.
- Cumbersome internal procedures, perhaps especially for procurement, are mentioned in interviews in all three agencies, but particularly by USAID staff.
- Many respondents state that poor coordination among donors continues to be a major problem, despite multiple and on-going efforts at improved cooperation.

## III. Variation in Respondents' Views

With respect to many of the themes discussed above, respondents' views did not seem to be strongly affected by the geographic region with which they worked, their agency, or their professional background. However, perceptions of the most important obstacles to better health status did vary by region, and respondents did express some concerns specific to each of the three aid agencies.

### 1. Variation by geographic region of responsibility

- Respondents in the Africa Region of the World Bank and the Africa Bureau of USAID emphasized their region's particular problems, especially
    - Extremely weak institutions, in the health sector and at the level of national governance;
    - Civil war, or lack of basic law and order, in many countries;
    - Extreme scarcity of trained people, exacerbated by out-migration to wealthier countries;
    - Extremely limited budgets, reflecting both poverty and weak governmental commitment regarding health issues;
    - Heterogeneous societies, reducing trust and capacity for cooperation;
    - Above all, the devastating AIDs pandemic.

- Those with responsibilities for South Asia programs also stressed their region's massive poverty, but noted somewhat stronger institutions and human resources.

- Respondents working on Latin America generally noted the following points:
    - With the exception of the poorest countries in the region, lack of funds to address health issues is not the most severe obstacle to progress, but poor allocation of resources within the sector is a major problem.
    - Again with the exception of the poorest countries, levels of institutional development and human resources, while far from adequate in most cases, are sufficient to permit options that are not available to most of Africa, such as subsidized insurance schemes.
    - AIDs is not yet a major problem in most of the region.
    - In most Latin American countries, the past decade or more has been a period of intense debate regarding health sector reform, including re-orienting the roles of the state. In several countries, there is growing but fragile consensus. This could help to establish a framework for effective

and creative use of additional resources. However, it also heightens the possible costs of externally prompted re-direction of priorities to favor categorical programs.
    - Civil society in most Latin American countries has been rapidly expanding, in numbers, diversity and sophistication, for the past two decades. This creates a strong potential base for expanded partnerships for better coverage and improved quality of health services.

- Among post-communist countries, Central East European health systems are in need of and engaged in systemic reforms, but inadequate funding is not the binding constraint. In many of the post-Soviet republics, old health systems are in near-collapse, reflecting much broader problems of economic recovery, revenue collection and governance. Some partial recovery and reform of these institutions, political commitment and appropriate priorities, rather than funding, were identified as the key issues.

2. Variation among agencies

Certain issues and concerns were specific to interviews in each of the three agencies.

- USAID staff are acutely aware of the formal legal restrictions and less specific political constraints on their programs imposed by Congress. It is probably fair to say that the massive accumulation of restrictions and constraints, plus repeated staff reductions over many years, have taught many in the agency to lower expectations and aspirations. According to one respondent, when the agency recently launched an "Expanded Response" initiative and asked missions resident in client countries whether additional staff were needed, there was "total silence" from the missions!
    - More specifically, virtually all health sector assistance (with the exception of population programs) is channeled through the Child Survival and Disease Account. Congress has specified some twenty pages of detailed instructions regarding the uses of that account.
    - The Government Performance Review Act requires annual reports from USAID with quantitative evidence of evidence toward specified targets. This emphasis on tangible and rapid results strongly discourages efforts to support longer-run institutional and human resource development in the sector.
    - USAID in general (with some exceptions including the Development Fund for Africa) grants funds only for projects, not for budget support. That restriction rules out experimentation with some of the newer instruments and approaches introduced by the two multilateral banks in health and other sectors in the past decade.
    - USAID is also specifically barred from participating with other aid agencies in SWAPs in the health sector (though not in other sectors!).
    - In contrast with the two multilateral banks, USAID does not have a large pipeline of delayed projects in the health sector. Respondents

state that this is because USAID funds are provided as grants rather than loans, and because USAID has not tried to condition its assistance on complex sector reforms. .

- The perceptions of health issues and priorities described for those with Latin American responsibilities of course apply to the IDB as a whole. A few additional factors or perspectives specific to the IDB were mentioned in the interviews.
    - Compared both to the World Bank and USAID, IDB has very few staff concentrating on health issues: a total of approximately a dozen, including central and sub-regional positions.
    - As noted earlier, a large and growing proportion of IDB loans relevant to health issues are channeled through Social Protection loans. These loans are large and complex, and preempt a large share of limited health sector staff time.
    - One of those interviewed at IDB mentioned pressure from the U.S. government as a factor shaping policy.

- The major contrast between interviews with World Bank staff, taken as a group, and those with IDB and USAID staff was the wide range of views within the Bank. That contrast presumably reflects the World Bank's much larger scale, its global scope (compared to IDB's regional focus) and its substantial autonomy.
    - World Bank staff were more likely than those in the other two agencies to emphasize sector-wide and economy-wide programming approaches (SWAPs, PRSP).
    - World Bank staff also were more prone to focus (either explicitly or by implication) on broad government policies and on actual or potential policy reforms.

3. Informants' scope of responsibilities and their views

Somewhat surprisingly, there seemed to be few consistent contrasts between the perceptions and judgments of those development professionals responsible for health or broader human development programs, on the one hand, and those with broader country, regional, or global responsibilities, on the other. Respondents in the latter category were perhaps a bit more likely to note that policies and development in non-health sectors strongly affect health status, but several of the health specialists made the same observation. Similarly, health specialists as well as generalists noted the importance of government-wide procedures, capacities, and incentives as a framework for the health sector. The scope of a respondent's responsibilities did not seem to determine attitudes toward vertical or categorical health programs. Generalists, however, did seem somewhat more likely to have confidence in broad budget support, rather than sector-specific program aid, project aid, or a mix of the two.

Attachment 1

**List of Persons Interviewed**

World Bank

Alan Gelb
Chief Economist, Africa Region

Ritva Reinikka
Research Manager, Development Research Group

Julie McLaughlin
Senior Health Specialist, Health, Nutrition and Population/Africa Region

Charles Humphreys
Sector Manager, Macroeconomics

Ok Pannenborg
Sector Director, Health, Nutrition and Population/Africa Region

Hans Binswanger
Sector Director, Environment, Rural and Social Development/Africa Region

Brian David Levy
Sector Manager, Public Sector Reform and Capacity/Africa Region

Xavier E. Coll
Sector Director, Human Development/Latin America Region

Charles C. Griffin
Sector Manager, Health, Nutrition and Population/Latin America Region

Emmanuel Jimenez
Sector Director, Education/ South Asia Region

Richard Skolnik
Sector Director, Health, Nutrition and Population/South Asia Region

Roberta Zagha
Sector Director, PREM Sector Unit

Marcelo Selowsky
Chief Economist, Europe and Central Asia Region

Shantayanan Devarajan
Chief Economist, Human Development Network

Geoffrey Lamb
Director, Resource Mobilization Unit

Amie Batson
Senior Health Specialist, Health Nutrition and Population

Inter-American Development Bank

Myra Buvinic

Christian Gomez
Social Programs Division Chief, Region I (Southern Cone, Brazil, Bolivia, Paraguay)

Andre Medici
Social Development Specialist, Region I

Wolfgang Munar
Senior Social Sector Specialist, Division II (?) (Central America and the Caribbean)

William Savedoff

U.S. Agency for International Development

Duff G. Gillespie
Deputy Assistant Administrator, Population, Health, and Nutrition

Donald R. Mackenzie
Associate Assistant Administrator, Center for Human Capacity Development

Joy Riggs-Perla
Director, Office of Health and Nutrition, Bureau for Global Programs

Kenneth G. Schofield
Deputy Assistant Administrator, Program Policy and Coordination

James T. Smith
Director, Development Planning, Africa Bureau

Other Interviews

Carol Graham
The Brookings Institution
Charlotte Leighton
Abt Associates