

## Strategic Issues in Health Sector Development

### Introduction

The present annex on strategic issues in the health sector is intended as an outline of the issues to be addressed in more detail in the full poverty reduction strategy. Its primary focus is poverty and the linkages between health and poverty. The key objective here is to provide a framework for progressing towards pro-poor health planning at both the strategic and operational levels.<sup>30</sup>

This annex is produced as work proceeds on the development of the next sector plan for health, provisionally labeled as the *Health, Nutrition and Population Sector Program* (HNPSPP). The processes for developing the full-blown strategy (and the TYRP) and the HNPSPP are distinct but interlinked. Preparation of the full-blown strategy is a national, multi-sectoral process for poverty reduction and economic growth, and will provide the broad framework within which the health sector will address poverty goals. As an interim step in the development of a full-blown strategy and the TYRP, the present paper sets out the broad thrust of a national poverty reduction plan. It highlights a number of key crosscutting issues, several of which have particular relevance to health (e.g. governance, participatory planning, and poverty monitoring). In contrast, the HNPSPP is a strategic and operational plan for the health sector that incorporates poverty goals. In practical terms, HNPSPP will have a more focused sectoral scope, and will include much more detail on how health sectoral goals will be achieved.

In process terms, this annex elaborates on the health content of the poverty reduction and social development strategy and indicates the further work required to generate a strong health component of the full-blown strategy. This annex and the process for producing the poverty reduction strategy will simultaneously support the development of the strategic elements of the HNPSPP. Consequently, the focus here is on further developing the health content of such areas as the poverty diagnosis.

Embodied in this annex is a statement of the core goals and guiding principles for pro-poor health development. Of course, HNPSPP is also an operational document, and as such will need to detail specific actions to be taken for improving the health of the poor. This task lies outside of the scope of this annex, although it is intended that it assists others to translate the strategic content and framework into action and interventions. The annex indicates some ways in which this latter process might progress.

The poverty reduction and social development strategy has highlighted a number of crosscutting issues for national poverty reduction and economic growth that have relevance across many sectors, including health. These include issues focused around: better governance; improvements in the quality of public services; and, social safety nets for the poor. Whilst a detailed examination of these themes lies outside the scope of this annex, they are being examined as part of the broader process of strengthening the poverty content of HNPSPP.

<sup>30</sup> This annex draws on the written inputs provided by the Health Economics Unit of the Ministry of Health entitled *Health as a Goal of and a Mechanism for Poverty Reduction and Economic Development*, September 2002 as well as consultations held with the major stakeholders within the Ministry of Health.

## **Background and Context to Pro-Poor Health Planning**

Recent years have seen a major shift in the way that health and related sectors are perceived in the development process. Previously, health was conceived primarily as a goal of development and as a consumption sector. In other words, health was seen, primarily, as a drain on resources that might otherwise have accelerated the pace of socio-economic growth and development. That perception has changed markedly in recent years. Health, and the related sectors of nutrition and population, are now widely recognized to have an important role to play in the development process. Rather than being merely a goal of development, health is seen to be an important input to development.

The current sectoral program for health – the Health and Population Sector Program (HPSP) – started in 1998 and will conclude in June 2003. A key feature of HPSP is its adoption of a sector wide approach (SWAP), with donors providing co-ordinated support against an agreed national policy and expenditure framework.

The HPSP incorporates broadly defined poverty goals. It aims to improve the health of the poor, women and other vulnerable groups through the provision of client centered, quality health services. A central objective is to re-direct a substantial share of public health expenditures to an Essential Service Package (ESP). The ESP was defined using a number of criteria. The most important of these were consideration of the diseases posing the greatest burden of ill health in the country, especially to the poor, and the relative cost effectiveness of health interventions. HPSP focuses primarily on rural areas and delivers the ESP through primary level health facilities, defined as Upazilla and below. This includes the development of a new tier of health facility at the community level, called community clinics. HPSP also specifies a number of policy and institutional reform objectives, such as unification of the health and family welfare wings, and decentralization.

The Pro-Poor focus of HPSP may be summarized thus:

- Through ESP, it focuses resources on cost-effective interventions that address the most common health problems of the country overall, and the poor in particular;
- Its rural focus concentrates services where the majority – though not all - of the poor reside;
- The focus on delivery at the primary level supports services and facilities that are most used by the poor;
- The introduction of a new community level health service tier (the community health clinic) aimed to improve access by the poor; and
- Parallel activities to support health policy and systems development were introduced to strengthen service delivery.

Some successes can be reported against these objectives. There has been some success in re-orientating service delivery towards the poor. In terms of resource allocation, the PER indicates a shift in public health spending towards the essential package so that now over 65% of public health spending was on the ESP. In terms of service utilization, over 55% of those using Upazilla and lower level health facilities are from two poorest income quintiles.

## **The Next Sectoral Program and Poverty**

A new sectoral program is scheduled to commence in 2003. Although the overall strategic goals for the strategy are still being debated, there is a clear consensus that the next sector plan will need to improve upon past poverty goals and achievements. For example, it will need to strengthen targeting of public health spending to the poor and most vulnerable. This will require continuing implementation of a number of the policy and institutional reforms initiated under HPSP, such as ESP delivery through primary level facilities. However, it will also entail shifting from a fairly broad-brush targeting approach to one that is more refined and precise, and views health and poverty in a holistic context.

A number of factors will need to be considered in the context of a more pro-poor health program. The first concerns the scope of the program. HPSP largely confined itself to the health needs of the rural population. This was understandable, given that the majority of the poor do reside in rural area, although it does sideline the need of a large number of poor who reside in urban areas, particularly in urban slums. The next program will need to specify more clearly how the health needs of this population group will be met.

Whilst HPSP has made a good start in re-orientating health systems and interventions towards the poor, some challenges remain.

The next strategy will need to address the following:

- HPSP did not explicitly define or quantify poverty objectives. Whilst overall health and population targets are specified, no targets were set for reducing inequalities, nor have steps been taken to monitor inequality reduction.
- HPSP is limited in its identification of target groups. It does not consider the heterogeneity of the rural population (not all of whom are poor), nor does it address the needs of a large group of urban poor.
- Overall spending, and public spending on health remains low, thereby limiting the scope for improving health overall as well as reducing inequalities.
- Resource allocation practices continue to be based upon past facility and staffing norms, which in turn reflect historical decisions not based upon need, demographic or socio-economic differentials.
- The poor face particular barriers in accessing government health services. For example, unofficial fees in government health facilities impose a greater burden on poor households compared to richer households, and have been identified by the poor as one of the major deterrents to their use of government health services (SDS) which is often erratic.
- It has not fully overcome some of the systemic barriers to improvement of the situation of the poor.
- It does not reflect the complex relationship between poverty and ill health. Greater recognition will need to be given to the multiple determinants of ill health, and of the need for actions beyond the traditional boundaries of the health sector, such as in

nutrition, water and sanitation. More creative actions are needed to address this complex cause and affect relationship.

- The content of the ESP will need to be re-visited to ensure that these remain the priority services of the poor. In addition, the relative emphasis given to individual ESP services will need to be examined. Available evidence suggests that maternal health is the most under-resourced of all the ESP services relative to needs.
- The poor face a number of demand side barriers. These include physical and financial barriers, as well as knowledge, provider behaviors and socio-cultural factors. Special attention will need to be given to gender and health care access. First there is need to better understand these access barriers, their relative importance and how they interact with each other to prevent health access of the poor.
- Further attention is needed in respect of systems strengthening and development to ensure delivery of relevant, high quality, and accountable health services. This includes Human Resource development, improving service discipline, decentralization, and local participation in health planning and monitoring, amongst others.
- Catastrophic health events are a major problem in driving households into poverty. It is important that the next sector plan identifies ways of addressing this problem.

### **Key Steps in Developing the Health Content of the Strategy**

This annex highlights three broad aspects of pro-poor planning: participation, poverty diagnosis, and objectives and actions.

#### **Stakeholder Participation**

The various documents and guidelines produced on the poverty reduction strategy emphasize the importance of stakeholder participation. There is a long tradition of participatory consultations in Bangladesh and much had already been done prior to the current poverty reduction and social development strategy. Although the NGO and development community (rather than government) had undertaken much of this work, health is consistently ranked as a high priority for, and concern of, the poor. Similar findings emerge from the different consultations with the poor (e.g. poor quality, staff absenteeism, drug shortages, unofficial fees, cleanliness and facilities). The poor consistently acknowledge the threat that poor health poses in terms of poverty and the importance of good health care.

In order to elaborate further on the health specific elements, the following steps are required:

- Agreeing the purpose and form of participation;
- Identifying key stakeholders and participants in health and poverty; and
- Establishing a process and structure for participation.

#### **The Health Poverty Diagnosis**

Effective planning for poverty reduction should be based upon sound evidence on the nature and extent of socio-economic inequalities, how they arise, and what are the resulting

problems. This process is often termed as *Poverty Diagnosis*. Expressed concisely, a poverty diagnosis for health would comprise the following:

*Elements of a Strategic Health Plan*

- The identification of key health-poverty variables and health-poverty indicators;
- An assessment of the extent of, and trends, in socio-economic inequalities in health;
- An assessment of who the poor are and the differences amongst them;
- An analysis of the health-poverty process and the factors that contribute to socioeconomic inequalities in health;
- An identification and analysis of the major health problems of the poor and the consequences of those problems for the poor; and
- A critical appraisal of the capacity of current data and information systems to support pro-poor health planning and the subsequent monitoring and evaluation of poverty reduction activities and outcomes.

### **Identifying and Prioritising Objectives and Actions**

The poverty diagnosis is an essential process in identifying the cause and extent of health status differentials. It is an important precursor to the development of a pro-poor health strategy and the subsequent expression of that strategy at the operational level (i.e. in terms of specific objectives and actions). The poverty diagnosis will facilitate the design of a sector plan that addresses two broad goals: first, maximizing overall national health status; and, second reducing health status inequalities and prioritizing the needs of the poor. In practical terms, this challenge can be addressed in terms of three specific objectives. Expressed simply, a pro-poor plan will need to achieve the following:

- It will need to increase the resources available for health and health related activities.
- It will need to ensure that those resources achieve maximum impact (i.e. are used efficiently and effectively to produce quality care with the minimum of waste).
- That the benefits of health spending and health interventions are distributed so that inequalities in health are reduced.

The next section indicates how these goals and objectives can be translated into a strategic health plan.

### ***Spending More (Broadening and deepening the resource base)***

A fundamental problem is that insufficient resources are available for health in Bangladesh. Overall health spending is approximately \$12 per capita of which one third is channeled through government with the remaining two thirds coming from private out-of-pocket expenditures. Recent empirical studies indicate that this level of spending falls far short of the level required for providing even a basic service package. A first challenge, therefore, is to explore options for increasing resources for health.

Progress will require efforts to increase funding across all sources. In terms of public funding, increases are partly dependent upon progress in economic growth per se. However, irrespective of progress in per capita GDP, the health sector can present a case for higher

sectoral allocations. Traditionally health has been seen as primarily a consumption sector and as a goal of broader socio-economic development. Recent empirical research establishes a strong link between health expenditures and economic growth and development (WHO- MCH). This message needs to be appreciated in full and realized in broad allocational terms. It is not sufficient for public expenditures to increase in line with GDP growth but at a faster rate.

A significant share of current health expenditures is funded by development partners, with much of that now being channeled through a sector wide approach. There are several factors that suggest that with purposeful action this level of funding can be increased. There is broad recognition amongst the development community that expenditures on health are important in the development process. However, donor policies emphasize the importance of improving the effectiveness and efficiency of health spending and ensuring that such investments benefits the poor. If more resources are to be secured from development partners they will need some indication as to how the next sector plan will be pro-poor whilst at the same time indicating how improvements will be achieved in respect of quality, efficiency, effectiveness.

Out-of-pocket household expenditures currently constitute the major share of health expenditures. Some scope exists to increase household spending on health by encouraging households to spend more on health as well as by providing opportunities for them to do so (e.g. social marketing and BCC and schemes such as micro health insurance).

There is recognition that a small number of conditions result in a large share of the burden of disease e.g. malaria, TB and HIV/AIDS. In many countries these health problems are on the increase. In recognition of this, a number of international agencies have earmarked funds specifically for these health problems. It is important that Bangladesh takes the necessary steps required to access these special funds.

In developing sources of funding it is also important to consider how the burden of costs are distributed. Resource mobilization options need to be assessed not only in terms of the how much they generate but also how the costs are shared. In short, the burden of costs should be distributed according to ability to pay.

### ***Spending Better (Doing the rights things in the right way)***

It is not sensible to try and increase resources for health without at the same time taking steps to ensure that both existing and additional resources are not wasted. If the next sector plan is to achieve maximum health status improvements, all resources (new and existing) will need to be used effectively and efficiently. There is evidence that many resources currently allocated to health are diverted from their intended purpose. Losses result from many sources including: staff absenteeism, resource misuse and corruption. These problems are compounded by systems and procedures that do not promote efficiency, effectiveness or quality. For example, resource allocation is facility based with financial and staffing allocations based upon facility size (e.g. beds). For overall health objectives to be achieved as well as poverty objectives, allocation practices need to be reoriented to better reflect such factors as: population size and structure, health and socio-economic status, and geographic variations in the costs of services delivery. Once allocated resources should be used effectively and efficiently to produce services that are relevant to needs and of good quality.

Again, there is much evidence to suggest that there is considerable scope for improvement here.

These objectives do not presume any specific service models. Current arrangements involve government in resource generation and allocation, and as a provider and manager of services. As part of preparations for HNPS, various alternative models are being appraised with a view to determining the essential core functions of the public sector.

While a detailed technical debate on the relative effectiveness and efficiency among different health options is beyond the scope of this annex, the challenge can be expressed simply as: doing the right things, and doing them in the right way. The right things are those that address the major health problems in a technically appropriate manner. Doing them in the right way involves considerations of resource use and costs. Amongst the key issues to be considered are:

- The funding and content of the Essential Service Package (ESP); and
- Improving the quality of health services.

### ***Spending on Right Groups (Determining how costs and benefits are to be distributed)***

Spending more and spending better are key elements in planning for health gain at the national level. However, it is also important that consideration be given to distributional objectives: that is, to the health of the poorest, the most disadvantaged and the vulnerable. In broad terms, this requires that overall health sector goals and targets be differentiated according to population sub-groups. Primarily this differentiation will be by socio-economic status (i.e. by poverty ranking) although in some cases the differentiation will be by other aspects of disadvantage or vulnerability (e.g. by gender, by demographic or household characteristics, by place of residence, or by exposure to risks or hazards). In practical terms, targets for health gain should aim to reduce inequalities in health at the same time as improving health status at the aggregate level. This requires means for identifying who the poor are, and ways of ensuring that benefits actually reach them.

Pro-poor health planning requires the identification and ranking of those in poverty. From a conceptual and methodological perspective, it is necessary to establish criteria for disaggregating the population into discrete beneficiary or target groups and to establish measures for ranking them according to their relative health status and needs. A commonly used approach is to allocate households to one of five groups (or quintiles) based upon measures of income or assets. Such devices facilitate pro-poor planning by identifying those groups for priority actions and interventions.

Having identified and prioritized target sub-groups, the next step is to try and ensure that benefits do reach them. Currently, HNPS employs a relatively simple approach to targeting, a combination based on geography, the burden of disease and cost effectiveness. The most comprehensive approach to targeting is one based on individual and household attributes. This approach is costly to implement and requires detailed and timely data collection. Whilst it may be possible to pilot such an approach at the local levels, such sophistication is neither necessary nor feasible for the next sector plan. The question is how to improve upon current targeting given the quality and level of disaggregation of current data and subject to very real resource constraints.