

SECTOR SYNTHESIS OF POSTEVALUATION FINDINGS

IN THE

HEALTH AND POPULATION SECTOR

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I. INTRODUCTION

1. The Sector Synthesis of Postevaluation Findings (SSPF) in the health and population sector identifies key issues and provides a summary of the lessons learned from 12 postevaluated projects in nine developing member countries (DMCs), based on an analysis of the major factors affecting the implementation and operational experience of these Bank-financed projects. These projects were appraised during a nine-year period from 1978 to 1986. It aims to disseminate the lessons suggested by the experience of these completed projects in order to improve the design, implementation and operation of future development projects and programs. The SSPF is based on a review of the findings of postevaluation reports prepared by the Post-Evaluation Office (PEO), namely: Project Performance Audit Reports (PPARs), Impact Evaluation Studies, and Technical Assistance Performance Audit Reports (TPARs). It also takes into account the information and data stored in the Postevaluation Information System, including the Abstracts of Postevaluation Findings.

II. BANK OPERATIONS IN THE SECTOR

A. Overview

2. The Bank first became involved in the health and population sector in 1978, more than ten years after its initial operations in December 1966. Two loans from the ordinary capital resources (OCR) amounting to \$38.5 million were approved for the Sha Tin Hospital-Polyclinic in Hong Kong¹ and the Kent Ridge Hospital-Polyclinic in Singapore.² Initially, loan approvals for health projects averaged about two per year. During the 1990s however, the number of Bank-assisted health and population sector projects increased. More than half (53 percent) of all loans were approved after 1990, and \$418.1 million (about 39 percent) have been approved only within the last five years. Nonetheless, the health and population sector remains one of the least assisted sectors in the Bank, representing only about 1.75 percent of total loans approved as of 31 June 1997.

3. At present, 35 loans amounting to \$1,079.95 million have been approved for 34 health and population projects (Appendix 1). Twelve loans amounting to \$535.73 million were funded from the OCR, and 23 loans amounting to \$544.22 million were from the special fund resources. About 41 percent of the total lending went to Group B countries, with Indonesia having the highest share at 23.5 percent. Group A countries accounted for 38 percent, while Group C countries received some 20 percent of the funding. Next to Indonesia, Malaysia and Pakistan received the largest shares of Bank assistance at 16.8 percent and 13.6 percent, respectively. The main objectives of Bank's health and population projects are: (i) improving the health conditions in DMCs, particularly in the rural areas, and (ii) helping DMC Governments in attaining the rates of population growth and fertility most appropriate to their specific circumstances. Major areas of assistance in the health sector have included: (i) the expansion and/or improvement of the infrastructure for service delivery (i.e. clinics, primary health facilities, training facilities, and hospitals); (ii) strengthening the administration and management of health services, including planning; (iii) development of health personnel mainly through training and fellowships; and (iv) strengthening various other support areas particularly in the storage and distribution of drugs and medical supplies, and repair and maintenance of equipment.

4. The Bank has also provided 77 technical assistance (TA) projects in the health and population sector comprising 39 project preparatory technical assistance (PPTAs) and 38 advisory TAs, in the total amount of \$28.054 million (Appendix 1). About 52 percent of the TAs were provided to Group A countries, 41 percent to Group B countries, and 7 percent to Group C countries. The three largest recipients of TA financing all belong to Group B countries with Indonesia having the highest share at 18 percent, and Papua New Guinea and Philippines each receiving about 12 percent of the total TA amount. Pakistan, in Group A, received 11 percent of Bank's total financing.

5. A Bank paper³ published in 1991 reviewed the sector's situation and needs in the

¹ Loan No. 354-HKG: *Sha Tin Hospital-Polyclinic Project*, for \$19.5 million, approved on 14 September 1978.

² Loan No. 386-SIN: *Kent Ridge Hospital-Polyclinic*, for \$19.0 million, approved on 20 December 1978.

³ Health, Population and Development in Asia and the Pacific, Asian Development Bank, approved on 11 April

region. The paper took into consideration lessons learned from 16 completed and ongoing projects, particularly the 12 postevaluated projects. The paper reflected major changes in the priority areas on which it proposed Bank's assistance should focus in the future. It recommended that as a general rule, available health resources, both public and private, be utilized as equitably and efficiently as possible; the bulk of public resources and initiative should be devoted to the basic health needs of low-income individuals and above all, high-risk groups such as children and women of reproductive age, who otherwise would have no access to, or could not afford, such services. To this end, it identified the following additional principles that should guide sectoral resource allocation:

- (i) There should be a balance between the use of public and nonpublic resources available to address regional health needs. As a general rule, the public sector should focus its limited resources on attending to the preventive and promotive health care needs of low-income individuals, while private health providers should assist in meeting the largely curative needs of wealthier individuals.
- (ii) Quality health delivery presumes proper management and planning, and should include: (a) development of a viable referral network; (b) gradual decentralization of financial and management authority; and (c) development of effective and responsive organizational and management practices, including management information systems.
- (iii) Human resource development must address not only the appropriateness and quality of training, but also issues of incentives, deployment and career development.
- (iv) Capital investment should be accompanied by adequate funds for recurrent items (e.g., for basic supplies and maintenance), to ensure the viability, credibility and sustainability of basic health programs.
- (v) In view of the limited public funds, some degree of cost recovery should be introduced ranging from user fees to risk-sharing schemes (targeted mainly at tertiary level health care). Simultaneously, mechanisms must be devised to guarantee the continued provision of free (or highly subsidized) care to identified indigents.

B. Postevaluation Operations

6. Of the 34 health and population projects, More than half have been completed and 12 have been postevaluated to date.¹ Except for the two hospital-polyclinic projects in Hong Kong and Singapore, all of the postevaluated projects were approved between December 1980 and December 1986, and completed between September 1984 and December 1993. Five of the postevaluated projects included distinct population and family planning (FP) components. Appendix 2 provides the list of postevaluated projects in the health and population sector as of 30 June 1997. In addition, a TPAR (TE-2) was prepared for TA No. 932-INO: Second Health and Population Project and two impact evaluation studies were conducted on the Bank's assistance in the health and population sector, i.e., (i) in Sri Lanka [IE-33], and (ii) in Bangladesh, Pakistan, Papua New Guinea and Sri Lanka [IE-44].

III. IMPLEMENTATION EXPERIENCE AND PERFORMANCE RESULTS

7. This section examines the implementation efficiency and performance results of completed Bank-financed projects and TA operations in the sector. It assesses the extent to which Bank operations achieved their objectives in terms of improving the health conditions in the various project areas, and in terms of institutional development, social and economic impact, effect on women, environmental impact, and sustainability.

A. Implementation Experience

1. Project Design

8. Bank's design of health projects can be summarized as largely comprising the following: (i) infrastructure and civil works; (ii) drugs, and health support facilities/equipment; (iii) health personnel training and other institutional development software; and (iv) technology transfer through consultancy inputs. Almost all of the postevaluated projects supported some form of civil works such as the construction or upgrading of hospitals and clinics, residential facilities for medical staff, and warehousing facilities for drugs and medical equipment. To further enhance health care operations, medical, dental, and laboratory equipment/facilities, and vehicles have also been provided.

9. Training conducted under the projects was mostly in the areas of hospital planning and design, repairs and maintenance of medical equipment, hospital management/services, and medical/paramedical health and FP services. Generally, training inputs included consulting services of international and local health and population experts.

10. An important component of implementation and operation, and a principle that was identified above, but not commonly found among the postevaluated projects, was installation of a

¹ The First and Second Rural Health Service Project in Papua New Guinea (Loan Nos. 586, 746(SF)/747-PNG) were postevaluated under one PPAR (PE-422).

health management information system (HMIS), including benefit monitoring and evaluation (BME). Among the projects, it was only under the Health and Population Project in Sri Lanka where the installation of a BME system, and the necessary personnel training for its implementation, were identified as specific components. Given the inherent difficulties of identifying and measuring the benefits arising from health projects, installation of a BME system would provide an effective tool in assessing project impact. However, even in this lone project, the BME component was subsequently canceled because the consultants could not conduct the necessary field work due to deteriorating peace and order conditions, and the Government's inability to set up the required institutional links and framework.¹

11. Notwithstanding the above, and given the health and population sector requirements of the DMCs, the design of postevaluated projects was considered appropriate in meeting their specific objectives. Seven of the 12 projects were preceded by PPTAs and feasibility studies. It is interesting to note however, that the five projects² which did not have PPTAs were also the first health and population sector projects in their respective countries. However, health sector reviews undertaken by ministries and departments of health/population and other donor agencies, notably the World Bank, were used in the preparation of Bank-financed projects. Sector analyses and social assessments with community participation and with particular focus on the proposed project areas could have resulted in greater ownership of the Project by the intended beneficiaries.

12. While the design of earlier projects tends to be more hardware oriented, recent ones have included more institutional and human resource development components to address health planning, administration, and management issues. In terms of services however, the postevaluated projects were more inclined towards providing curative than preventive health care. This arises mainly from the greater urgency and the tangible short-term benefits that can be expected from addressing the former, and the inadequate budgetary allocations to the health sector which necessitates prioritization of health concerns.

2. Physical Achievements

13. The physical infrastructure associated with the implementation of the postevaluated projects (e.g., hospitals, health clinics, residential buildings, related medical and non-medical facilities, warehouses and workshops), were generally completed as originally envisaged and in some cases exceeded the targets. Except for the Health and Population Project in Malaysia where only one of the targeted three district hospitals³ was constructed because the Bank did not agree with the Government's decision to construct the hospitals on a turnkey basis, there were no other major shortfalls in the civil works components. However, differences between the actual and expected number and type of medical and non-medical equipment, ambulance and other support

¹ The PEO's impact evaluation study on BME (IE-42) carried out in 1996 identified various issues pertaining to the Bank's current BME policy, and actions have been initiated to replace BME with a more effective and practical project performance management system (PPMS).

² Sha Tin Hospital Polyclinic in Hong Kong; Kent Ridge Hospital-Polyclinic in Singapore; Public Health Program in Bangladesh; Health and Population in Malaysia; and Health and Population in Sri Lanka.

³ Construction of the other two district hospitals was included in the follow-up project, Loan No. 980-MAL: *Third Health (Sector) Project*, for \$105 million, approved on 31 October 1989. The project has not been postevaluated.

vehicles, varied widely among the projects. Additionally, training programs and consultancy services were also subjected to subsequent revisions and/or deletions, particularly when there were changes in the Government's health policies and thrusts. Overall, the main reasons cited for the changes included: (i) procurement and implementation problems; (ii) lack of counterpart funds; (iii) security problems and natural calamities/disturbances; and (iv) changes in the health policies and priorities of the Government.

3. Project Management

14. Most of the projects were implemented through a Project Implementation Unit (PIU) which handled day-to-day administration of project activities and overall financial management. In cases where several Government agencies were involved, a Project Coordinating Committee (PCC) was also established to facilitate and coordinate overall operations. The existence of the PIU and PCC however, was not able to exact smooth implementation of the projects at all times. Common problems experienced by the executing agencies (EAs) included: (i) the lack of coordination and teamwork among implementing agencies, and between Bank supervising staff and EA/PIU staff, resulting partly from the multiplicity of implementing agencies; (ii) inadequate institutional capability and lack of qualified personnel in some of the EAs; and (iii) limited decision-making powers of the EAs, as well as of some project directors, as a result of tendency towards centralized operations.

15. On the part of the Bank, project management was more straightforward and less problematic. Generally, the frequency and composition of the review missions *were* considered adequate. However, there was a tendency by the review missions to concentrate on monitoring physical targets and the loan disbursement schedule, while failing to assess operational impact, as well as Bank and Borrower performance within the framework of institutional development and sustainability. There was a need for more frequent review missions and adequate time for field visits. It would also have been more useful if the emphasis of earlier review missions was to relate developments to the accomplishment of project objectives and to assist PIUs in resolving implementation difficulties and improving administrative processes. For example, in the Sha Tin Hospital-Polyclinic Project in Hong Kong, the Government had expected that Bank operations would enable a "technical audit" of local operations and procedures. This did not take place however, as Bank loan administration became a routine confirmation of Government proposals, partly because of the lack of sustained involvement and relatively infrequent reviews.

4. Project Costs

16. The total cost of the projects at completion was \$531.06 million, compared with the total appraisal estimate of \$599.87 million (Appendix 3). Ten projects incurred cost underruns averaging 22.8 percent, while two had cost overruns averaging 24 percent (Appendix 4). Lower actual project costs were largely due to the (i) depreciation of the local currency against the US dollar; (ii) deletion/changes in some of the project components; (iii) overestimation of project costs at Appraisal; (iv) over provision for price contingencies; and (v) changes in design due to changes in Government's policies. The cost overruns were brought about by delays in project

implementation, underestimation of project costs, addition/changes in project scope, and increase in local/international prices of project inputs.

5. Project Completion

17. The average estimated implementation period of the postevaluated projects was 4.3 years (Appendix 5). All of the projects experienced implementation delays, requiring an average of about 2.5 years (60 percent) more to complete. The delays ranged from 19 percent in the Second Rural Health Services Project in Papua New Guinea, to more than twice the estimated implementation period for the Health and Family Planning Services Project in Bangladesh. The major factors which contributed to the delays were (i) lack of counterpart funds; (ii) inexperience of the EA in implementing Bank-assisted projects; (iii) lengthy procurement procedures; (iv) implementation difficulties relating to consultant recruitment, site selection and land acquisition, shortage of construction materials; (v) technical problems; and (vi) peace and order, and adverse weather conditions. The common experience of the postevaluated projects in incurring implementation delays needs to be considered carefully in planning future health and population projects as it appears that there is a tendency to set over-optimistic implementation schedules at Appraisal. It may also be indicative of some unrealistic expectations on the capability of the EAs to implement externally-financed projects.

B. Performance Results

1. Sector Analysis

18. The improvement of health has always been a high priority in the Bank's function as a development institution. Thus, health and population sector projects were designed to address specific needs at a micro level. Performance results bring out the need to consider two major strategic conditions before project investment is undertaken: (i) overall health sector financing issues in relation to any macro policy distortions and impediments; and (ii) verifiable and monitorable indicators in order to effectively gauge the developmental impact of the intervention. Proper sector analysis should address a number of key policy issues in the allocation of public resources including: (i) the adequacy of the overall budget share and the likely sustainability of proposed public investments; (ii) the appropriateness of the functional allocation of resources; (iii) whether the composition of expenditures gives adequate priority to key components of non-capital expenditure on health; and (iv) whether the sub-national distribution of public resources achieves appropriate distribution objectives given the usual differences in local capacity, per capita income and urban/rural disparities. Sector analysis should also examine the health system structure and organization in order to effect not only institutional capacity improvements, but also structural reforms in the health services delivery system.

2. Policy Issues

19. Policy dialogue or reform considerations were not specifically included in the design of the postevaluated projects. The health policy agenda should be clearly understood on how best to deploy major policy instruments at Government's disposal for financing and staffing the health sector prior to project interventions. Issues include the following: (i) priorities for public expenditure policy, including the medium-term investment program and repositioning of resources to attain efficiency gains; (ii) appropriate pricing policies to achieve the broad objectives of revenue generation, efficiency and equity issues; (iii) promoting private sector development through appropriate improvements in the regulatory framework; and (iv) staff rationalizing, deployment and management strengthening. These should be adequately investigated before the Bank commits any resources.

20. Health and FP service delivery could be made more efficient, equitable and effective if linked to policy reform. For example, the lack of discussion on the policy environment during project preparation, and the absence of an appropriate national health policy at the time of implementing the Public Health Program in Bangladesh (i.e., community participation in malaria control cuts across geographical [including international] and sectoral boundaries), had negative repercussions on the Program's performance. On the other hand, the Program contributed to the formulation and adoption of a national drug policy and a subsequent drug (control) ordinance to ensure the availability of safe, useful and good quality drugs at reasonable prices.

3. Developments in Health and Population Planning

21. The provision of health infrastructure, facilities, and equipment in most of the postevaluated projects enhanced access, particularly in rural areas, to better health and FP services. However, increased accessibility was not sufficient to ensure high utilization rates. For example, the two new hospitals supported under the Health Services Development (Sector) Project in Malaysia had low bed occupancy rates of 29 and 16 percent only. As was characteristic of hospital facilities under other postevaluated projects which also had low utilization rates, the major factors contributing to low bed occupancy were the lack of medical specialists and other medical staff in the project-supported hospitals, poor road infrastructure linking the rural communities to larger cities, and reduced confidence in rural hospitals because of the lack of medical specialists, as well as lack of medicines and supplies due to inadequate operation and maintenance (O&M) budgets.

22. The level of health care provided through the projects was considered below international standards. Adequate supply of medicines was a problem, as well as underutilization of medical equipment related to the shortage of technical expertise and O&M funds. A major concern for health service operations across the DMCs was the chronic shortage of qualified medical practitioners and technicians. While training and fellowships have been included in the Bank's health and population projects to ensure the availability of sufficient and qualified health personnel, shortages persist due to low salaries, lack of equipment and absence of a clear path in career development. Compounding the problem is the loss of medical practitioners/staff to the well-paid

private sector. The policy of allowing public sector doctors to do private practice is causing serious chronic absenteeism in Group A countries.

23. A positive experience of some of the projects was the success in using midwives and rural female health workers in reproductive health care (e.g., disseminating information on the FP program). There was increased efficiency and coverage in the distribution of FP information and contraceptive devices. Additionally, the rural female health workers provided primary health care and maternal services to a large number of women and their children. However, rural health workers would have performed better with more effective programming and supervision of the health care services.

24. Another pervasive problem in the health projects was the low budget allocation to the sector, particularly for recurrent costs such as repairs and preventive maintenance. A large number of projects had cited the lack of O&M budgets as the reason for low equipment utilization rates. Further, there was wastage and incorrect prioritization in the utilization of the meager resources allocated to health facilities. In Group A and Group B countries, "breakdown maintenance" was still in practice. Health administrators in these countries were of the opinion that planned and preventive maintenance for medical equipment was too expensive. Given that some of the equipment was quite sophisticated, even minor breakdowns could not be attended to and repaired quickly. This was unfortunate, as properly maintained medical equipment could provide valuable medical assistance and service. For example, the blood bank refrigerator in the Jhenaidaha District Hospital that was provided under the Health and Family Planning Service Project in Bangladesh, was credited with helping save the lives of over a hundred people, largely injured in traffic accidents, within only two years of its installation.

4. Institutional Development

25. While the majority of the postevaluated projects had some form of institutional strengthening component, these were believed to have had a limited impact in improving local health services. Many countries did not have long-term perspective health plans (see Para. 31). Thus, projects that were designed to address specific needs did not fit into the longer time frame necessary to generate and sustain the momentum needed to effect change. The marginal results were attributed to: (i) subsequent cancellation/ downgrading of the training/ consultancy components during the implementation period; (ii) lack of qualified medical and paramedical trainers to sustain training operations after project completion; and (iii) loss of medical, paramedical and technical personnel to the private sector which had better compensation and career development opportunities. The design of the institutional development components was generally not based on a thorough institutional analysis of the sector. Thus, the cohesion of the training/ consultancy programs was poor, and only the broad aspects/ areas of health operations were identified. Additionally, the training programs and technology transfer from consultancy services were not sustainable as these were not fully integrated into the country's institutional development program. Given the shortage of qualified health service providers, the projects further strained the operations of the EAs and related health agencies, and contributed to the further deterioration in the quality of some services.

5. Socioeconomic Impact

26. Improving the accessibility of health and FP services among the rural population was one of the major objectives of the projects that had been accomplished relatively well. Health centers and hospitals in underserved rural areas that were improved/ constructed generally helped boost outpatient consultations and admissions. Housing and teaching facilities for medical professionals/staff also generally helped in retaining more competent and qualified medical personnel. There was a general reduction in the maternal and infant mortality rates in the project areas, as well as a decline in fertility rates. However, these developments could not be attributed solely to the Bank-assisted projects. Except for the Health and Population Project in Sri Lanka, no other postevaluated project included BME systems that would have enabled accurate measurements of the benefits. The evaluation of the health impacts was often based on local and national health statistics that did not segregate specific project results.

27. Because of the difficulty in ascertaining with relative accuracy the incremental benefits arising from these projects, there were no economic evaluations done at postevaluation, except for some components in the Public Health Program in Bangladesh. Until recently, quantitative analysis was not required for health sector projects. Even with the presence of health sector guidelines however, these have been rarely used. In July 1996, a Strategic Planning Workshop on Health Sector Policy Priorities was conducted in the Bank, and a Health Policy Working Group was subsequently formed to identify areas where health sector operations could be improved. One area would be the preparation of Bank guidelines for the economic analysis of health sector projects, where work is ongoing.

6. Environmental Impact

28. The environmental impacts of postevaluated health projects have been found to be quite positive. In general it was considered that projects would contribute to reduce pressure on the environment through promotion of improved health, increased productivity, better quality of life or population planning. More recent projects, however, have been concerned with case specific technical issues such as management of hospital waste, disposal of medical wastes, control of infection, and health sector associated civil works. For example, in the Health Services Development (Sector) Project in Malaysia, one of the requirements which was specifically stated in the Loan Agreement was the Ministry of Health's responsibility in ensuring that requisite arrangements be made for the disposal of medical waste, including water supply and sanitation, collection and storage of solid waste materials and sewerage treatment. It was believed that through such measures, health authorities could be made more aware of the need to properly dispose of hazardous waste materials. Despite such efforts, however, the effective and safe disposal of medical waste remains one of the more pressing problems in the health sector, particularly for poorer countries with limited health budgets.

7. Impact on Women

29. While health services benefit both genders, the emphasis on family health care, including mother and child and reproductive health care, helps ensure a positive impact on women's health. FP methods that contribute to better child spacing have a beneficial effect on women, not only in terms of health aspects, but also in terms of enabling them to engage in other personal and career development and economic activities. The participation of midwives and rural female health workers highlights the advantages of employing the services of women in FP activities, often considered a delicate issue in DMCs.

8. Sustainability

30. The sustainability of benefits from the health and population projects was found to be largely dependent on the following: (i) continuous demand for the use of facilities; (ii) commitment of the government through its health policies and programs; (iii) sufficient financial resources for O&M; (iv) presence of adequate trained personnel; and (v) institutional capacity of concerned agencies to run the facilities. Given the low budgetary support and shortage of qualified health personnel in many of the DMCs, the long-term sustainability of the benefits generated from the postevaluated projects could not be assured.

31. While the commitment and support of every Government to the health sector is not an issue, the reality of increasing medical and health care costs vis-a-vis limited budgetary allocations highlights the need for an appropriate health financing plan. For long-term sustainability, health care institutions would need to become more self-reliant and less dependent on scarce Government allocations. In order to address the shortage of resources to meet recurrent costs, some projects have espoused more use of cost recovery measures to ensure sustainability. However, user charges account for a very small proportion of total revenues and have been found in fact to be counter-productive to the overall goal of improving health status (see para. 38). Nonetheless, if cost recovery measures are found to be imperative, these should be introduced gradually. Pilot studies and information, education and communication (IEC) campaigns would be helpful. Health personnel would also need to be improved through better education systems, requiring pre-service and in-service training, and better incentives and career prospects for public health professionals and staff. On the other hand, service accountability of health personnel needs also to be emphasized. Some alternatives that have been suggested to help alleviate the health resource shortage and health cost burden of the Government include: (i) mobilization of non-governmental organizations (NGOs) in health service delivery; (ii) use of health care volunteers; (iii) privatization of some health operations especially for curative health care; and (iv) use of health insurance, cooperatives, and other health financing options.

9. Overall Performance of the Postevaluated Projects

32. The Bank's overall experience in the health sector has not been favorable. Eight (about 67 percent) of the twelve postevaluated projects were rated partly successful, while the rest were rated generally successful (Appendix 6). Of the four generally successful projects, three were from Group C countries and only one was from a Group A country (i.e., Sri Lanka). As the improvement of health conditions is largely a long-term endeavor, sustainability issues became a

critical factor in the assessment of the overall performance of the projects. Many of the postevaluated projects suffered from operational, staffing, and funding deficiencies that placed benefits at risk over the long-term. Thus, in DMCs where adequate health budgets and sufficient medical personnel could not be assured, health projects have been rated as partly successful. Additionally, the cancellation of some software project components, in particular training and consultancy services, had made the hardware components less than effective in achieving targeted health and FP results.

IV. CONCLUSIONS, KEY ISSUES AND LESSONS LEARNED

33. This section summarizes the main conclusions and the critical sectoral issues and major lessons learned from postevaluation experience. A list of major postevaluation findings that need to be addressed during the preparation and design of future projects in the sector is given in Appendix 7.

A. Conclusions

34. While health statistics from the DMCs have indicated positive improvements in the health conditions of their constituents, it is difficult to ascertain the extent of Bank's overall contribution to these developments. By their nature, social projects such as those in the health and population sector are difficult to evaluate particularly in the absence of specific performance and developmental impact indicators. Since none of the postevaluated projects employed BME systems, there was no data base for measuring incremental benefits. There is no doubt however, that the Bank-assisted projects helped improve access to health services. Medical facilities and equipment, training, and consultancy inputs have improved the quality and accessibility of health and FP services to the poor and underserved. Given the success in this aspect, the Bank's next concern should be the efficient operationalization and optimal utilization of these resources, and the long-term sustainability of benefits. The future performance of Bank activities in the health and population sector will be dependent on how certain key issues will be addressed, and how lessons learned from past projects will be used to improve the design of future projects. Some of these key issues and lessons learned are discussed in the following paragraphs.

B. Key Issues

1. Developing Health Care Personnel to Improve Services

35. Even with the existence of adequate and sophisticated medical facilities, optimal health services could not be provided without properly trained medical, paramedical and technical personnel. This is illustrated in several of the postevaluated projects which experienced underutilization of facilities and equipment, and low bed occupancy rates. The shortage of qualified

medical service personnel in the public health sector was a problem which was common to most of the projects. There are few who would be willing to engage in public health service if given the option to work for the private sector because of the former's lower compensation package and less attractive career opportunities. Thus, for as long as health specialization remains as a relatively more expensive career option, and there exists a wide gap in the perceived overall compensation package between private and public sector health service providers, there will be a shortage of qualified medical personnel to implement public health projects. The public health sector service should be made more competitive through improved compensation packages, better career opportunities, and availability of medical and technical support facilities/equipment.

2. Recurrent Expenses and Cost Recovery

36. The increasing budgetary constraints experienced by most DMCs and the lack of alternative funding mechanisms would tend to affect negatively the quality and accessibility of public health services, including those available to the poor. Repairs and preventive maintenance expenditures of vital medical equipment and facilities were deferred in view of more pressing needs such as medicines and medical supplies. This eventually led to under- or non-utilization of facilities/equipment and suboptimal health care services. Thus, while cost recovery issues were often not treated with major concern during project preparation due to governmental policies to provide free health services, particularly primary health care to the poor, project design in the late 1980s and early 1990s gave more emphasis to the increasing use of cost recovery measures to ensure sustainability.

37. The initial optimism that user charges could raise 15 or 20 percent of health sector revenues has proven unrealistic. Public health facilities have found it difficult to raise more than 5 percent, and even well-run NGOs have had difficulty charging as much as 10 percent of total costs. User charges suffer from four serious problems. First, they tend to be difficult to administer and have high administrative costs relative to the amount collected. Second, user charges are inequitable. A study carried out in Indonesia indicates that user charges decrease utilization by the poor, the young and the elderly. Worse, the study showed an actual decline in the health status of these groups in the districts in which user charges were introduced. Unfortunately, there does not appear to be a simple way of means-testing to allow the poor to be exempted. Third, implementing user charges in the public sector leads the private sector to raise their prices, further reducing options for the poor. Fourth, user charges for services which have positive externalities, such as treatment of sexually transmitted diseases, can endanger disease control efforts in the community.

38. With minimal cost recovery rates of less than five percent in most of the projects, and the inability of majority of the rural population to pay for health services received, there is a need to look for measures that will relieve the Governments of the health cost burden (e.g., through a comprehensive health insurance program, and the participation of NGOs and health volunteers). Efforts to shift public subsidies to low income groups and to expand private sector service for the higher income groups will also need to be considered. Unless alternative systems for increased sustainability are eventually installed with necessary built-in mechanisms to protect the poor and socially disadvantaged, and unless scarce Government resources can then be channeled to the more needy rural areas, the accessibility to quality public health care services and FP services will be a continuing concern.

3. Benefit Monitoring and Evaluation

39. Health and population statistics and health management data are important for effective planning in the health sector. While national and local health information was available in some of the DMCs (through HMIS), none of the postevaluated projects employed a BME system that would monitor and identify health and FP developments arising from specific project initiatives. As health sector budgets remain limited and operating constraints persist, it is important that projects be prioritized in terms of the level of returns expected from each activity. This information can be obtained through the installation of effective and sustainable BME operations¹ in the health and population agencies and integrated with HMIS. In addition, postevaluation operations and developmental impact assessment would be enhanced with the existence of pre-implementation and post-completion data for project intervention and comparison areas as investments in the health sector need to be assessed on the basis of improved quality of health care, increased delivery of health services, health impact and cost-effectiveness. Also, the specification of performance indicators at various stages of the project cycle would be useful.

40. The concept of evaluation should be demystified with all levels of health personnel and the community in general, before planning and carrying out project evaluation. Simple data collection and analysis techniques need to be used to allow those who receive the project benefits to be actively involved in its evaluation. The focus of evaluation should not always be on identifying weakness in the project per se, but rather on developing lessons learned based upon project successes and problems. Outcomes of a BME exercise should also not be vague in their conclusions and recommendations, but rather have specific lessons learned. Community participation in BME activities should lead to comprehensive and practical lessons for future projects and programs. In addition it also performs an important capacity building exercise. By involving a wide range of beneficiaries in the process, it can benefit their skills in project and program evaluation and also increase their understanding of basic management and administration requirements.

4. Role of the Private Sector

41. In view of declining health sector budget allocations in real terms and other constraints facing the health and FP agencies, the privatization of some of the public health and FP services is becoming an increasingly viable option in public health management. Secondary and tertiary health care, particularly in the semi-urban and urban areas, are areas where private sector participation can be encouraged. Non-medical support services such as laundry, janitorial, maintenance, human resource development, and engineering may also be contracted to the private sector. While the private sector is encouraged to participate in areas where cost recovery will sustain operations, it can as well provide services to the poor. However, the Government should establish acceptable schedule of fees, user charges and premiums, in cooperation with the

¹ As indicated in the footnote in para. 10, however, recent PEO findings indicate that BME needs to be replaced with a more effective and practical PPMS.

private sector, as well as monitor and maintain the quality of health care. Increased privatization can channel scarce Government funds into the most essential public health operations and provide more Government subsidization of health costs to the impoverished and those who are unable to pay. The sector analysis (see para. 18) should examine: (i) the number of private sector health facilities and utilization rates of health facilities by the different health and population programs; (ii) mechanisms for enhancing private health provision; and (iii) scope for improving the regulatory framework to encourage cost recovery while maintaining quality and equity considerations.

5. Promoting Preventive Health Services

42. Given the funding and staffing constraints experienced by most of the health projects, the use of resources needs to be prioritized. In most instances, curative health care was given preference over preventive health care because the issues involved have a greater sense of urgency, the results are more straightforward, outputs are linked to measurable hardware (e.g., number of hospitals built), and the gestation of benefits and project impact is short-term. Thus, even with the absence of BME systems, the measurement of project "benefits" from curative health services can easily be done. On the other hand, preventive health initiatives are more susceptible to uncertainties and risks, and real benefits are reaped mostly in the long-term. Sustainability of operations is also a critical factor for the success of preventive health projects. In many countries in Groups A and B, planning and implementation of national health preventive programs are weak.

43. Prevention and health education are essential strategies to improve health and population status. As well, disease prevention translates directly to reduced costs of curative care, especially for those which are expensive to treat. Thus, DMCs would greatly benefit if future health projects would provide sizable preventive health services and health/population education components. This is because investment costs would be lower, the number of beneficiaries would be higher, and there would be lower economic costs involved. Nonetheless, preventive services and health promotion must be supported by quality curative services that inspire the confidence of patients.

C. Major Findings and Lessons Learned

44. The major findings and lessons from the postevaluated projects in the health sector are the following:

45. **Project preparation was often inadequate.** Most of the projects were not preceded by feasibility or preparatory studies, even for those which were considered as the first in the country's health and population sector. This often resulted in inadequate identification and prioritization of sectoral issues and problems, and sub-optimal formulation of strategies. In many cases, project design underestimated management and institutional problems, identifying only broad areas for improvements and Bank intervention. Bank operations now conduct health sector reviews as part of project preparatory activities, including social assessment, fiscal analysis and public expenditure reviews.

46. **Institutional capability and development issues were not given sufficient consideration during project design.** The design of the postevaluated health projects seemed to have assumed that the physical infrastructure improvements would automatically result in efficiency gains without necessarily changing systems and procedures. Since institutional capacity is critical to attaining success, particularly in health and population sector projects which are service-oriented, capacity building and an in-depth analysis of institutional constraints are paramount concerns throughout the project life cycle. Thus, current Bank operations necessarily focus on policy analyses and formulation, governance, quality assurance of health care provided, health system structure and organization, provision of effective and integrated preventive health care programs, and address new and emerging issues. These have resulted in institutional capacity improvements and structural reforms in the health services delivery system of participating DMCs.

47. **There were no effective and workable mechanisms employed to monitor and evaluate the benefits accruing from the projects.** Since the main goal of Bank-assisted health and population projects (i.e., to improve the efficiency of health and FP service delivery) was not elaborated with measurable objectives, it is important that (i) project objectives be stated as specific and as quantifiable targets to determine the level of operating efficiency; and (ii) baseline data be established for the indicators before the inception of the BME system. Additionally, BME systems should be implementable and sustainable, and designed with the institutional capability of the implementing agency in mind.

48. **The lack of mechanisms that would ensure funding for recurrent expenses and a shortage of qualified personnel to operate the facilities had adversely affected project sustainability.** Future health and population projects would therefore need to take into account the affordability of incremental recurrent costs and staffing requirements. It is important to realistically project the anticipated O&M and staffing requirements, and identify alternatives on how these requirements would be met. A review of the planning and budgeting processes of the Government in allocating public resources to the health sector will be useful in ensuring project sustainability.

49. **There is a need to provide incentives and encourage the private sector to provide health and FP services in areas where there is heavy reliance on Government subsidy, especially for the operation of secondary and tertiary health facilities.** Experience from the projects highlighted that cost recovery measures have greater chances of success when introduced gradually through pilot studies and combined with an intensive information campaign for community participation. At the same time, there is a need to emphasize cost sharing and containment measures, as well as waste reduction through effective management.

50. **The provision of consultant services and limited training of a few individuals are not sufficient to overcome institutional weaknesses.** The decision-making processes, work and information flows, procedures, and health regulations must be reviewed to identify internal inefficiency problems that affect the delivery of health services. For some cases, efficiency gains can be achieved by changing processes rather than upgrading physical health facilities.

APPENDIXES

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