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**POVERTY AND SOCIAL
DEVELOPMENT PAPERS**

**Scaling-Up Health Sector Activities
for Poverty Reduction:
Lessons from Papua New Guinea,
Cambodia, and Sri Lanka**

**Indu Bhushan, Shiladitya Chatterjee
Leo Deville, Maryse Dugue,
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Regional and Sustainable Development Department

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ABBREVIATIONS

ADB	-	Asian Development Bank
AusAID	-	Australian Agency for International Development
DALY	-	disability adjusted life years
DFID	-	Department for International Development of the United Kingdom
ERP	-	Economic Recovery Program
GDP	-	gross domestic product
HIV/AIDS	-	human immunodeficiency virus/acquired immune deficiency syndrome
HSDP	-	Health Sector Development Program
HSSP	-	Health Sector Support Project
IMR	-	infant mortality rate
MDG	-	Millennium Development Goals
NDOH	-	National Department of Health of Papua New Guinea
NGO	-	nongovernment organization
PHC	-	primary health care
PNG	-	Papua New Guinea
RRP	-	Report and Recommendation of the President
SWAP	-	sector-wide approach
WHO	-	World Health Organization

NOTE

In this report, "\$" refers to US dollars.

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EXECUTIVE SUMMARY

1. This paper attempts principally to draw lessons from the Asian Development Bank's (ADB) long-term involvement with the Papua New Guinea (PNG) health sector. In doing so, it makes selective references to health sector experiences in two other countries where ADB has been involved, Cambodia and Sri Lanka. While there are considerable differences in the overall economic and social achievements among the three countries, there are many lessons that can be drawn from a comparative study to understand scaling-up of health outcomes for the poor.

2. ADB's assistance to the health sector in PNG in the 1980s and the early 1990s focused on improving access to rural health services by investing mainly in infrastructure (aid posts, health centers, staff housing) through three rural health projects. Difficult terrain and remoteness of communities had prevented health services from being delivered effectively and initial interventions focused on building up delivery infrastructure. After 1994, the health sector strategy was refocused from expansion of the service delivery network to quality improvements, and eventually resulted in the Health Sector Development Program (HSDP). In both Cambodia and Sri Lanka, the emphasis has been supporting primary health care. Since Cambodia began the current process of reintegration in 1991, ADB has had three projects there— the Basic Skills Project (1995), the Basic Health Services Project (1996), and the current Health Sector Support Project (2002). ADB has been involved in the Sri Lanka health sector since the early 1980s. Support was first provided under the Health and Population Project, which was designed to help implement the Government's Health for All initiative. This was followed by a second project that essentially supported the implementation of the new National Health Policy of 1992.

3. Despite significant increases in allocation of funds for health in PNG, and improvements in management culture in the national Department of Health, key output indicators in maternal and child health deteriorated during 1995–2001. A special study revealed that the poor have the worst access to health facilities. In Cambodia, while poverty remained stagnant, there were distinct improvements in health outcomes in areas where health services were contracted out to nongovernment organizations. In Sri Lanka, the interventions supported by ADB appear to have strengthened basic services to the poor and compensated for the decline brought about by reductions in public health expenditures. They led to an enhanced primary referral system in terms of both physical outreach and quality human resources.

4. A brief survey undertaken in this paper of factors that influenced these outcomes reveals that the following were relevant:

- (i) **Commitment, Leadership, and Motivation.** These factors were critical to scaling-up. Strong public commitment was evident in Cambodia and Sri Lanka. In PNG, strong leadership was evident, but mainly confined to the health sector at the central level.
- (ii) **Innovations in Lending and Service Delivery.** Innovations have to be appropriate to the context. The innovation of policy-based lending, a logical outcome of the ADB involvement process, around which the HSDP/sector-wide approach (SWAP) was anchored in PNG, could not fully deliver because of problems of complexity, coordination, and sudden changes in administrative structures following decentralization. The Cambodia contracting-out experience illustrates how innovation can succeed in favorable environments.

- (iii) **Decentralization.** The disruptions caused by decentralization, particularly lack of capacity and fiduciary environment, were important causes of the unsatisfactory outcomes of projects in PNG. In Sri Lanka, where decentralization had already occurred, the project design and implementation took this into account and maintained good supervision; in fact, the projects helped to strengthen capacities at local levels.
- (iv) **Governance.** Governance was identified as an important factor explaining differences in outcomes. In explaining comparative performance of health service delivery in PNG vis-à-vis that of Sri Lanka, governance was an important factor.
- (v) **External Catalysts.** Macroeconomic and fiscal problems negatively affected the projects in PNG. Cambodia benefited from positive trends, such as stability, economic growth, and the “peace dividend.” In Sri Lanka, the projects were isolated from and unaffected by the internal civil strife. In all three countries, the role of external development partners was significant.

5. Following are the main lessons from this study.

- (i) **Targeting the Poor.** Establish a process whereby the needs of the poor are incorporated into development planning and implementation, involving efficient monitoring of outcomes and granting specific incentives for better delivery.
- (ii) **Performance Indicators and an Evaluation System.** Projects should develop a set of efficient monitoring indicators and a framework to evaluate and disseminate the results. This can be used to increase incentives for providers and to build political support for scaling-up successful interventions.
- (iii) **Decentralization and Basic Services Delivery.** Decentralization can be a powerful instrument to increase local ownership and participation. It should be realistic in its design and phased in carefully so as to not create too many disruptions in transferring services and responsibilities, and to allow strong local involvement and participation.
- (iv) **Health Financing.** The distribution of subsidies and the organization of the health finance system can have a major impact on poverty; projects should explicitly take this into account when designing interventions in the health sector.
- (v) **Capacity and Human Resource Development and Management.** Capacity constraints should be specifically addressed. Project designs should be realistic and should take into account the capacity of governments.
- (vi) **Scaling-up to a Sector-wide Approach.** Partnerships can play an important role in coordination and lowering transaction costs for the government and development partners, but their design should be realistic. Rather than simply trying to apply the best-practice examples used in other countries to develop a SWAP, the scaling-up process should be gradual and be built around the proven capacity of local stakeholders.

I. INTRODUCTION¹

1. Health is an important dimension of poverty. In many societies, poverty and bad health are synonymous—a person with poor health is poor. As Amartya Sen (1999) explains: “The usefulness of wealth lies in the things that it allows us to do, the substantive freedoms it helps us to achieve.... And among the most important freedoms that we can have is the freedom from avoidable ill-health and from escapable mortality.” Better health leads to an immediate welfare gain for the poor and access to essential health services is a basic human right. It is not surprising that health and nutrition are the center point of the Millennium Development Goals (MDGs).

2. The last few decades have seen substantial gains in the health of populations throughout the world. However these gains have not been shared by many of the poor and often the poorest and most vulnerable groups of society have been left behind. This has led to the so-called “vicious circle” of bad health and poverty and growing inequality in health status in many countries (Bhushan et al., 2001; Bloom et al., 2004).

3. The central issue in designing health sector interventions is to make health services accessible to the poor, a well-documented policy prescription in developing countries. Unless they are well designed, health services provided by government tend to be distributed in favor of the nonpoor at the expense of the poor (Gwatkin 2000; Wagstaff 2000; Jha et al. 2002). Targeting the poor within the broad scope of health sector reform is difficult, especially when fees are charged to help offset the cost of services (Abel-Smith and Rawal 1992; Besley and Kanbur 1993). At the same time, user fees and private participation can strengthen client power and improve the services provided (World Bank 2003).

4. Reaching the poor with health services requires more than simply increasing spending. It needs a two-tiered approach that focuses both on (1) generating incentives for the health systems to function efficiently and encouraging both public and private providers to operate and provide pro-poor services (“creating an investment climate”), and (2) increasing the equity and pro-poor orientation of public policy in the health sector (“social inclusion”). There is no panacea or “one size fits all” approach that will improve the health status of the poor in different countries. Rather countries need to learn from each other, experiment, and scale-up approaches that work best.

5. This paper draws lessons from the long-term involvement of the Asian Development Bank (ADB) in the health sector of Papua New Guinea (PNG), and makes some comparisons with health sector experiences in two other countries where ADB has also been involved—Cambodia and Sri Lanka. While there are considerable differences in overall economic and social achievements among the three countries (see Table 1), there are many lessons that can

¹ This paper was prepared in the context of the Shanghai Upscaling Poverty Interventions Conference of May 2004. The paper draws on project documents (Report and Recommendation of the President [RRP] of Asian Development Bank [ADB]) for health sector projects in Papua New Guinea (PNG) and Sri Lanka, post-evaluation studies of these projects where available, or project completion reports. The results of the technical assistance to PNG for a health sector review—*Trends in the Distribution of Health and Health Services in PNG 1991–2000* (ADB 2002b) were also used. This paper was prepared by a team consisting of (in alphabetical order) Indu Bhushan, Shiladitya Chatterjee, Leo Devillé, Maryse Dugue, Colandavelu Narayanasuwami, and Brahm Prakash. Valuable feedback was also received from the members of the ADB Health Committee, particularly Erik Bloom who made significant contributions. We are indebted also to Dr. Puka Temu, Minister for State Enterprises and Information, PNG, for reviewing the document and providing his comments. Feedback on the paper is welcome and may be addressed to schatterjee@adb.org. The views expressed in this paper are those of the authors and do not necessarily represent the views of the ADB or the governments of PNG, Cambodia, and Sri Lanka.

be drawn from a comparative study to explain the health outcomes in PNG. In the paper, the rationale, objectives, and implementation process of ADB health sector investments in the three countries are first described (Chapter II). The impacts of the interventions on health, particularly health of the poor, are then examined (Chapter III). Factors behind the observed impacts are described in Chapter IV. Finally, a generalized set of lessons learned is provided (Chapter V).

6. The basis of the PNG study is a special staff assessment conducted for the purposes of this Conference, a health sector review (ADB 2002b), and study done on the health sector development program experience (Dugue and Izard 2003).² The Cambodia results are based on the 2000 national health survey of the National Institute of Statistics (National Institute of Statistics and ORC Macro 2000). The Sri Lanka experience is based on post-evaluation studies (ADB 1993 and 2003b).

II. ADB'S HEALTH INTERVENTIONS IN PNG, CAMBODIA, AND SRI LANKA

A. Papua New Guinea

7. ADB's program for improving public service delivery included assistance to the health and water supply and sanitation sectors, with ADB playing a major role in both. Modalities included investments, technical assistance, and policy dialogue to develop national strategies and to guide the sector's development program. In the health sector, ADB funded the development of the 1996–2000 national health plan that was used to help officials make informed policy and investment choices. ADB's focus in the 1980s and the early 1990s was on improving access to rural health services by investing mainly in infrastructure (aid posts, health centers, staff housing) through three rural health projects. Difficult terrain and remote communities had hindered effective delivery of health services and initial interventions were on building up delivery infrastructure. Evaluations confirmed the improved physical accessibility to health facilities in many remote parts of the country, but showed that extending facilities did not solve the problems of closure or limited operation of facilities due to shortage of staff, insufficient drugs, malfunctioning equipment, and poor maintenance of buildings. A loan focusing on support for population and family planning was provided in 1993. After 1994, the Government's health sector strategy was refocused from expansion of the service delivery network to improvements in quality, and in 1997, resulted in the Health Sector Development Program (HSDP).

8. While considerable health gains were made in the first decade after PNG's independence in 1975, progress in a number of key indicators has slowed since the early 1990s. The deterioration of health services has many causes, including a macro-economic crisis in 1994–1995. The economic recovery package in 1995–1996 by the International Monetary Fund and the World Bank, assisted by both Australia and Japan, provided for government policy to redirect spending to the social sector, particularly in health and education. These events established a framework conducive to an ADB health sector program loan as part of the overall economic recovery effort.

9. Among Pacific countries, PNG's human development index (HDI) is the lowest (rank 133 in 2002), and poverty incidence, as measured by the human poverty index (HPI), the highest (rank 62 in 2002). Poverty and low levels of human development have an important gender

² Several project RRP's have also been consulted, including the RRP on the loan and technical assistance grant to PNG for the Third Rural Health Services Project (ADB 1991).

dimension. Life expectancy, income, and educational achievements of women are universally lower than those of men. Although men and women have equal rights under the constitution, gender inequality remains a severe impediment to development. PNG's total burden of disease is high. It is calculated at 21,000 DALY³ per 100,000 compared to 16,000 in the western Pacific countries as a whole. In the communicable, maternal, and perinatal category, the difference is striking: 12,301 DALY per 100,000 compared to 3,900 in the western Pacific. Maternal mortality is 370 per 100,000 births, placing it second highest in the western Pacific. Infant mortality rates are also very high, ranging from 33 to 87 per 1,000 live births and averaging 73. The under-5 mortality rate is recorded as 102 per 1,000 live births. Obviously, PNG is lagging far behind the 2015 MDG targets. These pose a major challenge to policymakers.

10. Health services are often not delivered effectively. Many facilities are closed or not properly staffed, equipped, or supplied. Only half the scheduled outreach clinics⁴ (immunization, and maternal and child health) are actually held and only 57% of pregnant women receive any prenatal care (Department of Health 2003). Childhood immunization is less than 60% (ibid.) resulting in epidemics of preventable childhood communicable diseases, such as measles.

11. PNG spent in 1997 only 2.8% of gross domestic product (GDP) on health in the public sector (falling from 3% in 1990), the lowest among western Pacific countries as a proportion of GNP and as health expenditure per capita. Within this overall allocation to health, there are also significant variations between provinces. These variations reflect past investment decisions as well as current perceived provincial priorities. However, there was a significant increase in health expenditures after 1997, reaching 3.9% of GDP in 2001.

12. Prior to HSDP, the public health system had tried to cope with its poor performance essentially without any change in management style. A series of reforms and policy initiatives was identified as critical to reverse the declining trend in health services. Focusing on the whole sector with a major emphasis on performance of rural health service delivery, the HSDP marked a new approach to assisting the health sector. Under the strong leadership and high commitment of the Secretary for Health, issues of sector performance and decentralization were addressed (although with variable degrees of success) through new partnerships between the central and provincial levels.

13. The HSDP was the first sector-wide assistance program in health in PNG designed to support the National Health Policy, which was developed through a broad consultative process in 1995. The policy focused on improving health services to the rural majority and the need to adopt health promotion and preventive health strategies to ensure improved health status. It also addressed issues of management reform in all areas and all levels of the public health hierarchy. The policy gave shape to the National Health Plan, a cohesive document that presents a comprehensive set of objectives and strategies in the public health sector to be pursued over five years. The objectives and strategies of HSDP, consolidated as benchmarks for evaluating performance, were drawn from the Government's National Health Plan 1996–2000. The policy-based loans under the HSDP were also designed to support the reform process embodied in the

³ Disability adjusted life years (DALY) is a measure of morbidity and mortality that calculates the number of years of healthy life lost each year. These results are from Hiawalyer and Spohr (2002).

⁴ PNG health indicators from the National Health Information System.

Organic Law on Provincial Governments and Local Level Governments⁵ passed in 1995, adjusting and completing the process of decentralization begun after Independence. Implementation of HSDP began in 1998, coinciding with the progressive implementation of the National Health Administration Act (1997). A technical assistance project was attached to HSDP to provide advisory support on the objectives of the development program. The overall goal was to provide services to the majority of people and, in particular, to the rural poor. Consequently, assistance focused on rural areas and on primary and maternal and child health care.

14. Apart from ADB, other development partners have also been active. The Australian Agency for International Development (AusAID) is the biggest donor in the health sector. Australia has provided general budgetary support of approximately A\$300 million per year to the government of PNG. In a change of policy, budgetary support was phased out in favor of project aid between 1995 and 2000. Early in this transition, AusAID focused on hospital management and operations, and assistance in training health professionals. The Health Sector Support Program, which provides comprehensive assistance to the National Department of Health of Papua New Guinea (NDOH) and targets six provinces, started in 1998–1999. A Women and Children’s Health Project was included, designed to improve vaccination coverage and women and children’s health extension activities nationwide. Other development partners active in the public health sector are European Community, Japan, New Zealand, and United States Agency for International Development.

B. Cambodia

15. While terrain, geography, and habitat pattern initially posed major constraints in PNG, in Cambodia it was the almost total destruction of administrative machinery and human resources as a result of war and political strife. From near nonexistent to extremely low levels only 10 years ago, the Cambodian private and public sector health system has developed rapidly and has had a number of important achievements. The Government developed a national health policy that included major financial reforms (e.g., budgetary reforms, introduction of user fees) and a national system of primary health care coverage. The country has also made substantial progress in other critical areas of public health, including HIV/AIDS prevention and in the introduction of modern birth-spacing methods.

16. Notwithstanding the progress in the last decade, health indicators in Cambodia are still among the worst in the Asia and Pacific region. Average life expectancy at birth is estimated at only 56 years—54 years for men and 58 years for women. The infant mortality rate (IMR) is estimated to be 95 per 1,000 live births, while the mortality rate under the age of 5 is 124 and the maternal mortality ratio is 437 per 100,000 live births (Ministry of Planning 2003). Rates of malnutrition are the second highest in Southeast Asia, with 56% of children under 5 affected by chronic malnutrition.

17. Despite the loss of infrastructure during the hostilities, there were sufficient paramedical and management staff, but training and quality of care were inconsistent and morale was low (Bhushan, Keller, and Schwartz 2002). The primary health care system was not able to deliver adequate services; in 1998 only 39% of children 12–23 months of age were fully immunized (National Institute of Statistics and ORC Macro 2000).

⁵ The Organic Law on Provincial Governments and Local Level Governments (New Organic Law), enacted in 1995, provided the framework for a greater devolution of powers to the provinces and local governments, with clear definitions of the division of administrative and service functions between the three levels of government.

18. Since Cambodia began the current process of reintegration in 1991, ADB has had three projects related to health: the Basic Skills Project (approved 1995), the Basic Health Services Project (approved in 1996), and the ongoing Health Sector Support Project ([HSSP] approved in 2002). The Basic Skills Project had primary health care training as one of its two main components. The objective of the Basic Health Services Project is to assist the development and implementation of a coverage plan modeled according to World Health Organization (WHO) guidelines to restructure and broaden the primary health care system. The plan included the construction or rehabilitation of health centers designed to provide services to a population of about 10,000, and the creation of operational districts with populations averaging about 150,000. The plan also defined a minimum package of activities for health centers, consisting of basic preventive and curative services, including immunization, birth spacing, antenatal care, provision of micronutrients, and simple curative care for diarrhea, acute respiratory tract infections, and tuberculosis. One innovative part of this project was to pilot the contracting of health services to nongovernment organizations (NGOs) in some operational districts.⁶

19. The HSSP builds on the Basic Health Services Project. It was designed in the context of the Government's Health Sector Strategy, which was also approved in 2002. This strategy is the health sector's main input into the National Poverty Reduction Strategy and fully reflects the MDGs in its monitoring framework. It has received widespread support from stakeholders and builds on previous policies in the health sector, including the minimum package of services. To support the implementation of the health strategy, ADB, the World Bank, and Department for International Development of the United Kingdom (DFID) entered into a partnership to develop and implement a joint project. Although HSSP is not a sector-wide approach (SWAP) in the classic sense of the term, it does have many of the characteristics of SWAP. The partners coordinate their activities closely, share resources when feasible, and have adopted the same technical approach for their activities. Given the proven success of contracting (see below), HSSP supported the expansion of the model to 11 districts.

C. Sri Lanka

20. Compared to PNG and Cambodia, the health system in Sri Lanka presents almost a model of a functioning health care system if not a well functioning system. The Government of Sri Lanka has traditionally made substantial efforts in human resource development, including health care and family planning services. This was reflected in Sri Lanka's 2000 indicators, which were better than those of its neighboring countries in South Asia. In 1980, the Government signed the Charter for Health Development and endorsed the global strategy of Health for All by year 2000. The charter promoted primary health care (PHC) as the main health delivery system. A new National Health Policy was adopted in 1992, which aimed at strengthening human resources development and management in the health sector, stressing managerial capacity, education research and training, improving capacity for monitoring and control of diseases, and encouragement of the private sector to provide health services. A special emphasis was also placed on integrating primary health care services with family planning. Thanks to the long-standing support of the Government to the health sector over the decades, Sri Lanka's health indicators are quite impressive compared to those in some comparative Asian countries (Table 1), even though sector expenditures in Sri Lanka as a share of GDP are relatively low.

⁶ The Cambodia contracting experiment is discussed in the World Development Report 2004 (World Bank 2003) and in Bhushan, Keller, and Schwartz (2002).

Table 1: Selected Health and Human Development Indicators in Selected Countries

Country	(1)	(2)	(3)	(4)		(5)		(6)		(7)		(8)						
	HDI Rank	HPI Rank	GDP per capita PPP (constant 1995 international \$)	Adult Female Literacy Rate (% of females aged 15 & above)		Maternal Mortality (per 100,000 live births)		Infant Mortality (per 1,000 live births)		Under-5 Mortality Rate (per 1,000 live births)		Health Expenditures (% of GDP)						
	2002		2001	1990	2000	1990	1995	1990	2000	1990	2000	Public		Private		Total		
												1990 ^a	1997	2001	1997	2001	1997	2001
PNG	133	62	2056.5	48^a	57^a	930	370^b	79	79	101	95	3.0	2.8	3.9	0.4	0.5	3.2	4.4
Cambodia	130	75	1746.9	48.79	57.24	900	437^c	80	95	115	124^c	1.5	1.1	1.7	9.8	10	10.9	11.7
Sri Lanka	89	31	3083.3	84.67	89.3	140	60	22	17	26	20	1.6	1.6	1.8	1.6	1.9	3.2	3.7
Thailand	70	21	5932.2	89.45	90.52	200	44	34	25	40	29	...	2.1	2.1	1.6	1.6	3.7	3.7
Philippines	77	23	3671.8	91.21	92.65	280	172 ^b	45	30	63	40	0.7	1.6	1.5	2.0	1.8	3.6	3.3
Indonesia	110	33	2768.1	72.51	81.94	650	470	60	35	91	48	0.3	0.6	0.6	1.8	1.8	2.4	2.4

HDI = human development index, HPI = human poverty index, GDP = gross domestic product, PNG = Papua New Guinea, PPP = purchasing power parity.

^a ADB (2002a).

^b For the most recent year available from 1996–2000.

^c Ministry of Planning (2003).

Sources: Unless otherwise specified, columns 1 and 2: UNDP (2002); column 5: ADB (2002); columns 3, 4, 6, 7, and 8: World Bank (1990–2001).

21. ADB has been involved in the Sri Lanka health sector since the early 1980s. Support was first provided as a loan under the Health and Population Project, which was designed to help implement the Government's Health for All initiative. The loan, which was approved in 1982, aimed at strengthening the PHC delivery system. It was rated generally successful in post-evaluation, having been satisfactorily implemented and achieved its objectives.

22. ADB followed up its first health and population loan with a second project that essentially supported the implementation of the new National Health Policy of 1992. The key issues that required assistance in the implementation of the Policy were: (i) PHC services that needed strengthening in terms of equipment, communication, and transport facilities, and upgrading of physical infrastructure to enable functioning and delivering of quality services; (ii) support for human resource development and training; (iii) modern hospital management methods to improve the efficiency and cost effectiveness of hospital services; (iv) strengthening the referral system between small hospitals in rural areas with larger, better equipped hospitals; (v) maintaining the high acceptance of family planning methods that experienced a setback due to the civil unrest, meeting the demand for clinical contraceptives, and training the providers of these services; (vi) setting up a computerized management information system to monitor the decentralized health care delivery system, particularly at the PHC level; and (vii) preparing a proposal for promoting health insurance.

23. The Policy was also in line with ADB's focus in the health and population sector at that time, which was to upgrade existing assets and improve efficiency through human resource and institutional development. The project, which was approved in 1992, aimed to benefit the rural population directly, particularly the poor, elderly women, and children. The post-evaluation report found this project, like the first Sri Lanka health project, to have been successful in meeting its objectives.

24. Other development partners active in the sector include Finland, Japan, United States, World Bank, and the United Nations system. ADB's activities were coordinated with these partners, particularly the United Nations Children's Fund (UNICEF), WHO, and World Bank.

III. IMPACT ANALYSIS

A. Papua New Guinea

1. Health Expenditures

25. During 1996–2001, there was a 65% increase in real public sector expenditure on health in PNG. When population increases are taken into account, there was an increase of 42% in the overall availability of resources for the health sector in this period (Dugue and Izard 2003). Per capita domestic resources for health rose by 4% brought about by increasing the proportion of the national budget spent on health from 4.8% in 1996 to 6.2% in 1999. Foreign assistance has provided the bulk of additional resources to the health sector. Due to these efforts, public health expenditures rose to 3.9% of GDP in 2001. Public resources are supplemented to a significant extent by NGOs (principally church and missionary-run facilities, which run about half of the rural centers) and to a lesser extent by the private sector. Initial concerns about lack of adequate financial resources in the health sector led to prioritizing financial allocations for health. With better financial resources availability, deeper structural issues were unmasked (as discussed later).

26. Under the HSDP's first policy reform area "Shift Emphasis from Urban to Rural Health Services," the first of the benchmarks reflecting the Government's priorities was to increase financial allocations for rural health services by not less than 10% per year in 1997, 1998, and 1999 over the 1996 level of expenditure. In fact, rural health services expenditure increases well exceeded the benchmarks, specifically: 44.1% on 1997, 22.4% in 1998, and 16.2% in 1999. The large increase in 1997 was due to the inclusion of AusAID project aid for the first time. Two other benchmarks were also exceeded. One was to "increase the value of drug supplies to health centers and aid posts to K3.00⁷ per capita in the area served." In 1998, the value was K4.29 per capita, and in 1999, it was K6.00 per capita. The second was to "increase the allocation for drugs and medical supplies to 25% of NDOH's budgetary allocation for 1998." The actual increase was 28%. In 1999, the value increased to 31.8%. More importantly, meeting this benchmark resolved the persistent problem of inadequate drug supplies reaching the lowest level of the public health system, the aid posts.

2. Output Indicators

27. Although most important program benchmarks were achieved under the HSDP and financial resources for health increased considerably, health outcomes did not improve over those achieved in the mid-1990s. Also, poverty is reported to be increasing in both urban and rural areas. A review of the National Health Plan 1996–2000 revealed deterioration in several indicators, such as a drop in immunization coverage, a rise in mortality from malaria, an increase in malnutrition, and a shortage of drugs, especially in hospitals. While there have been gains shown in demographic indicators over the last decade, with an increase in life expectancy from around 52 years in the 1990 census to around 54 years in 1996—which, however, remains low by standards of the Pacific region—the IMR rose from 72 to 77 per 1,000 births over the same period. PNG was the only country in the Pacific to record an increase in IMR. There are significant urban and rural differences in IMR: 33 and 86 per 1,000 live births, respectively. Importantly, there are indications that PNG may soon face a serious HIV/AIDS epidemic (Dugue and Izard 2003).

28. While inputs (measured by financial resources) to the health sector increased significantly between 1995 and 2001, output indicators showed only a marginal increase over the period with significant falls in 2000 and 2001. The performance for 2001 was, for most indicators, worse than in 1995. Table 2 provides the output indicator measurements for five key mother and child health indicators for these years. There are also significant differences in the performance of provinces (Table 3). A well-designed management information system for the health sector put in place with ADB support made available good data on these reversals and helped in signaling policymakers to take corrective action.

⁷ At the time of HSDP, a kina was equivalent to \$0.73.

Table 2: Output Indicators for Five Key Maternal and Child Health Activities, PNG, 1995 and 2001

Indicator	1995	2001
% of deliveries in health facilities	42	38
% of pregnant women receiving TT vaccination	62	63
% of women getting at least one antenatal visit	68	58
% of children, <1 year, receiving 3 rd dose TA vaccination	61	55
% of children getting measles vaccination	42	47

TA = triple antigen ; TT = tetanus toxoid.

Source: Dugue and Izard (2003).

Table 3: Performance of Best and Worst Performing Provinces for Five Key Maternal and Child Health Activities, PNG, 2001

Indicator	Best	Worst
% of deliveries in health facilities	68	11
% of pregnant women receiving TT vaccination	77	39
% of women getting at least one antenatal visit	108 ^a	37
% of children, <1 year, receiving 3 rd dose TA vaccination	107 ^a	40
% of children getting measles vaccination	79	30

TA = triple antigen ; TT = tetanus toxoid.

^a These figures of over 100% probably reflect problems with the population figures used as the denominator.

Source: Dugue and Izard (2003).

29. Several factors have contributed to the mixed performance of the health sector in PNG. Some indicators are particularly resistant to change, being influenced by factors outside the sector (such as women's education and nutritional status) and geographical barriers (such as supervised delivery rate, which is influenced by accessibility to health centers). Difficult terrain, combined with poor infrastructure and lack of transport, reduces considerably the physical accessibility of health services. Other indicators (such as immunization coverage) have fluctuated according to availability of funds, quality of support and supervision, and personnel involved.

3. Impact on the Poor

30. A special study conducted by ADB (2002b) on trends of health services delivery to the poor during 1991–2000, which divided the population into 5 quintiles according to possession of selected household assets, found that poorer households in PNG have less access to health facilities, lower uptake of services, and worse health outcomes. The study confirmed that there were large disparities in the delivery of services between households in the poorer and richer quintiles and that the poor were most affected by closure of health facilities—although toward the end of the period some improvements in quality of services run by government facilities benefited the poor (see Box 1).

4. Management Culture and Sustainability

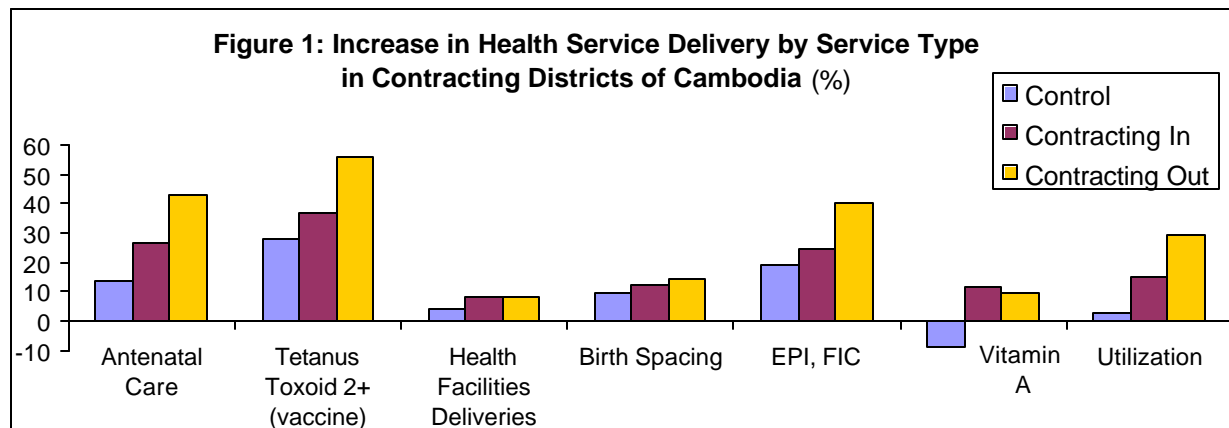
31. Although output indicators have not improved, HSDP has contributed to changes in management culture that may have longer-term effects. Lack of impact on output indicators could also be due to the fact that the efficacy of bringing about improvements in the health sector also depends on improvements in the overall administrative system of the Government, which has not taken place. The reform process initiated under HSDP introduced a framework that established a working relationship between the NDOH and the provinces, in line with the Organic Law on Provincial Governments and Local Level Governments, and to which other departments, and

government agencies and NGOs (e.g., church-managed health services) are also party. Management innovations were instituted, creating an environment of greater transparency and accountability. Issues related to performance began receiving greater attention and public service officials became increasingly responsive to governance issues. This is of fundamental importance in a country where increased public spending on health has hardly translated into a larger supply of effective health services, due to inefficiency, poor accountability, and lack of transparency in public service provision.

B. Cambodia

32. In contrast to PNG where health conditions failed to improve despite support, there was general improvement in Cambodia both in areas where the ADB projects were active and in other parts of the country, where other development partners, including the World Bank, were active. In comparison with PNG and Sri Lanka, poverty seemed to be extremely severe in Cambodia. This makes it difficult to analyze the overall impact of the ADB projects or to isolate many of the positive aspects.

33. However, the contracting out component of HSSP did have a separate and rigorous analysis, showing how contracting of health services to NGOs affected the welfare of the poor. Initially, only five districts were selected for contracting out and the selection of districts was done randomly for statistical validity. In general, the results of the mid-term surveys, representing only 2.5 years of the experiment, indicated that all contracted out districts had already achieved their contractual obligations for most of their service coverage evaluation indicators. The overall results suggest that measurement of objectively verifiable, baseline, service coverage indicators, combined with close monitoring, well defined contractual goals, and independent follow-up measurement provides a level of accountability that encourages increased performance. Figure 1 outlines the impact of the project in the two types of contracting districts (contracting out and contracting in⁸) and in control districts.



EPI = Expanded Programme on Immunization, FIC = fully immunized child, TT2+ = tetanus toxoid 2+.

⁸ In the Basic Health Services Project, two different types of contracts were used. "Contracting out" involved having an NGO administer all aspects of the government system. In "contracting-in" districts, NGOs provided management support to the government system.

Box 1: Trends in the Distribution of Health Services in Papua New Guinea, 1991–2000

An Asian Development Bank (ADB) health sector review examined the changes in health care delivery during 1991–2000 using the 1996 Demographic and Health Survey to divide the population into five socioeconomic groups (quintiles) according to the possession of selected household assets. The major findings follow.

Poverty. The Highlands and Momase regions have the highest incidence of poverty as measured by the asset index. The difference between regions is partly due to the percentage of the population living in urban settings but also due to differences in socioeconomic status between rural populations.

Availability of and Access to Health Services. The percentage of the population living within 5 kilometers (km) of a health facility was 85% in 1995. Poorer households live further away from health facilities (aid posts, government and mission health centers). The number of doctors employed in rural facilities decreased during the 1990s. The number of nurses increased but not in line with population growth. Many aid posts were closed during the 1990s. Consequently the percentage of the population living within 5 km of a facility decreased to 80% in 2000. The change initially affected the very poorest quintile.

Quality of Services. The services offered to poorer households are of lower quality than those available to more prosperous households in terms of qualifications of staff, equipment available at health facilities, availability of medical supplies, and the extent of clinical supervision. There was some improvement in 1998–2000. Such improvement directly benefited the poorer households, but improvements in clinical supervision and medical supplies were largely confined to government-run facilities.

Family Planning Services. There are large disparities in the uptake of family planning between quintiles. Contraception use is lowest among the poorest two quintiles. The disparities in the use of family planning between quintiles were probably exacerbated by the closures of aid posts.

Maternal Health. Poor women have more complications during pregnancy and are less likely to receive antenatal care or a supervised delivery than nonpoor women. Distance appears to have a strong influence on the rate of supervised delivery, but is not the only barrier to the uptake of services because many poor women living within 5 km of a facility do not use it for their delivery. There was a fall in the proportion of deliveries undertaken in all types of facilities during 1991–2000, with a sharp drop in mid-1995 that was most pronounced in rural facilities run by missionaries.

Child Health–Immunization. Immunization services have succeeded in reaching poorer households as judged by BCG coverage and 1st dose triple antigen. However, fewer children in poorer households complete the immunization schedule. Overall rates for completion of triple antigen immunization fell by approximately 10% during the 1990s. It appears that immunization rates were maintained in urban areas but were reduced in rural areas.

Child Health–Use of Curative Services. Poorer quintiles had a higher incidence of self-reported illness, particularly fever, but were less likely to seek treatment. Poorer quintiles were more likely to use government health centers followed by aid posts then mission health centers for treating children.

Child Health–Mortality. There were large differences in childhood mortality rates between quintiles. The difference could be ascribed primarily to differences in post-neonatal mortality. The leading causes of death at 1–11 months were pneumonia and other respiratory diseases (50%), followed by meningitis (12%), malaria (6%), septicemia (5%), and diarrhea (4%). Early recognition of symptoms and appropriate treatment for pneumonia are essential but do not address the root causes of severe respiratory illness in poor children, which relate to nutritional status, housing, and environment.

Source: ADB (2002b).

34. Coverage of health services in contracted out districts is seen to have achieved significant improvements in a short time. The results of the mid-term survey suggest that contracted out districts outperformed the control districts with respect to the contractually obligated coverage indicators. In addition, contracted-out districts appear to have outperformed contracted-in districts, on average.⁹ This is particularly the case for the use of reproductive health services, child health services, and curative health services. While all districts achieved increases in antenatal care, coverage of antenatal care in contracted-out districts increased by more than 43% compared to 27% in contracted-in districts, and 14% in control districts. A similar pattern was found with maternal tetanus toxoid immunization.

35. Contracted out services, in general, appeared to be more effective than services run by the Government in reaching the poor, both in absolute and relative terms. Contractual targets established at the baseline defined “the poor” as the lower 50% socioeconomic group in each district.¹⁰ The data suggest that use of primary and district health facilities by the poor increased dramatically. Contracted-out districts had the highest increase in use by the poor, with utilization rates increasing from 3% to 33%, compared to an increase of 4% to 8% in control districts. One possible explanation is that contracted-out districts did not implement official user fees and discouraged “unofficial” user fees by paying significantly higher salaries to low-level health care providers than did the other types of districts.

36. Out-of-pocket expenditure on health services by the poor decreased in contracting-in districts, while it slightly increased in contracted-out and control districts. There was a significant decline in the per capita private out-of-pocket expenditure in the contracted districts, especially for the poor. Private out-of-pocket health care expenditures by the lower 50% socioeconomic group in contracted-out districts fell by 70%. The reduction in out-of-pocket costs was greater among this population than among the overall population, indicating successful targeting of the desired beneficiaries and efficient transfer of subsidies. Out-of-pocket health care expenditures for households in the lower 50% of the socioeconomic scale decreased by \$35 per capita per year, which is a very attractive return on about \$5 per capita per year public investment through contracting the services. This is particularly important in Cambodia, where most health care expenditures are private (around 75% of health care is estimated to be paid out of pocket) and the high cost of health care is a leading cause of poverty and vulnerability.

C. Sri Lanka

1. Health Expenditures

37. ADB’s policy dialogue has always stressed adequacy of health expenditures. The evaluation report of the Second Health and Population Project (1992–1999) indicated that public expenditures were inadequate for proper maintenance of facilities. In 2001, the total government health expenditures in Sri Lanka amounted to around 1.8% of GDP, only a small increase over the 1.6% recorded in 1990. The report found that the share of health in the budget was only 4.2% in 2000, declining from the average of 4.6% in the first half of the 1990s. This decline was influenced by general market-based policies adopted since 1977, which encouraged a greater

⁹ The differences in performance are statistically significant at the 5% level or better.

¹⁰ An index of socioeconomic status was developed based on ownership of household assets which serves as a proxy variable for household wealth. These assets include (i) whether there was a permanent type of roof on the house (brick, cement, metal, or a combination of these materials), and whether anyone in the household owned a (ii) bicycle; (iii) radio; (iv) motorcycle; (v) television; (vi) oxcart; (vii) motor boat; and (viii) at least one cow.

role for private provision and recovery of costs from users. The main effort of public health expenditures was to maintain public health infrastructure that was already in place and increase coverage of referral centers in rural areas to address the needs of the poor. Extending government primary referral centers to rural areas in Sri Lanka appears to have benefited the rural poor, who began making increasing use of them.

2. Health Outcomes

38. Data from post-evaluation reports of the Second Health and Population Project indicate a strong inverse relationship between government health expenditure and the average duration of stay for inpatients in the two main categories of PHC hospitals—district and rural. During 1993–2000, duration of stay fell by 26% and 30% in district and rural hospitals, respectively. This suggests that the quality of services in the lower levels of the referral system improved in the target areas during this period. Overall, the patients benefited socially and economically from having to spend fewer days in hospital, while health providers delivered their services more efficiently. As most of the PHC hospitals are located in remote areas, the main beneficiaries were poor families.

39. The report also concluded that significant improvements were made in the referral system in geographically disadvantaged areas and in the quality of services provided by key PHC training institutes in Sri Lanka. Improved trends in family planning practices were also observed. During the latter half of the 1990s, there was a steady increase in new contraceptive acceptors and in the contraceptive prevalence rate under the national program. The 2000 demographic and health survey indicated that around 99% of married women had knowledge of at least one contraceptive method. The total fertility rate was 2.1 in 2000 compared with 2.6 in 1990.

40. One of the contributors to success was highly effective in-service and on-the job- training provided to the entire range of health service personnel. Training on counseling was provided, especially for midwives, and the rural poor went regularly to midwives and rural hospitals for family planning counseling.

41. A key national outcome was to reduce the problem of bypassing of district, peripheral, and rural hospitals; prior to the project they were very much underutilized. The proportion of registered live births in public hospitals increased from 85% in 1993 to 93% in 1999, which speaks well for the referral system. Between 1993 and 2000, malnutrition among preschool children declined sharply from 23.8% to 13.5%, while the prevalence of wasting declined slightly from 15.5% to 14%. The IMR decreased marginally from 17 to 16 per 1,000 live births, and the maternal mortality rate fell from 25 to 23 per 100,000 live births.

42. While it is difficult to indicate in quantitative terms the project's contribution, it seems to have had a significant impact on the health sector in qualitative terms. The performance appraisal report concluded that by "training around 1,600 health workers, upgrading PHC hospitals and training facilities across the country, strengthening the referral system, and targeting support for antenatal care, child welfare, preventive medicine and family planning," the project helped improve the delivery services of the health and population sector to the poor.

3. Impact on Poverty

43. The impact on poverty reduction was significant because the PHC services were directly targeted to reach the rural poor in isolated areas. Closer access to health services reduced travel time and cost, while improvement of health enhanced employment opportunities and reduced work absenteeism, thus having a direct impact on income generation and poverty reduction. The project helped in stemming the decline in basic services for the poor. It reinforced the Government's concerted efforts over several decades to achieve better health for all. In many ways, it contributed to achieving some of the MDGs for health. Sri Lanka is one of the few countries in South Asia to have achieved MDG goals for health and social development ahead of time.

Table 4. Sri Lanka Health Output Indicators

Health Output Indicator	1993	2000
% registered live births in public hospital	85.0	93 (1999)
% malnutrition among preschool children	23.8	13.5
% prevalence of wasting (low weight for height)	15.5	14
% infant mortality rate per 1,000 live births	17	16
% maternal mortality rate per 100,000 live births	25	23
Total fertility rate (births per woman)	2.6 (1990)	2.1
% contraceptive prevalence rate (any method)	66.1	70.8
Inpatients treated in rural PHC hospitals (upgraded under the ADB project)	39,280	72,432
Family planning new acceptors	169,689	214,627
% of one-year olds fully immunized against:		
tuberculosis	90 (1995–1998) ^a	97 (1999)
measles	91 (1995–1998) ^a	95 (1999)
% births attended by skilled health personnel	85 (1990)	95 (1996)
% pregnant women immunized against tetanus	83.7(1997)	89 (1995–1997) ^a

ADB=Asian Development Bank, PHC= primary health care.

Note: Figures are for 1993 and 2000, other than those specified.

^a Percent average for this period.

Sources: ADB (2003a and 2003b) and UNDP (2002).

IV. FACTORS THAT INFLUENCED SCALING-UP

A. Commitment, Leadership, and Motivation

44. The PNG case suggests that many favorable factors were present that may have implications for health services delivery in the long-term. The full gamut of interventions was brought to bear in the health sector, ranging from extension of infrastructure to systems improvements and policy change. There was strong leadership at the central ministry level. This was supported by the donor community and resulted in testing new ways of partnership between the central and provincial level, the development of an exemplary health policy and a national health strategic plan, and initial brainstorming about how best to structure a sustainable partnership between government and development partners. Mechanisms necessary for project monitoring and coordination were drawn up by teams that also included provincial representatives and all interested stakeholders in the public health sector. Strong leadership was provided by the Secretary for Health on all issues of importance covering health services delivery.

45. The weakness was the inadequate incentives to motivate service delivery staff at low levels, especially provincial. Support from other key government agencies was inadequate, including for education and transport, and was reflected in the lackluster implementation experience of health projects. Improved functioning and sustainable change in public service culture of the health sector cannot occur without the active involvement of the relevant government support agencies in addition to the health agencies directly concerned.

46. Cambodia was going through a period of reconstruction and recovery from a protracted and very violent conflict. Indeed, when the Basic Skills and the Basic Health Services projects were approved, there was still a situation of conflict in some parts of the country. There was, however, a strong commitment on the part of all stakeholders to work together to restore peace and stability. This was enunciated clearly by the new Government after the elections of 1998. At the same time, there was an understanding that while the level of health services for the poor was extremely low or nonexistent, hard and realistic choices needed to be made. The Ministry of Health, working with WHO, built on the experience of other countries and an assessment of Cambodia's needs, and developed a minimum package of services. This helped keep expectations realistic. Also, with the very low level of service, it was easy for the ministry and development partners to show early success, which was an important incentive to continue investing in the system and reconstructing damaged facilities.

47. The Basic Health Services Project combined proven elements, such as training and infrastructure, with new components, such as contracting out implemented on a pilot basis. This slow approach was realistic given the limited capacity in Cambodia, and was necessary to ensure political support. Some policymakers saw contracting out as an erosion of their area of influence and authority and they often found it uncomfortable to deal with NGOs. One important factor for success in Cambodia was a commitment to invest more in primary health care. Because the program was new, it was possible to start with a primary health care focus in poorer areas. It also required political will to prioritize in favor of the poor.

48. In Sri Lanka, the Government's strong commitment to improve health care delivery was clearly articulated in the new National Health Policy adopted in 1992. It reinforced again Sri Lanka's traditional commitments to basic services provision, some of which had been affected by the shift to market-based policies. The second ADB project there was one of the main instruments through which the new policy was implemented successfully in targeted areas. As a continuing endeavor to maintain the gains of the last few decades in human development in general and health and population in particular, the Government ensured that all loan covenants were generally complied with and adequate counterpart funds were provided and sustained. In its poverty reduction strategy, the Government declared its intention to modernize its health care services and has committed itself to continuing the work undertaken under the ADB project to enhance institutional capability at all levels and promote private sector participation in both preventive and curative health care.

B. Innovations in Lending and Service Delivery

49. In PNG, the sector development loan modality was an innovation in the PNG context. Its nonprescriptive nature and the diversity of objectives made it poorly understood, especially outside the NDOH. Because HSDP was widely seen as ADB's contribution to the Economic Recovery Program (ERP), there was not uncommon belief that the HSDP loans were intended to be budgetary support, albeit to the health sector, similar to the assistance from other contributors

to the ERP. At different times, the Department of Finance's top management felt that the loan proceeds could be used to cover NDOH's recurrent budget without increasing its funds in order to implement the National Health Plan. Protecting the loan funds became difficult under the general budgetary scarcities.

50. While the sector development program modality has many advantages when driven by a well-coordinated and determined program of action, giving flexibility to a government to use available funds for high priority areas of intervention, it can break down when the general government system, particularly at local levels, is regressing. Given the obvious stresses and dislocations of fiscal decentralization and evident lack of coordination, the situation called perhaps for continuation of pre-appraised investment projects that left no ambiguity about the use of funds, as in Sri Lanka and Cambodia, where all projects supported by ADB were investment projects with simple and specific components.

51. In Cambodia, ADB's health sector investments combined established project components with innovative experiments in contracting health services and with other proposed innovations in health finance. These innovations and the willingness of the Government clearly contributed to the success of the contracting experiment. The design of the contracts themselves contributed to their success. The basis of contracting was the assurance that providers would be adequately compensated for their services and effectively supervised and supported. NGOs working in contracted-out districts revised the salaries of health care providers and brought them in line with average salaries in the private sector. In return, the NGOs required the providers to work full time in health facilities and have no private practice. In contracted-in districts, the NGOs supplemented providers' salaries through their own funds and by allocating a share of user-fee incomes. This ensured that providers in poor areas were not at a disadvantage because they were working with people with low paying capacity. Market-based salaries motivated the staff to work in remote and poor areas and made it easier for the contractors to enforce full commitment from them. Regular supervision and support from the district health management teams kept their motivation high and ensured that they performed as per the agreement.

C. Decentralization

52. The design of HSDP in PNG was overtaken by decentralization embodied in the New Organic Law, which affected the health sector. Responsibilities were devolved first to provincial governments then to districts. As a result of this process, the Department of Health lost control over the delivery of health services at subnational levels. At the same time, capacities in districts were extremely limited, lacking (i) technical knowledge, (ii) staff (who were to be transferred from provinces but actually remained in their positions for lack of physical facilities at the district level), and (iii) financial resources (funds were not transferred from provinces to districts).

53. In summary, the implementation of the New Organic Law was not adequately prepared and lacked support from the central level. The funding levels to local governments initially envisioned under this law were unrealistic and unattainable. The framework of grants to local governments sought to establish both equity and respect for central government priorities but the low funding upset these objectives. As a result, performance varied and, during 1999–2001, one third of the provincial governments were suspended for poor financial management and failure to deliver services. Other provincial governments experienced similar problems and, although not suspended, were largely inoperative. Funding responsibility was given to the provincial administrations but most failed to allocate funds adequately to health care.

54. Authorities in Sri Lanka appeared to have managed decentralization well and retained good supervision over the process. A constitutional amendment in 1988 established provincial councils responsible for the formulation, implementation, and monitoring of provincial health plans based on national policies and strategies. The Second Health and Population Project in Sri Lanka was, therefore, implemented in an already decentralized environment and did not suffer as much from the trauma of decentralization. The post-evaluation report for the project felt that it had, in fact, helped the fiscal decentralization process, which called for, *inter alia*, improved governance at the provincial level through its human resource development components. The quality of policy planning and program budgeting has improved, as has the capacity of planning units under the provincial directors of health to undertake performance monitoring. This is shown by the quality of annual planning documents, which have become more comprehensive, analytical, and result-oriented, allowing greater accountability and support for the Government's move toward performance-based budgeting.

D. Governance

55. Opposing influences—the rising consumer price index and weakening purchasing power of public servants' salaries, coupled with poor management established by weak government leadership over the years—hindered initiatives to improve governance and management in PNG. Cultural parameters, such as clan affiliation and the pervasive *wantok*¹¹ system, contributed to limiting good governance. An independent provincial-level performance audit highlighted governance issues. This served to underscore the need for a similar review process in NDOH. The report established that controls over procurement and expenditure within NDOH were ineffective and were not conducive to efficient operation. Only incremental progress has been achieved to date, but with the potential to influence public service culture positively.

56. Again, this contrasts sharply with the Sri Lankan case. An ADB impact evaluation study for the health sector (ADB 2001) noted that “the contrasts in impacts between PNG and Sri Lanka could be attributed to governance. Sri Lanka's stronger social services served as a foundation that the ADB projects built on to succeed, whereas PNG's weak governance cut into the projects' effectiveness.” Sri Lanka was able to devote its scarce budgetary resources in a cost-effective manner. This was also reflected, for instance, in the Second Health and Population Project's own implementation record. Despite civil unrest, construction works were completed with only minor delay. The project cost was 16% lower than the appraisal estimate, part of which is explained by savings in procurement. The coordination between the project management office and provincial authorities was good and no undue bureaucratic delays took place in the large subprojects.

E. External Catalysts

57. Interventions in the health sector do not happen in isolation. External factors always play a major role in determining policy success. As previously argued, the health sector is only one of many factors contributing to health and is only effective if households take advantage of the services and information offered by the health system.

¹¹ In most traditional settings, the *wantok* system provides for an egalitarian sharing of wealth and responsibilities. It provides a kind of safety net with strong community obligations. While the *wantok* system provides advantages for the clan, it often does so at the expense of modern and social obligations, which go beyond the boundaries of one's extended family or clan. In the public service, the *wantok* system leads to much conflict of interest and nepotism.

58. In Papua New Guinea, many external factors intervened to complicate the reforms proposed under HSDP. In particular, the project was introduced in a time of serious economic and fiscal problems. While development partners were active in the country to try to limit the social consequences of these reversals, their support was often not sufficient to compensate for the lost income and development opportunities. The general trend of health indicators was negative, partly due to the general economic problems that the country faced.

59. Cambodia, in contrast, benefited from a number of positive trends, including economic growth, as a result of stability and the "peace dividend," and consequently a general improvement in the health status of the population. Although there are serious concerns about governance, development partners have generally been supportive of the country and have provided generous financing for development programs, including those in the health sector. The capacity of the Government and the Ministry of Health has increased noticeably in the past decade, allowing them to develop and implement realistic strategies. In Sri Lanka, the projects were isolated from the internal civil strife; hence, they remained unaffected.

60. External development partners have played an important role in all three countries. ADB and other development partners have provided critical assistance in formulating policies and shaping investments. In Cambodia, when the HSSP was approved in 2002, there was a growing consensus about the need for partners to work together under the government-owned strategy. The health sector strategy was built on existing policies and was an attempt by the Ministry of Health to consolidate and up-scale these policies, rather than to start from scratch. The partnership of ADB, DFID, and the World Bank also built on existing efforts and was not an attempt to develop a "textbook" SWAP but rather to improve coordination and cooperation in the short term. The Cambodian Government and partners were able to channel the real commitment to rebuild the country and improve access of health services for the poor into a set of realistic policies and actions designed to continue the positive momentum.

V. LESSONS LEARNED

- *Targeting the poor: Establish a process whereby the needs of the poor are incorporated into development planning and implementation, through monitoring and granting specific incentives.*

61. The PNG case highlighted the wide differences in delivery of health services between poor and better-off households. This calls for particular emphasis to reach the poor, particularly poor women and children in rural areas. Their needs should be explicitly considered in government and donor policies. Health interventions should be so targeted that they would benefit the poor in terms of the main diseases that affect them, facilities that they are more likely to use, and geographic areas where they are concentrated. For example, targeting in PNG should be on acute respiratory infections that affect the poor; emphasizing highland areas with concentrations of the poor; and strengthening of aid posts and missions on which the poor rely heavily. But more important than specific interventions is the establishment of a process whereby the needs of the poor are incorporated into development planning and implementation.

62. The projects in Cambodia specifically targeted the poor both in their design (focusing on poor and underserved districts) and monitoring framework that gave incentives to contractors.

The evaluation suggests that this approach was successful. Similarly, the Sri Lanka projects specifically focused on primary health care in rural areas, which benefited the poor.

- *Performance indicators and an evaluation system: Projects should develop a set of monitoring indicators and a framework to evaluate the results. These can be used to increase incentives for providers and to build political support for scaling-up successful interventions.*

63. One critical element in the success of projects in Cambodia was the use of a set of performance indicators to monitor the progress of the providers (in this case, NGOs) and also to make the case to the Government and other development partners on successes in the health sector. Contracting requires clear agreements on deliverables and an enforceable contract. It also requires an independent and mutually agreeable performance verification system. In the Cambodia experiment, targets for 13 key health indicators were agreed on. These indicators specifically included measures for improving access to health services by the poor. The progress toward achieving these targets was measured through independent household surveys and spot checks by government staff. Payment for contracts was linked to achievement of targets. When performance exceeded the minimum level, the contractor was entitled to a bonus payment. The same data were also used to carry out rigorous evaluations that were widely disseminated. This approach played a central role in building political support for scaling-up the contracting and in attracting new sources of finance. Performance monitoring was also emphasized in the capacity-building efforts under the second Sri Lanka project.

- *Decentralization and basic services delivery: Decentralization can be a powerful instrument to increase local ownership and participation. It should be realistic in its design and phased in carefully so as to not create too many disruptions in transferring services and responsibilities, and also allow strong local involvement and participation.*

64. Decentralization brings opportunities but also risks. Apart from the issue of developing a proper fiduciary environment to prevent malfeasance, there is the general issue of capacity building for basic services delivery. This also has implications for attainment of MDGs in general—many countries in Asia have decentralized basic services delivery functions without adequate capacity building. The PNG and Sri Lanka examples have both good lessons to offer. An important cause of the lackluster performance of the health sector in PNG is the breakdown of the vertical integration of health services brought by the New Organic Law. Decentralization can alleviate overloading the central government and improve access to decision making and participation by more people. However, decentralization can also lead to deterioration in the use and control of resources if the administrative capacity is lacking—particularly at local levels if it leads to loss of previously available central expertise—or if there is insufficient prioritization for national goals, which is the case in PNG. Many provincial authorities did not prioritize health services through budget support. Provincial governors had all agreed to allocate 15% of provincial revenue to health; yet none did so. The Organic Law did not allow for prioritizing funds to poorer provinces. There was inadequate supervision from the central level.

65. While clearly the PNG case suggests lack of sufficient preparation for decentralization, the Sri Lanka case illustrates a different issue connected with decentralization. It was noted at the

evaluation of the Second Health and Population Project that the central government project managers were hesitant to part with authority and maintained strict supervision. The authorities' response was understandable in the context of perceived weaknesses in capacities at decentralized levels and need to maintain strict monitoring over a matter of high national priority. However, these considerations need to be balanced with local needs and priorities, calling for better participation by all relevant parties. Cambodia is introducing decentralization gradually and most financial responsibility remains at the central level.

- *Health financing: The distribution of subsidies and the organization of the health finance system can have a major impact on poverty and projects should take this into account explicitly when designing interventions in the health sector.*

66. How health is financed has a major impact on the poor. Although the private sector can play an important role in providing health care, the high cost of health care can also be a major burden on them and is often a leading cause of poverty. In Cambodia, better management of health care, including reduction of informal fees and the establishment of a transparent fee schedule, has aided this process. In Sri Lanka, the State's comparatively low spending on health was at the cost of high private expenditures and cost sharing by the users of services. However, the Government's emphasis on extension of public primary health services in rural areas encouraged a large increase in the use of these services by the poor. In PNG, however, it appears that despite increased funding and predominance of public provision of health care, insufficient health outcomes occurred, particularly for the poor.

- *Capacity and human resource development and management: Capacity constraints should be specifically addressed. Project designs should be realistic and should take into account the capacity of governments.*

67. Capacity development is crucial for delivery of health services. In PNG, the health sector suffered from the general malaise of weak governance and human resource management in the Government. This included inadequacy in data collection, planning, supervision, enforcing transfers, defining roles and responsibilities, control of absenteeism, and failure to implement retrenchment programs. Contractual staff, paid for by external technical assistance and project funds, have been engaged in an attempt to overcome these problems. However, public service reforms addressing personnel management issues should reach across all government agencies and all levels of government in order to have a permanent impact on public service culture.

68. In Cambodia, delivery capacity of the Government was also weak. However, the design of projects took this factor into account. The design of the first ADB project was quite simple, focusing on increasing capacity and generating the right set of incentives. In Sri Lanka, emphasis on human resource development was part of a long learning process. Initial health sector interventions had neglected human resource issues. The second project successfully addressed this issue. The Government learnt that improving the technical and managerial skills of human resources contributed to improving the delivery of health care services, including the referral system. This was achieved through domestic and overseas training programs.

- *Scaling-up to a sector-wide approach: Partnerships can play an important role in coordination and lowering transaction costs for the government and development partners, but their design should be realistic. Rather than simply trying to apply the best practice examples used in other countries, the scaling-up process should be gradual and be built around the capacity of local stakeholders.*

69. In all three countries, scaling-up delivery of health services (supported by ADB and other donors) began by improving health infrastructure, then focused on quality improvements and human resource development. In the case of PNG, it has now been extended to policy reform, with limited success. In both Cambodia and PNG, there is interest in using SWAPs for the health sector. Much still is required to be done in PNG, particularly in coordinating the multiplicity of interventions and the different agencies in the Government involved with health issues, and also different approaches of partners. Although there is an ongoing SWAP, the conditions in PNG may not suit this approach. Managing a SWAP requires a high degree of capacity in coordination and close cooperation among all agencies. In Cambodia, the goals of the partnerships have been more modest, focusing on improving coordination and working to implement the Government's health sector strategy.

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