WHEC UPDATE
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Shaping the Future

Governments and the public are concerned about waste and inefficiency in the health sector. Although there are likely to be various underlying causes, wastage often results from limited information and from limited accountability for decisions about the use of resources. Corruption and fraud occur where there are conflicting interests in combination with limited accountability. Policy-makers, managers, healthcare providers and service users should feel responsible for ensuring that scarce health resources are used efficiently. They should actively combat wastage by identifying the causes, and then make corresponding changes in policy, management and technical procedures.

Spiraling health care costs are causing worldwide concern, and a key component of health sector reform efforts in many countries has to do with making the best use of existing resources. Accounts in newspapers, journals and reports have alerted the public and governments about the wasteful use of money, health personnel, time and supplies in the production of better health. *Inefficiency* occurs when the resources used to produce a given result are greater than necessary. *Wastage* is the careless use or squandering of resources, often in connection with excessive or particularly conspicuous inefficiency. *Allocative inefficiency* is said to occur when decision on what to do with limited resources fail to yield the greatest possible health gains at the lowest possible cost. It is seen where the healthcare system does not provide enough for priority diseases or when health facilities are located beyond the reach of the people who need them. This occurs, for example, when funds are allocated to urban areas instead of the underserved rural populations, or to tertiary care despite greater needs in primary care. *Technical inefficiency* is found where the costs of providing specific services or goods are higher than necessary. This happens when inappropriate resources (technology, drugs, senior healthcare workers, etc.) are used instead of a cheaper alternative of similar quality. The common element in these types of wastage is that resources are not utilized to their greatest possible effect for improving the healthcare status of populations.

Strategies to correct waste: Efforts to reduce wastage should be concentrated in areas where the greatest savings will result. Wastage can be reduced through changes in the following areas:

- Policy decisions (e.g. easing restrictions on the use of staff);
- Management (e.g. bringing about increased use of automated laboratory equipment, where appropriate);
- Training (e.g. improving the diagnostic skills of providers);
- Education and communications (e.g. leading to more appropriate use of services by the population).

Good information is especially important in the health sector because market and price mechanisms do not provide the guidance that managers need to decide what to do. Nor do they help consumers to decide what they need and what to pay for it. Decentralization facilities several of the above actions should be aimed at reducing wastage by: providing improved information and feedback for decision-makers; increasing the control of managers and providers over factors affecting wastage; and increasing the accountability and responsiveness of the healthcare system to its stake-holders.

Wastage occurs in the health systems of all countries, and very little is done to change the situation. Rather than steadily seeking more funds, healthcare systems would do well to take energetic action to reduce wastage.

Tackling Wastage in the Health Sector
Rita Luthra, MD

Your Questions, Our Reply

What are the costs of wastage in healthcare sector, and on whom do they fall? Can common causes be identified in different situations and are the solutions similar?

Sources of Wastage: Efficient healthcare systems provide a maximum of quality healthcare at a minimum cost. Few countries, if any, reach this standard of economic efficiency. Very frequently either expenditure is higher than it should be or the amount and quality of healthcare are lower than they could be for the costs incurred. Broadly speaking, inefficiency and wastage arise at the levels of:

1. Policy-makers and health service funders;
2. Health service managers;
3. Healthcare providers;
4. Households and communities.

The *policy level* refers to decision-making by officials in health and related ministries and private agencies, by senior managers of health services, and by funders such as insurance companies, social security agencies and employers. In developing countries, multilateral, bilateral and international non-governmental organizations (NGOs) are important members of this group through their influence on the type and structure of assistance.

Decisions on resource allocation made at the policy level affect the whole healthcare system and are often responsible for largest amount of wastage. Major problems can be caused by decision to provide support to facilities and levels of care that do not met the criteria for primary health care (i.e. they do not meet the needs of the majority of people). Funds may not be available to operate services for which facilities and health workers are in place. This often arises when external funding to pay salaries is stopped, or when exorbitant prices are paid for pharmaceuticals because of lack of appropriate procurement procedures. Problems sometimes arise because donors insist on support for inappropriate facilities and services and for multiple vertical programs, resulting in considerable duplication.

At the *managerial level*, it is unfortunately true that healthcare workers are often assigned tasks that do not correspond to health priorities. They may be concentrating on medical care, leaving little time for prevention and outreach activities. For certain services it is widely found that either expenditure is higher than it should be or output is lower than it could be for the costs incurred.

Healthcare workers are responsible for many important decisions about the use of resources. Efforts to achieve healthcare reforms may encounter differences of opinion about the definition of wastage. There is general agreement; however, that much wastage can be reduced at all levels of care without adversely affecting the quality and amount of care provided.

Accountability to the population served is also important. This can be achieved through involvement of the population in decision-making on healthcare thorough local health committees and the boards of health centers and hospitals. Education and information are also important for the users of services, to ensure that the services are used most appropriately to meet health needs.

Join our efforts; we welcome everyone

United Nations At A Glance

United Nations and Republic of Benin

The Permanent Mission of Benin to the United Nations is the property located at 125East on 38th Street between Lexington and Park Avenues. It is run by a team of twenty people, including seven (7) diplomats. Activities the diplomatic staff of the mission consists essentially represent Benin in the various committees, bodies and Institutions and Funds and Programmes of the United Nations. Diplomats present the positions of Benin and ensure that they are taken into account in the negotiations. They work

in collaboration with the African Group, the Group of 77, the Movement of Non-Aligned Countries and / or the Group of Francophone countries. 's various meetings interventions Benin representatives are generally based on the need for concerns developing countries the attention they deserve, to give them the means to gradually confront the economic and social challenges they face and the resulting lack of financial resources, the problem of debt and the impact negative phenomenon of globalization. Reports detailing these activities are regularly sent to Cotonou, or seat the government of Benin There is also a Consular recently established which, under the supervision of the Mission, the establishment of consular documents, the provision of civil status and visa services. A fall of each year, during the course of the main part of the session of the General Assembly, the Permanent Mission team is strengthened by a delegation of diplomats who come mainly from the Ministry of Foreign Affairs or other diplomatic representations of Benin. On 23 October 2003, Benin has been elected as non-permanent member of the Security Council for the 2004-2005 biennium.

Details: http://www.un.int/wcm/content/site/benin/lang/en/pid/5176

Collaboration with World Health Organization (WHO)

WHO | Benin

In Benin, life expectancy had improved during last decades and is estimated at 60 years for both sexes in 2012. Improvements are observed in the infant and under five mortality rate as well, which decreased from 83 per 1000 and 151 per 1000 in 1993 to 42 and 70 per 1000 in 2011 respectively.

The reduction in maternal mortality on the other hand is very slow from 497 per 100000 live births in 1996 to an estimate of 350 in 2012, despite the increasing number of births attended by skilled health workers, 84% in 2012. As a result the MDG 4 is still likely to be achieved, but the country is off track for MDG # 5.There is an inequality between rural and urban areas as well as between the different poverty quintiles.

Benin is facing a double burden of communicable and non-communicable diseases. Malaria is the leading cause of morbidity in the general population (41% of prevalence) and the leading cause of mortality among children under 5, followed by Acute Respiratory Infections and other infections. HIV AIDS prevalence is stable at 1.2% since 2005. The number of patients receiving ARVs has been doubled during the last 5 years and the proportion of HIV/AIDS patients needing ARVs and receiving them was 86% in 2012. The number of PMCTCT centres is increasing. Results in the fight against TB are quite encouraging.

The proportion of newly detected cases successfully managed is over 90% and the proportion of TB/HIV co infected patients receiving cotrimoxazole is 98%. Dracunculosis had been eradicated in Benin since 2009 and the elimination threshold has been achieved for Leprosies, Onchocerciasis and filariosis, and is well maintained. Main challenges include scaling up the case management of the growing number of schistosomiasis and improving early detection of Buruli ulcers in order to prevent sequelae and other complications. A STEP study conducted in 2008 has clearly demonstrated that non communicable diseases are a real public health threat, but adequate policies and strategies to tackle the issue are still to be adapted and implemented in the country .In the context of the 1000 days to 2015 initiative launched by the UN GS, Benin has developed a MDGs Acceleration Framework. The country is off track for most health related MDGs, even though some sub-targets may be achieved for MDG 4 and 6

Details: http://www.who.int/countries/ben/en/

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Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Does foreign aid in education foster gender equality in developing countries?

This paper examines the impact of foreign aid on gender equality in education outcomes in developing countries. Heterogeneity effects by type of aid received and by type of recipients are investigated using system GMM methods. The results indicate that aggregate aid disbursements to the education sector negatively affect gender parity in enrolment at the secondary and tertiary education levels and have no impact on gender parity in primary education. No impact of subsector specific aid was found. Heterogeneity in aid recipient type does not seem to matter. The same goes for heterogeneity in aid flows.

For tertiary education, the average parity is high in the sample of countries used in this study (102.9 per cent) which may be one of the reasons why tertiary aid to education does not impact gender parity in tertiary education enrolment. However, the gap between the lagging and high performing countries in terms of tertiary education enrolment gender parity is quite large (ranges from 6.4 per cent to 338.5 per cent versus 44.0 per cent to 126.1 per cent for primary education). Therefore much more needs to be done to close the gap between countries as far as gender parity in tertiary education enrolment is concerned. The same argument goes for secondary education for which the gap in gender parity is also very large (21.0 per cent to 139.8 per cent).

This situation calls for supporting the lagging countries by studying how the best performing countries have achieved parity and see what lessons can be learned, adopted and adapted by the lagging counties.

Finally, the short panel used in this study may be the reason for inconclusive results. Indeed, there were only ten years of reliable aid disbursement data available to this study; having longer panel data on aid disbursements would help shed more light into the aid effectiveness debate but this data would only be available with time.

Publisher: UNU-WIDER; Author: Eugenie W. H. Maïga; Sponsor: UNU-WIDER gratefully acknowledges specific programme contributions from the governments of Denmark (Ministry of Foreign Affairs, Danida) and Sweden (Swedish International Development Cooperation Agency—Sida) for ReCom. UNU-WIDER also gratefully acknowledges core financial support to its work programme from the governments of Denmark, Finland, Sweden, and the United Kingdom.

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

United Nations Girls' Education Initiative (UNGEI)

The Effort to Advance the Global Strategy
(Continued)

Benin: Background

Overview

Benin has one of the rare democratic systems seen in Africa and has achieved relative economic stability. However, it is also a country where infant and maternal mortality and women's illiteracy are high. Poverty, illiteracy and illnesses are some of the factors hindering progress toward the achievement of child rights. The Girls' Education Acceleration strategy was launched in October, 2005 with the Essential Learning Package (ELP) integrated as a strategy for acceleration.

Barriers to Girls' Education

- Poverty and the traditional division of domestic labour means that girls are often required to stay at home to work;
- A general belief by parents that education for girls is irrelevant for their realities;
- Lack of educational support in terms of infrastructure, equipment, teachers, handbooks, etc;
- High costs of education;
- Lack of quality in education which reduces retention of students;

UNGEI in Action

UNGEI's partnership in Benin is known as 'Paquet Educatif Essentiel pour l'Accélération de la Scolarisation des Filles' (Essential Educational Package for the Acceleration of Girls' Education).

Key Initiatives

- Mobilize the Government and the development of partners to improve the availability of education, in both quantity and quality;
- Strengthen communication to change the behavior of the parents and the way they view education;
- Improve the economic means of parents to allow them to pay for the direct and indirect costs of school.

Partnership

At the governmental level, there are close partnerships notably with the Ministries of National Education, Health, Finance, Sports and Culture. Key UN partners include: United Nations Population Fund (UNFPA), World Bank, and Programme Alimentaire Mondial (PAM). Bi-lateral partnerships include: United States Agency for International Development (USAID), Agence Française de Développement (AFD), and Danish International Development Agency (DANIDA). Partnerships with national Non-Governmental Organizations include: Plan Bénin, Action Aid, BorneFonden, and Catholic Relief Services.

UNGEI within other National and International Frameworks

UNGEI's work is completely integrated within the development frameworks, which recognize the education of girls as a priority. The Essential Learning Package for the acceleration of girls' education is one of the strategies retained in the Sector Wide Approaches (SWAPs). The coordination framework of the Technical and Financial Partners and the committee monitoring the set-up of the Essential Learning Package are working in close collaboration.

To be continued……

Top Two-Articles Accessed in August 2014

1. Bone Health: Osteoporosis Prevention Strategies;
   http://www.womenshealthsection.com/content/gyn/gyn010.php3
   WHEC Publications. Special thanks to writers, editors and reviewers for the assistance with update of the review. Financing provided by WHEC Initiatives for Global Health.

2. The Diseases of Addiction: Opiate Use and Dependence;
   http://www.womenshealthsection.com/content/gynmh/gynmh013.php3
   WHEC Publications. Special thanks to our partners in Addiction Management for compiling the review. We are grateful to the healthcare providers who help our patients with addiction diseases and the management.

From Editor's Desk

Welcome to the United Nations Office for Partnerships

The United Nations Office for Partnerships serves as a gateway for partnership opportunities with the United Nations family. It promotes new collaborations and alliances in furtherance of the Millennium Development Goals (MDGs) and provides support to new initiatives of the Secretary-General. UNOP provides Partnership Advisory services and outreach to a variety of entities, as well as managing the United Nations Fund for International Partnerships (UNFIP), established by the Secretary-General in March 1998 to serve as the interface in the partnership between the UN system and the UN Foundation, and the United Nations Democracy Fund (UNDEF), established by the Secretary-General in July 2005 to support democratization throughout the world. The office, headed by Ms. Ann de la Roche, Officer-in Charge, reports to the Secretary-General, Ban Ki-moon. The Deputy Secretary-General, Mr. Jan Eliasson, oversees the day-to-day operations of UNOP.

The United Nations Fund for International Partnerships (UNFIP) was established in 1998 to serve as the interface between the United Nations Foundation and the United Nations system. The work of UNFIP is overseen by the UNFIP Advisory Board chaired by the Deputy Secretary-General.

At the end of 2013, the cumulative allocations to UNFIP projects reached approximately $1.3 billion, out of which $0.45 billion (about 35 per cent) comes from core Turner funds and $0.85 billion (about 65 per cent) was generated as co-financing from other partners. Five hundred and forty four (544) projects have been implemented by 43 United Nations entities in 124 countries. An overview of these programmes and initiatives are provided below.

The United Nations Foundation continues to work in support of the United Nations in a variety of ways: to engage in partnerships that assist the Organization to more effectively deliver on its mandate; to advocate for and help to build a robust constituency for the United Nations, **especially in the United States**; and to ensure that the role and work of the United Nations is better understood and appreciated by policymakers and the public.

Advisory Board: http://www.un.org/partnerships/advisory.html

Words *of* Wisdom

I cannot do everything;
But still I can do something;
And because I cannot do everything;
I will not refuse to do the something that I can do.

– Edward E. Hale (1822-1909) American Author, Historian and Unitarian Minister

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities

http://www.womenshealthsection.com/