

ADB's Policy for the Health Sector

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- The Asia and Pacific region is home to 690 million people living on incomes of less than \$1 per day. They account for more than two thirds of the world's poor. Most live in areas where health services are inadequate or nonexistent. Poverty leads to poor nutrition and inadequate access to health care, which cause health to deteriorate. In turn, poor health prevents the poor from being productive members of society. This is a vicious cycle of impoverishment. Health is also a key input to economic development: good health enhances the productivity of the workforce and increases the attractiveness of the economy to domestic and foreign investors.
- The **Millennium Development Goals** emphasize the many dimensions of poverty and explicitly recognize that health interventions can reduce poverty.
- ADB's **Policy for the Health Sector**, approved in 1999, aims to provide direction to ADB's operations, inform developing member countries about ADB's priorities, and assist them to identify priorities and strategies for achieving them.

Background

The first loan of the Asian Development Bank (ADB) in the **health sector** was approved in 1978. Over the period 1978–2004, ADB lent \$2.45 billion to support 66 health projects, including two private sector projects. This represents 2.7% of cumulative ADB lending. Over the same period, 144 technical assistance projects, including some funded by the **Japan Fund for Poverty Reduction**, were approved for \$71.9 million.

Additionally, 34 regional technical assistance projects, including four funded by the Japan Fund for Poverty Reduction, were financed at a total cost of \$34.8 million.

Despite progress, much needs to be accomplished in the health sector. The poor, women, and indigenous peoples are disproportionately prey to ill health. Almost half of the financial crises faced by the poor come from meeting medical expenses. Infant mortality rates, especially in **South Asia**, are higher than in any other region in the world, except Sub-Saharan Africa. Asia and the Pacific is home to three quarters of the malnourished children of the world. The poorest-income quintile suffers infant mortality rates that are almost three times higher than the wealthiest quintile, and the poor suffer graver economic consequences from

being sick. Women also face a burden of disease as witnessed by high maternal mortality ratios that have changed little in the last 25 years. In most countries, indigenous peoples suffer an infant mortality rate that is about twice that of the general population. Despite progress in making modern contraception available, there are still countries and regions where fertility constrains economic and social development. Smoking, HIV/AIDS, and use of illegal drugs are increasing too.

The policy intended to make ADB's efforts to meet such challenges more effective and efficient. Under the policy, ADB's activities are guided by five strategic considerations: (i) improve the health of vulnerable groups; (ii) focus on achieving tangible results; (iii) support testing of innovations and deployment of new technologies; (iv) encourage governments to take an appropriate and activist role; and (v) increase the efficiency of health sector investments. The policy does not cover nutrition in detail.

In 2004, in the fifth year of implementation, the Regional and Sustainable Development Department requested the Operations Evaluation Department to conduct an independent evaluation of the policy. The **Special Evaluation Study on ADB Policy for the**

Health Sector reviewed 209 ADB documents on health and non-health loan, grant, and technical assistance projects; information on health from the pre-policy and post-policy periods; and country strategies and programs.¹ It selected Bangladesh, People's Republic of China, Indonesia, Mongolia, Papua New Guinea, Philippines, and Viet Nam for in-depth review. The Operations Evaluation Department had earlier conducted a **Special Evaluation Study on Selected ADB Interventions on Nutrition and Food Fortification**.²

Summary of Findings

The study assessed the first strategic consideration as relevant, the second as highly relevant, the third as relevant, the fourth as relevant, and the fifth as highly relevant.

ADB has generally adhered to and implemented the policy's strategic thrusts and incorporated priorities into post-policy health-related operations, as shown in assessments of health, nutrition, and population operations that compared those approved 5 years before the policy was adopted and with those approved 5 years after. In general, increases were demonstrated under all five strategic thrusts. For this reason, ADB's adherence to and implementation of the policy were considered satisfactory.

The policy had a positive impact in changing the way ADB operates in the health sector. Positive trends were revealed by: (i) the large increase in the number of loans using specific health-outcome indicators; (ii) the inclusion of cost-benefit and/or economic sustainability analysis in all loans approved since 2001; (iii) the inclusion of economic rate of return calculations in most of these projects; and (iv) the attention to supporting governance through health sector reforms and institutional capacity building.

The policy did not lead to an increase in lending to the **health sector**. Many clients do not borrow **ordinary capital resources** from ADB for health and do not see that ADB has a competitive advantage there. This has implications for ADB policies, strategies, and products that cannot be addressed in a single sector policy study.

Recommendations

The study supported ADB's plan to update the policy and recommended that it be transformed into an integrated strategy for health, nutrition, and population by 2006.

- Cover health, nutrition, and population and other related social sectors;
- Identify innovative loan and grant products that will facilitate greater ADB involvement in health, nutrition, and population;
- Cover governance and corruption in the context of ADB's overall initiative of fighting corruption in each developing member country;
- Allow ADB to finance health infrastructure and equipment, particularly in a decentralized system where these are lacking;
- Place more emphasis on developing partnerships with other donors, the private sector, and civil society; and
- Analyze the staffing implications associated with different options considered so that the Board of Directors and ADB Management understand the trade-offs between strategic options and resource considerations.

Feedback

ADB Management's Response recognized that the study laid an excellent foundation for removing constraints faced in the health sector and mainstreaming health interventions in ADB. Management expressed the hope that a paper on **Enhancing Asian Development Bank Support to Middle Income Countries and Ordinary Capital Resources Borrowers** might suggest ways for ADB to meet the financing demand from the social sectors of these countries. ADB's **Innovation and Efficiency Initiative** would also pilot financing instruments and modalities to facilitate greater ADB involvement. The **Chair's Summary of the Development Effectiveness Committee Discussions** commended the high quality of the study and acknowledged Management's supportive response

¹ ADB. 2005. *Special Evaluation Study on ADB Policy for the Health Sector*. Manila. Available: <http://www.adb.org/Documents/Reports/Evaluation/sst-reg-2005-04.pdf>

² ADB. 2004. *Special Evaluation Study on Selected ADB Interventions on Nutrition and Food Fortification*. Manila. Available: <http://www.adb.org/Documents/Reports/Evaluation/sst-reg-2004-19/ses-food-nutrition.pdf>