

**LESSONS OF EXPERIENCE
FROM SECTOR-WIDE APPROACHES
IN HEALTH**

This paper has been prepared by Mick Foster of the Centre for Aid and Public Expenditure (CAPE), Overseas Development Institute, UK, on behalf of the World Health Organization. It is a preliminary document which will be updated and expanded on the basis of a number of country case study carried out by CAPE on behalf of WHO and the Inter-Agency Working Group on Sector-Wide Approaches and Development Cooperation.

WORLD HEALTH ORGANIZATION SEPTEMBER 1999

GENEVA

Lessons of Experience from Health Sector SWAPs

1. The first section briefly defines Sector Wide Approaches, introduces the rationale for them, and discusses the broader policy and budget context in which they should be set. This will include brief discussion of how SWAP approaches may relate to the recent debates on aid effectiveness, and their relationship to medium term budget frameworks, and to the ideas on Comprehensive Development Frameworks which have been developed in the World Bank.
2. The paper then goes on to discuss some of the emerging issues and lessons from the experience to date of the SWAP approach, drawing mainly on the health sector experience. This is organised into sub-sections dealing with the role of Government and the boundary of the SWAP; the budget process and the SWAP; planning and appraising a SWAP; poverty; and management issues. The main conclusions are summarised at the end.

Definition of SWAPs

3. The Sector Wide Approach defines a method of working between Government and donors, and should not be confused with the specific instruments of development co-operation, such as the World Bank Sector Investment Programmes (SIPs) which have been associated with the approach in particular countries. Various definitions have been proposed for the broad sector approach, though the criteria defined have often gone far beyond the actual achievement so far in those operations usually defined as taking a Sector Wide Approach. For the purpose of this short paper, the defining characteristics of a SWAP are that all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds. However, a key message from the experience so far is that the SWAP is, as the name implies, an approach rather than a blueprint. Most programmes, even quite well established ones, are in the midst of a process for moving over time towards broadening support to all sources of funding, making the coverage of the sector more comprehensive, bringing ongoing projects into line with the SWAP, and developing common procedures and increased reliance on Government. The working definition thus focuses on the intended direction of change rather than just the current attainment.
4. The approach to the aid relationship which is described here is mainly appropriate in highly aid dependant countries. Where Government is able to provide adequately for the recurrent budget, while also financing significant capital spending from domestic resources, an intrusive role for donors in the budget process would be inappropriate and it may make sense to confine donor flows to financing projects within the capital budget. This traditional approach can avoid the worst of the distortions described previously, provided Government retains control over the size of the investment programme, and of the selection of projects (though possibly appraising them jointly with donors). This model can work where policies are sound and there is a strong planning and budget process which keeps a balance between capital and recurrent funds, and where donor flows are modest, and do not excessively absorb Government attention. Examples might include the approach taken in much of South Asia. Within Africa, Botswana perhaps comes closest to this model.

The Broad Policy Context within which SWAPs are Developing

5. It is important to understand the evolving experience and literature on aid effectiveness, as part of the rationale for the SWAP approach, together with other recent developments in policy and practice which provide the context within which health sector SWAPs will be developed and implemented.

The Evolution of SWAPs from both Macro and Project approaches

6. The SWAP approach has evolved from two main directions.
7. Macro economists and the designers of structural adjustment programmes have become more interested in a second generation of reforms as the liberalisation and macro stability objectives of early programmes are achieved. The focus has been on improving the allocation of the national budget and donor flows both between and within sectors. Those who come to sector programmes from this direction have had a strong focus on the allocation of limited resources. The concern has been to overcome the problems of budgets where failure to prioritise leads to universal under-funding. In the health sector, the focus has been on the share of the budget going to health, the share within that going to primary and preventive services, and the definition of the role of Government and non-Government providers in meeting the demand for health services. A key objective has been to improve the budget process, capturing all funding sources and expenditures, and fitting health sector plans within a rolling medium-term budget where overall allocation decisions can be made in line with national priorities. This would ensure that the health sector does not undermine national priorities by going direct to donors. This approach has been commonest in Africa, where quick disbursing support for structural adjustment has been dominant in development cooperation thinking since the early 1980s.
8. The sector wide approach also developed from the concern of health professionals that the traditional project approach is not producing sustainable improvements in services. There has been increasing recognition that donor driven projects have often absorbed scarce human and financial resources in activities with limited coverage, that projects often adopted standards which could not be replicated or sustained, and that heavy reliance on expatriate technical assistance has been unhelpful to the development of local capacity or management systems. Those who have arrived at the sector approach from this direction have focused more on the detail of the policy and institutional arrangements within the health sector, and on how to strengthen the management, delivery, and responsiveness of health services to needs.

SWAPs and Broader Aid Relationships

9. The recent literature on aid effectiveness suggests that aid only works where the policy environment is conducive, but that conditionality has no observable positive impact on the policy environment. Recent empirical work also confirms the common-sense view that fungibility places severe limitations on what can be achieved with a project approach. Governments can and do adjust their own expenditures in the light of donor commitments, to achieve the Government's desired pattern of spending. The result is that a donor focus on primary services may not lead to any net increase in total resources used for that purpose.
10. The policy implication most usually drawn is to be more selective in deciding which countries to help, and which sectors and institutions within those countries, giving less emphasis to ex ante conditions, and more to assessing the track record and commitment of partner countries. Where there is commitment to priorities which Government and development partners both share, the evidence is that aid adds substantial value; where there is not, it is far less clear that aid produces significant benefits.
11. The evidence on aid effectiveness has reinforced the trend towards broadening the nature of the development co-operation relationship, and the instruments to support it. The risk of aid being wasted in poor policy environments, or of priorities being undermined by offsetting action by Government are being tackled head on. Sector wide approaches are one of a number of instruments which go some way towards defining relevant aspects of the policy environment and the use of resources at the outset. This does not mean a return to old-style conditionality, though the differences are subtle ones. The poor record of donor imposed conditionality in achieving policy change is addressed by focusing more on track records and evidence of genuine commitment to change, rather than just financing programmes which Governments have been persuaded to sign up to in order to get the money. The content of reforms is of course important, but so is the process by

which policies were put together, and the efforts to consult local stakeholders and communicate the reasons for decisions with appropriate high-level support.

12. The most recent, and most comprehensive, of the new approaches is the Comprehensive Development Framework being promoted by the World Bank, and associated with the personal initiative of James Wolfenson, the Bank president. The CDF envisages a structure in which all major development partners in Government, private sector, civil society organisations, and official and NGO partners co-ordinate their efforts around a national consensus on where the country is going and what is required in order to get there. Though ambitious, and no-one (including the World Bank) believes complete consensus is either achievable nor necessarily desirable, there are some precedents. The vision 2020 statement in Ghana, and the poverty eradication action plan in Uganda, both represent examples of attempts to forge a broad view of national problems, and how they should be tackled, and are widely known and discussed within the country. Below this level, there is increasing recognition of the need to develop public understanding of the issues and policy choices which need to be made. For example, there has been much discussion of opening up the policy debate around the policy framework paper, the key document negotiated between the Government and the IMF and World Bank in low-income countries receiving adjustment support.. This sets out the policy measures which Government has agreed to implement over a three year period. Governments are increasingly being encouraged to take charge of drafting it, and to ensure that there is a national debate on the measures and transparency on the decisions arrived at. Pakistan and Kenya for example both published the policy framework paper, and Kenya has held national fora to discuss the future direction of policy.

Defining the role of Government, and the Role of the SWAP

13. The clearest lesson on sector wide approaches in all sectors is that Government must have a clear vision of the role which it will play in the sector, and a determination to make the choices necessary if priority programmes are to be adequately funded.
14. The broader context is important to SWAPs for a number of reasons. The public sector role is only part of what happens in the health system, and public expenditures need to be supported by an appropriate legal and regulatory framework for private providers and sources of finance. The growth of revenues for the health sector will depend on the growth of the national economy, the revenue policies of Government, the perception of the country formed by donors (and by private investors), the share of public revenues available to allocate after debt service is accounted for, and the share of that which is made available to health services. The institutional mechanisms for the SWAP may be decided by national policies on decentralisation and delegation of powers to local Government, while the motivation of staff will be powerfully influenced by public sector pay policies. The quality of financial management may be determined by national systems and capacity building programmes in financial management, accounting, and audit. This short list of examples illustrates that some issues of central importance to the success of a SWAP need to be resolved at a higher level, requiring action by for example the Cabinet or the central economic ministries. The health SWAP will always be dependent on allocation of resources in the budget, and will usually also be influenced by policy changes in reforms beyond the responsibility of health sector managers.
15. Most sector-wide approaches in health have been concerned essentially with the public sector role in the health sector. This means that in practice the expenditure programmes covered by the SWAP typically represent less than half of total spending in the sector, even in low income countries. The SWAPs have not covered policy and spending in related areas which may have important health benefits (e.g. water or education). They have not covered health expenditures funded by private contributions, or by insurance schemes, nor have they covered health services to employees funded by defence ministries or major parastatal employers. The private for profit and not for profit (Religious and NGO) sectors are also not normally captured. In what sense then are SWAPs sector wide, what rationale is there for where the boundaries have been drawn, and should the SWAPs evolve to become more (or less!) comprehensive in their coverage?
16. One of the lessons from previous reviews of the experience with sector wide approaches is that they work best where there is correspondence between the definition of the programme, and the area of responsibility of a single Ministry or Agency of Government, with a single budget:

institutional rivalries and simple co-ordination problems have proved major impediments to implementing sector programmes across more than one Government Department. They nevertheless need to reflect "sector wide thinking". It is important to obtain a clear picture of the overall pattern of services and resource flows in the sector, perhaps by compiling health sector accounts as in Bangladesh. The Government role is typically defined as regulating the sector as a whole, and ensuring the provision of high priority services which will not be provided if left to the private sector. This might be because of market failures which are familiar and widespread in the health service, or because the private sector is unable to reach some low income groups with services at affordable cost. The definition of services actually supplied by Government may in practice reflect political rather than economic logic. It is common for the largest subsidies to be enjoyed by urban hospitals, which is inequitable, but may be politically difficult for a Government which depends on the goodwill of the urban elite to dismantle.

17. Ensuring the provision of services may not require Government to actually provide them: Mozambique and Bangladesh both include provision for Government financing of non-Government health services. This can help avoid wasteful duplication, though there may be issues over the terms of access: NGO providers often charge higher prices, and the problems of securing subsidised access for the poor are non-trivial.

SWAPs and the Budget Process

18. Policy statements, however good, are only meaningful when linked to a process for allocating the resources needed for the Government to carry out the tasks which it sets for itself. This remains true across the spectrum of public sector responsibilities from setting and enforcing the legal and institutional framework within which the non-Government sector will work, to raising revenue and directly financing and supplying services. Stating that primary and preventive services are the first priority, as health policies invariably do, needs to be backed by specific action to maintain or increase the budget for these priorities by restraining the budgets of other parts of the health system. Donors risk undermining this process if extra funds for the health sector begin to flow before the hard decisions have been taken. A key task is to define the resource envelope for the sector, the resources available from Government, donor, and private and NGO contributions, both currently and projected into the future. Government then needs to prioritise what it can afford to do to fit within that envelope. This needs to relate the budget to programmes and outputs, rather than just to the historical pattern of budget allocation and spending. The costing of the programme can be done with various levels of sophistication, and there is much to be said for keeping it simple. However, there is a clear need to confront directly the issue of whether the available financial and staff resources are consistent with the aims of the programme, and to make cuts in the lowest priority programmes where they are not. The budget process is therefore crucial to any vision of an improved development framework, and is the forum in which it is most critical for all funding partners to work together.
19. The process towards which a number of countries are struggling to evolve is one in which Government and donor funds are jointly allocated through a process of dialogue in which Government, donors, and other stakeholders are involved. This needs to take place at both national and sector level. At national level, a medium term budget framework (MTBF) is prepared to set out what Government wishes to achieve, what it will cost, and how it proposes to finance it from both domestic and foreign sources. This is discussed and broadly agreed with donors at appropriate points in the budget cycle. Sector programmes are nested within the MTBF, with a similar process at sector level, and with iteration from sector discussions to the overall budget discussion, to ensure consistency of financing assumptions with the national resource envelope. Tanzania and Uganda are both in the second budget year in which donors have been involved in dialogue on the MTBF as part of the budget cycle. The process is not perfect, but progress is being made in increasing the proportion of donor funds captured in the budget presentation, and in improving the discipline on line ministries to prepare realistic budgets.
20. The MTBF approach can provide the overall framework for prioritising expenditures by Government and donors, and the envelope for sector and project interventions. In return for a transparent dialogue which permits legitimate donor influence, donors should ensure that their interventions are developed fully in accordance with the budget process. To enable Governments to make optimal use of available resources, donor funding should be longer term while the

conditions of partnership are in place, and in flexible form. Under this approach, the SWAP is embedded in the budget process. Government defines policy in the sector, linked to the resources required, which are bid for in an annual budget process which captures Government and donor resources in a medium-term framework, and which is rolled forward in each annual budget round. This is the approach which has been taken in Uganda, Ghana, and Tanzania. The budget for the health sector and the expenditure programme for the SWAP should be seen as identical to each other. The SWAP programme is not set in stone: it is annually adjusted in the light of donor and Government funding available, which would imply that targets would also need to be adjusted.

21. This approach enables distortions in the pattern of expenditure to be addressed, and the recurrent cost implications of development projects to be provided for. In principle, if the key problem in the current pattern of funding is a shortage of non-salary recurrent funding for drugs, consumables, maintenance and transport, this can be addressed by shifting Government and donor resources in the required direction. It requires a long-term forecast of the development of future resources for the health sector, in order to ensure that the level of spending does not exceed a level which can be sustained. However, in a growing economy, it may be entirely reasonable for donors to finance recurrent costs now, in the expectation of an eventual exit as growing Government resources permit. This explicit approach is preferable to the common pattern on donor projects, where recurrent costs are financed de facto, but without a clear strategy for eventual exit.
22. The MTBF approach requires a reasonable degree of budget stability, with budget releases closely aligned with the approved budget. Where line ministries have no faith in the budget process, it can degenerate into unrealistic budget bids by line ministries, arbitrary cuts by the finance ministry, and actual expenditures bearing little relationship to either. A credible budget process is hard to establish, but credibility is easily lost. If donor funding can become more predictable (which it is not at present), and be linked to agreements which place some safety net under the Government contribution, then the SWAP process can help to build improved budget planning and execution.
23. The planning process in Bangladesh Health and Population Sector Programme has followed a different route, with the focus mainly on the development budget, planned by a special office largely staffed by local consultants, while the recurrent budget continues to be allocated through an incremental process, based on the traditional pattern of spending. This dual budget approach has serious disadvantages, not least the lack of relation to macro budget constraints. Incremental recurrent costs of development spending tend to be included as project costs, with little planning for their eventual absorption in the recurrent budget. The move away from the project approach has not fundamentally altered this problem.

The Process for Planning a SWAP

24. Health SWAPs do not start from a blank sheet of paper. There are usually earlier policy papers setting out the role of Government and policies in the sector. There are inherited projects and programmes. There may be existing efforts and projects to strengthen planning and management processes and capacity. The complexity of moving from this patchwork of activities to a single strategy is daunting for departments with limited capacity, largely absorbed in dealing with donors. There will often be a history of past plans and reform efforts, possibly a history which has bred cynicism among staff. The SWAP approach therefore has to build commitment and trust among stakeholders at various levels within and outside the sector. It is preferable to consult widely, though there are dangers of capture by narrow interests such as the hospital doctors or staff reluctant to be posted to the rural areas.
25. The SWAP process once started risks becoming unstoppable, with donors keen to make commitments to their own timetables and placing pressure on Government to quickly develop policy positions and budget proposals. These pressures can lead to Government signing up to policies and programmes which have not been widely enough discussed to ensure local ownership, or which have not adequately recognised constraints on implementation. This can lead to extended delays and sluggish implementation. There is much to be said for Government developing a national health strategy through a domestic consultation process before approaching the donor community for help with funding it.

26. The SWAP process itself is too cumbersome and involves too many actors to be a suitable approach for defining health policies. The donors themselves are numerous, have their own interests which they may protect, and may not speak with one voice. There have been significant disagreements between the donor community on the appropriate role of Government in the health sector. Those from a European tradition of Government health services have frequently found themselves at variance with advisers more comfortable with the North American tradition of health service markets. Those involved with vertical programmes which have proved effective in combating specific health problems may feel threatened by approaches promoting integrated district services. It is important to emphasise that a sector wide approach can accommodate both vertical and horizontal approaches, with the balance determined by what appears cost-effective and sustainable in particular situations. Disagreements of principle are most easily resolved pragmatically when faced with empirical evidence of what is working and what is not.
27. On the Government side, political as well as technocratic pressures need to be accommodated. The process of national consensus building on the health policy is an inherently political one, not likely to be helped by the perception of inordinate influence by foreign donors. The sequencing which appears to work best involves the Government first defining the main priorities and institutional arrangements which it wishes to put in place, before approaching the donors for support. The further negotiation of the detailed programme may well call on technical support from donors, and will clearly need to involve them in dialogue. However, the key directions of change should be defined before reaching the stage of involving the donors.
28. The complexity of the process of moving from possibly hundreds of donor projects towards a single sector policy and expenditure programme is daunting. A realistic approach will focus on a few clearly strategic objectives, leaving some of the more tricky and complex issues to be tackled later. In the case of Ghana health, the diagnosis was that district level services needed improving in order to better meet health needs at affordable cost. The key priorities were to make an increased share of increased resources available to fund district level services, and to provide increased authority to managers at district level to manage their budgets in line with national priorities. This focus implied a whole sequence of other measures, developing district and regional planning and budgeting, defining criteria of readiness to manage funds, defining performance measures and indicators of progress, and building staff capacity. The basic shift of emphasis, however, was both clear, and monitorable, and carried implications for the balance of future development and recurrent budgets.
29. A consensus on the policy framework between Government and the donor partners is the one critical precondition. Capacity to implement can be built, but there is no substitute for lack of agreement on aims and instruments. Where this key pre-condition is not met, whether due to local capacity constraints or lack of consensus on policies, scepticism about the sector-wide approach is inevitable. In some countries this scepticism is reinforced by the perceived active promotion of the approach by the donors, without necessarily taking account of local capacities, or even objectives. A central lesson which emerges strongly from the SWAP experience is the need to allow time and space for local consensus on policy to be formed without driving too strongly towards 'closure.' It has often taken longer than first anticipated, and the initial agreement requires constant maintenance by further discussion and promotion as personalities change and events throw new challenges in the path of the programme. This can be a problem if donors become tied too early to an inflexible approval schedule. Stakeholder participation can be formulaic. This absence of a real partnership often leads to three problems for the implementation of the sector programme: an ill-defined role of the state, not winning the backing of senior officials, and not having representation of the poor. The worst case scenario is that where a SWAP is designed without a clear commitment to tackle major problems within the health sector. The SWAP can then become a mechanism for pouring more money into failing systems, delaying reform and achieving little sustainable impact.

Building Commitment and Ownership

30. Health sector reform has in most cases been a top-down process, initiated by senior technocrats (or more rarely by politicians), and there are few examples of SWAPs which emerged after a broader national debate. However the programme is designed, it will be important to ensure that those

required to implement it both understand what is required of them, and have the incentives to behave as they are expected to.

31. In Zambia there was strong high-level political and administrative backing for the health sector programme. It survived a change of Minister. The Ministry was involved jointly with donors in determining conditionality and used the conditions to protect key reforms and health expenditures against domestic opposition. However, participation in the preparation of the programme was weak. Other Ministries, NGOs, private health providers, some Ministry of Health staff and local communities were left out of the consultations. As a consequence local ownership was not broad enough to prevent reversals in policies. When the sector wide approach appeared to fail to deliver, government expenditure switched back from primary health to hospital funding.
32. The Ghanaian health sector benefited from broad local ownership. This was achieved through regular consultations with stakeholders from all levels of the central Ministry and the district level, as well as with key representatives from the central government agencies. The considerable effort devoted to two-way communication with staff at all levels has been sustained, and is a major strength of the programme. The May 1999 annual review involved a wide cross-section of staff, and field visits confirmed strong understanding and commitment down to district level and below. In order to keep the process manageable, large six monthly meetings with strong involvement by local stakeholders had to be supplemented with smaller 'business meetings' at which concerns of Government and donor partners could be raised openly, and addressed in greater detail.
33. Communication alone will not lead to action unless the message is clear and credible, and accompanied by positive incentives. The Ghana case represented a fortunate combination of rising budgets and increased delegation, which empowered and enthused district level staff. The Bangladesh Health and Population Sector Programme has also devoted considerable effort to explaining the objectives and new procedures to staff. However, the messages were more mixed. Delay in resolving the key staff concern in securing the position of those currently on the development budget may have undermined confidence in other measures. Powers have been redistributed within the line ministry, but without significant delegation down the line. Procedures have been changed but remain subject to inter-departmental dispute, while the new structures and procedures are themselves quite complex. The reported lack of staff understanding and knowledge of the HPSP may thus not reflect so much a lack of communication effort as staff reluctance to absorb a message which was perceived as complex, which might yet be revised, and which was perceived as bringing few benefits to them, or their work.

SWAPs and Donor Appraisal

34. Although the SWAP is an approach rather than a blueprint, donors will need to complete a formal appraisal process in order to commit funds to the programme. There has been a serious problem both of long delays in completing appraisal, and examples of delayed disbursement of approved funds. This risks undermining the credibility of the approach. It will be important to avoid a sag in disbursements during the commitment phase, which may require continued encouragement of new or extended project commitments during the transition. It is also important to deliver early evidence of benefits, perhaps by designing in some early measures which are both popular and visible: better availability of drugs and consumables, or early commitment to vaccination drives might be considered.
35. The approval process for donor commitments has usually but not always featured joint appraisal of the proposed programme. This typically includes sub-groups looking at the budget and financial issues, procurement and accounting arrangements, the building and investment programme, human resource development, and specialists looking at primary, secondary, and tertiary services, and at relations with NGO and private service providers. The organisation of teams differs, but the issues to be addressed do not. The most effective arrangement for appraisal seems to be the clear separation between programme document preparation by Government, followed by independent appraisal by a common team with relevant expertise but performing the role on behalf of the donor partners as a whole. The resulting appraisal document can then be put to a joint Government-donor meeting for discussion and approval in principle. Detailed financing negotiations with individual donors will then be undertaken, based on the jointly agreed report and aide memoire from the general meeting. To keep the process manageable, there can be merit in splitting the discussion

with donors between the core group willing to provide programme financing, and the larger group who may continue to provide project finance for the moment. The continuing role of project finance should of course be limited to the financing of expenditures which form part of the agreed sector programme.

36. The Ghana health sector provides a good example of a partnership between government and donors. With the introduction of a sector wide approach, the Ministry of Health became more assertive in controlling and co-ordinating donors. It urged donors to work within existing government structures, rather than creating parallel systems. This move coincided with key donors such as the World Bank, DFID, Danida, the EC and USAID becoming more flexible in their funding and more aware of sector concerns than narrow project interests. This flexibility on the part of donors also included a willingness to give time and space for commitment in the Ghana government to develop. Achieving a sector wide approach has taken time as trust and respect needs to be built on both sides. It doesn't allow for quick fixes, and has been built on the foundations of previous work. Before the sector programme in health was started Ghana had already gone through "10 years of institutional development, 4 years of major policy/strategy work, 3 years of strengthening of core management functions, 2 years of negotiations, planning and design, and 1 year of slippage and delays". (presentation by Paul Smithson to NORAD conference), p. 14.
37. The implication to be drawn from this is to emphasise that the SWAP should not be conceived as a blueprint which has all activities defined in advance and all starting from day one. Premature implementation of complex components may prove ineffective or even counter-productive. The SWAP should rather be thought of as a process. The definition of the policy framework and the commencement of institution building needs to start early. The definition of the expenditure priorities and programme will also be scheduled early, but may initially be supported in part from project support. Progress towards common procedures should be sequenced to build up as capacity and confidence allows. The expenditure programmes should be built around the MTEF, with only the first year firm, and with the planning horizon rolled forward each year. The SWAP should be an approach, a new way of doing business which, if successful, will have neither start nor end date, though it will have time bound objectives and indicators for measuring progress.

Poverty in Sector Programmes

38. Most sector programmes in health have attempted to move resources towards primary and preventive health services, towards funding an essential package of health services, and towards improved national coverage of primary health care. The approach may have been too focused on the supply side, but in terms of conventionally accepted paradigms, the direction of change in the pattern of resources has been avowedly pro poor. Most have recognised the importance to the poor of access to first referral curative treatment, and have included district hospitals in the programme priorities.
39. Donor interest in health sector funding has normally been quite heavily focused on preventative and primary level services, with a keen interest to see funds move in this direction, and earmarking or common funds sometimes limited to such services, as in Zambia. In order to achieve this, there has been recognition of the need to ring-fence the portion of the budget taken by the tertiary hospitals. User fees are increasingly common at this level, and attempts have been made, as in Zambia, to make the tertiary hospitals separate accounting bodies, responsible for living within a fixed budget, and targeted to cover more of their costs from revenue. The Zambia experience illustrates that this is a difficult trick to pull off. The hospitals started from a position of serious management problems, and a shortage of Zambian qualified medical staff, paid low salaries obliging them to focus on private practice. The introduction of a hard budget constraint for the hospitals and challenging revenue targets coincided with the withdrawal of expatriate medical staff. The deep-seated problems of waste and mis-management were not adequately addressed, perhaps due to inadequate staff incentives. Hospital performance was perceived to have declined, leading eventually to a political decision to move resources back in the direction of the hospital sector. The case deserves further study, as an example of the need to give serious attention to hospital management if the reforms to primary services are to be sustained.

40. Expenditure tends to follow the location of facilities, and is typically quite skewed at the outset. The Ghana health SWAP collected information on the regional pattern of expenditure, and future plans are based on the objective of bringing all populations within access of a health facility. The formula for resource allocation moves tentatively in the direction of narrowing the gap. Bangladesh HPSP has a similar objective of establishing primary health facilities within reach of all, but collects no data to enable regional disparities in facilities and staff to be identified, and progress in narrowing them monitored. Budgets are standardised for the type of facility, with the result that 30 bed facilities may have budget surplus or shortfall depending on utilisation. Tanzania's tracking study of public expenditure revealed that inequality in expenditures within districts was as severe as inequality between them, partly reflecting staff preferences to cluster near to the district capital. A similar pattern may be present in other countries. Tackling the problems of regional inequality, which are correlated with poorest access by poor regions and poor people within them, requires action on a number of fronts, with the solution to persuading staff to serve in remote and poor districts a critical constraint everywhere. The SWAP approach gives an opportunity to tackle these issues in a holistic way, though few have yet been able to do so.
41. Discussion of the poverty issue so far has focused largely on the supply side issues of resource allocation. The relative lack of attention to the demand side, however, can have serious consequences. Some health sector programmes feature an increased role for user charges as a source of funding for health services. The gap between available Government and donor resources and the cost of a minimum essential package of services often makes some user contribution inevitable, before even considering how politically feasible it is to cut subsidisation of services outside the essential package. It is beyond this paper to explore in detail the complex issues involved in policy in this area, but there are some concerns. User fees are usually accompanied by exemption policies for the poor, but monitoring of the effects of exemptions has been weak at best, and limited data suggests serious difficulty. Both in Ghana and in Tanzania, private expenditure on drugs represents around 50% of total national expenditure on health, much of it probably not well spent. The key point to make is not that user fees are necessarily bad for the access of the poor to quality health services, though they may be in some cases. The critical point is that the user fee policy has not usually been informed by a good understanding of the health seeking behaviour of the poor, and of the multitude of constraints on their access to services, and their willingness to use and pay for Government services.
42. A key input to a more pro-poor approach will be better understanding of the current views of the poor on the services available to them, and the constraints on their access. This needs to cover non-users as well as users, and for credibility should be collected by researchers rather than relying only on staff to undertake their own surveys of customer satisfaction. The latter can be a worthwhile exercise, but serves a rather different purpose of improving staff understanding of the population they are trying to serve.
43. There are a number of approaches to collecting information on health seeking behaviour and attitudes to health services. In Zambia, the participatory poverty assessment and subsequent studies by Booth et al collected useful information both on health services, and on the reaction to user fees. Key findings included different priorities between staff, who valued improved physical surroundings, and patients, who complained at staff treatment of them, and of charges for consultation where drugs were unavailable. Service Delivery Surveys, as in Bangladesh, and Core Welfare Indicators surveys, as in Ghana, have enabled information to be collected on user opinions of services, and on the existence of informal and illegal charging practices. The tracking studies of public expenditure, which were undertaken in Uganda and Tanzania, have been helpful in determining whether budget resources intended for funding primary health programmes actually got there. Household expenditure surveys are also a rich source of information on what the poor actually spend on health, and where they go for service. The key point is the need to better connect the SWAPs to information and analysis on the constraints which the poor face, and to take appropriate action to address them. Where they are regularly repeated, as is intended with the CWIQ survey in Ghana and the service delivery survey in Bangladesh, they also provide a means to track changes in attitude, behaviour, and perceived quality of services over time. This gives a good proxy indicator of the impact of the SWAP in a situation where more fundamental indicators of morbidity and mortality are not collected frequently enough, nor likely to respond quickly or predictably to improved services, rendering them of little value for monitoring purposes.

44. Recent discussion of routes to making Government services more responsive to the needs of the poor have focused on increasing transparency, and information available to the poor on their rights. Clear display of schedules of user fees and of mission statements and the like may have some positive impact. There are more severe limitations on this process in health than in sectors such as education. The engagement of the users of health services is less continuous than is the case with the local school, the facility may serve a larger catchment reducing community ownership, and the information gap between health staff and patients makes it more difficult to be confident that empowering patients will necessarily lead to better health outcomes. The Bamako approach to community involvement in drug revolving funds may be an important exception, which has achieved some success in promoting community involvement in management: it has been widely reviewed in the literature and is not further discussed here.

Monitoring, Evaluation and Objective Setting

45. All SWAPs have struggled to define objectives with monitorable indicators which can be tracked over the period of the programme, and related back to the resources used. A few general points emerge from the experience.
46. Health outcome indicators move slowly and unpredictably, and are measured infrequently via demographic and health surveys. Proxy indicators are therefore needed to track impact over a realistic time frame. Use of service delivery surveys, utilisation statistics, and tracking studies of public expenditures can help in developing convincing indicators likely to be correlated with ultimate service quality and health outcomes.
47. Most SWAPs have been more successful in tracking process indicators (i.e. have decisions been taken on time), and financial flows, than in developing convincing indicators of what is being delivered or how it relates to cost-effectiveness.
48. Ambitious MIS systems are usually subject to long delay, and excuse failure to provide even basic data to monitor the programme.
49. There is need to change management culture towards one in which data plays a role in decision-making, if staff are to see a positive reason to collect and use it.
50. Where data is collected, resources for further analysis are often under-provided. The health economics unit in HPSP Bangladesh provides one example of an approach to overcoming this difficulty and ensuring that a capacity exists to provide policy relevant analysis
51. There is a strong case for further research to identify best practice in this area.

Health Sector Management in SWAPs

52. All health SWAPs currently in operation have hybrid arrangements, with some funds flowing as general programme support, and some continuing to use project or commodity aid type arrangements, more dependent on donor management. Moving towards common arrangements has been gradual, with a core of donors often leading the way, initially with a portion of their committed funds, and with a larger share of the funding following as trust and confidence is developed.
53. Zambia and Ghana both featured some pooled funding. In the Zambia case, the 'common basket' did not use Government disbursement procedures, and was limited to district level services. It was provided in support of district health plans, with releases dependent upon submission of reporting and accounting information from earlier periods. In Ghana, pooled funds are in principle available to all cost centres meeting 'readiness criteria' to manage funds, criteria which focus heavily on ability to meet basic financial accountability requirements: this has gone hand in hand with efforts

to build financial management capacity, providing useful synergy between capacity and delegation of authority. Cost centres in Ghana health are being asked as part of the Medium Term Expenditure Framework, to sign up to performance agreements, specifying the outputs they will deliver with the financial resources for which they are responsible. This approach sounds attractive in principle. However, earlier attempts to apply performance contracts to reform public enterprises largely failed, and the credibility of the process risks being undermined by prolonged delays in the release of budgets in 1999: departments can not be held responsible for anything if promised resources are not provided.

54. Restrictions required by donors have had an excessive influence on management arrangements in some SWAPs. In order to build capacity, the aim should be for the Ministry's own planning, budget and management processes to merge with the SWAP. Bangladesh HPSP is an example of a situation where the overall management of the programme is the responsibility of a Programme Coordination Cell of local consultants and seconded staff, responsible directly to the Secretary, paid from the development budget, and advised by a consultant led Management Change Unit. Both are located together, separated from the Ministry. Pooled donor funding is managed by the World Bank using World Bank procedures, administered via a Health Sector Coordination Unit with seconded World Bank staff. These arrangements may be appropriate, but their enclave nature contrasts with the approach being taken in Ghana, where the emphasis on strengthening local systems and using them to disburse funds is much stronger. The differing approaches would merit further study.
55. Poor donor performance in converting discussions to commitments and disbursements has been a major problem, as has the difficulty of persuading donors to provide information on actual disbursements and future financing intentions. The unpredictability and unreliability of donor flows has serious consequences not only at sector level, but is also a problem for macro-economic management. Donor flows can be highly uncertain as to their timing for purely bureaucratic reasons. Conditions have also proliferated at all levels from the project to macro economic and Governance issues. Managers at all levels can find that the financial resources on which they depend can be interrupted because of the failure to meet conditions at a higher or lower level over which they have no direct control.
56. The increased stress on working in partnership with Government implies obligations on both sides of the partnership. However, Governments in receipt of concessional funds lack sanctions to hold donors to their commitments. It would also be a backwards step if donors held back information on their financing intentions for fear of contracting a commitment which would be difficult to break. It is more useful to recipients to have a best estimate of future spending levels than to plan only on the basis of firm commitments. Nevertheless, where a formal commitment has been entered into, donors should be expected to honour it, and there may be a role for peer pressure from other donors who are also financing the programme. The elaboration and agreement of a 'code of practice' for donors supporting the SWAP, as was done for Tanzania education, can be useful in providing a framework for peer pressure. There is also a strong case for those donors who are able to do so, to sign up for longer-term commitments to provide support for sector programmes. This is no different in principle from the firm project commitments which many donors have traditionally entered into: there is no reason why commitments to provide budgetary support, or to help fund an agreed sector programme should be any less firm. Increased predictability of the amount and timing of donor support should be a major goal if 'partnership' is to be made meaningful.
57. On the Government side, the policies and programme described in the sector programme planning documents should also be regarded as a firm commitment, entered into between the Government and the funding partners, and subject to an agreed process of consultation for modifying it and rolling it forward to the next financial year. The policies and expenditure plans of a democratic Government can not be set in stone by a five-year agreement with the donor community, nor should they be. However, it is reasonable to establish an agreed policy direction and set of spending priorities, and agreed procedures for discussing new policy and programme developments, which impinge on the objectives of the sector programme. It is important to define the process by which disagreements will be discussed, and the sanctions, which may be triggered. There is a subtle distinction between this approach and the style of conditionality used in structural adjustment. For sector programmes, the conditions will consist of agreeing to undertake such

measures as are necessary to achieve the objectives of the sector expenditure programme, and to refrain from actions which are inconsistent with achieving those objectives. They are closer to the traditional approach to project level conditions, than to the approach of structural adjustment where the role of the aid was to purchase policy reforms which Government might not otherwise have undertaken.

Decentralisation

58. The increasing pressure to move towards decentralised local Government with jurisdiction over primary and secondary health services, and funded by block grants, is a major issue in a number of countries in Africa (Uganda, Tanzania, Ghana). Although the intention is to move services closer to people and hence make them more accountable, the evidence seems to suggest that accountability at local Government level is as weak as at the centre. There is as yet little experience of how to implement a SWAP using a decentralised local Government structure. In Ghana, the current intention of the Ministry of Health is to avoid the problem by setting up the Ghana Health Service, not responsible to local government authority. In Uganda, one approach has been to make earmarked grants for specific purposes. In theory, it should be feasible to operate a SWAP via a decentralised system provided national policy priorities are clear, including establishing clear definitions of the services which local Government is expected to provide. In practice, defining affordable services and holding local authorities to account will be extremely difficult if the block grant route is chosen for financing.
59. Tanzania may be facing an additional problem in retaining staff motivation and a national career structure in a situation where staff are due to become the employees of over 100 separate local authorities, posing problems of pension liabilities and staff transfer.

Conclusions

60. The SWAP approach aims to make progress towards ensuring that all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds. It is primarily appropriate in highly aid dependent countries.
61. Government must have a clear vision of the role which it will play in the sector, and a determination to make the choices necessary if priority programmes are to be adequately funded. Government needs time and space to ensure local ownership if extended delays and sluggish implementation are to be avoided.
62. The public sector expenditure programmes covered by the SWAP typically represent less than half of total spending in the sector, though they must be informed by 'sector wide thinking' on policy. SWAPs work best where there is correspondence between the definition of the programme, and the area of responsibility of a single Ministry or Agency of Government, with a single budget.
63. Government policy in the sector needs to be linked to the resources required, which are bid for in an annual budget process which captures Government and donor resources in a medium-term framework, which is adjusted and rolled forward in each annual budget round. Donors should ensure that their interventions are fully in accordance with the budget, longer term, and in flexible form.
64. SWAPs need to take an explicit long term view of the development of future resources for the health sector. In a growing economy, it may be entirely reasonable for donors to finance recurrent costs now, in the expectation of an eventual exit as growing Government resources permit.
65. SWAPs should initially focus on a small number of strategic issues, prioritised and carefully sequenced. The definition of the policy framework, the commencement of institution building, and the definition of the expenditure priorities and programme will be scheduled early, but may initially be supported in part from project support. Progress towards common procedures should be sequenced to build up as capacity and confidence allows. The SWAP should be an approach, a

new way of doing business which, if successful, will have neither start nor end date, though it will have time bound objectives and indicators for measuring progress.

66. Implementation requires clear responsibilities, and positive incentives.
67. Avoiding a sag in disbursements during the commitment phase may require continued encouragement of new or extended project commitments during the transition.
68. It is important to deliver early benefits, by designing early measures which are both popular and visible.
69. Efficient appraisal arrangements involve: programme document preparation by Government, followed by independent appraisal by a team with relevant expertise performing the role on behalf of the donor partners as a whole. The resulting appraisal document can then be put to a joint Government-donor meeting for discussion and approval in principle. Detailed financing negotiations with individual donors will then be undertaken, based on the jointly agreed report and aide memoire from the general meeting.
70. It is essential to agree procedures for discussing new policy and programme developments, which impinge on the objectives of the sector programme, and to define the process by which disagreements will be discussed, and the sanctions which may be triggered.
71. The approach may have been too focused on the supply side, but in terms of conventionally accepted paradigms, the direction of change in the pattern of resources has been avowedly pro poor. Sustaining support for desired re-allocations of spending requires difficult problems of hospital management and incentives for staff re-allocation to be addressed.
72. More attention and analysis is needed on the demand for services and constraints on access, especially by the poor.
73. SWAPs need better information on outcomes. Mortality and morbidity statistics move too slowly, but tracking of changes in attitude, behaviour, and perceived quality of services can be a useful proxy to complement output figures.
74. Empowering the users with information and influence over resources can help improve quality and access to services, but there are more limitations on this process in health than in sectors such as education.
75. In order to build capacity, the aim should be for the Ministry's own planning, budget and management processes to merge with the SWAP..
76. Poor donor performance in converting discussions to commitments and disbursements has been a major problem, as has the difficulty of persuading donors to provide information on actual disbursements and future financing intentions. There may be a role for peer pressure to address this.
77. There is also a strong case for those donors who are able to do so, to sign up for longer-term commitments to provide support for sector programmes.
78. The Ghana experiment to introduce performance agreements for sector managers is interesting, though attempts to use performance contracts to reform public enterprises largely failed, and managers can only be held responsible if promised resources are provided.
79. No country has yet succeeded in reconciling decentralisation based on block grants with a health sector programme; in practice, the issue has been avoided by use of conditional grants or other institutional mechanisms which preserve professional and financial delegation within the health sector.

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