



Asian Development Bank

Draft: Check against Delivery

**Address**

**by**

**Ursula Schaefer-Preuss  
Vice President for Knowledge Management and Sustainable Development  
Asian Development Bank**

**THE SOUTH ASIA REGIONAL MINISTERIAL MEETING**

**Sri Lanka**

**16 – 18 March 2009**

### **Introduction**

Distinguished delegates, ladies and gentlemen: thank you very much for the opportunity to address all of you on behalf of the Asian Development Bank (ADB). Foremost, let me begin by thanking our hosts, the Government of Sri Lanka. I think it is appropriate that this important meeting is held here in Sri Lanka, as the country has made considerable progress in health outcomes. Starting in the early 1950s, Sri Lanka was able to reduce the maternal mortality rate by half in just three years; and then, in the subsequent years, it was halved again.<sup>1</sup> This impressive gain has been sustained to the recent years, which exemplifies the strong commitment of the country on equitable and affordable health care system.

Today, I hope to discuss on the following three themes which I think are relevant to this important conference:

- First, the importance of finance on some of the key health challenges facing South Asia;
- Second, ADB's activities to help our developing member countries (DMCs) to respond; and
- Finally, and most importantly, what the countries in the region can do to enhance financing for health care, especially given the current global financial crisis.

### **Finance and Health Challenges**

As I have mentioned about Sri Lanka already, we all know that South Asia has achieved some very impressive health outcomes. But we also know that South Asia still faces enormous health challenges, including:

- About 45% of the children under the age of 5 in South Asia are moderately or severely underweight, the highest rate for any region in the world, and a rate much worse than Sub Saharan Africa.<sup>2</sup>

- Over half of the 450 newborn babies who die every hour in the world die in just six Asian countries: Afghanistan, Bangladesh, China, India, Indonesia and Pakistan. Three of these are in South Asia.
- An alarming 15% of the world's newborn deaths occur in just three states of India: Bihar, Madhya Pradesh and Uttar Pradesh.

Thus, despite the region's progress, we have still many challenges facing us. Many factors explain the breadth, and depth, of these challenges: poverty, customs, class, caste, gender, education, environmental factors and so on. However, today, I hope to focus on another key issue: financing, and particularly on public financing which is ultimately in the hands of the Governments. Some things really stand out when looking at health financing in South Asia. For example:

- *Total expenditure on health in this region is the lowest in the world.* South Asia spends, on average, just \$US 26 per capita per year on health from all sources – public, private and foreign aid – which is lower than even Sub Saharan Africa.<sup>3</sup>
- *Government expenditure is often very low.* For example, per capita Government expenditure on health was just \$US 3 per person in Bangladesh in 2005; US\$3 dollars in Pakistan; US\$4 in Nepal; and US\$7 in India.<sup>4</sup> And what little is spent by Government often benefits urban or wealthier people.<sup>5</sup>
- *Out of pocket, private, expenditure, is often very high, with implications for equity and impoverishment.* In Bangladesh, Nepal, India and Pakistan, about 70 % of total expenditure on health comes "out of pocket".<sup>6</sup> Even small payments like this can be a barrier to essential health care for poor people, and often become a source of increasing inequality and impoverishment. For example, a recent ADB study found that about 40 million people in India fell below the poverty line due to health payments.<sup>7</sup>
- *Health financing is going to become even more challenging, for both Governments and individual households.* Even without the current global financial crisis, Governments and households were facing an enormous challenge of health financing due to the increase – and ageing – of their populations. The World Bank estimates that changes in population size and structure alone will increase total health care spending needs by 45 per cent in South Asia over the next 20 years.<sup>8</sup> The rise of expensive to treat non-communicable diseases such as cancers, heart disease, and diabetes will impose even further cost burdens on Governments and households. For example, the WHO estimates that India will lose \$ 237 billion in lost national income over the period 2006 – 2015 as a result of premature deaths arising from heart disease, stroke and diabetes. They estimate Pakistan will lose \$31 billion. These are huge figures. Rising costs to treat traffic accidents will also be a significant factor, especially in this region.
- *The Global Financial Crisis will further amplify all these trends.* Finally, with the current financial crisis, the challenges can only increase. National and household budgets will be under greater pressure during economic slowdowns; prices of pharmaceuticals often rise as currencies depreciate; Governments and

individuals are tempted to delay or reduce expenditure on sound prevention and promotion activities for health, thereby exacerbating problems and increasing cost burdens even more.

Ladies and gentlemen – I believe all of us need to respond to these gloomy figures and facts. Again, this is why I believe this event is a very important one.

### **ADB's Activities**

To meet the increasing challenge of the region, ADB is responding in a number of ways. First, ADB is selectively, and in partnership with other agencies, providing direct, long term, development finance, to help DMCs expand and improve public expenditure on health. For example, as recently as December last year, ADB approved a \$ 400 million program loan focused on maternal and child health in Punjab, Pakistan. Similarly, ADB has provided over \$24 million development finance to the Bangladesh Urban Primary Health Care Project, a project that resulted in the following: (i) visitation by professional health workers to poor pregnant women rise from 18% to 97% over a five year period; (ii) Vitamin A supplementation to poor children rise from 26% to 92%; and (iii) women delivering with the assistance of a trained health worker rising from 22% to 97%.<sup>9</sup>

Second, ADB is leveraging its core business lines – and especially water and sanitation - to improve health outcomes. This is important in South Asia where only 23% of rural households have access to improve sanitation, a rate lower than rural areas in Sub Saharan Africa or indeed any other region in the world.<sup>10</sup> As part of this conscious effort to strategically use our core business lines to improve health outcomes, ADB has recently decided it will measure and monitor health outcomes in all its water and sanitation programs – an important decision when "what gets measured gets done".

Third, ADB is actively generating and supporting "knowledge products" that can shape and inform better public financing policy. For example, ADB has just launched a regional study that analyzes the links between out of pocket expenditures for maternal and child health on the one hand and, on the other hand, inequity and impoverishment. That study covers many countries, including those from South Asia. In partnership with others, ADB is also supporting analytical work to identify those "best buys" which will help achieve the health MDGs, especially as they relate to women, newborn and children. ADB has also been supporting economic analysis of disease prevention and control, including for example cost – effectiveness analysis of prevention of HIV and AIDS amongst intravenous drug users in Kathmandu, Nepal. In partnership with others, ADB also supports analytical work on regional pandemics, national health accounts, and so on, all of which improve the basis for public policy and better financial decision making and resource allocations.

### **The Region's Activities**

Despite the efforts from ADB – our goals can not be achieved without the strong partnership and commitment from the Government in the region. We have also recognized that Governments face many, many, competing challenges and priorities in their budget decisions, especially in the current circumstances of sharp contractions in economic growth.

But a global financial crisis and prospects of very constrained budgets is *the very time when it is even more important to set health expenditure priorities well*. Please allow me to reiterate: a time of global financial stress and pressure on public budgets is the *very time* when we need to drive out waste, allocate resources to where they have the biggest effect, and focus expenditure

on the really big strategic wins. The current crisis can also be seen as an opportunity to make some much needed reforms.

And while it is for Governments to decide such priorities and strategic wins, allow me to suggest four areas that would seem to have genuinely *strategic* impact and pay off, especially in this region.

- The first is the need for public expenditure to protect the poor. The poor already have higher health needs and burdens, and disproportionately lower access to good quality health care. Unfortunately, public expenditure patterns often actually tend to reinforce – or even amplify - these inequities: we only need to think of the starving of funds to rural health services where most of the poor live. And what little is spent on health is often out of pocket, with adverse health, social and financial consequences for the poor and near poor. The poor health outcomes undermine national and household productivity in this generation and the next. In brief, we believe that a well-designed expenditure on essential health care that benefits and protects the poor is an investment in national productivity, social inclusiveness, and social stability.
- Second, and related to the first, is the need to invest money in effective measuring, monitoring and evaluation. Even before the current global financial crisis, it was clear that we are simply not generating enough solid data to make strategic decisions about resource allocation and expenditure. One could say that we waste scarce health dollars through lack of useful and usable data.
- Third, when considering health financing and South Asia, I cannot help but mention nutrition. It remains a public health catastrophe that 45 % of children under 5 in South Asia are still moderately or severely underweight, the highest rate for any region in the world, and easily much worse than Sub Saharan Africa.<sup>11</sup> Over one quarter of all infants in South Asia have a low birth weight, easily the highest rate of any region in the world, and much worse than even Sub Saharan Africa where 15% of infants are low birth weight. Only a half of South Asian households use iodised salt. Again, there are high levels of inequity within these overall rates: almost one third of the poorest quintile in South Asia is severely stunted, compared to less than 10 per cent in the wealthiest quintile.<sup>12</sup>

It is of particular concern that such poor nutrition persists in South Asia when so many interventions are both affordable and cost-effective. Some are even cost *saving*. I want to refer here to the well-regarded *Copenhagen Consensus*, where experts were asked last year to identify, from any field, the most cost-effective interventions to assist the poor. Micronutrient supplementation for children was identified as the most cost – effective intervention to help the poor, with the trade reform under the Doha round rated as the second most cost-effective intervention. \ Microfinance – which I personally also support, and which I know is a powerful antidote to poverty for women in Bangladesh and elsewhere – was ranked 22<sup>nd</sup> on this list. But this is the part that is particularly interesting. Out of all the possibilities canvassed, seven of the top ten most cost – effective interventions were directly health related.<sup>13</sup> And five of the top ten were directly nutrition related.

In short, when we are talking health financing in South Asia, the discussion needs to include a discussion about investing in nutrition.

- My fourth and final observation about health financing in South Asia deals with a complex and sensitive issue. But because it is such a strategically important driver of health outcomes and health costs – and yet is in the hands of Governments to manage – it needs to be on the table. It is tobacco taxation, earmarked for under – funded public health budgets. True, tobacco is a legal industry that generates revenues and jobs. But it also imposes fearful – and preventable – costs to government and households. If we are interested in health financing, we may have to think about taxing tobacco consumption and using the revenue gained to add to – not displace – existing public expenditure for health.

## Conclusions

Ladies and Gentlemen: thank you again for the opportunity to participate in this important event. I want to conclude my address with a clear appreciation that South Asia has achieved some remarkable health outcomes. Yet even *with* dynamic and sustained economic growth, and expanding fiscal space over recent years, health outcomes often lag for the poor, and public health financing has not been sufficiently effective, efficient, or equitable. The current global financial crisis means Ministries of Finance are – quite correctly – going to demand even greater value for money from expenditure proposals from all sectors. We believe that well designed public expenditure on health is justified in its own right – it is a 'merit good'. But increased and better allocated public expenditure on health is also justified because it is an investment in national productivity, an investment in social inclusiveness and social capital, and a key responsibility and role of Government.

While the key decisions must – as always – be made by Governments themselves, ADB also wishes to be helpful, either through program lending in collaboration with other development partners, or through the generation of knowledge products. Thank you.

- 
- <sup>1</sup> Pathmanathan I et al. *Investing in Maternal Health. Learning from Malaysia and Sri Lanka*. World Bank. 2003. Page 2
  - <sup>2</sup> UNICEF. *The State of The World's Children 2009*. New York. 2009 Table 2 page 125. Low birth weight is defined as infants weighing less than 2500 grams at birth.
  - <sup>3</sup> World Bank. *Health Financing Revisited. A Practitioner's Guide*. 2006. Page 41.
  - <sup>4</sup> WHO. *World Health Statistics 2008* pp 84 – 85.
  - <sup>5</sup> World Bank. *Attacking Inequality in the Health Sector*. 2009
  - <sup>6</sup> WHO. *World Health Statistics 2008* pp 84 – 85
  - <sup>7</sup> Bonu S, Bhushan I, Peters D. *Incidence, Intensity, and Correlates of Catastrophic Out of Pocket Health Payments in India*. ERD Working Paper Series No 102 Asian Development Bank. 2007.
  - <sup>8</sup> World Bank. *Health Financing Revisited. A Practitioner's Guide*. 2006. page 3
  - <sup>9</sup> ADB. *Bangladesh: Urban Primary Health Care Project*. Project Completion Report. Project Number 29033. March 2007.
  - <sup>10</sup> UNICEF. *The State of The World's Children 2009*. New York. 2009 page 129
  - <sup>11</sup> UNICEF. *The State of the World's Children 2009*. New York. 2009 Table 2 page 125. Low birth weight is defined as infants weighing less than 2500 grams at birth.
  - <sup>12</sup> World Bank. *Attacking Inequality in the Health Sector*. 2009. Page 44.
  - <sup>13</sup> The top ten most cost – effective interventions were, in order: 1. Micronutrient supplements for children (vitamin A and zinc); 2. Doha Development Round. 3. Micronutrient fortification (iron and salt iodisation); 4. Expanded immunization coverage for children. 5. Biofortification. 6. Deworming and other nutrition programs at school. 7. Lowering the price of schooling. 8. Increase and Improve girls' schooling. 9. Community based nutrition promotion.