An agenda for action

The policy conclusions of this Report can be tailored to the widely varying circumstances of developing countries. This chapter highlights the priority policy issues and actions that are likely to be most relevant for three groups of countries: low-income countries in Africa and South Asia, middle-income countries in Latin America and East Asia, and the formerly socialist countries of Europe and Central Asia. It describes the reforms needed in the health sector and assesses their feasibility, examines the principal obstacles to reform, and outlines possible strategies for overcoming these obstacles. Although policy reform must deal with difficult underlying problems, the experience of a number of developing countries with implementing significant policy changes shows that success is possible.

This chapter also examines the role of the international community in supporting improvements in health policies and programs in developing countries. Despite widespread calls for more donor investment in human resources and in poverty reduction programs, aid flows to the health sector declined from 7 percent of total development assistance in the early 1980s to 6 percent in the latter half of the 1980s. Donors need to match their verbal commitments with actions: the share of aid for health should be restored to its previous level immediately and should be increased substantially over the next five years. An additional $2 billion in aid would help to finance the transitional cost of health policy reforms, as well as priority programs, including AIDS prevention. At the same time, donors and developing countries need to focus on measures to improve the effectiveness of external assistance for health. Doing so will require donor backing for major reforms in the allocation of public spending for health and in health policy more generally.

The effectiveness of donor spending can be improved through increased investment in basic public health measures and essential clinical care, steps to strengthen the policy and regulatory framework for insurance and for delivery of services, and backing for research to expand the range of cost-effective treatments available to the poor in developing countries. Aid for lower-priority items, including tertiary care hospitals and training of medical specialists, needs to be correspondingly reduced or eliminated.

Finally, improved coordination among donors could raise the effectiveness of aid. Despite the many serious obstacles, the recent experience of a number of African and Asian countries shows that such coordination can be achieved.

Health policy reform in developing countries

The policies that this Report suggests should be at the top of the agenda for developing countries and the donor community are summarized in Table 7.1. This section describes those policies and provides examples of successful policy reforms in various developing countries.

Low-income countries

Previous chapters have outlined the main characteristics of health systems in low-income countries. In general, there is little public or private insurance. Out-of-pocket spending for drugs, traditional medicine, and user fees usually accounts
Table 7.1 The relevance of policy changes for three country groups

<table>
<thead>
<tr>
<th>Government objectives and policies</th>
<th>Low-income countries</th>
<th>Middle-income countries</th>
<th>Formerly socialist countries</th>
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<td><strong>Foster an enabling environment for households to improve health</strong></td>
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<td>Pursue economic growth policies that benefit the poor</td>
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<td>Expand investment in education, particularly for females</td>
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<td>Promote the rights and status of women through political and economic empowerment and legal protection against abuse</td>
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<tr>
<td><strong>Improve government investments in health</strong></td>
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<td>Reduce government expenditures for tertiary care facilities, specialist training, and discretionary services</td>
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<td>Finance and ensure delivery of a public health package, including AIDS prevention</td>
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<tr>
<td>Finance and ensure delivery of essential clinical services, at least to the poor</td>
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<td>Improve the management of public health services</td>
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<td><strong>Facilitate involvement by the private sector</strong></td>
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<td>Encourage private finance and provision of insurance (with incentives to contain costs) for all discretionary clinical services</td>
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<tr>
<td>Encourage private sector delivery of clinical services, including those that are publicly financed</td>
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<td>Provide information on performance and cost</td>
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for more than half of total spending for health. Government financing from general tax revenues—and sometimes substantial donor contributions—account for the remainder. Government hospitals and clinics provide the bulk of modern medical care, but they suffer from highly centralized decisionmaking, wide fluctuations in annual budget allocations, and poor motivation of both facility managers and health care workers. Ministries of health and other government agencies often have only limited capacity to formulate health policy, implement health plans, and regulate the private sector. Private providers (mainly religious organizations in Africa and private physicians and unlicensed practitioners in South Asia) account for the remainder of the health facilities and deliver most outpatient care. They offer a service that is perceived to be of higher quality than that provided by the public sector. Large segments of the population, especially the rural poor, do not have access to modern health services. Female literacy and enrollment of girls in primary and secondary school are low.

Five policies for better health are crucial in this environment: providing solid primary schooling for all children, especially girls; investing more resources in highly cost-effective public health activities that can substantially improve the health of
the poor; shifting health spending for clinical services from tertiary care facilities to district health infrastructure capable of delivering essential clinical care; reducing waste and inefficiency in government health programs; and encouraging increased community control and financing of essential health care.

Increased Schooling. Despite the often formidable obstacles—both in providing access to schools and in eliminating cultural barriers that keep girls out—a number of low-income countries have proved that dramatic change is possible in a short period of time. Between 1970 and 1990 Indonesia and Kenya, for example, achieved rapid and sustained growth of primary school enrollments and raised the proportion of girls to nearly half of all pupils. These gains were brought about by a combination of high-level political commitment to universal primary schooling, information programs that created stronger demand on the part of parents, and support from the international community.

Investment in Public Health Activities. The public health activities with the largest payoff will vary from country to country: vitamin A and iodine supplementation in India and Indonesia, antismoking campaigns in China, and policies to reduce traffic injuries in urban areas of Sub-Saharan Africa. Completion of immunization coverage should be a high priority in all low-income countries, especially in India and in much of Sub-Saharan Africa, where coverage remains low. Similarly, a greatly intensified effort to reduce transmission of HIV and other sexually transmitted diseases is warranted. In the parts of Africa in which the AIDS epidemic is already widespread, behavioral change through education and condom distribution should be high on the list of public health actions. And where, as in Bangladesh and Indonesia, the preconditions (widespread commercial sex and high prevalence of other STDs) exist for rapid spread of HIV, governments urgently need to take steps to halt the spread of AIDS from high-risk groups into the population at large.

Better Allocation of Spending on Clinical Services. Governments should invest in district health infrastructure by (as described in Chapter 6) expanding training programs for primary care providers, particularly nurses and midwives; targeting construction funds to improve health posts, health centers, and district hospitals; financing ambulances and other vehicles needed for effective emergency transport, together with the necessary radio and telephone networks; and building the capacity to plan and manage health services at the district level and in individual facilities. In many low-income countries, focusing on district health infrastructure will mean limiting new investment in central hospitals and reorienting those facilities toward research and teaching activities that are more relevant to key national health problems. At the same time, there is considerable scope for improving the efficiency of large government hospitals, especially through performance-linked incentives for managers and staff and expanded cost recovery from the wealthy and insured.

To deliver essential clinical services, a greater share of government health budgets needs to be devoted to the operations of lower-level facilities and especially to nonsalary recurrent items. Initial emphasis needs to be placed on building capacity to deliver the services included in the minimum essential package described in Chapter 5. This is now happening in a number of countries. Senegal has set annual targets for increasing its spending for drugs, transport, and maintenance. Ghana is trying to reduce the number of civil servants working for the Ministry of Health. In India, where state governments account for more than three-quarters of total public spending for health, the central government is attempting to act as a catalyst for more cost-effective resource allocation by earmarking its funds for immunization, treatment of leprosy and tuberculosis, and AIDS control.

Some low-income countries will need to increase government outlays for health if they are to finance a package of public health measures and essential clinical services for the poor. In 1990 government spending for health in low-income countries averaged only $6 per capita—1.5 percent of GNP if foreign assistance is excluded and 1.6 percent including aid. The analysis in this Report indicates that provision of a minimum package will cost about $12 per capita in low-income countries, or nearly 3 percent of GNP. Effective targeting of publicly subsidized clinical services to the poor, and corresponding efforts to encourage cost recovery from more affluent groups, would help stretch limited government budgets. Modest fees collected at health centers could also be retained and reinvested locally to improve the quality and reliability of basic services.

But even with these efforts, many governments in low-income countries will have to increase the share of the budget allocated to health. (In Sub-Saharan Africa health spending declined during the 1980s to an average of less than 4 percent of public expenditure and less than 2 percent of
Box 7.1  Community financing of health centers: the Bamako Initiative

The principal aim of the Bamako Initiative, launched in 1988, is to “revitalize the public sector health care delivery system [by] strengthening district management [and] capturing some of the resources the people themselves are spending on health” (UNICEF 1992).

Both revolving funds for drug purchases and community-managed health centers have existed for many years in developing countries, but the Bamako Initiative is attempting to implement these schemes on a much larger scale in Africa and other low-income countries. The initiative is based on two premises: that where public institutions are weak, as they are in many low-income countries, bottom-up action by communities is badly needed to complement top-down health policy reforms, and that even poor households are willing to pay for higher-quality and more reliable health services.

Under the initiative, members of local communities who use a health center or pharmacy agree to pay modest charges for outpatient care, including drugs. The revenues generated from fees are retained by the health centers and managed by local elected committees. The committees reinvest in additional drugs (through a revolving fund), in incentive payments for health workers, and in other improvements. The government and donors assist health centers in purchasing inexpensive generic drugs, thus increasing the cost-effectiveness of services at the health center.

The initiative is only five years old, but its achievements are impressive. Eighteen African countries were participating as of late 1991, and nearly 1,800 health centers located in 221 districts were part of the program. In Benin the first forty-four health centers targeted by the initiative are covering 42 to 46 percent of their operating costs with user charges, and in the first seventeen centers in Guinea’s program, user fees cover 38 to 49 percent of expenditures. Utilization of health centers has increased. In Benin average monthly visits to pilot health centers rose from 100 in 1987 to 250 in 1989.

Despite the initiative’s promising accomplishments, it is not yet certain that the reforms can be sustained on a large scale. A number of health centers covered by the initiative have received both financial and technical assistance from UNICEF, WHO, and other donors—more than $36 million has come from UNICEF alone. Problems may emerge when this external assistance ends, particularly in converting local revenues generated through user charges into the foreign exchange needed to purchase imported drugs. In addition, efforts to encourage local private financing of health care by poor urban and rural households may allow governments to avoid tackling basic reforms of their health systems, especially the reallocation of public revenues from tertiary care hospitals to more basic services.

Reduction of waste and inefficiency. There is substantial scope for reduction of waste and inefficiency in government health programs, especially in drug management. Pharmaceuticals, which account for 10 to 30 percent of public spending for health in most countries, are the most promising area for efficiency gains in the short run. Very large savings can be achieved by improving the selection and quantification of drug requirements, in part through the use of essential national drug lists, and by purchasing drugs competitively. Numerous successes have already been recorded. Bulk procurement of drugs enabled a group of church-run African health associations to save 40 percent of their annual drug bill. Similar efforts by several Caribbean states led to an average reduction of 44 percent in the price paid for the twenty-five most frequently used drugs. An essential-drugs revolving fund for several Central American nations yielded savings of 65 percent of the costs of pharmaceuticals.

Community control and financing. Community financing, in the form of user charges and prepaid insurance schemes, has become a practical necessity in a number of low-income countries. But community financing is also a virtuous necessity: it can help to improve the quality and reliability of services, in part by making health workers more accountable to their clienteles.

This is the approach being taken in the Bamako Initiative, sponsored by WHO and UNICEF (Box 7.1). Recent experience from a number of African
countries shows that rural households are prepared to pay modest charges for drugs in government health centers, provided that the quality of services improves, that fees are retained and utilized at the point of service, and that the local population has a strong voice in the operation of the facility. In Guinea, for example, about half of the country's 350 health centers were practicing community financing in 1991. Of these, all the urban-based facilities and a third of the rural clinics were able to cover their operating expenses with income from fees. Governments should act cautiously, however. Experience suggests that fees substantial enough to cover the full cost of clinical services can discourage utilization by the poor. Under these circumstances, the poor should be charged reduced fees or should be exempted from payment.

Problems and Prospects. Health policy reforms face formidable obstacles in low-income developing countries. The health ministry often makes only a weak case for a larger share of the (sometimes shrinking) budget. Politicians, doctors, and the urban population exert strong pressures for higher spending on tertiary care facilities in the major metropolitan areas at the expense of the district health infrastructure. Professional associations and trade unions representing doctors and nurses strongly resist both staff cuts designed to increase nonsalary spending and efforts to redeploy health workers to rural areas. Despite these obstacles, some low-income countries are currently carrying out major health policy reforms. Malawi, for example, is implementing sweeping changes as part of a World Bank project. It is increasing the share of the government budget allocated to health from 7.1 percent in 1991 to 9.1 percent by 1995, raising the fraction of health spending for district health services from 15 to 23 percent, and reducing the share devoted to the country's three central hospitals from 35 to 25 percent. To strengthen the district health system, the government is also engaging more than 3,500 new lower-level health workers to serve in rural clinics and communities. Donor funds are being used to help pay for these workers.

Middle-income countries

In middle-income developing countries out-of-pocket payments for health usually account for less than a third of total spending. Some middle-income countries, such as South Africa and Zimbabwe, have private insurance, even though most of the population receives services financed through general tax revenues. Other countries use social insurance, with part of the population covered by mandatory employment-based contributions, usually pooled in a single fund run by a parastatal agency. The share of the population protected by social insurance varies widely, from less than 10 percent in the Dominican Republic, Ecuador, and El Salvador to more than 80 percent in Brazil, Costa Rica, and Cuba. Brazil and Chile employ hybrids of private and public insurance. In Brazil every citizen is legally entitled to services financed from a combination of general revenues and social security contributions, and social insurance is deducted from the wages of every salaried worker. Yet more than one-fifth of the country's population currently opts for some form of private insurance coverage.

Middle-income countries need to focus on at least four key areas of policy reform: phasing out public subsidies to better-off groups; extending insurance coverage more widely; giving consumers a choice of insurer; and encouraging payment methods that control costs.

Reduction of Subsidies to Better-off Groups. Governments should reduce and eventually eliminate public subsidies to relatively affluent groups. This can be done by charging full-cost fees to insured persons who use government hospitals and clinics for services not included in the national essential clinical package and by cutting tax deductions for insurance contributions. In South Africa and Zimbabwe privately insured individuals have been charged less than the full cost of the services they receive in government health facilities. In addition, they have been allowed to deduct from taxable income part or all of their out-of-pocket payments for health care, as well as their health insurance premiums. Employers can also deduct their insurance contributions. These measures reduce the amounts available for financing essential services. In South Africa individual tax deductions were estimated to be equivalent to 18 percent of total public sector health expenditures in 1990. In a recent effort to reverse a similar situation, Zimbabwe has sharply limited tax deductions for health care and insurance, raised fees, and intensified efforts to collect fees from privately insured patients. Government hospitals have learned that they can often identify insured patients by offering them extra nonmedical amenities, such as private hospital rooms, and can then target them for aggressive cost recovery if they accept.
In countries where social insurance covers only a fraction of the population, governments can increase the extent to which health services are self-financing by eliminating public subsidies to social insurance. These subsidies, which are widespread in Latin America, mostly benefit the middle classes and are therefore regressive. Elimination of the subsidies would free resources for health services for the poor. Eliminating subsidies also imposes more financial discipline on the social insurance agencies, which are often allowed to run deficits that are later covered by transfers from other social security programs or from the general government budget. In Venezuela, for example, the government subsidizes contributions to the medical assistance fund within the parastatal social security agency. Despite this subsidy, in 1990 the fund ran a deficit equivalent to 37 percent of its health expenditures.

**Extension of Insurance.** Where the bulk of the labor force is already employed, government policies that extend insurance coverage to the rest of the population—including the self-employed, the elderly, and the poor—remove the inequities inherent in multitiered systems of health financing and expand the content of the universally available package of care. When insurance coverage becomes universal, as in Costa Rica and Korea, subsidies actually end up targeting the poor and are thus progressive. But only a few middle-income countries that have adequate financial resources, political resolve, and administrative capacity will be able to achieve such universal insurance coverage. Korea’s bold initiative to create a national health insurance system from scratch between 1978 and 1989 and Costa Rica’s efforts in the 1980s to universalize a system that had previously covered only the industrial labor force show that this is a difficult but achievable goal. Attaining universal coverage would be more feasible if governments limited the essential package of insured services to those with high cost-effectiveness.

**Consumer Choice.** Competition among suppliers of a clearly specified prepaid package of health services would improve quality and encourage efficiency. And even where there is little or no direct competition among insurance funds, as in Japan and Korea, multiple semi-independent insurance institutions may still have advantages over a single large parastatal agency. Local insurance funds managed by boards composed of representatives of workers, employers, and local government, as in Germany, tend to be more accountable to their members. In a number of Latin American countries monolithic social security “institutes” are already heavily discredited because of their past inefficiencies and corruption. Greater competition and accountability are two of the main objectives of current proposals for reforming social insurance in Argentina.

**Cost Containment.** Copayment by insured individuals for some services can help to restrain their use of the services but is unlikely to be a very powerful cost-containment method. Copayments amounting to an average 40 percent of expenditures in Korea have done little to slow the rate of increase in health spending, which grew from 3.7 to 6.6 percent of GNP during the 1980s. Similarly, the practice, introduced by private U.S. insurers, of retrospective reviews of utilization of medical care appears to lead to a modest one-time savings in health spending but does not have long-lasting effects on the rate of growth of expenditures.

By contrast, prepayment of health care providers is a promising approach to containing health expenditures. Governments could help to promote such schemes by removing legal barriers that in many countries prevent the same institution from acting as both insurer and provider. In South Africa the government recently decided to allow the creation of health maintenance organizations (HMOs), mainly as a way of containing health costs. More than twenty such organizations have been established in just a few years. They have introduced capitation and negotiated fees, which limit costs more effectively than did the open-ended fee-for-service payment arrangements historically used in South Africa.

Governments can do much to improve the incentives created by social insurance. Where the insured use private providers, fee-for-service payment schemes need to be replaced with an alternative—capitation or annually negotiated uniform fees for doctors and hospitals (based on diagnostic-related groups of procedures, for example) or preset overall budgets for hospitals. Where social insurance covers services by government hospitals, competition with the private sector can improve performance. Other promising approaches are to allow government hospitals to compete with one another as semiautonomous enterprises, as in the United Kingdom in recent years, and to give hospital managers financial and career incentives to meet performance targets, as in Chile.

The example of Chile (Box 7.2) illustrates the
benefits and perils of health sector reform in a middle-income country. Chile has been able to improve efficiency, quality of care, and consumer choice, but the reforms have also created new problems regarding administration, financing, and equity.

**Formerly socialist countries**

Historically, the government was responsible for both the finance and the delivery of health care in the formerly socialist countries of Eastern Europe and the Soviet Union. Health expenditures were financed from general revenues. In principle, they were provided free of cost to the population at government clinics and hospitals and at facilities run by state enterprises, but in practice, “informal” payments oiled the wheels of bureaucracy. Today the health systems in these countries are in severe crisis. Many doctors and pharmacists are leaving the government health services to practice

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**Box 7.2  Health sector reforms in Chile**

Over the past fifteen years Chile has undertaken dramatic reforms of its health sector. Its experience shows that reform is a permanent process, not a one-time effort, and that countries undertaking reform must have both the capacity and the political will to review and revise health policies continuously.

Starting in the late 1970s, Chile (then under a military government) decentralized the government-run health system and created private health insurance institutions. Responsibility for operating primary care services was devolved to the country’s 325 municipalities. The Ministry of Health transferred its primary care budget and about half of its personnel to the municipalities, which could also draw for financing on local tax revenues and on resources from the central government’s Municipal Common Fund. More important, the government encouraged the establishment of privately owned and operated health insurance funds, known as ISAPREs. The roughly 70 percent of the population covered by social security schemes had the option of using their payroll deduction to buy a prepaid private health plan. The competing plans were regulated by a new oversight unit (superintendencia) in the Ministry of Health. By 1990 about 2.5 million people, or 18 percent of the population, were covered by thirty-five ISAPREs.

Both decentralization and the creation of the private insurers brought about some improvements in the health system. The municipalities expanded primary care services. The ISAPREs introduced more competition and consumer choice into the financing and delivery of services and spurred growth in the numbers of private doctors and hospitals.

But the reforms also created new problems. In the early years of the reforms, when local officials were appointed by the military regime, municipal health services were not responsive to the local population. Transfers of Ministry of Health staff to the municipalities created job insecurity and caused a decline in staff morale. Many municipalities lacked the capacity to plan and manage primary health services. The municipalities tended to overrefer patients to hospitals, which were still funded by the ministry. The ministry had few incentives to help supervise municipal facilities.

Because municipalities were reimbursed for each unit of service delivered, they tended to provide too much high-cost curative care and too few preventive services, which caused costs to explode. The government then moved to cap allocations to local authorities, using as a basis historical budget shares that favored the wealthier municipalities.

The ISAPREs, by targeting the richest segments of Chilean society, impoverished the rest of the social insurance system. Each salaried beneficiary who chose to shift to an ISAPRE cost the public system 2.5 times the contribution of an average salaried worker. Because the ISAPREs are permitted to rate individual health risks, they have “skimmed” the population for good risks, leaving the public sector to care for the sick and the elderly.

The democratically elected government that came to power in 1989 has chosen to maintain the broad thrust of the health reforms while seeking ways to overcome their adverse effects. Municipal elections have been held to ensure that popularly chosen and accountable officials look after primary health services. Training programs have been organized for municipal health officers. Responsibility for hospitals is being decentralized to twenty-seven health service areas that will enter into management contracts with the Ministry of Health. Finally, under a new proposal, central funds would be allocated to the municipalities on a capitation basis, with a further adjustment to favor the poorest localities.

The government is also beginning to look at ways to reduce inequities in the ISAPRE health financing system. The superintendencia that regulates ISAPRE is being strengthened. It is considering requiring the private plans to use community risk-rating and to accept all applicants able to pay the community-rated premiums; making it mandatory for all ISAPREs to offer a similar basic medical plan in order to promote direct competition among suppliers (as in the managed care systems being developed in the United States); and eliminating the deduction for employer contributions.
fee-for-service medicine in the private sector. Since real government spending for health has fallen dramatically during the recent transition toward a market economy, the government health system is also experiencing serious shortages of drugs and equipment.

Largely because they know all too well the problems of repressive central government control, policymakers, medical professionals, and consumers in the formerly socialist countries are looking to systems of public and private insurance in industrial countries as possible models for reform. Some countries—for example, the Czech Republic, Hungary, and Poland—have much in common with upper-middle-income countries such as Argentina, Costa Rica, and Korea. They may be also able to adapt some features of the systems of the Nordic countries and the United Kingdom, which are financed from general revenues, or of the universal social insurance approaches of Germany and Japan. Others in this group—including the relatively poor Central Asian republics—face many of the same issues currently confronting lower-middle-income and even low-income countries, such as Pakistan and Yemen.

Despite this diversity, the governments of all the formerly socialist countries need to consider health sector reforms in at least three main areas: improving the efficiency of government health facilities and services, partly by reducing the size of the public system; finding new ways to finance health care; and encouraging private supply of health services while strengthening public regulatory capacity.

Efficiency of government services. Decentralization of government health services is potentially the most important force for improving efficiency and responding to local health conditions and demands. It will be successful only when local government health agencies and hospitals have a sound financial base, solid administrative capacity, and incentives for improving efficiency—and when they are accountable to patients and local citizens. Extreme and hasty decentralization can create inefficiencies. In Poland, for example, the government has decentralized health care to the level of the country’s forty-nine provinces. The average provincial population of less than a million is proving too small to make efficient use of the tertiary care hospitals being built in each province, and the available medical personnel are being spread too thin. For these reasons, the government is now experimenting with health regions covering two to four provinces, but the provinces are reluctant to finance such regions. Moreover, there are political pressures for further decentralization to the level of the district governments, where there is now very little capacity for managing health systems.

At the same time that they decentralize, governments will have to reduce the size of publicly owned health services, which have far too many hospitals, hospital beds, and physicians. In this way, governments can free resources for vital public health services, including immunization, workplace and food safety, environmental regulation, measures such as education and higher taxes to discourage consumption of alcohol and tobacco, and quality control of privately delivered clinical care. The clinical and managerial skills of the remaining government health personnel need to be substantially upgraded and reoriented from the previous system of centralized bureaucratic control toward the emerging system of semi-autonomous health facilities.

New modes of financing. The examples of other countries could help the formerly socialist countries establish insurance systems that preserve the main virtue of their old system—widespread coverage of the population. It could also help them to recognize the circumstances under which general government revenues can play a positive role, as the dominant source of funding (the pattern in the United Kingdom) or as a complement to insurance (as in Japan). Experience elsewhere offers important lessons on how to create financing systems that are sustainable and that contain costs by, for example, discouraging fee-for-service compensation. The formerly socialist countries will also want to avoid the large and inequitable government subsidies commonly provided to private insurance for the wealthy or to social insurance for the middle class.

Most formerly socialist countries are already on the road to reform. The Czech and Slovak republics and Hungary are experimenting with forms of social insurance. Because the Czech system included a very comprehensive package of health benefits and paid private doctors on a fee-for-service basis, it encountered serious financial difficulties after just a few months of operation. Under the recently revised Hungarian health-financing system, public sector doctors will be salaried employees of the central and local governments, and private general practitioners will be paid on a capitation basis. Russia and Ukraine are also prepar-
Before the political upheavals of 1990–91 that led to the breakup of the Soviet Union, the 3 to 4 percent of GNP that the Russian republic spent on health care for its nearly 150 million inhabitants was financed from general government revenues and delivered through a vast network of public facilities, programs, and employees. This highly centralized and bureaucratic system led to excessive numbers of doctors and hospitals. It gave few incentives for efficiency or for providing quality care, and it neglected the preventive measures needed to combat the country’s most serious environmental and behavioral problems: industrial pollution, alcohol and tobacco dependency, and poor nutrition. Consequently, the health status of Russians stagnated during the 1970s and 1980s. In 1990 life expectancy for Russian men was just sixty-four years, a full ten years less than in Western Europe, and the infant mortality rate, at twenty-two per 1,000 live births, was twice the Western European average.

The new Russian government has pursued several fundamental reforms of the old Soviet health system. Health financing and management are being decentralized to eighty-eight regions. Much medical practice is being privatized, and a recent health insurance law provides for the introduction and regulation of new forms of insurance. Under the law and its proposed amendments, each region is to have a social insurance fund, and a national fund will equalize resources across regions. These insurance funds will receive a combination of compulsory payroll deductions and budget transfers from general government revenues. They will sign contracts for care with public and private providers. Individuals can then voluntarily purchase supplementary private insurance to cover additional health services.

The health insurance legislation has been in effect since late 1991, but progress in implementing it has been slow. Some important issues in the design of the system still need to be resolved. These include the role and extent of competition among public and private insurers; whether risks are to be rated on an individual basis or across larger pools of individuals; and how the insurance funds will pay providers—on a fee-for-service basis, through capitation, or by some other method or combination of methods.

The practical obstacles to the implementation of the new system are formidable, partly because of the unsettled administrative and economic environment. The regional governments lack the capacity to manage and regulate the health system they are inheriting. The economy and the government budget are under severe strain. Real wages have fallen dramatically in the past few years. The costs of drugs and equipment have increased faster than inflation, leading to serious shortages. Payroll taxes to cover employee benefits already absorb 38 percent of wages, making it difficult to finance an affordable package of health services through the social insurance system. To help overcome these problems, a number of international agencies, including the World Bank, are working closely with Russian health officials on designing and carrying out health policy reforms.

**Box 7.3 Reform of the Russian health system**

Before the political upheavals of 1990–91 that led to the breakup of the Soviet Union, the 3 to 4 percent of GNP that the Russian republic spent on health care for its nearly 150 million inhabitants was financed from general government revenues and delivered through a vast network of public facilities, programs, and employees. This highly centralized and bureaucratic system led to excessive numbers of doctors and hospitals. It gave few incentives for efficiency or for providing quality care, and it neglected the preventive measures needed to combat the country's most serious environmental and behavioral problems: industrial pollution, alcohol and tobacco dependency, and poor nutrition. Consequently, the health status of Russians stagnated during the 1970s and 1980s. In 1990 life expectancy for Russian men was just sixty-four years, a full ten years less than in Western Europe, and the infant mortality rate, at twenty-two per 1,000 live births, was twice the Western European average.

The new Russian government has pursued several fundamental reforms of the old Soviet health system. Health financing and management are being decentralized to eighty-eight regions. Much medical practice is being privatized, and a recent health insurance law provides for the introduction and regulation of new forms of insurance. Under the law and its proposed amendments, each region is to have a social insurance fund, and a national fund will equalize resources across regions. These insurance funds will receive a combination of compulsory payroll deductions and budget transfers from general government revenues.

**Competitive provision and public regulation.** Although private medical practice is now permitted in most of the formerly socialist countries, the legal and regulatory environment for private doctors, hospitals, and insurance institutions is often either nonexistent or hostile. With large numbers of private doctors establishing practices and private hospitals and clinics being created, regulation of providers will be critical for reducing the incidence of medical malpractice and financial fraud. It is also essential that regulation encourage the development of efficient institutions, such as health maintenance organizations, for financing and providing clinical care for the bulk of the population. Already there are signs of poorly conceived regulations, such as Romania's recent decision to issue lifetime licenses to doctors without establishing strict standards of practice or recertification requirements. Since government regulatory capacity is likely to be weak in the next few years, health system reforms should be designed in ways that minimize the need for direct government regulation. Encouraging self-regulation through associations of private medical schools, doctors, and hospitals would be one such approach. In the long run, better regulation will require both training of government inspectors and other regulatory personnel and development of government institutions such as medical licensing boards and national and local medical ethics committees.

**Directions and prospects for reform**

The world's diversity of health care systems is matched by the diversity of reform movements.
But several common themes are beginning to emerge. First, governments are increasingly recognizing the centrality of their own role in public health—for example, in achieving the enormous global gains in immunization coverage. Second, governments are exploring ways to introduce more competition and foster a diversity of public and private institutions in the delivery of clinical services. Third, governments are examining new approaches to finance and insurance, including selective user fees in the public sector, systems that discourage third-party reimbursement, systems that mix finance from compulsory social insurance and from general tax revenues, and systems that set fixed budgets for each patient or each case.

Everywhere, health sector reform is a continuous and complex struggle. Neither governments nor free markets can by themselves allocate resources for health efficiently. As policymakers try to reach compromises, they must deal with powerful interest groups (private doctors, drug companies, medical equipment manufacturers, and insurers) and strong political constituencies, including urban dwellers and industrial workers.

Strategies for overcoming these obstacles to health sector reform will vary from country to country, but some common approaches are discernible. Political leadership, beginning with the head of state, is an indispensable element in reform programs almost everywhere. The 1990 World Summit for Children proved an effective means for engaging the attention and commitment of heads of state (see Box 2 in the Overview). Senior officials of ministries of health can be strongly influenced by the prevailing views of the international health community, particularly those of WHO and other major donors, and by participation in international meetings and seminars on health policy and management.

Professional associations may be able to bring about some reorientation of health workers, especially physicians. Appeals to the sense of social responsibility of these associations have helped advance agendas for preventive health in the United States and elsewhere. Such groups, however, are often the sources of the strongest resistance to change. Reshaping the training curricula of medical and nursing schools to include a greater emphasis on public health and general practice is likely to be a more effective way to enlist the support of physicians and nurses.

Public opinion can be a powerful force for health reform, not only in industrial countries but also in developing countries such as Brazil, Chile, Nigeria, and South Africa and in Eastern Europe. A free press is important, as are consumer advocacy groups, for conveying a diversity of views on health reform and for stimulating debate.

In many countries, maintaining the support of the middle class and of urban groups for health policy reforms—including the reallocation of public spending from tertiary care to basic public health and clinical care for the poor—will require a gradual shift in resources rather than wholesale changes in just one or two years. For this reason, universal government financing (or government-mandated financing) for a nationally defined essential package of services will often be more successful than a highly targeted approach that may undermine the political base for reform. Similarly, continued government ownership of some hospitals that offer high-quality tertiary care, with a phased reduction in public subsidies to the wealthy for this care, may be more feasible politically than rapid divestiture to the private sector. External financial assistance can help countries handle these politically difficult tradeoffs and can ease the process of policy change.

International assistance for health

After growing rapidly in the 1970s, aid for health stagnated during the 1980s. As a share of official development assistance, aid for health declined from an average of 7 percent for the period 1981-85 to 6 percent during 1986-90. Total aid flows to the health sector in 1990 were $4.8 billion—almost $4 billion in official development assistance and $0.8 billion from NGOs and foundations (Figure 7.1). This amounts to about one dollar per person in developing countries. (The figure for official development assistance is based on reports from donor governments. Only $3.3 billion of the $4 billion can be accounted for as receipts by individual countries; this is the amount that appears in the total health expenditure estimated in Chapter 3 and in Appendix table A.9.) Bilateral agencies accounted for the largest share (40 percent), followed by United Nations agencies (33 percent), NGOs (17 percent), development banks (8 percent), and foundations (2 percent).

The trend is for donors to provide aid for health through multilateral channels. The share of multilateral assistance has grown from 25 percent in 1980 to 40 percent in 1990 and is likely to exceed 50 percent by 1995. As a result of the quadrupling of World Bank lending for health over the past six years, disbursements of Bank funds are expected
External assistance to developing countries for health comes from many sources, public and private.

Figure 7.1 Disbursements of external assistance for the health sector, 1990
(millions of dollars)

<table>
<thead>
<tr>
<th>Source</th>
<th>Disbursements (millions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public agencies</td>
<td>3,925</td>
</tr>
<tr>
<td>Private agencies</td>
<td>869</td>
</tr>
<tr>
<td>Development banks</td>
<td>382</td>
</tr>
<tr>
<td>United Nations agencies</td>
<td>1,601</td>
</tr>
<tr>
<td>Nongovernmental organizations</td>
<td>830</td>
</tr>
<tr>
<td>Foundations</td>
<td>68</td>
</tr>
<tr>
<td>Donor countries</td>
<td>4,794</td>
</tr>
<tr>
<td>Developing countries</td>
<td>4,794</td>
</tr>
</tbody>
</table>

a. Includes $84 million in nonconcessional loans.
Source: Michaud and Murray, background paper.

To grow from about $350 million in 1992 to about $1 billion in 1995, making the World Bank the largest single source of external funding for health. Since the portion of aid going to middle-income countries from the World Bank and other development banks is nonconcessional lending, some of the projected increase in lending for health will involve a hardening of terms. It would be desirable for bilateral grant-funding agencies and concessional arms of the development banks (such as the World Bank’s International Development Association) to increase their assistance to health as well.

The amount of health aid has stagnated, and its share in total development assistance has declined, even as donors continue to express concern about health. Over the past ten years the United Nations and other international agencies have called for increased investments in the development of human resources, including health, both by developing countries themselves and by the donor community. The United Nations Development Programme (UNDP), in its annual Human Development Report, has argued for more donor spending on health, and in its recent World Development Reports the World Bank has made similar recommendations. World Development Report 1990 proposed a 3 percent annual increase in aid during the 1990s, to be targeted at poverty-reducing activities, including basic health care. The donor community needs to review these goals and targets in light of the actual trends in aid flows for health.

The share of aid going to health should be restored immediately to its earlier level of 7 percent of total official development assistance and should rise substantially over the next five years. Such an increase would have a significant impact on the health status of the poor, particularly if it is directed toward the transitional costs of reallocating government spending to public health measures and essential clinical care and to seriously underfunded disease control efforts such as those for tuberculosis and AIDS. A rise in donor assistance...
of $2 billion, for example, could finance a quarter of the estimated additional costs of a basic package in low-income countries and of strengthened efforts to prevent AIDS. Such an increase, which would boost from 6 to 9 percent the share of total official aid going to health, would be feasible if other donors matched the rise in World Bank disbursements for health that is expected to occur in coming years. It would also be consistent with the proposal in the UNDP’s Human Development Report 1993 (also endorsed by UNICEF) that 20 percent of aid be spent on health, education, water and sanitation, and environmental protection for the world’s poor.

There are a number of ways, in addition to the traditional annual and multiyear programming of aid by individual donors, for the international community to mobilize more financial resources for health. Coordinated sectorwide pledging at consultative group meetings and donor roundtables has been used successfully in countries such as Tanzania and Zambia. Another approach is program-specific pledging, as illustrated by the dozens of national AIDS-control donor meetings chaired by WHO in recent years. The role of debt-for-development swaps as a means of generating extra resources for both government and NGO-provided health services should be assessed in this context. Ecuador, Sudan, and Zimbabwe have already carried out swaps, and Nigeria is exploring a major swap of its debt currently held by donors in return for increased public spending for essential health services.

**Improving the effectiveness of aid for health**

It is crucial that the donor community and developing countries focus on ways to improve the effectiveness of existing and future assistance to the health sector, particularly in the low-income countries where donor assistance already accounts for a large share of health expenditure. In Africa aid makes up an average 10 percent of national health spending (Table 7.2), or 20 percent if South Africa is excluded. Aid covers more than half of all health expenditures in countries such as Burkina Faso, Chad, Guinea-Bissau, Mozambique, and Tanzania. In these countries donors finance an important share of recurrent costs, as well as investment items. In Mozambique, for example, aid accounted for more than half of recurrent spending in 1991 and for 90 percent of capital expenditures for health. Even when aid amounts to 2 percent or less of total health spending, as in the other developing regions, improvements in its use would still be an important catalyst for reform.

General lessons on improving aid effectiveness apply equally to the health sector (Box 7.4). Donors need to set their priorities carefully and allocate their resources in accordance with these priorities. The productivity of aid would increase substantially if donors were to direct more of their assistance to public health measures and essential clinical services, especially in low-income countries. They might also usefully focus on capacity building, research, and reform of health policy. Countries that show a willingness to improve access to health services for the poor and to undertake reforms of the health system should be strong candidates for aid.

The World Bank increasingly stresses policy reform in its lending for health, which has grown nearly fourfold in recent years (Box 7.5). For some donors, adjustment of priorities would mean spending less on hospitals, sophisticated medical equipment, and training for medical specialists. During 1988–90 Japan spent more than 33 percent of its bilateral assistance for health on construction of hospitals, France spent 25 percent, and Germany and Italy spent nearly 15 percent each.

Within the domain of public health and essential clinical care, several areas of intervention deserve greater attention from donors, including tuberculosis control, the EPI Plus program, micronutrient supplementation, AIDS prevention and control, and programs to reduce tobacco consumption. These problems impose a large burden of illness, in some cases because rapid growth of the threat has gone unrecognized. Their control offers large externalities or economies of scale. Often, solutions will require a global effort.

The efficiency of aid for health can be greatly enhanced through better coordination of donor projects and policies. Fragmentation of external support in the health sector is a long-standing problem in many countries and imposes a heavy

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**Table 7.2 Official development assistance for health by demographic region, 1990**

<table>
<thead>
<tr>
<th>Region</th>
<th>Health aid received (millions of dollars)</th>
<th>Health aid per capita (dollars)</th>
<th>Health aid as a percentage of health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>1,251</td>
<td>2.45</td>
<td>10.4</td>
</tr>
<tr>
<td>Other Asia and islands</td>
<td>594</td>
<td>0.87</td>
<td>1.4</td>
</tr>
<tr>
<td>Latin America and the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caribbean</td>
<td>591</td>
<td>1.33</td>
<td>1.3</td>
</tr>
<tr>
<td>Middle Eastern crescent</td>
<td>453</td>
<td>1.31</td>
<td>1.3</td>
</tr>
<tr>
<td>India</td>
<td>286</td>
<td>0.34</td>
<td>1.6</td>
</tr>
<tr>
<td>China</td>
<td>77</td>
<td>0.07</td>
<td>0.6</td>
</tr>
</tbody>
</table>

**Source:** Michaud and Murray, background paper.
Box 7.4 Health assistance and the effectiveness of aid

Recent evaluations of the effectiveness of aid, including a classic 1986 study commissioned by the world donor community, point toward the same conclusion: most aid has been successful, but a considerable share, perhaps a third or more, has been much less so, and a small percentage has failed completely or has even been harmful. These broad-brush averages hide significant regional differences: in Asia and Latin America performance has been better; in Sub-Saharan Africa it has been worse. Aid has been least effective in the poorest countries, where success is most needed.

The reasons for inferior performance lie with both donors and recipients. Poor countries and those experiencing political conflict and instability constitute a difficult environment for aid, as they have little administrative capacity or infrastructure. But these difficulties have in many cases been compounded by unfortunate policies. Aid projects have been poorly designed, both technically and because of inadequate understanding of the human, social, institutional, and political environment. When it comes to coordination, both sides have been at fault. Donors have pursued their own objectives without attempting to ensure that their aid complements that of others. And all too often, aid recipients have played one donor off against another, while ministers and ministries have focused on their own concerns rather than looking to the national good.

Aid for health has generally had a good technical record. It has fit in well with development priorities, especially in recent years, as the concentration on hospitals and high-technology curative medicine has been replaced by an emphasis on primary care. There have also been major successes—mainly highly focused initiatives such as the program for the eradication of smallpox, the drive against child mortality, and the effort to control river blindness in Africa. What is still lacking is the ability of the aid system to help set in place and sustain locally appropriate public health programs and essential clinical services.

burden on already overextended government officials. In the extreme, fragmentation can lead to conflicting policies being put into effect. Recently in one West African country, for example, three different cost recovery policies, each sponsored by a different donor agency, were being applied in separate regions of the country. The dangers of fragmentation are especially great in poor countries where different donors choose to focus their health sector activities on different provinces or districts and either lose sight of or undermine the formulation of national policies.

Much can be done to improve donor coordination, globally and regionally, but especially at the country level. Donors can agree with countries on overall national health and assistance strategies. This is especially effective when the government takes the lead in planning and in coordinating the donors, as has happened recently in Zimbabwe. Another approach is for donors to form large consortia to fund national programs, as in the case of maternal and child health and family planning in Bangladesh. (The experiences of these two countries are reviewed in Box 7.6.) At a minimum, donors should create informal local groups that meet periodically to review progress and problems in the health sector, as in Mozambique and Senegal.

The efficiency with which aid for health is spent depends critically on building local capacity to plan and manage health systems. This requires strengthening the public institutions that finance and deliver health services, both through broad civil service reform and through changes within the health sector. Donors can play an important role in these areas by supporting decentralization and other organizational reforms and by assisting the groups that formulate national health policies. Additional support is required for initiatives such as the foundation-backed International Health Policy Program and for bilateral projects to train health planners and managers, economists, and sociologists.

International programs for research and development in health

Investments in health research and development have yielded high returns in better health. For example, the programs for tropical disease research and human reproduction funded by donors and executed by WHO have produced a number of new or improved drugs and diagnostic tests and have strengthened research capacity in developing countries. Yet according to the 1990 report of the Commission on Health Research for Development, only 5 percent of global expenditures on health research are directed at the health problems unique to developing countries, and less than 10 percent of donor assistance for health is devoted to research, both biomedical and in the social sciences.
The commission identified several serious deficiencies in the international health research and development system. The expertise of the global pharmaceutical industry is not being adequately applied to the development of drugs and vaccines that could reduce the toll of early childhood diseases. Technology assessment is weak, as is the support that could reduce the toll of early childhood diseases. Most important, the commission noted, local research capacity in developing countries is woefully inadequate. A number of promising research efforts, including the Children's Vaccine Initiative and programs to deal with acute respiratory infections, tuberculosis, micronutrient deficiencies and worm infections, suffer from weak and uncertain donor funding. In general, the problems of constrained funding for research are compounded by donors' limited capacity to stay abreast of the latest research proposals and to assess the relative priorities for funding this research.

To help stabilize funding, to improve the setting of priorities, and to boost efficiency, developing countries, donors, and scientists should consider the development of a global mechanism for better coordination of international health research. A number of institutional arrangements are possible, including well-defined networks of research centers, informal consultative bodies, and large global funds that pool donor assistance. Examples of these institutional arrangements in other sectors, such as the Consultative Group for International Agricultural Research and the Global Environment Facility, may provide models for improving the coordination of international health research.

Box 7.5  World Bank support for reform of the health sector

World Bank support for the health sector has grown dramatically over the past six years. The number of new World Bank–financed health, population, and nutrition projects approved each year increased from an average of eight during fiscal 1987–89 to twenty-one during fiscal 1990–92, and the value of credits and loans committed each year rose from $317 million to $1,151 million over the same period. As of June 1992, eighty-one Bank-financed health projects were being implemented. As a share of new World Bank lending, projects for health, population, and nutrition grew from less than 1 percent in 1987 to nearly 7 percent in 1991.

Whereas most of these projects continue the Bank's traditional support for basic health services—including district health infrastructure and personnel, maternal and child health, and control of infectious diseases—World Bank lending for health is increasingly focusing on broad policy reforms in the health sector. For example, in connection with a recent Bank project, the government of Mauritania has developed a financing plan to improve the availability of basic health services for its widely dispersed population. The share of the general recurrent budget going to the Ministry of Public Health will increase from 5.5 percent in 1992 to 7.5 percent in 1996. The project is introducing community-based cost recovery in three of the country's thirteen regions as a way of improving the efficiency and quality of services. Revenues are being raised mainly through the sale of drugs, organized and managed by local health communities.

In Tunisia the government is carrying out comprehensive reforms, including granting greater management autonomy to health facilities and decentralizing resources to the regional level. Doctors, nurses, and other health personnel are being encouraged to work in better-equipped health centers and other basic facilities. And health-financing mechanisms are being revised, with updated fee schedules, new exemption procedures for the poor, and changes to the health benefits covered by existing insurance schemes. The Hospital Restructuring Project, supported by the World Bank, is assisting the improvement of management systems and the quality of health services in the largest government hospitals, which were recently granted autonomous legal status. The project dovetails with the concurrent World Bank–financed Population and Family Health Project, designed to improve the quality and efficiency of public health services and essential clinical care, especially for mothers and children. It is expected that better basic services at the health center level will reduce the demand for hospital care, thus slowing the expansion of the country's hospitals.

The Romania Health Rehabilitation Project supports government efforts to diversify sources of health financing and thus to reduce dependence on the public budget, which is under pressure because of weak and unstable macroeconomic conditions and rising health care costs. The government is pilot testing decentralization of health sector policymaking, planning, management, and evaluation in three subregions. It is also discussing how to create a legal and regulatory environment to support reform of health financing.
Meeting the challenges of health policy reform

If policymakers are to accelerate the substantial health gains of recent decades, especially for the poor in developing countries, the agenda for reform is clear. It includes increasing overall rates of economic growth and expanding basic schooling, particularly for girls; reallocating government spending for health from tertiary care and specialist training to public health measures and essential clinical services; encouraging more diversity and competition in the provision of clinical care and the development of cost-containing approaches to insurance; increasing the efficiency of government health services; and fostering greater involvement of communities and households in promoting healthier behavior on their own part and in managing their local health services.

Policymakers in developing countries and officials of the international donor community face a number of difficult challenges in pursuing this agenda. The changing demographic profile of the developing world, including the aging of the population, is creating new patterns of disease. Emerging microbial threats, such as AIDS and drug-resistant strains of tuberculosis and malaria, call for changes in personal behavior, new drugs, and new ways of delivering services effectively.

In virtually every country interest groups will resist health policy reforms of the kind suggested in this Report. Health workers will object to changes that threaten their job security, income levels, and degree of professional autonomy. Drug companies, medical equipment manufacturers, and other suppliers will try to block policies that they see as having an adverse effect on their mar-
kets, revenues, and profits. Political and economic elites and organized labor groups will seek to preserve existing public subsidies for insurance and health services from which they benefit and to maintain their privileged access to clinical care.

Beyond this, policymakers will have to wrestle with the reality that in the area of health there is no simple paradigm for policy choice. Free markets for public health activities and clinical care often fail, and when governments intervene in financing and delivery, as they frequently do, they can fail just as badly. Effective government regulation of private suppliers of health services and inputs, combined with public financing of cost-effective packages of public health and essential clinical services, is needed to deal with these failures. But this in turn requires strong private and public institutions—and institutional capacity is seriously lacking in many developing countries.

Despite these obstacles, there have been a number of successes in specific intervention programs such as polio eradication and river blindness control and a smaller but still important number of successes in broader health sector reform in such countries as Chile, Tunisia, and Zimbabwe, as well as in many OECD countries. These successes now need to be multiplied, especially in the area of sector reform, if countries are to address the acute weaknesses in existing institutional structures and to lay the foundation for major improvements in future living standards.

Developing country governments need to do more to translate into practice today’s rhetoric about reallocating resources, improving access, and increasing efficiency. To do this, higher and sustained rates of macroeconomic growth are required. In many cases countries will also need to enact fundamental political reforms designed to increase participation and to improve the accountability of governments for their health spending, service delivery, and regulatory performance.

The donor community has a major responsibility to back up with concrete actions its verbal commitment to poverty reduction and to investment in health and human resources. In particular, donors should do more to support the formulation of improved health policies and more effective health sector reform programs in developing countries. As suggested in this Report, they can do this by financing some of the transitional costs of reallocating government budgets to public health measures and essential clinical care, by building local planning, management, and research capacity, and by providing sound assessments of the worldwide experience with the cost-effectiveness of interventions and with reform of systems.

If developing country governments and donors accept the challenges and embrace the key health policy reforms outlined above, improvements in human welfare in the coming years will be enormous. A large share of the current burden of disease—perhaps as much as one-quarter—will be prevented. And people around the world, especially the more than 1 billion people now living in poverty, will live longer, healthier, and more productive lives.