Moving beyond health service delivery: health in development

Development is an intersectoral and interdependent

process

As such, the eight MDGs are synergistic and cannot be achieved in isolation. This is particularly true for the health goals: increased coverage of disease interventions alone will not improve health outcomes, which are determined by a host of political, social, and economic factors.

Strategies to improve health also need to look beyond health service delivery and take action to address the broad determinants of health (see page 45). These include gender equality (which affects maternal mortality and the spread of HIV/AIDS); water and sanitation, food security and nutrition (which all affect child health and the spread of communicable disease); and education (which impacts on maternal health, including fertility, and child health). The eighth MDG - which concerns developing a global partnership for development - recognizes that this holistic approach must also include the actions of rich countries (see Chapter 5).

Health and development: what does it mean in practice?

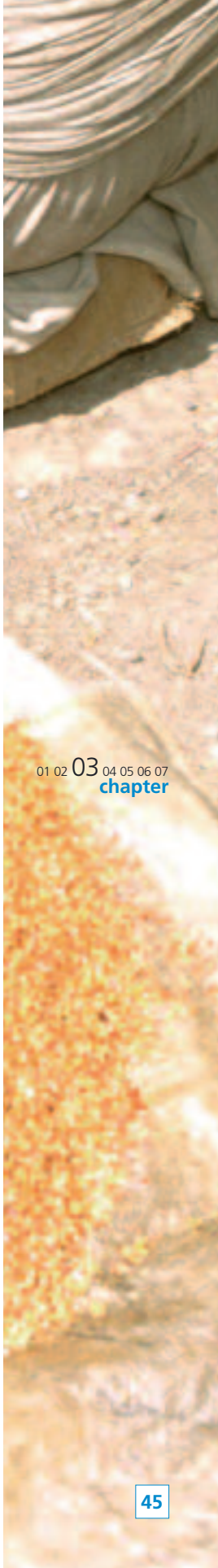
Long-standing knowledge of the cross-sectoral nature of health determinants has more recently evolved into a more comprehensive approach, namely that health be addressed within a broad economic and political framework. In practice, this means looking at how public systems - and public policy more generally - impact on and are affected by health, through some form of health-impact assessment. This approach is pertinent to processes such as civil service reform and decentralization, as well as efforts to reduce poverty, and economic policy in general. While the relationship between health and 'social determinants' - such as income and employment - is well documented, this chapter looks at whether and how developing country governments can use a range of policy levers across government to the benefit of health.

Addressing health within a broad developmental framework must, of course, be carefully balanced with support for development of 'pro-poor' health systems, as discussed in Chapter 2. More equitable health systems are prerequisites for achieving the MDGs. They also contribute to social protection, the empowerment of marginalized groups, and the fulfilment of human rights, and are therefore central to poverty reduction efforts.

It goes without saying that the approach taken should be tailored to the country context. Fragile states (countries emerging from conflict and those with weak structures and institutions) may require a different set of policies from

Broad determinants of health

- Among children under five years, 53% of annual deaths are associated with malnutrition.
- Iron-deficiency anaemia is the second leading cause of disability and may contribute to 20% of maternal deaths.
- At least 25% of the global burden of disease may be attributed to environmental conditions; a child dies every 15 seconds from diarrhoea, caused largely by unsafe water and inadequate sanitation; indoor air pollution causes an estimated two million deaths a year; women are more likely than men to be exposed to harmful cooking fumes.
- There is a strong correlation between literacy of mothers and child mortality: a study in India suggests that a 10% reduction in female illiteracy would result in the reduction of infant mortality by 12.5 deaths per thousand (1).



poor but well-governed countries, which in turn are different from middle-income countries with large pockets of poverty. Equally, international development partners have an important role to play in supporting health in development processes. Both issues - fragile states and development cooperation - are discussed in Chapter 5.

Raising the profile of health in national development processes

Good health is a human right and a measure of human well-being. It is also a driver of growth: investments in health have positive economic returns (2). During the period 1965-1990, health and demographic variables accounted for as much as half of the difference in growth rates between Africa and the rest of the world (3). Healthier populations and disease eradication can also help to attract private investments and encourage tourism.

Similarly, broader economic policies and government-wide reform programmes can have a profound impact on the functioning of the ministry of health and the delivery of health services. Yet health issues are rarely taken into account when such programmes are designed and implemented, and the contribution of health professionals to these processes is usually limited. There are good reasons for this: lack of capacity within already overstretched ministries of health; no tradition in oversight ministries (such as finance and planning) of consultation with line ministries; and no clear mechanisms for consultation.

Some examples of broader processes with direct impact on health include the following:

- Civil service reform, which affects the supply of health workers. Low salaries make it hard to attract and retain staff, particularly in remote rural areas, and can fuel corruption. In most countries, it is impossible to increase salaries for health staff at a different rate than that for other public sector workers, yet given the current crisis in human resources for health (see Chapter 2), there may be a special case for doing just that. The health sector must engage with civil service reform processes if it is to win this argument.

- Budgeting and expenditure systems. In addition to receiving insufficient resources, health services may receive their budget - for salaries, medicines, etc. - erratically or late. This creates management and administrative difficulties, and contributes to poor-quality services. These problems are typical across the public sector, and can only be addressed with government-wide reform. Public expenditure reviews can help to diagnose key problems, and action needs to be taken based on review recommendations.

■ Decentralization can have a profound impact on the delivery of health services. On the one hand, it may bring the managers of health services closer to the people they serve, increasing responsiveness to local needs. On the other, scarce resources may be diverted away from national health priorities once local authorities have jurisdiction over the allocation of funds. Decentralization of administrative and budgeting authority also poses challenges for the delivery and coordination of aid (see Chapter 5).

■ National poverty reduction strategies (PRS) and medium-term expenditure frameworks. A prominent place for health in PRS and associated budgets will help to ensure political backing for health strategies, coordination with other sectors, and appropriate funding.

■ Participatory processes, including those associated with PRS, are important mechanisms for ensuring that poor communities and their representatives are involved in setting the national development agenda. (Millennium Development Goal 3, which includes an indicator on women's political participation, is relevant in this regard.) Health policy-makers could make good use of the results of participatory processes - which can help to identify the varying needs of different poor populations, for example by sex, age, and ethnicity - to ensure that the poor are not treated as an aggregate group.

Research into how health is reflected in poverty reduction strategies gives some indication of the challenges involved in integrating health concerns into broader economic and public policy processes. The evidence (4) suggests that the health content of PRS tends to be poorly elaborated, and does not show how suggested actions (inputs) will lead to desired results (outcomes). In addition, there is often a mismatch between the priorities as expressed in PRS and the main areas of expenditure in budgets. For example, PRS tend to say little about how non-priority expenditures can be reduced in order to fund expanded health services for the poor over the medium term. Finally, PRS do not make use of their potential as intersectoral instruments to encourage action on health in other sectors; rather, they focus on delivery of health services to improve health outcomes.

These findings suggest that action in three areas is required.

■ Building leadership capacity within health ministries to engage ministries of finance and planning. This will require better understanding of economic policies (including macroeconomics) and the kinds of government-wide reform processes mentioned above.

■ Stronger planning processes within ministries of health, and in particular greater capacity to link plans with budgets.

■ Improved mechanisms and processes for intersectoral dialogue - which should in turn be supported by greater collaboration among development partners providing assistance to various sectors.

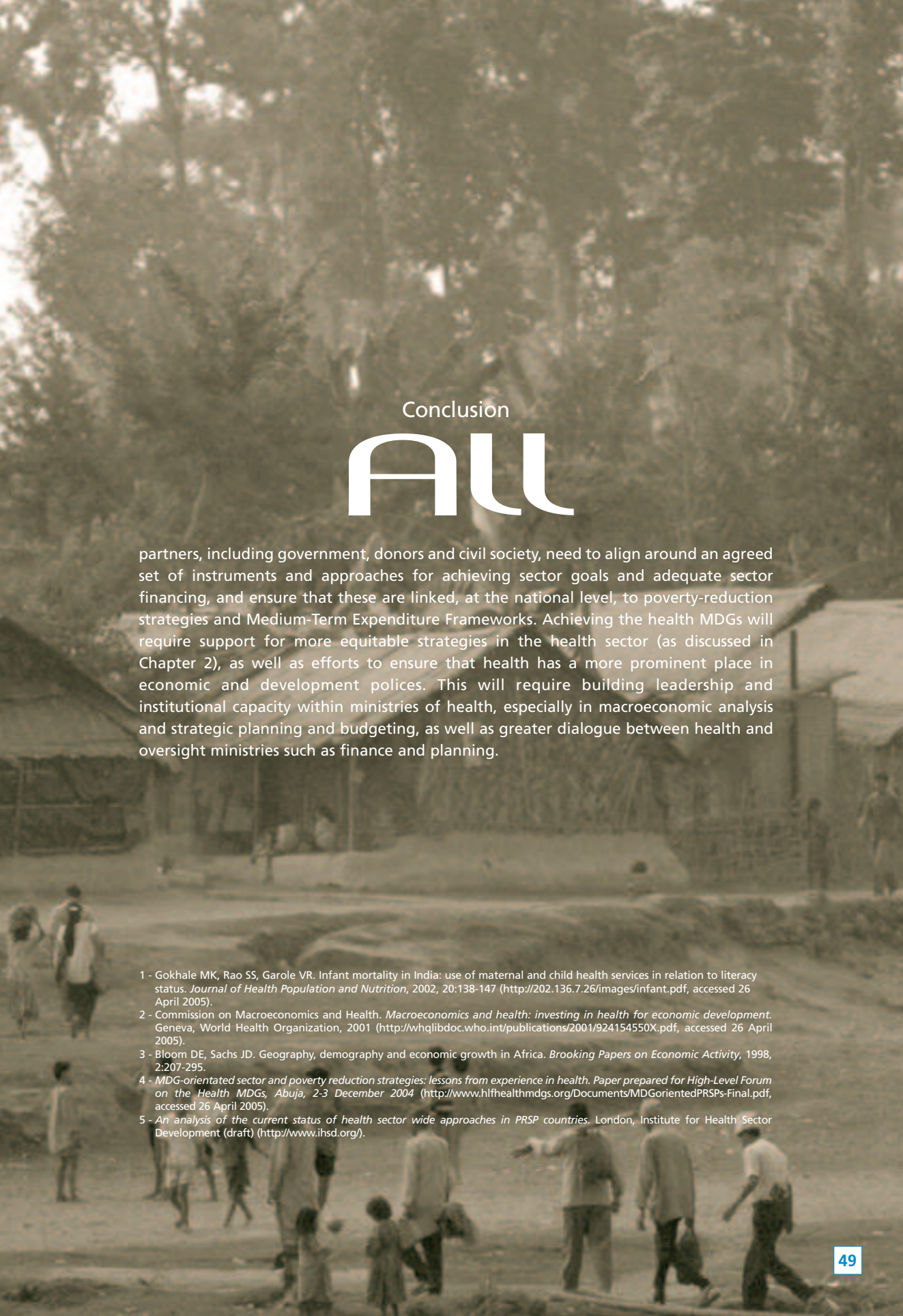
Such efforts will help make the case for larger health budgets - funded from both domestic and external sources. Research

by WHO and the World Bank (4) suggests that most low-income countries are producing fiscal frameworks that assume only modest increases in aid levels over the period of their poverty reduction strategy. This makes it unlikely that further aid increases will be forthcoming. The evidence also shows that actual health expenditures are rising only slowly - too slowly to implement the health objectives outlined in poverty reduction strategies. This suggests a pattern of low ambitions - that ministries of health and governments are planning for only very modest rises in health spending, and that donors in turn are providing only modest increases in aid. Chapter 5 discusses funding for health in more detail.

Programme-based approaches

Poverty reduction strategies are not, and do not include, detailed planning instruments at the sectoral level. If health is to be a priority for government, the ministry of health needs to put its own house in order. This means developing a strong sector plan, a sound financing and expenditure framework, and a reliable monitoring mechanism. These should be elaborated and agreed upon by government and donors through a programme-based or sector-wide approach. All donor assistance - including that provided by nongovernmental donors and global funds - should then be 'on-plan', in the sense that priorities and strategies articulated in the plan are respected.

While the concept of sector-wide approach (SWAp) has been around for more than a decade and has gained widespread acceptance, there are only a few examples of fully-functioning SWAps in the health sector. A recent analysis (5) of the status of health SWAps suggests that just seven countries have well-developed versions of them and eight have pooled funding mechanisms in place. Other research by WHO and the World Bank suggests that the amount of health aid provided in flexible form is surprisingly low: in 14 countries studied, just 20% of aid is provided as budget support - some of which is itself earmarked for specific sectors or budget lines (4). One implication of these findings is that the success of a SWAp should not necessarily be judged by whether it attracts pooled funding - the development of joint policy, monitoring, and management frameworks may be more important.



Conclusion

ALL

partners, including government, donors and civil society, need to align around an agreed set of instruments and approaches for achieving sector goals and adequate sector financing, and ensure that these are linked, at the national level, to poverty-reduction strategies and Medium-Term Expenditure Frameworks. Achieving the health MDGs will require support for more equitable strategies in the health sector (as discussed in Chapter 2), as well as efforts to ensure that health has a more prominent place in economic and development polices. This will require building leadership and institutional capacity within ministries of health, especially in macroeconomic analysis and strategic planning and budgeting, as well as greater dialogue between health and oversight ministries such as finance and planning.

1 - Gokhale MK, Rao SS, Garole VR. Infant mortality in India: use of maternal and child health services in relation to literacy status. *Journal of Health Population and Nutrition*, 2002, 20:138-147 (http://202.136.7.26/images/infant.pdf, accessed 26 April 2005).

2 - Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001 (http://whqlibdoc.who.int/publications/2001/924154550X.pdf, accessed 26 April 2005).

3 - Bloom DE, Sachs JD. Geography, demography and economic growth in Africa. *Brooking Papers on Economic Activity*, 1998, 2:207-295.

4 - *MDG-orientated sector and poverty reduction strategies: lessons from experience in health. Paper prepared for High-Level Forum on the Health MDGs, Abuja, 2-3 December 2004* (http://www.hlfhealthmdgs.org/Documents/MDGorientedPRSPs-Final.pdf, accessed 26 April 2005).

5 - *An analysis of the current status of health sector wide approaches in PRSP countries*. London, Institute for Health Sector Development (draft) (http://www.ihsd.org/).