SECTOR STRATEGY

Health, Nutrition, & Population

THE HUMAN DEVELOPMENT NETWORK
The World Bank Group

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The World Bank Group
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The World Bank's Sector Strategy papers are designed to complement Country Assistance Strategies by providing a sectoral perspective on the Bank's comparative advantage, effectiveness, and priorities.

Each Sector Strategy paper provides a statement of the Bank's current strategy in a particular sector. These papers reflect the lessons learned about past Bank involvement in particular sectors based on internal and external evaluations. They also determine priorities for research, staffing, and policy work and contribute to the Country Assistance Strategy by identifying countries where particular sector issues loom large. They are intended to contribute to an ongoing dialogue among parties interested in promoting development in the sector.

The Sector Strategy papers will be produced by the Bank's Human Development Network, Poverty Reduction and Economic Management Network, Environment and Socially Sustainable Development Network, and Finance, Private Sector, and Infrastructure Network. It is hoped that the information provided in this and subsequent volumes of the series will prove valuable not only to Bank staff, but also to the international development community and to readers from client countries. These papers are viewed as a reflection of current thinking in the sector and a contribution to a dynamic dialogue among practitioners. It is hoped that they will promote constructive discussions leading to improvements in sector strategies over time.

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Foreword

The World Bank's mandate is to work with governments to achieve sustainable progress in reducing poverty, promoting growth, and improving the quality of people's lives in developing countries. Current strategies to assist the poor rest on three mutually reinforcing pillars of development policy:

- expansion of opportunities through broad-based sustainable economic growth, especially to raise productivity and employment of the poor
- access by the poor to services that improve education, health, and nutrition outcomes, and that reduce fertility
- appropriate social safety net programs to protect especially vulnerable groups.

Good health, nutrition, and reproductive policies, and effective health services, are critical links in the chain of events that allow countries to break out of the vicious circle of poverty, high fertility, poor health, and low economic growth, replacing this with a virtuous circle of greater productivity, low fertility, better health, and rising incomes.

This Sector Strategy paper presents the World Bank's strategy in the health, nutrition, and population (HNP) area. The objectives of this paper are to:

- review major trends in the HNP sector, key development challenges, and the emerging consensus on reform strategies
- assess past and current Bank involvement in the HNP sector in low- and middle-income countries
- define a clear strategy to guide the Bank's future work in the HNP sector.

Many aspects of development policy that are not directly related to the health sector or to health services affect health, nutrition, and population outcomes. For example, education, water, sanitation, transport policy, and gun control affect health; agricultural and food policies affect nutrition; and multiple social and cultural dimensions affect population growth. Bank strategies toward the intersectoral determinants of health, nutrition, and population outcomes will be presented in forthcoming strategy papers.

In developing the Bank's strategy for the HNP sector, the following principles have been influential:

- a focus on the human dimension of development
- responsiveness to clients, especially the poor
- sound technical analysis and attention to outcomes
- recognition of the political dimensions of reforms
- respect for diversity in values and social choices
- the need for local ownership and partnerships.

The HNP Sector Strategy paper is the first major product of the HNP Family, which is part of the Bank's new Human Development Network, under the general guidance of the HNP Sector Board (see Annex D, Figure D.2). Its recommendations are closely linked to other Bank activities that are intended to improve operational effectiveness and contribute to each of five areas of responsibility of the HNP Sector Board: strategy, knowledge, staff development, quality assurance, and external partnerships.

An extensive consultative process has taken place to produce this document, involving interested staff in the Regions and the HNP Family as well as external partners. The strategy has been approved by senior management and endorsed by the Board.

The HNP Sector Strategy paper is not a final statement of the Bank's work in the HNP sector. This strategy will continue to evolve over time and will be revised.

David De Ferranti, HD Network Head & Director

Richard G.A. Feachem, HNP Director

Acknowledgments

This report was prepared by a team of technical specialists from the Health, Nutrition, and Population (HNP) Family of the Human Development (HD) Network of the World Bank under the guidance of the HNP Sector Board. The process involved staff and managers in other fields and sectors of the World Bank Group. The work was led by Alexander S. Preker, Principal Economist; Richard G.A. Feachem, HNP Director; and David De Ferranti, HD Network Head and Director. The document was edited by Madelyn Ross and document processing was done by Sancta E.M. Watley.

Summary

This HNP Sector Strategy paper is presented in three main sections, with supportive statistical annexes.

Development Challenges and Policy Directions

As described in Chapter I, this century has witnessed greater gains in health, nutrition, and population outcomes than at any other time in history.

These gains are partly the result of improvements in income and education, with accompanying improvements in nutrition, access to contraceptives, hygiene, housing, water supplies, and sanitation. They are also the result of new knowledge about the causes, prevention, and treatment of disease, and the introduction of policies that make interventions more accessible.

Despite past achievements, however, 2 million childhood deaths occur annually due to vaccine-preventable diseases; 200 million children under the age of five still suffer from malnutrition; 120 million couples still lack options in family planning; 7.5 million children die every year during the perinatal period; and 30 percent of the world is still without access to safe water and sanitation systems. In addition, disease patterns observed during the past century are rapidly changing.

As shown by broad international experience, the underlying threats to good health, nutrition, and population outcomes are well known, and affordable solutions are frequently available. But, because of weak government implementation capacity and market imperfections in the private sector, potentially effective policies and programs often fail.

Reform strategies to address these problems often require a redefinition of the role of the state, with greater government involvement in providing public health activities with large externalities, securing access to essential health services for the poor, providing information, supporting research and development (R&D) and medical education, regulating the sector, and securing adequate financing. They also require enhanced partnerships with non-governmental providers.

The Bank's Growing Engagement in the HNP Sector

Chapter II explains why investing in people is at the center of the Bank's development strategy, reflecting the fact that no country can secure sustainable economic growth or poverty reduction without healthy, well-nourished, and well-educated people. Since none of the international organizations can address today's complex health, nutrition, and population challenges alone, the Bank works closely with many other organizations. The Bank's comparative advantage is its global experience and ability to combine country-specific research and analysis with the mobilization of significant financial resources across many sectors.

Bank involvement in the HNP sector, which started in the early 1970s, initially helped countries strengthen and expand the infrastructure and supplies for basic programs. Although modest success was achieved through this approach, it became apparent that institutional and systemic changes were often needed for a sustained impact on outcomes for the poor, improved performance of health systems, and sustainable financing. The Country Assistance Strategy (CAS) is a key instrument for mobilizing the multi-sectoral involvement that is often needed to address systemic problems.

Since its first HNP loan in 1970, the Bank's activities in this sector have grown rapidly to the point where it is now the single largest external source of HNP financing in low- and middle-income countries. Today, there are 154 active and 94 completed Bank HNP projects, for a total cumulative value of US$13.5 billion in 1996 prices. This paper elaborates on the lessons learned from this experience and raises concerns about the recent decrease in analytical and policy work, a weakening in the presentation of HNP issues in the CAS, and the number of projects at risk.

The Bank's Strategy in the HNP Sector

Chapter III describes the Bank's enhanced commitment to the HNP sector during the period leading into the 21st cen-

tury. The Bank's objectives in the HNP sector are to assist client countries to:

- ***improve the health, nutrition, and population outcomes of the poor***, and to protect the population from the impoverishing effects of illness, malnutrition, and high fertility
- ***enhance the performance of health care systems*** by promoting equitable access to preventive and curative health, nutrition, and population services that are affordable, effective, well managed, of good quality, and responsive to clients
- ***secure sustainable health care financing*** by mobilizing adequate levels of resources, establishing broad-based risk pooling mechanisms, and maintaining effective control over public and private expenditure.

The Bank's strategic direction in the HNP sector will continue to evolve in a dynamic way based on international best practice. The complexities of the HNP sector and changing approaches to health, nutrition, and population problems generally do not lend themselves to rigid policy prescriptions. Instead, policy advice and financial support will continue to be guided by country-specific approaches. This will be achieved through action in the following four areas:

Sharpening Strategic Directions. Governments will be encouraged to address each of the three HNP priorities outlined above, through decentralization, greater partnerships with non-governmental providers, and a more direct public involvement in securing sustainable financing. Governments will also be encouraged to address often neglected areas that have an impact on health, nutrition, and population outcomes such as rural and urban development, other broad-based population and social policies, education, control of tobacco and alcohol abuse, food and agricultural policies, environment, water supply, sanitation, and transportation.

The Bank's Country Assistance Strategy papers will be used as key instruments for delivering this message during high-level country dialogue. Greater efforts will be made to ensure that adequate budgets and staff time are allocated to the preparation of these important documents. Efforts will also be made to underpin lending with better research and analysis by reversing recent cutbacks in country-specific sector studies and linking the Bank's research agenda more closely to the HNP priorities. Staff will be encouraged to increase selectivity based on consistency with the HNP policy objectives, potential development impact, and political commitment by clients to significant reform.

Achieving Greater Impact. The quality of client services and client responsiveness will be enhanced by strengthening the HNP knowledge base; applying lessons learned more systematically; enhancing the quality of project preparation and the piloting of new approaches; improving supervision of existing projects; using a broader range of instruments; streamlining business processes and procurement procedures; and conducting client satisfaction surveys. Finally, a renewed effort will be made to strengthen monitoring and evaluation by developing better indicators and by integrating monitoring and evaluation into project designs.

Empowering Bank HNP Staff. Resolving three staffing issues will be a key priority for the new HNP Sector Board. Are there enough staff? Are their skills adequate to the tasks they must perform? Are they deployed effectively between headquarters and resident missions? This paper suggests how the Bank will be enhancing its capacity in these areas. An effort will be made to link training to the three strategic directions, include both Bank staff and clients in training events, increase participation by resident mission staff, and extend the target audience to sectors outside the HNP sector.

Building Partnerships. The Bank will continue to build relations with partners based on its comparative advantage and clear agreement on mutual roles, as it is now doing with WHO and UNAIDS. It will build on the past success in river blindness control and support other international health, nutrition, and population initiatives. Likely candidates include collaboration with African governments in a major effort to control the malaria epidemic, work with WHO and others to combat the pandemic of tuberculosis and to promote integrated management of childhood illness, and work with many partners to launch the Global Forum on Health Research.

Through such actions, the Bank expects to enhance its contribution to the global effort to improve human development during the first decade of the 21st century.

Acronyms and Initials

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AsDB	Asian Development Bank
CAS	Country Assistance Strategy
CODE	Committee on Development Effectiveness
DEC	Development Economics and Office of the Chief Economist
EAP	East Asia and Pacific Region of the World Bank
EBRD	European Bank for Reconstruction and Development
ECA	Europe and Central Asia Region of the World Bank
EDI	Economic Development Institute
ESW	Economic and Sector Work
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross Domestic Product
GNP	Gross National Product
HD	Human Development
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition, and Population
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDB	Inter-American Development Bank
IFC	International Finance Corporation
ILO	International Labour Organization
IMF	International Monetary Fund
LAC	Latin America and the Caribbean Region of the World Bank
LLC	Learning and Leadership Center
MIGA	Multilateral Investment Guarantee Agency
MNA	Middle East and North Africa Region of the World Bank
NGO	Non-Governmental Organization
OECD	Organization for Economic Cooperation and Development
OED	Operations Evaluation Department
PAHO	Pan American Health Organization
PPP	Purchasing Power Parity
PSD	Private Sector Development Department
QAG	Quality Assurance Group
R&D	Research and Development
SAS	South Asia Region of the World Bank
SECALs	Sector Adjustment Loans
SGP	Special Grants Program
SSA	Sub-Saharan Africa Region of the World Bank
TA	Technical Assistance
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Contents

CHAPTER 1

Development Challenges and Policy Directions: A Changing World

Impressive Recent Gains in Outcomes

Advances in HNP during the past few decades are impressive. The increase in life expectancy and the decrease in fertility throughout the world have been greater in the past 40 years than during the previous 4,000 years. Furthermore, based on projections, the year 2000 will mark the mid-point of a century of global transition from high mortality and high fertility to low mortality and low fertility (see Figure 1.1 below and maps on Fertility Decline and Child Survival Goals in Annex G).

Unparalleled Improvements in Life Expectancy and Fertility Rates

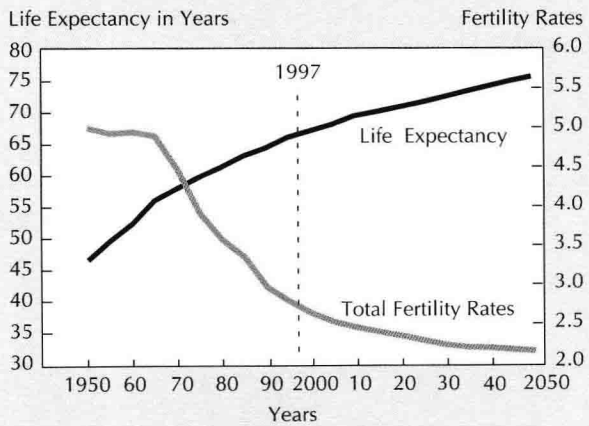

FIGURE 1.1

As described by the World Health Organization (WHO) in its *1996 World Health Report*, hundreds of millions of people in low- and middle-income countries are on the threshold of an era in which they will be safe from some of the world's most threatening diseases. According to the *1996 State of the World's Children*, by the United Nations Children's Fund (UNICEF), the proportion of children who now die before reaching age five is less than half the level in 1960. Immunization saves an estimated 3 million children annually. Better control of diarrhea saves over 1 million a year.

Economic progress during the past century has contributed significantly to health advances. Nutrition has improved not only from higher agricultural outputs per person and a greater ability to deal with local famines, but also from the introduction of a more varied diet. Child malnutrition rates in low- and middle-income countries are now 20 percent lower than they were 30 years ago, while certain nutrient deficiency diseases have almost disappeared in some countries.

Population growth rates are also slowing. The average number of children born to women of childbearing age (the total fertility rate) is now three, down from five in 1960. Some low- and middle-income countries have already reached replacement levels of around two children per family. Improvements in access to family planning, together with rising incomes and better education of girls and women, have facilitated this trend. Contraceptive use in low- and middle-income countries rose from 10 percent of married couples in the mid-1960s to 55 percent in 1990.

Origins of Good Health and Illness

Several factors influence the great variability in health, nutrition, and fertility still observed across population groups. These include:

- income levels and poverty;
- education, especially of girls and women;
- adequate food, clean water, and sanitation;
- culture and behavior; and
- health-related public policies and interventions.

Economic growth and reductions in poverty—with their impact on basic needs such as nutrition, better housing, and access to clean water and satisfactory sanitation—remain among the most powerful determinants of good health at low-income levels.

As shown in China, Costa Rica, and Sri Lanka, basic education of girls and women is also good for health. Educated individuals tend to adopt healthier lifestyles, make more efficient use of scarce resources such as food and health care, and avoid risks caused by the abuse of tobacco, alcohol, and illicit drugs. In most societies, norms regarding childbirth and child care, the status of women, personal hygiene, and sexual behavior exert powerful influences on health and are deeply rooted in local culture.

Population-based preventive services such as immunization play an important role in reducing the risk of illness, and curative services can greatly ameliorate the consequences of diseases and injuries when they occur. Other public policies can enhance health by promoting healthy environments and lifestyles, and regulating against dangerous or unhealthy activities by individuals and organizations. Successful public policies have helped reduce pollution in India, make road travel safer in Mexico, tighten gun control in the United Kingdom, improve water and sanitation systems in Turkey, and limit tobacco, alcohol, and illicit drug use in Indonesia. Stronger public policies are also still needed to eliminate female genital mutilation.

As a result of complex synergies among income levels, education, behavior, public policy, and health services, people all over the world live almost 25 years longer today than they would have at similar income levels in 1900 (see Figure 1.2).

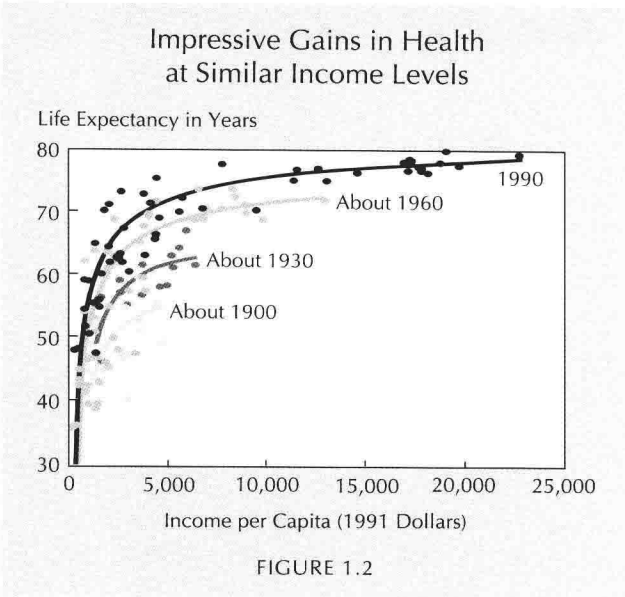

FIGURE 1.2

Impact on Quality of Life and Productivity

Good health contributes to the overall quality of life as well as to productivity. Many diseases are not fatal, but disabling. Some 200 million people throughout the world—90 percent in Sub-Saharan Africa—are infected with the parasitic schistosome worm, and 1 billion people suffer from anemia. The economic burdens of such illnesses include low productivity due to chronic fatigue and other symptoms, loss of income, out-of-pocket expenditure, and the cost of treatment.

Good health, by contributing to human capital, is essential to economic growth. For example, a single treatment of children in the West Indies for whipworm infection dramatically improved school learning. Labor productivity has increased with better iron and calorie intake in Indonesia and Kenya. Similarly, there is some evidence that reduced fertility rates and declining youth dependency ratios can have a positive impact on economic growth, if associated with domestic savings and investment in human capital.

Development Challenges

To preserve past gains and address future threats in an effective way, policymakers in low- and middle-income countries face difficult challenges caused by continued poverty, malnutrition, high fertility, and poor health; poor performance of many health systems; and inadequate and/or unsustainable health care financing.

Poverty, Malnutrition, High Fertility, and Poor Health

According to World Bank estimates, nearly one-quarter of the world's population—1.3 billion people—con-

tinue to live in absolute poverty, earning less than US$1 per day. The *1993 World Development Report: Investing in Health* estimated loss of healthy life from over 100 of the most common diseases and injuries. Of the total global disease burden, 93 percent is concentrated in low- and middle-income countries and nearly 60 percent is in China, India, and Sub-Saharan Africa.

The world's poorest populations live in the shadow of a group of old enemies—malnutrition, childhood infections, poor maternal/perinatal health, and high fertility (see Annex G map on Child Malnutrition). A total of 2 million deaths in children occur annually due to vaccine-preventable diseases; 200 million children under the age of five still suffer from malnutrition and anemia; 7.5 million children die every year during the perinatal period, primarily due to poor maternal health care; and 30 percent of the world is still without safe water and sanitation. Furthermore, because 120 million couples still lack options in family planning and receive poor maternal health services, one in every 48 women dies from pregnancy-related causes in low- and middle-income countries (585,000 deaths per year), compared with one in 4,000 in higher-income countries.

Intrauterine or early childhood exposure to undernutrition, micronutrient malnutrition (iron, iodine), or infection (diarrhea, malaria), often results in long term or irreversible retardation of physical and mental development. These conditions are particularly devastating to the poor, whose children enter adulthood and the workforce handicapped by early life experiences.

Rapid population growth is also a major development challenge in many poor countries and places a heavy burden on health care and social services. Even when fertility approaches replacement levels (close to two children per family), 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. The world's population could increase from 5.3 billion people in 1990 to over 10 billion in 2100. Most of this population growth will occur in poor countries.

The disease patterns of the past century are changing as population groups move from high mortality and fertility to low mortality and fertility. As a result, the share of global disease burden due to non-communicable diseases (mainly cardiovascular and neuro-psychiatric diseases, and cancers) is expected to increase from 36 percent in 1990 to 57 percent in 2020, while the burden due to infectious diseases, pregnancy, and perinatal causes is expected to drop from 49 to 22 percent. The emergence of new epidemics and drug resistant microbes and parasites will figure prominently among the remaining infectious diseases (see Annex G map on Malaria Distribution and Reported Drug Resistance).

Poor Performance of Many Health Systems

Much more research is needed to understand fully the factors that influence the performance of health systems. Partially as a result of differences in the effectiveness of broad social policies and health care systems, countries vary greatly in terms of the health, nutrition, and population outcomes they achieve at similar income levels (see Figure 1.3). As populations age and non-communicable diseases increase in low- and middle-income countries, there are obvious consequences for labor productivity, economic growth, and the cost of health care systems that must be adapted to new disease patterns and modes of intervention.

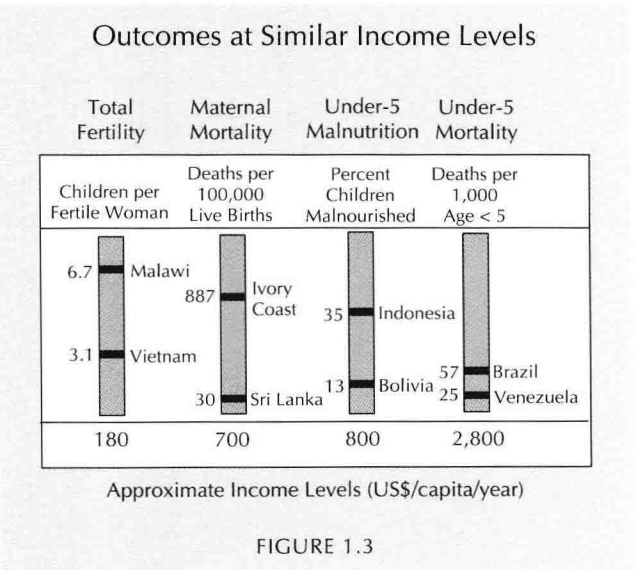

FIGURE 1.3

Differences in housing, access to clean water and satisfactory sanitation, education, income distribution, and culture all contribute to this variability, especially in low-income countries. But the use of knowledge about the determinants of poor health (e.g. the links between maternal nutrition and low birth weight, hygiene and infections, and smoking and heart disease) and implementation of effective preventive and curative health care (e.g. vaccinations, oral rehydration therapy, obstetrical care, and drug treatment of tuberculosis) are also important in explaining these differences.

Variability in Available Financing

Global spending on health care was about US$2,330 billion in 1994 (9 percent of global GDP), making it one of the largest sectors in the world economy. While low- and middle-income countries account for only 18 percent of world income and 11 percent of global health spending (US$250 billion or 4 percent of global GDP), 84 percent of the world's population lives in these countries, and they shoulder 93 percent of the world's disease burden. The sheer size of the sector, and the fact that growth in health expenditure exceeds income growth, make it critical to understand the economic and health impact of health financing policies.

Health care behaves like a superior good in economic terms—poor countries spend much less than rich countries, both relative to GDP and on a per capita basis (see Figure 1.4). In addition, a country's public expenditure on health care rises with income both in absolute and relative terms. This is reflected in the large differences in the proportion of national GDP spent on health—from under 1 percent in some countries to 15 percent in the United States. Per capita health expenditures (public and private) vary almost 1,000-fold among countries—from around US$3 to $5 per capita per year in some low-income countries such as Mali to $3,600 in the United States (the ratio would be 225 using PPP-adjusted dollars).

The Sub-Saharan Africa (SSA), South Asia (SAS), and East Asia and Pacific (EAP) regions spend the least on health care in absolute terms (see map on Health Expenditures in Annex G), and some countries are spending less over time. Low tax collection capacity and low personal income contribute to these trends. Lack of financing usually translates into low levels of capital stock such as beds, and of human resources such as doctors and nurses. Even where capital stock is more adequate on a national basis, inequitable resource distribution may result in poor access to services by the poor, such as in the Middle East and North Africa (MNA) region.

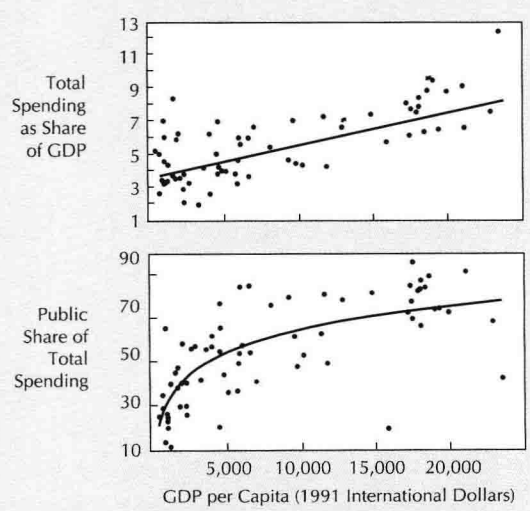

FIGURE 1.4

Recently a growing number of countries face a different challenge—rapidly rising health expenditures in both the public and private sector. Some countries have increased health spending from 3-5 percent of GDP to 8-10 percent of GDP in only a few years. Argentina now spends a higher share of GDP on health than Canada, which for years ranked second only to the United States. Often public funding is forced above what is fiscally sustainable, and too often additional spending goes to ineffective, inefficiently managed, and low quality care. Increased spending on health care alone does not necessarily increase health, nutrition, and population outcomes. Attention to population-based approaches and broad public health approaches are often needed before outcomes are influenced.

The reasons for these increases in health care expenditure include rapid escalation in the cost of new medical technology, the epidemiological transition in disease patterns (increase in chronic diseases and re-emerging or new communicable diseases), rising popular expectations, and the growth of fee-for-service medicine and third party insurance.

At a global annual growth rate for GDP of 3.5 percent, health care expenditure will increase by about US$82 billion a year worldwide, or US$9 billion a year in low- and middle-income countries at current rates of growth. In principle, this is enough money to pay for essential population-based preventive and curative services for the 900 million of the world's estimated 1.3 billion poor who still do not have adequate access to these services. However, if current trends persist, many of these resources will go to those who already have access and use services, rather than to the poor.

Major Policy Directions

The underlying threats to good health, nutrition, and population outcomes are well known, and affordable solutions are frequently available. But because of weak government implementation capacity and market im-

perfections in the private sector (especially with respect to public goods and activities with large externalities), recommended policies often fail to benefit the poor, fail to improve the impact of health systems, and fail to secure sustainable financing for the sector. This section provides a framework for understanding recent changes in the role of the state, and reforms that many countries are adopting in the HNP sector.

The Changing Roles of the State and Private Sectors

Throughout most of history, people used home remedies, private doctors and other health care workers, and non-governmental hospitals when they were ill. Often only the rich could afford such care and the range of effective treatment was limited. Today, in low-income countries—where public revenues are scarce (often less than 20 percent of GDP) and institutional capacity in the public sector is weak—the financing and delivery of HNP services is largely in the private sector. In many of these countries, large segments of the poor still have no access to basic or effective care for a variety of reasons discussed below.

In most developed countries—and many middle-income countries—governments have become central to social policy and health care. This involvement by the public sector is justified on both theoretical and practical grounds to improve: (a) **equity,** by securing access by the population to health, nutrition, and reproductive services; and (b) **efficiency,** by correcting for market failures, especially when there are significant externalities (public goods) or serious information asymmetries (health insurance).

One of the clearest cases for strong government intervention in the HNP sector can be made when there are large externalities (the benefits to society are greater than the sum of benefits to individuals). This is true in the case of clean water, sanitation services, vector control, food safety measures, and a range of public health interventions (e.g. immunization, family planning, maternal and perinatal health care, control of infectious diseases, and control of tobacco, alcohol, and illicit drug abuse). Medical education and R&D are two other areas for active government intervention.

Private voluntary health insurance is one area which is particularly prone to a number of market imperfections, many of which relate to information asymmetries. While insurance may succeed in protecting some people against selected risks, it usually fails to cover everyone willing to subscribe to insurance plans and it often excludes those who need health insurance the most or who are at greatest risk of illness. This happens because insurers have a strong incentive to enroll only healthy or low-cost clients (risk selection or cream-skimming). Private insurers also have incentives to exclude costly conditions or to minimize their financial risk through the use of benefit caps and exclusions. This limits protection against most expensive and catastrophic illnesses.

Because of these factors, individuals who know they are at risk of illness have a strong incentive to conceal their underlying medical condition (adverse selection). Individuals who are—or at least think they are—healthy will often try to pay as low premiums as possible. This prevents insurers from raising the funds needed to cover the expenses incurred by sicker or riskier members. Worse, the healthy may even deliberately under-insure themselves, in the hope that free or highly subsidized care will be available when they become ill (free-riding). When third-party insurers pay, both patients and providers have less incentive to be concerned about costs, and some may even become careless about maintaining good health. This leads not only to more care being used (the reason for insurance), but also to less effective care, or care that would not be needed if people maintained good health (moral hazard).

In addition to insurance market failure, private consumers are also at the mercy of medical providers who charge what the market will bear. Without good regulations and quality control systems, patients can spend a significant amount of their personal income on ineffective care. The poor and less well educated are particularly vulnerable to unscrupulous profit seeking by private providers, due to information asymmetries.

The main actions taken by governments to correct for such market failures, from least to greatest intervention, include: providing information to encourage behavior changes needed for long-term improvements in health, nutrition, and population outcomes; enforcing regulations and incentives to influence public and private sector activities; issuing mandates to indirectly finance or provide services; financing or providing subsidies to pay for services or influence prices; and direct public production of preventive and curative health services.

Both economic principles and empirical evidence suggest that a mixture of public and private involvement leads to the best results in the HNP sector. Neither sector is effective by itself—each needs the other. Both too much and too little involvement by either sector are often associated with problems.

Unfortunately, in low- and middle-income countries, weak institutional capacity to deal effectively with regulatory problems in the private sector often causes governments to become excessively involved in the direct production of health services. Such over-involvement in public production is typically associated with insufficient government involvement in: providing information about personal hygiene, healthy life-styles, and appropriate use of health care; regulating the private sector; financing essential health services, especially for the poor; and securing access to public goods with large externalities for the whole population. The reforms that are needed to strike an optimal balance at various income levels differ in the case of delivery systems and financing. This will be discussed in more detail below.

Recent Reform Strategies

Recent dissatisfaction with poor health, nutrition, and population outcomes, the low quality of health care in both public and private facilities, and the lack of sustainable financing and/or cost escalation have led to a wave of health care reforms throughout the world. (See the *At A Glance* tables in Annex A for clusters of countries that perform poorly in each of these three priority areas.)

Improving HNP Outcomes for the Poor

The majority of the world's 1.3 billion people identified by the Bank as living in absolute poverty, with incomes of less than US$1 per day, live in countries where a sizable proportion of the population still lacks adequate access to safe drinking water and sanitation, adequate nutrition, basic shelter, basic education, family planning, and essential health services.

In poor countries, the design of policies and programs to ensure access to essential HNP services—whether implemented through public or private channels—is an absolute priority (See Annex B for a discussion of the *UN Basic Social Services for All* initiative and Annex C for a more detailed description of selected essential HNP interventions). Often non-targeted and targeted strategies must be undertaken in parallel.

Non-Targeted Approaches. The experience in developed and middle-income countries is that universal access is one of the most effective ways to provide health care for the poor. But non-targeted approaches can also be wasteful. Some low-income countries spend as much as 4 percent of GDP on publicly-funded food subsidies with little impact on the nutrition of the poor. In low-income countries, non-targeted approaches often have to be restricted to a very limited range of public health and food fortification programs, and a few essential health services, to be financially viable.

Targeted Approaches. It is possible to ensure that essential programs reach those who need them most through use of careful targeting. The following four approaches are particularly relevant to the HNP sector in low- and middle-income countries:

- *Focus specifically on the poor individuals or households most vulnerable to illness, malnutrition, and high fertility*, by applying a means test to identify the neediest and providing free or subsidized services to only those qualifying for preferential access on this basis. In most low-income countries this technique is not administratively feasible on a large scale.
- *Focus on poor regions within a country or on population groups that are particularly vulnerable to poverty* (e.g., women, children, and ethnic minorities). At the global level, most of the world's 1.3 billion poor live in South Asia, Sub-Saharan Africa, and a few countries in other regions (see Annex A for country groupings). Within countries, the emphasis can be on the states, rural areas, and urban areas where the poor live, or on specific sub-groups within these areas—such as when nutrition programs are targeted at mothers and young children in disadvantaged areas.
- *Emphasize health, nutrition, and reproductive problems of the poor.* The old enemies of the poor—malnutrition, communicable diseases, childhood illnesses, high fertility, and maternal and perinatal conditions—can be specifically targeted in this way (see Figure 1.5). More than half of the disease burden in Sub-Saharan Africa and South Asia can be addressed effectively through local adaptation of interventions such as immunization, food fortification, targeted nutrition programs, integrated management of childhood illness, family planning, maternal and perinatal health, and school health (see Annex C). As populations age, non-communicable conditions and injuries increase rapidly. The poor and less well educated are particularly vulnerable to the adverse effects of mass marketing of tobacco, alcohol products, and unhealthy foods.

- *Give greatest attention to the types of service providers from whom the poor receive most of their care.* This often requires upgrading and extending the health, nutrition, and reproductive services (public and private) in low density rural areas and urban slums. This would include improving the supply of consumables and drugs, the management of facilities, and the skills of staff.

Communicable Diseases:
A Major Killer Among the Poor

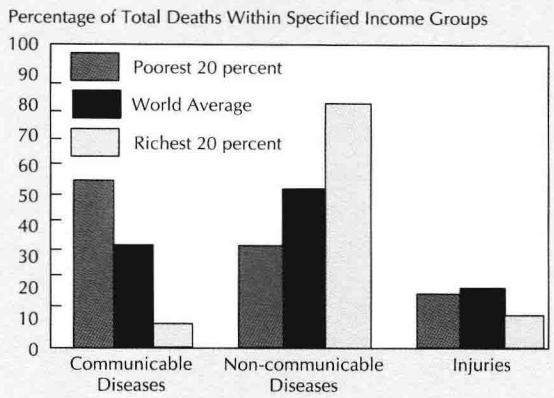

FIGURE 1.5

Enhancing Performance of HNP Services

Designing effective policies and reforms to improve the performance of both government-run and private health systems has bedeviled both rich and poor countries over the past decade.

Reforms in Public Delivery Systems. Much remains to be learned about how to make publicly-owned health systems more effective. The following public sector reforms are often needed:

- *Improving equity in access* to a range of preventive and clinical services through: (i) reduced geographic, financial, cultural, and other barriers; (ii) interventions that address conditions that are frequent and inexpensive to treat (at least for the poor); (iii) interventions that are less frequent, more damaging to health, and costlier but still within a country's means.
- *Raising efficiency in the use of scarce resources* through improvements in policymaking, governance, encouraging market incentives, management, decentralization, and accountability.
- *Improving the effectiveness of interventions* through improved clinical and management skills, design of basic preventive and clinical packages, treatment protocols, technology review panels, limited drug formularies, training, and research on the efficacy and cost of different interventions.
- *Raising the quality of care* through incentives, improved information, training, accreditation systems (for HNP staff and establishments), peer reviews, inspection systems, and routine surveillance.
- *Maximizing consumer satisfaction* through increased choice and attention to client surveys.

The Limits to Public Sector Reforms. Public sector reforms of government-run health services are often not enough to correct the deep-rooted problems that plague these systems. Despite years of effort and investment, many government-run systems continue to be underfinanced and perform poorly. In many cases they do not provide the desired access, effectiveness, efficiency, and quality. Even in the poorest of countries, patients frequently turn to private providers. Those who can afford to pay the price can sometimes find the quality of care that they seek. The poor often fall prey to cheap and ineffective remedies provided by unscrupulous profit seekers in an unregulated market place.

More Balanced Public/Private Mix. Although the optimal balance between public and private involvement varies considerably from one country to another, and is different in the case of financing from that in the case of service delivery, many recent reforms focus on correcting inequities and inefficiencies that occur when the balance between government and private sector roles becomes excessively distorted in one direction or another (see Annex A for a ranking of low- and middle-income countries that are at either extreme of the public/private mix and the left box in Figure 1.6 for distorted government roles).

Governments in countries that have introduced successful reforms often increase their role in providing information, regulations, mandates, and financing. While fostering a more balanced participation by NGOs, local communities, and the private sector in the service delivery systems, governments in these countries have shifted their attention and scarce resources to: securing access by the whole population to services with large externalities (preventive public health services); providing basic health, nutrition, and population services for the poor; and assuming sectoral oversight responsi-