Partnerships for Health Reform

A Compendium of Abstracts of PHR Publications

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Partnerships for Health Reform
PHR

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Partnerships
for Health
Reform

PHR

Mission

Partnerships for Health Reform (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *Better informed and more participatory policy processes in health sector reform*
- *More equitable and sustainable health financing systems*
- *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services*
- *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Technical Reports

PHR provides technical assistance to more than 30 countries, as well as USAID regional offices and bureaus. PHR technical reports describe analytical or methodological work carried out in a specific country or region. Findings in these reports undergo a comprehensive review process. Each report includes a summary and a bibliography.

AFRICA

Community-Based Health Insurance (CBHI): Experiences and Lessons Learned from East Africa

Technical Report 34

Stephen Musau

124 pages (August 1999) · Order No. TE 34

The annexes in this volume examine the strengths and limitations of community-based health insurance (CBHI) schemes currently operating to meet basic health care needs of rural populations in East and Southern Africa. These CBHI operations have achieved limited successes in designing and implementing affordable, participatory, and sustainable health care financing mechanisms for populations with limited resources but great need for health services. The scheme information presented here focuses on "lessons learned" from these operations, and recommendations derived from these lessons learned are designed to assist the rural communities interested in establishing similar, workable risk-sharing and financing mechanisms. These types of health care financing systems offer promising alternatives to centralized health care systems and promote community ownership in health care.

Health Reform Policy Issues in Malawi: A Rapid Assessment

Technical Report 21

Gil Cripps, Daniel Kress, Clifford Olson, and Alex Ross

35 pages (July 1998) · Order No. TE 21

Malawi's health sector reform options include decentralization, targeted efforts such as central hospital autonomy, and the convergence of these efforts. A number of policy implications have emerged from these reform efforts. As a result, the Malawi Ministry of Health and Population (MOHP) requested the participation of the United States Agency for International Development in a rapid assessment of health reform policy. This assessment report serves both as a stand-alone document and as the basis for the development of a proposed workplan for the Partnerships for Health Reform (PHR) Project. Major policy issues and options for the near future include: managing change, training for reform, planning and implementation, consensus-building workshops, performance monitoring, and sector-wide approaches. Conclusions emphasize evolving roles for the MOHP in health reform advocacy, policy development, and communicating goals to districts, non-health government institutions, the public, and other constituencies.

Household Health Seeking Behavior in Zambia

Technical Report 20

François P. Diop, Ventakesh Seshamani, and Chola Mulenga

89 pages (June 1998) · Order No. TE 20

This report represents an effort to supplement Zambia's long-running debate on health policy reforms. Since

the introduction of health reforms in Zambia in 1992, there have been several policy issues that have been the subject of continuous discussion, especially in the area of health-care financing. Some of these issues address raising more money for the health sector, improving the use of money for the health sector, and ensuring transparency and efficiency in the use of financial and technical assistance. This study examines consumer behavior in Zambia, with a special focus on that country's health-care financing options and strategies. The study analyzed information on health-seeking behavior, provider choice for consumers of health services, and participation in prepayment schemes. The report concludes, among other things, that prepayment schemes have the potential to improve social differentiation in the access to health care. But the existing schemes must be improved to ensure greater equity in their utilization. Additionally, the report concludes, regardless of the user fee charged at any given institution, the use of its services diminishes greatly with the distance at which the potential clientele are located.

The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care in West and Central Africa: Summary and Case Studies

Technical Report 19

Chris Atim, François P. Diop, Jean Etté, Dominique Evrard, Philippe Marcadent, and Nathalie Massiot

48 pages (May 1998) · Order No. TE 19

Mutuelles, or mutual health organizations (MHOs), are community and employment-based groupings that have grown progressively in West and Central Africa in recent years. With this growth has come interest in analyzing the actual and potential contribution of MHOs to the financing, delivery and access to health care in West and Central Africa. The study systematically examines the contributions of WCA MHOs to resource mobilization, efficiency, equity, quality improvement, health care access, sustainability, and democratic governance of the health sector. The contribution of MHOs to resource mobilization is currently limited, but the study shows that the potential is large, given current constraints such as low penetration of the target populations, low dues collection rates, inadequate marketing, and other factors. The study found that MHOs can potentially improve their efficiency significantly through a number of design features. In the area of health care quality improvement, most MHOs are not well-equipped to realize the potential that they possess. Because of the young age of most of the schemes, it is not possible to make an assessment of their long-term sustainability on the basis of experience to date. There are many recommendations contained in the synthesis for the MHOs and for all the key actors involved in the promotion, development and support of such organizations. The major recommendations have to do with reinforcing the institutional, managerial and administrative capacities of the MHOs.

Available in French: ***La contribution des mutuelles au financement, à la presentation et à l'accès aux soins de santé en Afrique Centrale et de l'Ouest: résumé et études de cas*** (Order No. TE 19F)

Le présent document est le résultat d'une recherche sur les mutuelles de santé en Afrique de l'Ouest et du Centre et qui a été réalisée de juin 1997 à mai 1998. La recherche avait pour objet d'évaluer la contribution des mutuelles de santé à l'amélioration du financement, de la fourniture et de l'accès aux soins de santé. Elle devait déboucher également sur des recommandations destinées aux mutuelles, aux prestataires de soins de santé, aux gouvernements et aux bailleurs de fonds. Les activités suivantes ont été réalisées: un document de synthèse, un inventaire de 50 mutuelles de santé dans six pays et 22 études de cas au total situés en Côte d'Ivoire, au Sénégal, au Mali, au Nigéria, au Ghana et au Bénin. Ce document présente un résumé de la synthèse et des études de cas. Il comprend également, en annexes, un tableau récapitulant les principales caractéristiques des mutuelles ayant fait l'objet des études de cas et une liste de l'ensemble des MHO inventoriées. Le document donne un aperçu rapide des enseignements dégagés par le recherche. Il sera suivi de la publication d'un ensemble de trois volumes: le volume I comprendra la version intégrale du document de synthèse, ainsi que la méthodologie qui a servi à la réalisation des études de cas; le volume II portera sur l'inventaire des mutuelles et le volume III présentera les études de cas dans leur intégralité.

The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care in West and Central Africa: Synthesis of Research in Nine Countries

Technical Report 18

Chris Atim

105 pages (June 1998) · Order No. TE 18

Mutual health organizations (MHOs) are community and employment-based groupings that have grown progressively in West and Central Africa (WCA) in recent years. The main purpose of this study is to present information that could be of use to key actors in the development of the MHOs: the members and leaders of those organizations; health care providers; policymakers, especially WCA ministries of health and labor; development partners (external cooperation agencies and technical support institutions); other MHO promoters such as trade unions; and mutualist organizations and associations outside the health sector. The emergence of a mutual health scheme movement in WCA are generally on a small to medium scale in terms of membership. Most are also young: about two-thirds of the 50 MHOs in the inventory survey were less than three years old. At present, MHO activities affect only a small fraction of the populations of the countries involved. However, this study shows that they have great potential to embrace more people, as well as to contribute more to the health care sectors of their countries. The study analyzes MHOs' actual and potential contributions in the areas of access to health care and extending social protection to disadvantaged sections of the population, resource mobilization, efficiency in the health sector, quality improvement, and democratic governance. This study's recommendations principally concern design features to enhance scheme success; reinforcing the MHOs' institutional, managerial, and administrative capacities; assisting MHOs with pricing and establishing relationships with providers; and the role of governments in establishing a favorable legal, fiscal, and institutional context.

Summary of a Market Analysis for a Franchise Network of Primary Health Care in Lusaka, Zambia

Technical Report 15sum

Marty Makinen and Charlotte Leighton

17 pages (December 1997) · Order No. TE 15sum

The purpose of this market analysis is to assess the implementation prospects for a network of franchised private clinics in Zambia, ZamHealth, based on the experience of a similar setup called PROSALUD in Bolivia. The market analysis is intended to: inform the design of a franchising program in Zambia that would follow PROSALUD; adapt an earlier analysis of the PROSALUD approach's applicability to Zambia to better tailor it to specific local conditions and needs; suggest towns and neighborhoods for clinic sites; and develop a strategy by which to establish a niche in the local health care market for ZamHealth. A break-even analysis was conducted to analyze several cost and revenue scenarios for ZamHealth based on alternative assumptions concerning demand, competition, and costs, using a computer spreadsheet simulation model. Qualitative data supplement the quantitative analysis. These are based on local provider interviews about the perception of quality of care of various types of providers, people's willingness to pay for health care, and providers' willingness to participate in a franchising program. The study involved collection and analysis of supply-side costs and competition data and demand-side information from Zambia. Data came from secondary sources, including available national-sample household surveys, and through a local market household survey conducted specifically for this analysis. The analysis estimates costs, revenues, utilization patterns and likely startup subsidies needed for ZamHealth. Adaptations of the PROSALUD approach to organizing and managing the delivery of services were made to take account the significant differences between the Zambian and Bolivian health sectors in a number of key aspects. These include the population's use of services, the supply of physicians and other health workers, and Zambia's recent and proposed health reforms. This summary of the market analysis does not address the advantages and disadvantages of options for involving PROSALUD in the development and operation of ZamHealth. The options include PROSALUD as the franchiser of the concept, with ZamHealth paying a franchise fee to PROSALUD for this

role, or PROSALUD being hired as a consultant to help get ZamHealth started. The analysis also focuses only on ZamHealth as a provider of outpatient services and does not consider a potential role for ZamHealth in relation to hospital services.

University Teaching Hospital in Zambia: The Strategic Plan Environment

Technical Report 14

George Purvis

38 pages (September 1997) · Order No. TE 14

The purpose of this technical effort by the Partnerships for Health Reform was to assess various issues, problems, and opportunities facing the University Teaching Hospital (UTH) in Zambia. This review serves to catalyze and provide input for the development of an effective strategic plan for the UTH and Zambia's health services in general. Findings from this review provide a basis for recommendations on how to effectively address these issues in order to improve management and, ultimately, positively affect efficiency, quality, equity, and sustainability of services. PHR Consultant George Purvis spent two weeks in Zambia reviewing documents, conducting workshops, compiling observations, and interviewing key management and clinical personnel. Rather than analyzing specific departments, this review focuses on the broader policy level. Chapter 5 specifically discusses findings, recommendations, and possible technical assistance (TA) in the following areas: general; board/governance; strategic/operational planning and information systems; finance and internal control; leadership, human resources, and management development; efficiency, cost, and productivity; marketing, public relations, and fund development; and quality assurance. This chapter is followed by recommendations for all parties involved in the strategic planning for UTH revitalization and management reconstruction. Despite the problems facing the UTH, this report also focuses on its opportunities to maintain and enhance its role as a functional and critical institution of Zambia.

Assessment of Niger's National Cost Recovery Policy in the Primary Health Care Sector

Technical Report 6

François P. Diop

34 pages (December 1996) · Order No. TE 6

Under a National Assembly law passed in 1995 and corresponding implementing regulations enacted in 1996, the government of Niger established a new cost recovery policy for primary health care services. According to these legal instruments, the concept of cost recovery is defined as a participatory mechanism for sharing the cost of health care services provided to the local population at public health facilities. Its purpose is to generate additional income from the sharing of health care costs with the local community in order to improve the quality of primary health care. However, attempts to implement the country's new cost recovery policy at the nationwide level have suffered from the unstable political climate, inadequate institutional framework, and lack of leadership within the Ministry of Public Health (MOH). This report presents the strengths and weaknesses of Niger's cost recovery policy for primary health care services and makes recommendations for short- and long-term follow-up activities for the MOH. Pilot tests on user fees and an annual head tax, implemented with technical assistance from the United States Agency for International Development (USAID)-funded Health Financing and Sustainability (HFS) Project, were used as the basis for developing a financial management system to safeguard revenues and ensure their judicious use by health committees. Drug management procedures were also improved by the installation of a simplified drug management system. Niger has already improved the availability of generic drugs through an ongoing program streamlining procurement procedures, and has trained medical personnel in local health districts in the use of standardized diagnosis and treatment protocols, and essential drugs. However, Niger's current cost recovery policy for primary health care services ignores two essential issues: income generated by cost recovery mechanisms cannot replace government funding, and means testing policies are needed to protect the poor. In addition to addressing these weaknesses of the cost recovery policy, the MOH needs to implement a major effort to increase the public's awareness of the new policy. All central bureaus and agencies of the

MOH need to become more involved in cost recovery activities and help reinforce the goals and objectives of the National Program for the Strengthening of Primary Health Care (PNASSP).

Social Health Insurance Working Group Meeting in Zimbabwe

Workshop Report 1

Daniel Kress, Alan Fairbank, and Chris Atim

16 pages (February 1998) · Order No. WR 1

This report captures the essence of the outputs of the Social Health Insurance Working Group Meeting in Zimbabwe, held at the Holiday Inn, Mutare on January 28–30, 1998. The objectives of the meeting were to: reach consensus on the structure, provision, and other technical details for social health insurance, including an examination of nationwide implementation of cost recovery, reimbursement mechanisms, hospital reforms, private sector interaction/regulation, and means testing/equity; develop a draft social health insurance framework; and develop a draft action plan.

ASIA AND NEAR EAST

Profile of the Uninsured in Jordan

Technical Report 37

Dwanye Banks, Lonna Milburn, and Hannan Sabri

22 pages (September 1999) · Order No. TE 37

The government of Jordan has established a goal of expanding formal health insurance coverage to uninsured Jordanians. In order to accomplish this task, the government needs detailed information and analysis on who the uninsured are, what barriers to medical access they face without insurance, and what the costs of expanding coverage entail. Since 1997 the Partnerships for Health Reform (PHR) Project has undertaken technical assistance at the request of the Ministry of Health (MOH) to provide information to assist the MOH in reaching this goal. This report, which is one of four ongoing research efforts by PHR on Jordanian insurance issues, describes the analysis of data from the 1996 Jordan Living Conditions Survey, a survey of more than 5,900 households. According to PHR's analysis of the data, 32 percent of Jordanians lack formal health insurance coverage and a majority of these seek treatment at private sector clinics when an illness occurs. The uninsured are primarily non-working Jordanian citizens residing in middle-income households. The analysis finds that special attention in program design needs to be paid to the aged who will benefit from insurance schemes that are not limited to employer-based policies.

Options for Financing Health Services in the Pilot Facilities in Alexandria

Technical Report 36

A.K. Nandakumar, Mahmound Abel-Latif, and Wessam El-Beih

41 pages (August 1999) · Order No. TE 36

Data on enrollee profile, utilization, and costs derived from the Family Health Units and Family Health Center at Seuf as well as other relevant studies have been used to present a set of financing options for the pilot sites in Alexandria. The introduction of Family Health Units has drawn into the health system those most in need and least likely to have insurance. It appears that creating an integrated delivery system of primary care services with well-defined referral systems and strong management oversight allows for the provision of services of acceptable quality at a reasonable cost with increased patient satisfaction. However, for the short- and long-term success of the reform it is critical to put in place a sustainable financing mechanism. This will require key policy decisions. Many of these issues along with options for dealing with them are presented in this report.

Health Expenditure Review: Alexandria, Egypt

Technical Report 35

A.K. Nandakumar, Khaled Nada, Ahmed Irahim, Marwa Ezzat, Mahmound Abel-Latif, and Ahnsan Sadiq
33 pages (May 1999) · Order No. TE 35
A major restructuring of the service delivery, financing, and provider payment is underway in the Alexandria governorate as part of the health reform initiative being undertaken by the Ministry of Health and Population. While two rounds of National Health Accounts studies were conducted at the national level, not enough information existed at the level of the Alexandria governorate. The purpose of this report is to fill this important information gap and to use the results in developing methods to finance the cost of the basic benefits package, which will be made available under the reform initiative. This is the first time in Egypt that the National Health Accounts methodology has been used to develop expenditure estimates at a sub-national level.

Reorganization Plan for the Egyptian National Information Center for Health and Population
Technical Report 33
Brad Atkinson, Tayseer El-Sawy, Gordon M. Cressman, and Les Fishbein
31 pages (June 1998) · Order No. TE 33
With the objective of creating a national information center that serves the data collection, production, and dissemination needs of the Egyptian Ministry of Health and Population, in January 1998 the Minister of Health and Population mandated the reorganization plan described herein. Design of the plan was the work of the director general of the existing Information and Documentation Center and the Partnerships for Health Reform, a United States Agency for International Development project. The plan employs conventional tools of organizational analysis to produce a new National Information Center for Health and Population (NICHP) with clearly defined objectives, structure, staffing, and position descriptions, space requirements, and relationships between the NICHP and the governorate health directorates. All components are designed so as to improve the quality, timeliness, and access of health care system data that will support informed decision making within the Ministry.

Monthly Indicators Reporting System for the National Center for Health and Population
Technical Report 31
Gary Gaumer
36 pages (July 1998) · Order No. TE 31
This report provides an assessment of feasibility for a monthly reporting system of key indicators produced from the data now gathered by the National Information Center for Health and Population (NICHP). The general problem to be addressed by such a system is that extraordinary data resources are being compiled within the NICHP, reported monthly from the governorate. Yet, not much data or information flows from NICHP to policy makers and technical staff within the Ministry of Health and Population (MOHP). Among the tactics for improving information flow to users is the concept of an Executive Information System (EIS) within the MOHP executive offices. Would it be feasible to use current data resources within the NICHP to create a monthly (or periodic) report on indicators of health care system performance, which could be communicated via such an EIS? This was the question for the technical assistance visit in late May 1998. The report concludes such indicators are feasible to be created from available NICHP data and staff resources.

Data Assessment for the National Information Center for Health and Population, Egypt
Technical Report 30
Gary Gaumer
36 pages (July 1998) · Order No. TE 30
This report contains results and recommendations from a study of the quality of data resources collected and archived by the National Information Center for Health and Population (NICHP). There are a number of

documentable data quality problems, probably stemming from the fact that the data are not used very much. As a consequence, problems with completeness, consistency, and accuracy are not identified, and the process is not subject to improvement pressures of user feedback. The report provides a taxonomy of data and information that might guide the NICHP as it extends the plan for data collection and archiving. The report proposes a changed NICHP data handling and quality control process, to help improve data quality. And the report proposes a five-point program for the director general of NICHP to adopt to promote more aggressive improvement of the Ministry of Health and Population data quality.

Rationalization Plans for Hospital Beds in Egypt

Technical Report 29

Gary Gaumer, Taghreed Adam, Wessam El Beih, Bhavya Lal, Elizabeth Arriaza, and Brad Atkinson

49 pages (December 1998) · Order No. TE 29

This report examines the adequacy of hospital bed supply in Egypt and in each of its governorates. It represents a plan for rationalizing hospital bed supply in Egypt, noting where there are too many beds, where there are not enough, and where capital investment should be heading. It also provides a quantitative and rational basis for the Ministry of Health and Population to evaluate the reasonableness of the requests by governorates. The rationalization plan is based upon estimates of bed needs, and the gaps that exist between these needs and the actual supply of beds. Bed needs are determined by means of an algebraic formula that expresses assumptions about the preferred patterns of hospital care seeking behavior, preferred medical practice patterns, and preferred patterns of hospital management and capacity utilization. These norms were developed from extensive analysis of Egyptian data by two panels of experts who reviewed and verified the values for this planning exercise. In summary, Egypt must rationalize bed supply because there are too many underutilized beds, particularly in urban portions of the governorates. The priorities for rationalization call for new construction in some areas and bed reductions in others. Overall, this plan is moving Egypt toward a bed standard in the 1.4 to 1.6 range, down from 2.1 today — while equalizing utilization across urban and rural areas (at a higher level), improving capacity utilization, and rationalizing the flow of patients across geography to get inpatient care. The plan proposes that the action pertaining to implementation in the rural areas be preceded by the development of a strategy for rural health care so that policy to provide better access to inpatient care in these areas is properly integrated and accounts for the needs to redistribute medical manpower as well as beds.

Egyptian Ministry of Health and Population Intranet/World Wide Web Site Strategic Plan

Technical Report 28

Bhavya Lal

61 pages (June 1998) · Order No. TE 28

The goal of the proposed Ministry of Health and Population (MOHP) Internet/World Wide Web is to support communication and coordination activities within MOHP and between the Ministry and its external stakeholders in a manner that is timely, reliable, and cost-effective. Based on discussions with MOHP stakeholders and other experts, a website strategy and implementation plan was developed. Phase I of the website was also created with the help of programmers from the MOHP. This report summarizes the strategic principles on which the site is based, a detailed implementation plan, critical success factors, and other key recommendations and caveats.

Assessment of Third Party Payers in Jordan

Technical Report 27

Neil Hollander and Margie Rauch

37 pages (September 1998) · Order No. TE 27

The Partnerships for Health Reform, funded by the United States Agency for International Development, provides technical assistance in a variety of areas—including universal coverage of health services—to help improve the efficiency, effectiveness, and equity of Jordan's health system. This report outlines the findings

of the assessment, conducted in June 1998, of private third party payers in the health sector and the potential roles they could play in a universal health system. The report also presents a brief overview of Jordan's health sector, quantitive data on third party payers, their organizational structure and business/service approach and plans. The report contains a list of short- and long-term recommendations on actions to take in order to determine the roles of private insurance and to enable third party payers to contribute to social health insurance.

Findings of the Egyptian Health Care Provider Survey

Technical Report 26

A.K. Nandakumar, Peter Berman, and Elaine Fleming

118 pages (May 1999) · Order No. TE 26

This report presents results from the Egypt Health Care Providers Survey, the objectives of which were to: provide a comprehensive picture of all sources of health care services; provide policy-relevant data on critical issues for health sector reform; and create a database on health care providers for use by the Ministry of Health and Population in developing policy reform proposals. Five separate surveys were conducted on health care institutions, private clinics, pharmacies, dayas (traditional birth attendants), and other practicioners. The sample of 10,048 providers was developed from a complete ennumeration of all health care providers in sampling areas and data from the 1986 national census. Key findings included that more than four-fifths of privately practicing physicians also have a public sector job; widespread use of part-time staffing in health facilities supports the multiple job-holding pattern. Multiple employment also is common among dentists, not so among pharmacists. The survey also measured factors such as patient volume among the different types of providers and facilities, and solicited objective and subjective reports on issues that have implications for quality of care: patient volume, drug availability, and job training and satisfcation.

Health Care Utilization and Expenditures in the Arab Republic of Egypt

Technical Report 25

Peter Berman, A.K. Nandakumar, and Winnie C. Yip

73 pages (January 1998) · Order No. TE 25

This report results from the Egypt Household Health Care Use and Expenditure Survey (EHHUES) carried out 1994-1995. Objectives included estimating: rates of self-reported illness and health care services used; providers chosen; health care expenditures; and perceptions of quality of care and problems and issues of the health system. The survey collected data on socio-demographic characteristics, health status, insurance coverage, factors affecting the decision to seek care, utilization of services, choice of provider, and expenditures. Questions on individuals' perceptions of quality and their ability to perform activities of daily living were included. Findings included that men and younger individuals were more likely to believe they enjoyed good health. The poorest were less likely to perceive their health status as bad and to take time off due to ill health. There were significant differences in utilization by income, age, and region, but not between men and women. Cost was a major reason for non-utilization of services. Of annual per capita health expenditure, 64 percent was spent on outpatient care, 31 percent on self-purchased drugs, and 5 percent on hospital-based inpatient case. Urban individuals, the richest, and the insured spent the most. Across all types of medical problems, results indicate a preference for private providers.

Stakeholder Analysis: The Women and Children's Health Project in India

Technical Report 13

Yogesh Kumar et al.

116 pages (December 1997) · Order No. TE 13

This stakeholder analysis identifies primary groups in selected districts of the Bhopal District of Madhya Pradesh state, India, that have an interest in or will be affected by proposed activities of the Women's and Children's Health (WACH) Project, a USAID-funded community-based health project focusing on reducing neonatal mortality. The analysis determines group reaction to: proposed activities; their possible roles in WACH; and approaches to monitoring the support of key WACH stakeholders. Results of this analysis may provide information on what groups to involve in the design, implementation, and monitoring of WACH; strategies to ensure community participation and direct planning and budgeting; roles for stakeholders to play in WACH to ensure their support of the project; and positive and negative impacts on the stakeholders from the proposed changes in the health system. The results of the analysis show that, in general, stakeholders agree with the WACH Project objective of improving the quality of women's and children's health. They also support the plan of starting with a pilot project in one district, and later expanding to other districts. There is also general agreement on the state overseeing the effort to involve and train a variety of people and institutions to help fill the gap in providing health-related services, although stakeholders indicate a need to clearly define all collaborators, their roles, responsibility, and areas of accountability. The stakeholders interviewed also believe the government should support flexible funding mechanisms, either through a government institution or a newly created non-governmental organization (NGO) which maintains government, NGO, and private provider representation.

International Comparative Review of Health Care Regulatory Systems

Technical Report 11

Nihal Hafez

69 pages (October 1997) · Order No. TE 11

This review of health care regulatory systems, commissioned by USAID, provides the Government of Egypt with information to support its own internal development of similar functions. The information was compiled using research results from existing documentation and telephone interviews with appropriate personnel. This report analytically and comparatively reviews international models and experiences in the development and implementation of health care regulations. The study commences with an introduction to the concept of health care regulations, and then describes the most universally common approaches for putting them into practice: licensing, accreditation, and certification. Depending on the country and its economic and political structures, different governmental and voluntary regulations over health services have evolved. Traditionally, in most countries, official licensure of health personnel has been the favored approach. Various other forms of control have, however, been applied to other health resources. The regulatory systems of four countries -- the United States, Canada, the United Kingdom, and Australia -- were selected for more comprehensive study due to their highly developed regulatory structures as well as their histories as model programs upon which systems in several other countries were based. The U.S. model, for example, directly influenced the systems in Canada and Australia. Several specific functions of these systems are examined, including health care facility regulation; health personnel credentialing; pharmaceuticals; and health care technology. The report concludes that, based on the experiences of the countries studied, interest in health care regulation is likely to increase worldwide. Without political commitment and feasible institutional capabilities (e.g., ministries of health and regulatory agencies) in place, efforts to regulate any country's health sector will likely fail. Additionally, controlling quality of care requires the integration of providers. Successful implementation of health care regulations often depends upon several specific factors, including a country's ability to recognize and assess market-based changes in the health care structure; the evolution of local medical care standards; and the context of regulation in the country's current political environment.

Building Health Management Information Systems in Egypt: The Role of USAID Technical Support in Program Assistance

Technical Report 10

Gordon Cressman

79 pages (March 1997) · Order No. TE 10

In Egypt there is increasingly strong political support for health sector reform including a widespread recognition that a working information system is necessary to undertake and monitor this reform. This paper assesses the role of USAID technical support to help build health management information systems in Egypt. The major objectives of the report are to: identify constraints to building the necessary information systems, identify and describe available resources, determine the most constructive role for the technical assistance element of the initiative, recommend a development strategy, and outline necessary resources. The study describes the history, characteristics, and status of project-based information system efforts carried out to date. It outlines guidelines that USAID program assistance should use for information systems development. Amongst others, the guidelines include: do not create a project-based information system, play a coordinating role, define and prioritize objectives, build organizational capacity, make available consolidated information at MOHP headquarters, produce information at the governorate level for local decision-making, strengthen human resources, do not introduce information technology faster than capacity is developed to use the technology, use the private sector for support, establish official standard coding systems, and develop a workplan with well defined stages and tasks.

A Reform Strategy for Primary Care in Egypt

Technical Report 9

Peter A. Berman, Maha El-Adawy, A.K. Nandakumar, et al.

77 pages (August 1997) · Order No. TE 9

Under its existing primary care strategy - universal access to primary care through government and public sector delivery and financing of services - Egypt has made substantial progress in some aspects of primary care in recent decades. Deficiencies exist, however, particularly in routine provision of care to individuals and families by public providers, in disparities of care that exist across regions and socio-economic groups, and in prospects for the sector to respond well to emerging health challenges. An examination of these deficiencies reveals a chronic shortfall between the promised comprehensive care and funding available to pay for that care; lack of appropriate incentives to improve efficiency and quality, and of mechanisms to introduce the incentives; fragmented and inefficient organization of services; and insufficient capacities in financing, management, planning, and research. Egypt's current primary care strategy is not well-suited to remedy these problems, and so this paper proposes development of a new strategy, key components of which are a defined basic primary care package; adequate funding levels and mechanisms to provide them; new methods of organizing the financing and delivery of care to obtain efficiency, quality, and patient satisfaction; and improving system capacities. It suggests a new role for government and new approaches, including separating financing of services from their provision and reorganization and integration of care delivery. Two models for organization of services are presented. This proposed primary care strategy and approaches must be reviewed for their suitability to the regions and demographics of the country, and to the broader health sector reform taking place in Egypt, and field-tested and refined before they can be implemented on a national scale. Nevertheless, several fast-track elements are recommended that can be financed and implemented in the near-term, which will contribute to reform regardless of the final strategy.

Community Control of Health Financing in India: A Review of Local Experiences

Technical Report 8

Priti Dave Sen

96 pages (January 1998) · Order No. TE 8

This study, which aims to gain information on community-controlled health financing in India, is commissioned by the United States Agency for International Development/India to inform the planning of the Women's and Children's Health (WACH) Project. The study consists of a review of the literature and five mini case studies. The literature review examines 10 instances of community financing, which indicate that community involvement in designing financing strategies resulted in more appropriate strategies. The five case studies suggest a link between community control and improvements in quality of care, equity and efficiency, and financial soundness. It was found that community-controlled financing is fairly widespread in India and, when established and supported correctly, can have a positive impact on health programs and lead to greater financial and institutional sustainability. Establishing community-controlled health financing under the WACH Project is recommended. Taking into consideration factors that can influence success, the following recommendations are made: support a variety of community financing models; provide inputs for building capacity; ensure that development needs, apart from health, are being met; involve local communities from the beginning; provide support to establish community financing; promote links with other local groups; and ensure access to technical and other expertise.

Suggested National Health Sector Reform Strategies, Benchmarks and Indicators in Egypt

Technical Report 5, Volume I

James C. Setzer

51 pages (June 1996) · Order No. TE 5/Vol. I

This document proposes appropriate, verifiable benchmarks that can be used by the United States Agency for International Development (USAID) and the Egyptian Ministry of Health and Population to track the ministry's progress toward the completion of a mutually agreed-upon health sector reform agenda. The agenda was developed by the USAID and has the ministry's approval. The USAID provided the agenda in draft form to be used as the basis for this document. The agenda contains a mixture of legal and legislative changes, government policy reforms, and administrative and management procedural changes. It is anticipated that a subset of this reform agenda will form the basis of a Sector Program Assistance agreement between the USAID and the government of Egypt. These benchmarks will be included in the program agreement as conditions precedent to the release of program funds. Program funds are intended primarily to assist the Egyptian Ministry of Health and Population and the government of Egypt to meet (or offset) short-term costs associated with the agreed-on reforms. This report was drafted by the Partnerships for Health Reform Project, a USAID-funded project, and it links suggested national health sector reform strategies to verifiable benchmarks and indicators. Assumptions are clearly stated. Benchmarks are delineated on an annual basis. The report concludes with a detailed table that links each indicator to specific strategies, definitions, data sources, and baseline values.

Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt

Technical Report 5, Volume II

James Knowles and David Hotchkiss

68 pages (June 1996) · Order No. TE 5/Vol. II

Volume II of Technical Report 5 analyzes the Egyptian economy's potential gains in efficiency and social benefits as a result of health reform strategies proposed by the Ministry of Health and Population and the United States Agency for International Development. The analysis is based on several approaches, including a perspective of Egypt's macroeconomic environment as it pertains to health sector reform; a cost-effectiveness comparison of several health sector interventions to the policy reform; estimates of the benefit-cost ratio and internal rate of return for the investment represented by the United States Agency for

International Development's proposed Program Assistance policy reform; and an analysis of the benefits and costs of the individual strategies that make up the Program Assistance. From data generated in these analyses, the report concludes that Egypt's health sector must attain only average levels of efficiency, as compared with 49 other developing countries represented in a World Bank report, to save US$1.7 billion and maintain its current health outcomes. The cost-effectiveness analysis indicates that if Program Assistance reduced just 10 percent of the Egyptian health sector's "efficiency gap," it could produce an extra year of life at a cost of only US$1.84. The benefit-cost analysis also illustrates that Program Assistance of $75 million would yield a benefit-cost ratio of 11.9 and an internal rate of return of 91 percent. An analysis based on welfare economics was also conducted on the individual policy reform strategies to be incorporated into Program Assistance. The analysis showed that substantial gains in efficiency could be expected from most components of the policy reform strategy. For example, using case-based reimbursement methods to allocate hospital funds could save as much as $36 million a year, making the Health Insurance Organization as efficient as the university hospitals. The analysis concludes that the policy reform program proposed by the Ministry of Health and Population and the United States Agency for International Development can play an important role in reducing the inefficiencies in Egypt's health sector and thus help reap substantial economic benefits.

Social Vulnerability Analysis for the Health Sector Reform Program Assistance in Egypt

Technical Report 5, Volume III

Denise DeRoeck, Heba Nassar, David Hotchkiss, et al.

59 pages (July 1996) · Order No. TE 5/Vol. III

This report, written for the United States Agency for International Development-funded Partnerships for Health Reform Project, examines the likely impact on socially vulnerable groups of the various health policy reform strategies proposed for the government of Egypt's National Health Sector Policy Reform Agenda. The report also identifies steps to maximize the policy reform benefits and minimize disadvantages for the socially vulnerable that the report identifies as the poor, residents of disadvantaged rural areas, and female-headed households, with a specific focus on women and children. The analysis concentrates on four primary effects in the government of Egypt's draft policy reform agenda: cost recovery in Ministry of Health and Population facilities, redirecting ministry resources from hospital-based curative care to primary and preventive health, reallocating ministry personnel and other resources from geographic areas of underutilization and excess supply to needy areas, and improving and expanding national health insurance.

Legal Analysis of the Health Sector Policy Reform Program Assistance in Egypt

Technical Report 5, Volume IV

Ahmed G. Abou Ali

65 pages (September 1996) · Order No. TE 5/Vol. IV

In cooperation with the Egyptian government and its Ministry of Health and Population, the United States Agency for International Development plans to develop health sector Program Assistance to facilitate needed health sector reform. Technical Report No. 5, Volume IV, identifies possible legal constraints to Program Assistance policies that are likely to be undertaken during the implementation of this project. The report also assesses the feasibility of accomplishing legislative changes or amendments that may be necessary to enact the project in a timely manner. In conducting the legal analysis, the report focused on three primary state and parastatal organizations that provide public health services: the Ministry of Health and Population, Health Insurance Organization, and the collective Curative Organizations. A brief analysis of the legal frameworks of university hospitals and educational hospitals and institutes was also included. The Information and Decision Support Center was frequently consulted during the scope of the study to verify the accuracy of amendments to laws, decrees, and regulations. Several specific strategies were analyzed to determine whether any could be implemented as part of the proposed health sector reform plan. Possible strategies included operating new Ministry of Health and Population hospitals as fee-for-service institutions, improving the autonomy of hospitals and curative units, subcontracting health services, and establishing a national health insurance fund. The authors conclude that although there are no absolute legal constraints to the policy reforms, there may be a need for issuance of presidential and ministerial decrees or amendments to existing laws to achieve some of the proposed objectives.

Analysis of the Political Environment for Health Policy Reform in Egypt

Technical Report 5, Volume V

Nihal Hafez

53 pages (September 1996) · Order No. TE 5/Vol. V

Technical Report No. 5, Volume V analyzes Egypt's political environment in the context of health sector reforms proposed by the Ministry of Health and Population and the United States Agency for International Development by examining political trends as well as the perceptions, agendas, and priorities of key health sector players and their collective impact on the health policy environment. This analysis consists of four parts: a review of Egyptian political trends that have affected health sector policy, a description of key players and stakeholders and their organizational objectives, an assessment of the international donors' role in Egypt's health sector reform, and an analysis of public opinion about the reform. Information for the analysis was collected from public documents, research papers, and a few telephone interviews.

Analysis of the Institutional Capacity for Health Policy Reform in Egypt

Technical Report 5, Volume VI

Nihal Hafez

62 pages (October 1996) · Order No. TE 5/Vol. VI

Technical Report 5, Volume VI is an institutional analysis of the health sector players most critical to Egypt. The report assesses the competence of each organization in performing its current role, and its potential capability to readily undertake its proposed new role, under the reform. The analysis also identifies some of the changes needed to enhance the reform's feasibility, prosperity, and sustainability. Internal reports and external audits were used to complete the analysis. Due to the scarcity of information available from these documents, however, a framework for institutional assessment was also developed, which provides methodologies and a comprehensive set of organizational indicators that can be used to produce a more detailed analysis. Both the United States Agency for International Development and the World Bank encourage restructuring the roles of major health sector players; separating finance, management, and service delivery; improving the sector's allocative and technical efficiency; developing the Ministry of Health and Population's and the Health Insurance Organization's institutional capacities; and reforming health manpower policy. In addition, the following changes were recommended: the Ministry of Health and Population should determine the reform agenda and create an in-house, institutional framework to coordinate policy development and implementation; planning and policy development roles of all key health sector

players must be strengthened and more clearly defined; the Ministry of Health and Population and the Health Insurance Organizations must undertake organizational analysis and restructuring; and the ministry should have more control over health care financing and budget allocation, while the Health Insurance Program should be granted more autonomy to pursue the expansion of population coverage and other initiatives. Although there are tremendous institutional problems confronting Egyptian health care organizations, the future of health sector reform appears positive, and its implementation should be encouraged. In fact, the diversity and intensity of the existing problems are ideal for a sector-level approach to reform. In addition, a reform will likely redefine the roles of health sector organizations, and this redefinition may, in itself, solve many of the institutional deficiencies with little need for further intervention.

Assessing Health Sector Policy Reform Strategies in Egypt: A Summary of PHR Analyses

Technical Report 5, Volume VII

Mark McEuen

46 pages (August 1997) · Order No. TE 5/Vol. VII

In response to a request from the Health Office of the United States Agency for International Development/Cairo, the Partnerships for Health Reform (PHR) Project conducted six analyses between June and September 1996 to support and inform the design of the Mission's upcoming Health Sector Reform Program Assistance. This Sector Program Assistance is intended to provide technical and financial assistance to the government of Egypt in planning and implementing a series of health policy reforms aimed at improving the financing, efficiency, access, and quality of health services in Egypt. PHR's six analyses were designed to answer two questions about the set of health sector reform strategies that were proposed jointly by the Ministry of Health and Population and the United States Agency for International Development: Are these reforms feasible? What will be the impact of these reforms? Findings of the six analyses suggest that the United States Agency for International Development's and the Ministry of Health and Population's health policy reform strategies aimed at improving the financing, efficiency, access, and quality of health services in Egypt comprise an ambitious yet feasible reform agenda. The reports attempt to estimate the impact of the reforms on the health sector, and several offer specific suggestions to refine reform strategies in order to achieve the best results.

Health Sector Reform in Cambodia

Technical Report 2

James Knowles

36 pages (February 1996) · Order No. TE 2

The poor health status of Cambodia's population is due in part to low levels of income and education and in part to the condition of its public health system, particularly in rural areas. The current state of the public health system reflects the severe shortages of resources available in recent years and the effects of extreme decentralization. The Khmer Rouge eliminated much of the country's skilled medical manpower personnel and, until recently, the Ministry of Health played a relatively minor role in directing the provincial health system. Current efforts in health reform are focused on generating additional resources through user fees to supplement the low salaries of government health workers and introducing management reforms used in the private sector into the government health system. The National Conference on Financing of Health Services was convened to develop guidelines for implementing a series of pilot tests in government health facilities that include user fees and innovative management approaches. This document presents a review of this conference and experiences of the United States Agency for International Development's grantees with cost recovery and financial sustainability. It recommends that more assistance be provided to for-profit health providers and suggests several approaches designed to encourage these providers to offer more preventive health services and improve the quality of their curative care. It also encourages grantees to become more cost conscious and to experiment with measures designed to reduce their unit costs.

LATIN AMERICA AND THE CARIBBEAN

An Assessment of the Community Drug Funds of Honduras

Technical Report 39

John L. Fiedler and Rolanda Godoy

141 pages (October 1999) · Order No. TE 39

The Community Drug Fund (CDF) in Honduras provides a more physically accessible source of medicines compared to the more traditional sources of health centers and pharmacies. The CDF provides what members of the community regard as a satisfactory alternative supply of medicines at lower prices. The CDFs, however, are not an unqualified success. The quantity of services they provide could be increased, and the quality of the services provided can and should be improved. There is a typical life cycle that most of the Funds have followed, suggesting that most CDFs are not fulfilling their potential and that many of them will survive, at most, no more than a few years. This study examined how a CDF typically evolves from its start-up and then becomes supply-constrained. Rather than attempting to address issues or problems individually, it is preferable to identify a package of CDF-related policy objectives and desired characteristics that should be addressed concurrently. In this way, potential alternatives and options will be considered in relation to the importance of other goals and measures that will be pursued simultaneously. This study makes several recommendations for improving the performance of CDFs. Whether the approach should be legalistic, mandating changes and strictly monitoring compliance, or more informal, based on suggestions and recommendations, will depend, in part, on the expected role of the CDFs in Honduras.

Evaluación del Seguro Nacional de Maternidad y Niñez en Bolivia

Technical Report 22S

Tania Dmytraczenko, Iain Aitken, Scarlet Escalante Carrasco, Lic. Katherina Capra Seoane, John Holley, Wendy Abramson, Antonio Saravia Valle, and Marilyn Aparicio Effen

109 pages (October 1998) · Order No. TE 22S

Available only in Spanish

Uno de los problemas de salud más serios en Bolivia son las elevadas tasas de mortalidad, tanto la materna como la infantil. Para mitigar este problema, se promulga en julio de 1996, mediante Decreto Supremo 24303, el Seguro Nacional de Maternidad y Niñez (SNMN). Este Seguro se plantea la provisión de una serie de servicios gratuitos para las madres gestantes, los recién nacidos y los niños menores de cinco años. El objetivo fundamental del programa es incrementar la cobertura médica en la población objetivo, para así reducir los índices de mortalidad materna e infantil. Este estudio pretende examinar el programa con la mayor profundidad para determinar los resultados alcanzados hasta el momento y evaluar cómo implementar los cambios para que promuevan mejoras. Mediante la comparación ex-ante y ex-post del Seguro, los patrones de utilización evidencian que, comparados con los servicios no cubiertos por el SNMN, el consumo de los servicios cubiertos tuvo un incremento importante. El mayor incremento en los niveles de utilización se produjo en los establecimientos terciarios, que comprenden a los hospitales generales y a los especializados. El incremento en los niveles de utilización derivados del Seguro originó-a su vez-un incremento de la carga de trabajo; pero, al no ir acompañado de los adecuados incentivos, generó un descontento en los establecimientos de la Seguridad Social. Finalmente, si bien la disponibilidad de los medicamentos mejoró en la mayoría de los establecimientos, los retrasos en los desembolsos y la deficiente provisión de la Central de Abastecimiento de Suministros en Salud (CEASS) generaron algunos problemas asociados, tanto a la liquidez necesaria para las compras como a la provisión privada. Mediante la estimación de los costos unitarios directos por cada prestación, se evidencia que los reembolsos no son suficientes para cubrir la totalidad de los costos efectivos. A su vez, se expresa que los distintos niveles de atención también presentan diferencias en sus estructuras de costos. Estos resultados resaltan la necesidad de evaluar cómo implementar las modificaciones financieras que favorezcan la eficiencia y la sostenibilidad del programa.

A Strategic Plan for Decentralizing the Health System in Paraguay

Technical Report 4

Hector Colindres and Tisna Veldhuyzen van Zanten

54 pages (August 1996) · Order No. TE 4

This report outlines a strategic plan to decentralize the health care system in Paraguay, particularly through the use of experimental pilot activities in three departments (e.g., regions) as a first step in building a new, decentralized National Health System. The plan identifies 16 strategies for achieving four overall objectives: 1) making citizens aware of and responsible for health planning and action in their communities, 2) effectively defining complementary roles for public and private health providers, 3) providing the health system with sufficient resources, and 4) ensuring that the health system promotes and maintains a healthy and sustainable environment that is appropriate for the integrated development of individuals. A model work plan lists the activities required to implement the 16 strategies, including a timetable, identifies the parties responsible, and assesses whether technical assistance is required. The plan was developed in 1996 at a seminar that included representatives of national government ministries; national, regional, and local health agencies; and local governmental bodies. The seminar was sponsored by the Partnerships for Health Reform Project, with funding from the United States Agency for International Development. Annexes to this report include background information on how the participants assessed the strengths and weaknesses of the current health care system and assessed the prospects for decentralization and reform.

Available in Spanish: ***Plan estratégico para descentralizar el sistema de salud en Paraguay***

(Order No. TE 4S)

Este informe esboza un plan estratégico para descentralizar el sistema de atención de salud en Paraguay, en particular a través del uso de actividades piloto experimentales en tres departamentos (es decir, regiones) como primer paso en el establecimiento de un nuevo sistema nacional de salud descentralizado. El plan identifica 16 estrategias para lograr cuatro objetivos generales: hacer a los ciudadanos conscientes y responsables de la planificación y acción de salud en sus comunidades, definir eficazmente funciones complementarias para los proveedores de atención de salud públicos y privados, proporcionar al sistema de salud recursos suficientes, y asegurar que el sistema de salud promueve y mantiene un entorno saludable y sostenible que es apropiado para el desarrollo integral de las personas. Un plan de trabajo modelo presenta las actividades requeridas para la ejecución de las 16 estrategias, incluyendo un calendario, identifica a las partes responsables y evalúa si se requiere asistencia técnica. El plan fue formulado en 1996 en un seminario que incluyó a representantes de ministerios de gobiernos nacionales; entidades de salud nacionales, regionales y locales; y órganos gubernamentales locales. El seminario fue patrocinado por el Proyecto Partnerships for Health Reform (PHR), con fondos de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID). Los anexos de este informe incluyen antecedentes sobre cómo los participantes evaluaron los puntos fuertes y debilidades del actual sistema de atención de salud y determinaron las posibilidades de descentralización y reforma.

Analysis of Decentralization in the Health Sector of Paraguay at the Departmental Level

Technical Report 3

Cristina Semidei, Maria Victoria Rojas de Wickzén, and Tisna Veldhuyzen van Zanten

37 pages (February 1996) · Order No. TE 3

This report provides an analysis of the decentralization process in the health sector of Paraguay at the departmental and district levels. It is based upon interviews with almost all of the departmental health secretaries, regional directors, and some municipal superintendents. The purpose of these interviews was to review progress toward decentralization at the departmental level and to analyze the challenges created by the process. The results of this assessment also provide the basis for outlining the United States Agency for International Development options for supporting decentralization in health.

Available in Spanish: ***Análisis del proceso de descentralización del sector de la salud de Paraguay a nivel departmental*** (Order No. TE 3S)
Este informe contiene un análisis del proceso de descentralización en el sector de la salud del Paraguay al nivel de departamento y de distrito. Se basa en entrevistas con casi todos los secretarios departamentales de sanidad, directores regionales y algunos superintendentes municipales. El fin de estas entrevistas fue examinar el progreso hacia la descentralización al nivel departamental y analizar las cuestiones planteadas por el proceso. Los resultados de dicho análisis también sirven de base para esbozar las opciones de la Agencia de los Estados Unidos para el Desarrollo Internacional en cuanto al apoyo prestado a la descentralización del sector de la salud.

Assessment of Health Sector Decentralization in Paraguay

Technical Report 1

Tisna Veldhuyzen van Zanten and Cristina Semidei

41 pages (January 1996) · Order No. TE 1

This report assesses Paraguay's current health sector decentralization effort and offers possibilities for the United States Agency for International Development (USAID) support. The assessment was carried out as part of a process to develop USAID/Asunción's five-year strategic plan. The objective was to assess the feasibility of continued support for decentralization of the health sector as part of the larger overall USAID strategic objective to strengthen democratic institutions, systems, and practices. This report outlines the challenges ahead for successful and sustainable decentralization. It serves as background to an in-depth analysis of the early experiences of departments and municipalities in implementing decentralization policies and to the design of a detailed technical assistance plan, which are published as separate Partnerships for Health Reform Technical Reports (Nos. 3 and 4, respectively).

Available in Spanish: ***Evaluación de la descentralización del sector salud en Paraguay***
(Order No. TE 1S)
Este informe evalúa la actual actividad de descentralización del sector salud y ofrece posibilidades para apoyo por parte de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID). La evaluación se realizó como parte de un proceso destinado a elaborar el plan estratégico quinquenal de la USAID/Asunción. El objetivo fue evaluar la factibilidad de que continúe el apoyo a la descentralización del sector salud como parte del objetivo estratégico general más amplio de la USAID consistente en fortalecer las instituciones, sistemas y prácticas democráticas. Este informe esboza los retos a los que hay que hacer frente para una descentralización eficaz y sostenible. Sirve de antecedentes para realizar un análisis a fondo de las experiencias iniciales de los departamentos y municipios en la ejecución de las políticas de descentralización y para diseñar un plan detallado de asistencia técnica, que se publican como Informes Técnicos separados de PHR (Nos. 3 y 4, respectivamente).

GLOBAL

Survey on Tax Treatment of Public Health Commodities

Technical Report 17

Katherine Krasovec and Catherine Connor

15 pages (June 1998) · Order No. TE 17

This report summarizes the results of a survey of 44 countries on the tax treatment of public health commodities. The survey, which was conducted by the United States Agency for International Development-funded Partnerships for Health Reform Project in late 1997, provides a view of which countries have granted tax relief on purchases of any of three public health commodities: vaccines, oral rehydration salts, and contraceptives. The report also contains information on how various tax policies have been implemented and what the perceived impact to date has been, summarizes the process for granting tax waivers in some

countries, and discusses the obstacles to finding reliable information on achieving the intended impact of tax relief and to measuring the actual impact. This report makes information on the survey results available to a broader audience, some members of which may be interested in pursuing similar reforms in their own countries. The results of this survey are already being used to help support policy dialogue in countries that are considering tax relief designed to help achieve public health goals.

Available in French: ***Enquête sur le statut fiscal des produits de santé publique*** (Order No TE 17F)
Ce rapport résume les résultats d'une étude sur le statut fiscal des produits de santé publique dans 44 pays. Cette étude, effectuée vers la fin de 1997, par le Projet Partenariats pour la Réforme de la Santé financé par l'Agence des États Unis pour le Développement International, fournit un aperçu des pays ayant accordé des allégement fiscaux sur l'achat d'au moins l'un des trois produits de la santé publique suivants: vaccins, sels de réhydratation orale et contraceptifs. Le rapport contient également des informations sur la façon dont les différentes politiques fiscales furent mises en application et quel en fut, à ce jour, l'impact perçu. Il résume le processus d'octroi d'exonération fiscale dans quelques pays et traite des obstacles à trouver des informations fiables sur la réalisation de l'impact visé de l'allégement fiscal et à mesurer son impact réel. Ce rapport rend les informations et résultats de l'étude accessibles à un public plus large, parmi lequel certaines personnes pourraient avoir l'intention de poursuivre des réformes similaires dans leurs propres pays. Ces résultats sont d'ores et déjà utilisés pour faciliter le dialogue de politiques dans des pays qui considèrent les allégement fiscaux comme une aide appropriée à la réalisation de leurs objectifs dans le domaine de la santé publique.

Health and Nutrition Financing and Sustainability in Developing Countries CD-ROM
Order No. CD 1

The Health Financing and Sustainabilty (HFS) and Latin America and Caribbean Health and Nutrition Sustainability (LAC/HNS) projects culminated in 1995 with a large body of work on health sector policy reform in more than 40 low- and middle-income countries around the world. USAID's Office of Health and Nutrition, Bureau for Global Programs, Field Support and Research sponsored both projects and USAID's Bureau for Latin America and the Caribbean also sponsored the LAC/HNS work led by University Research Corporation (URC). This CD-ROM presents the results of the technical assistance and applied research in a user-friendly (PC and Mac compatible) searchable format and includes literature reviews, surveys, policy studies, issue briefs, and analytical tools.

Special Initiatives

PHR Special Initiatives provide technical support to the USAID Population, Health, and Nutrition (PHN) Center's efforts to advance global knowledge and awareness of health sector issues, approaches, and methodologies. PHR is developing the following Special Initiatives at the request of the PHN Center:

- *Improving the Management and Sustainability of Maternal and Reproductive Health Programs*
- *Developing and Applying National Health Accounts*
- *Monitoring and Tracking Health Sector Reform*
- *The Role of NGOs in Health Sector Reform*
- *Child Survival: Vitamin A, Integrated Management of Childhood Illness, Polio Eradication and Immunization Financing*
- *Assessing the Impact of Health Sector Reform on HIV/AIDS Service Delivery*

These initiatives, in contrast to technical assistance to specific countries, provide the opportunity to conduct cross-country research; develop, test, and disseminate tools, methodologies, and approaches in different countries; and bring people and groups from different countries and regions together to share experiences, ideas, and knowledge.

- ***Maternal and Reproductive Health***

Costs of Maternal Health Care Services in Blantyre District, Malawi

Special Initiative Report 17

Ann Levin, Ronald Mangani, Mark McEuen, Regson Chaweza, and Nyson Chizani

42 pages (July 1999) · Order No. SIR 17

This study by the Partnerships for Health Reform and the University of Malawi Centre for Social Research evaluates provider and consumer costs of six maternal health services, along with selected quality indicators, at four health facilities (one public and one mission hospital center) and among traditional birth attendants in Blantyre District of Malawi. The study examines costs of providing the services in order to examine the reasons behind cost differences, assess the efficiency of service delivery, and determine whether management improvements might achieve cost savings without lowering service quality. Costs that consumers pay to obtain maternal health services are also determined, along with the percentage of total costs recovered by providers from fees for services. The study finds that routine maternal health services in the facilities cost less than $6 for antenatal care and less than $24 for vaginal delivery. Obstetrical complications are more costly, ranging from $30 for treatment of post-abortion complications at the mission hospital to $107 for treatment of eclampsia at the public hospital. The most costly input is materials, which comprise more than three-quarters of direct costs. The costs differ between hospitals and health centers as well as among mission and public facilities. As in other African countries, costs at the central public hospital exceed those at the mission hospital. The differentials are explained through differences in the role of the facility, use, and availability of materials and equipment, number and level of personnel delivering services, and utilization levels of services. The report concludes with several recommendations for cost savings, of particular importance to a country like Malawi with its high utilization of maternal health services but limited resources.

Costs of Maternal Health Care Services in Masaka District, Uganda

Special Initiative Report 16

Ann Levin, Tania Dmytraczenko, Mark McEuen, Freddie Ssengooba, Florence Mirembe, Olico Okui, Margaret Nakakeeto, and Peter Cowley

50 pages (May 1999) · Order No. SIR 16

This study evaluates provider and consumer costs of six maternal health services, along with selected quality indicators, at four health facilities and among community practitioners in Masaka District of Uganda. The study examines costs of providing the services in order to examine the reasons behind cost differences, assess the efficiency of service delivery and determine whether management improvements might achieve cost savings without lowering service quality. Costs that consumers pay to obtain maternal health services are also determined, along with the percent of total costs recovered by providers from fees for services. The Partnerships for Health Reform together with the Makerere University Institute of Public Health collected data in May 1998 on costs of maternal health services at a public and mission hospital, a public and mission health center, 17 private midwives, and 20 traditional birth attendants. The total costs of routine maternal health services in the four facilities were found to be less than $7.00 for antenatal care and less than $35.00 for vaginal delivery. Obstetrical complications were more costly due to the use of more and higher-level personnel and materials. Cost for cesarean sections and post-abortion complications ranged from $86.48 to $199.97; postpartum hemorrhage and eclampsia were higher and ranged from $50.63 to $159.66, respectively. The most costly input for maternal health care was materials, unlike many other health services where labor costs are more prominent. Material costs made up more than half of direct costs for four out of six services. The result of the costs in the four facilities surveyed indicate that differentials exist between unit costs of maternal health services between hospitals and health centers as well as among mission and public facilities. Theses differentials can be explained through differences in use and availability of materials and equipment, number and level of personnel delivering services, and utilization levels of services.

⮝ *National Health Accounts*

Cuentas Nacionales de Salud: Perú

Special Initiative Report 15S

49 pages (September 1998) · Order No. SIR 15S

Available only in Spanish

El Ministerio de Salud (MINSA) en los últimos años ha realizado esfuerzos significativos para contrar con información respecto a la estructura, distribuición, y evolución del gasto de salud en el país. En 1998, la propuesta del MINSA fue proceder al diseño y estimación de una Cuenta Satélite de Salud que permita reagrupar un conjunto de transacciones actualmente disperas en varios sectores productivos y sociales, en un sistema integrador como es el sistema de Cuentas Nacionales, para lograr dar consistencia y continuidad a las estadísticas económico-financieras integrándolas a las estadísticas de producción del sector. Este instrumento servirá como insumo para la definición de políticas de salud y para evaluar el impacto de la política económica en este sector. La implementación de las Cuentas Satélites de Salud, permite identificar las necesidades de información para mejorar y ampliar progresivamente el sistema. Este documento constituye el producto final de la consultoría "Cuentas Nationales de Salud", elaborado por el grupo de trabajo de las "Cuentas Satélites de Salud" en el marco de las actividades del Programa de Fortalecimiento de Servicios de Salud (PFSS), que ejecuta el Ministerio de Salud.

Cuentas Nacionales de Salud: México

Special Initiative Report 11S

112 pages (September 1998) · Order No. SIR 11S

Available only in Spanish

El proceso de reforma en el SNS ha hecho evidente la necesidad de estudiar el gasto en salud. Este es el objetivo de las Cuentas Nacionales de Salud (CNS), que constituyen un análisis de los recursos financieros del SNS en sus diferentes componentes institucionales. El gasto en salud de 1995 equivale a 5.5% del PIB. La cifra muestra un incremento a precios corrientes que, no obstante, no consigue superar al crecimiento de la inflación, y una caída por primera vez desde 1992 a precios de 1993. Las contribuciones directas se canalizan principalmente hacia los agentes de la seguridad social, en donde los aportes más elevados corresponden a las empresas (62%). La mayor parte de los agentes de la seguridad social reciben recursos federales, con un mínimo aporte de los gobiernos estatales. Los aportes indirectos se aplican principalmente en los agentes para los no asegurados. Estos recursos provienen fundamentalmente del gobierno federal (93%). En 1995 el gasto de las instituciones públicas de salud se distribuyeron en tres tipos de programas: de administración, planeación y capacitación (18%), de atención directa a la población, que incluyen atención curativa y preventiva (73%), y programas de apoyo como el fomento a la salud, la investigación, la producción de insumos y la construcción y conservación de infraestructura (9%). Las actividades de atención preventiva y curativa recibieron conjuntamente la mayor proporción de los recursos (9% y 79% respectivamente). Si se agrupan las entidades según las necesidades de salud y se utiliza como proxy del avance en la transición epidemiológica la mortalidad de adultos y de menores de 5 años, se observa entonces que a mayor necesidad menor el gasto en salud. En particular, las zonas de rezago muestran un menor gasto privado. Se observa también inequidad en la distribución del gasto por zona geográfica, lo que muestra la necesidad de reorientar el gasto en salud hacia las entidades con mayor rezago epidemiológico. Igualmente recomendable sería dar mayores recursos a las actividades preventivas que actualmente están poco financiadas. Asimismo, es necesario incrementar el gasto para los no asegurados pobres, así como desarrollar y regular el mercado privado, y fomentar modalidades de financiamiento que movilicen los gastos privados de bolsillo hacia el prepago, que no amenacen la economía familiar.

Cuentas Nacionales de Salud: Guatemala

Special Initiative Report 10S

55 pages (September 1998) · Order No. SIR 10S

Available only in Spanish

La reforma del sector salud persigue, entre otros objetivos, construir un sistema de salud más equitativo, eficaz y eficiente. Desde una perspectiva diagnóstica, cabría entonces hacer varias preguntas, relacionadas con el financiamiento y el gasto en salud. ¿Cuánto invierte la sociedad guatemalteca en servicios de salud? ¿En qué proporciones contribuyen al financiamiento de la salud los hogares, las empresas, el gobierno y la cooperación externa? ¿Cuál es la importancia relativa de los agentes de intermediación financiera, que captan los recursos de las fuentes y los asignan a proveedores, a programas y a elementos de gasto? ¿En qué tipos de servicio se está invirtiendo? La Iniciativa Regional de Cuentas Nacionales de Salud estimuló a un conjunto de países, entre ellos Guatemala, a realizar el intento de dar respuesta a dichas preguntas y utilizar ese conocimiento para alimentar las visiones de futuro, las directrices de implementación y los procesos decisorios en el marco de las reformas al sector salud. Los resultados de esta primera exploración plantean desafíos importantes en el proceso de reforma del sector salud. Parece necesario que, para elevar la equidad en la prestación de servicios y la eficiencia en la asignación del gasto, se simplifique el flujo de financiamiento, se reduzca la dispersión de agentes intermediarios (que también operan como proveedores) y se logre mayor acercamiento entre la aportación a la salud y la percepción de los beneficios. Por otra parte, es tarea inmediata del Estado generar un marco regulatorio y un esquema de acreditación de proveedores que, por medio de

información oportuna, facilite el acceso de la población a los proveedores de servicios por medio de un papel de rectoría fortalecido del Ministerio. Esta institución, junto al Instituto de Seguridad Social, deben ampliar su participación como agentes financieros del sistema de salud. El acceso universal a un conjunto básico de bienes asegurables de salud, y el cabal cumplimiento de las obligaciones estatales en materia de salud pública imponen cambios radicales en el flujo de financiamiento y gasto en salud.

Cuentas Nacionales de Salud: Ecuador

Special Initiative Report 9S

38 pages (September 1998) · Order No. SIR 9S

Available only in Spanish

Las Cuentas Nacionales de Gastos en Salud tienen como objetivo fundamental el proporcionar una radiografía o visión general sobre el origen de los fondos, esto es las fuentes, el destino o uso detallado de los recursos y los canales de flujo de los fondos utilizados en el sector salud. Se define como aquél realizado con el fin inmediato de promover o restaurar la salud, no consideramos por recomendación del II Seminario de CNGS los gastos en agua y saneamiento, o dotación de alimentos. Principales resultados obtenidos fueron: el gasto total en salud ecuatoriano, para 1995, representan el 4.6% del PIB nacional; el gasto per cápita anual de todo el sector salud, para 1995 fue de 182.759 sucres corrientes o US$ 71.22; el gasto de hogares se realizó el 74.7% en el área urbana y 25.3% en la rural; el rubro de mayor gasto de los hogares en salud fue el de “medicamentos, fármacos y otros productos perecederos” con 61.1%, siguiéndole “atención médica” con un 24.3%; el gasto público, según las fuentes de financiamiento (Presupuesto General del Estado, Municipios y Empleadores Públicos) representó el 34.78% del gasto total en salud en el Ecuador en 1995; y en el Gasto en Salud por Proveedores de Servicios, a nivel nacional, en los establecimientos del MSP se gastaría el 25.91 % del total, mientras en los servicios del IESS/SSC se estaría gastando el 20.95 y en farmacias el 11% del gasto total. Los hogares por su parte compran al Sector Privado sus servicios en un 86% y al público en un 14%. Del Gasto total anual en Salud el 2.3% se invierte en salud preventiva mientras el 97.7% en salud curativa. Dentro de esta última los gastos en atención primaria representan el 32.88% del gasto total, en atención secundaria se gasta el 30.4% y en terciaria el 36.72%. El gasto de los hogares por Nivel de Cuidado se distribuyó en un 42.87% para el nivel Primario, el 50.85% Nivel Secundario y el 6.28% en el Nivel Terciario.

Cuentas Nacionales de Salud: Bolivia

Special Initiative Report 8S

83 pages (September 1998) · Order No. SIR 8S

Available only in Spanish

El presente estudio sobre financiamiento y gasto del sector salud se adhiere a la Iniciativa de Cuentas Nacionales en Salud de varios países de la región, con el fin de contar con datos recientes del sector y compatibilizar las distintas estimaciones existentes. Bolivia es uno de los países seleccionados y este trabajo describe el proceso de construcción del sistema propuesto por dicha iniciativa a nivel nacional. En términos globales, se puede concluir que el sector que mayores recursos administra en el sistema de salud en Bolivia son las cajas de seguridad social (37,65% del total). Los hogares se encuentran en segundo lugar como agentes financieros, ya que administran el 28,59% de los recursos, lo cual demuestra la inexistencia de alternativas más eficientes para la administración de dichos recursos en el país. El subsector público es un importante intermediario financiero del 27,29% de los recursos del sistema y los seguros privados sólo captan un 2,48% del total. Finalmente, las ONG’s administran el restante 4% y se constituyen en una interesante alternativa para la canalización de la cooperación externa.

National Health Accounts: Summaries of Eight National Studies in Latin America and the Caribbean

Special Initiative Report 7

33 pages (September 1998) · Order No. SIR 7

National Health Accounts (NHA) are a tool for estimating total financial expenditure on health care in a country over a defined period of time. Although the procedure is widely accepted, developed and developing countries share problems in determining NHA estimates: useful definition of terms and classifications of expenditure, reliable data sources, use of the NHA estimates in policy making. In addition, developing countries face new and different issues: lack of detailed information on health expenditures, different composition of expenditures, greater need for resource mobilization, and less attention of cost control concerns. Cross-country collaboration is one way in which individual countries can approach some of these challenges. To this end, the Latin America and Caribbean National Health Accounts network was launched in 1997. A series of network workshops will culminate in June 1998 with presentation and discussion of case studies based on the experiences of the network's eight countries: Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, and Peru. This report contains the executive summaries of those case studies. Each summary outlines the objectives for utilizing NHAs, presents principal results, discusses limitations, and proposes recommendations for policy and future NHA studies.

Available in Spanish: ***Cuentas Nacionales de Salud: Resúmenes de ocho estudios nacionales en América Latina y el Caribe*** (Order No. SIR 7S)

Las Cuentas Nacionales de Salud (CNS) constituyen una herramienta valiosa para estimar el gasto financiero total en la atención de salud de un país durante un período de tiempo determinado. Si bien el procedimiento tiene amplia aceptación, tanto los países desarrollados como en desarrollo enfrentan los mismos problemas al momento de determinar las estimaciones de las CNS: una definición útil de los términos y clasificaciones de los gastos, fuentes confiables de datos, uso de las estimaciones de CNS en la toma de decisiones. Además, los países en desarrollo enfrentan problemas nuevos y de diferente orden: falta de información detallada sobre los gastos en salud, diferente composición de los gastos, mayor necesidad de movilización de recursos y una menor atención a los problemas de control de los costos. Una forma para que los países individuales puedan enfrentar algunos de estos desafíos es la colaboración entre varios países. Con este fin, se organizó en 1997 la red de Cuentas Nacionales de Salud de América Latina y el Caribe. Hay una serie de talleres de la red que concluirán en junio de 1998, con la presentación y análisis de estudios de casos que se basan en las experiencias de los ocho países que componen la red: Bolivia, República Dominicana, Ecuador, El Salvador, Guatemala, México, Nicaragua y Perú. En este informe se incluyen los resúmenes ejecutivos de esos estudios de casos. En cada resumen se delinean los objetivos que se persiguen al usar las CNS, se presentan los resultados más importantes, se analizan las limitaciones y se proponen recomendaciones de políticas y futuros estudios de las CNS.

Health Accounting: A Comparison of the System of National Accounts and National Health Accounts Approaches

Special Initiative Report 4

Ravindra P. Rannan-Eliya, Peter A. Berman, and Aparnaa Somanathan

42 pages (December 1997) · Order No. SIR 4

The measurement and description of national health expenditures has become a major informational requirement of policymakers, reflecting intensifying expenditure constraints in developed economies, and increased interest in improving health sector management in all countries. The United Nations System of National Accounts (SNA) and National Health Accounts (NHA) approaches to health expenditure estimation share conceptual and methodological characteristics but they evolved separately

and for different reasons. The SNA is a mature statistical system, with considerable international comparability and internal consistency. The NHA approach is not standardized, reflecting mainly national concerns. NHAs describe the flows of resources and expenditures within a health care system, rather than on links between the health sector and the macroeconomy. This emphasis on structuring data in a manner
understandable and relevant to health sector managers results in policy-relevant organization and presentation of data. At the institutional level, the policy use of NHAs is reflected in a different pattern of institutional responsibility and locus of control. The SNA and satellite accounts are the responsibility of a country's national income accounts office, while NHAs are the responsibility of other agencies, especially ministries of health. This institutional difference is critical. While adhering to the same principles of estimation as in the SNA, NHA work has greater flexibility in its use of data sources, and benefits from the institutional knowledge and comparative advantage in access to data of health agencies. This results in significant differences in actual results. The weakness of NHA remains its lack of international comparability and of internal consistency. An ever-increasing number of countries are estimating NHA. There is growing interest in regional and international agencies. It is recommended that the time is now opportune for international collaboration and consensus-building to develop an internationally consistent and agreed framework for NHA.

Egypt National Health Accounts, 1994-95

Special Initiative Report 3

Ravindra P. Rannan-Eliya, Khaled H. Nada, Abeer M. Kamal, and Ahmed Ibrahim Ali

83 pages (October 1997) · Order No. SIR 3

National Health Accounts (NHA) are designed to give a comprehensive description of resource flows in a health care system, showing where resources come from, and how they are used. Although previous health care expenditure studies had been carried out in Egypt, none had used the integrating framework of national health accounts to organize and compile the data. This report presents the results of the 1994/95 NHAs, provides details on the data collected to construct the estimations and gives details of the data estimation procedures used. It is structured in two parts. This first part provides an overview of the results and their implications. The second part is organized according to major institutional groupings, and gives technical details of where data were collected from. The third part provides additional information on how the collected data was adjusted to construct the final NHA matrices. A fourth part provides some information on differences between the estimation procedures and assumptions used in Egypt National Health Accounts (ENHA) 95 and ENHA91, and the possible impact on the final results. A statistical annex contains general socioeconomic data for Egypt, and several years of Ministry budgetary expenditures data.

User's Manual: National Health Accounts

Special Initiative Report 2

Peter A. Berman, David M. Cooper, Amanda Glassman, and Ravindra Rannan-Eliya

54 pages (June 1996) · Order No. SIR 2

The National Health Accounts (NHA) methodology is a way to organize, tabulate, and present health sector financing and expenditure information. As such, NHA are a powerful tool that can be used to improve the capacity of decision makers to identify health sector problems and opportunities for change and to develop and monitor reform strategies. The use of national health expenditure accounts in policy making is a recent phenomenon. This manual reviews NHA policy research and some of its policy uses in Egypt, Jordan, the Philippines, and the United States and the policy relevance of cross-national analyses based on the experience of the Organization for Economic Cooperation and Development (OECD) countries. It then proceeds to lead the user through the accompanying software: Chapter 1 provides an overview and context for the National Health Accounts methodology and software. Chapter 2 describes installation of the program and how to use its essentials. Chapter 3 covers the NHA method in greater detail and describes how to use the different data entry windows. Chapter 4 explains how to use the more complicated aspects of NHA through a guided tour of the first matrix, Sources to Financing Agents. Chapter 5 looks at other matrices. Chapter 6 explains how to print and export data, Chapter 7 how to handle the program's special tools.

Available in Spanish: ***Manual del usuario: Cuentas Nacionales de Salud*** (Order No. SIR 2S)
Las Cuentas Nacionales de Salud (CNS) son una poderosa herramienta que se puede utilizar para mejorar la capacidad de los encargados de tomar decisiones en la identificación de problemas y oportunidades para el cambio en el sector salud, y para el desarrollo y la supervisión de las estrategias de reforma. El uso de las cuentas de gasto nacional en salud para formular las políticas es relativamente reciente. Revisamos la investigación sobre la política de las CNS y algunos de sus usos relevantes en Egipto, Jordania, las Filipinas y los Estados Unidos. También revisa la pertinencia en la política de los análisis a través de las naciones, los cuales están basados en la experiencia de los países de la Organización para la Cooperación y el Desarrollo Económico (OCDE). El Capítulo 1 provee una reseña de la metodología y el programa de computación de las Cuentas Nacionales de Salud y su contexto. El Capítulo 2 lo ayuda a usted a instalar el programa y a familiarizarse con el uso de sus aspectos esenciales. El Capítulo 3 explica el método de las Cuentas Nacionales de Salud más detalladamente y describe como usar las diferentes ventan de entrada de datos. El Capítulo 4 explica cómo usar los aspectos más complicados de las Cuentas Nacionales de Salud a través de un recorrido guiado por la primera matriz Fuentes a Agentes Financieros. El Capítulo 6 demuestra cómo imprimir y exportar sus datos y el Capítulo 7 explica cómo manejar las herramientas especiales del programa.

➢ *The Role of NGOs*

New NGO Partners for Health Sector Reform in Central Asia: Family Group Practice Associations in Kazakhstan and Kyrgzstan

Special Initiative Report 19
Derick W. Brinkerhoff and Mark Mceuen
31 pages (July 1999) · Order No. SIR 19
Economic decline in the former Soviet Central Asian republics of Kazakhstan and Kyrgyzstan is leading the governments in those New Independent States to seek private and nonprofit partners in health care delivery. Family Group Practice Associations (FGPAs)Clegally sanctioned, non-governmental entities that are nonprofit, self-governing, and voluntaryCare being established to serve as intermediaries between government and new, primary care-oriented family group practices. This study looks at the development of FGPAs at the local and national levels in Kazakhstan and Kyrgyzstan. It describes the financing and structure of the FGPAs, their relationships with the state and with their members, and the role of international donors in their development. Based on interviews conducted in the region in early 1999 and on documents reviewed, the study assesses the effectiveness of the partnerships and examines conditions affecting the success and shortcomings of the collaborations. It identifies preliminary lessons

learned from the Central Asian experiences and evaluates the role of the organizations for the future.

Making Health-Sector Non-Governmental Organizations More Sustainable: A Review of NGO and Donor Efforts

Special Initiative Report 14

Denise DeRoeck

41 pages (March 1998) · Order No. SIR 14

The paper discusses innovative activities and efforts by indigenous non-governmental organizations (NGOs) working in the health sector that aim to improve their financial, technical, and programmatic sustainability through increased institutional and management capacity. A second section discusses activities that donors and cooperating agencies have undertaken to promote sustainability, including: donor projects aimed at creating NGOs; umbrella or co-financing projects; centrally funded projects that have as a major goal improving the capabilities and sustainability of local NGOs; and sectoral projects that include NGO participation. This review reveals that there is relatively little in the literature on the topic of sustainability of health sector NGOS. Despite the lack of documentation, there appears to be a great deal of interest in the topic of NGO sustainability in the international health and development community. Further research is warranted to provide national governments and local NGOs with information and tools to use as guides in planning the future of NGOs and to help donors and cooperating agencies determine the most effective and appropriate types of technical assistance.

A Short List of Topics for Prioritizing and Defining Future Work Related to Health Sector Non-Governmental Organizations

Special Initiative Report 13

Annemarie Wouters and Denise DeRoeck

32 pages (March 1998) · Order No. SIR 13

This report provides a short list of topics and activities related to the role of non-governmental organizations (NGOs) in health sector reform and health service delivery. The Partnerships for Health Reform (PHR) developed this list to help prioritize the topics and types of activities that should be pursued under its Special Initiative on NGOs. The report builds on a literature review on NGO's role in the health sector, with emphasis on NGO sustainability, as well as on an informal internal expert meeting of PHR staff and consultants. The document is organized into three main sections. Section 1 states that purpose and overall objective for this Initiative and explains the use of the document. Section 2 identifies the strategic and operational parameters of the NGO Special Initiative and presents a typology as well as selection criteria for choosing appropriate topics and NGOs for each PHR activity. Section 3 briefly describes four NGO topics and suggests related activities that PHR could undertake.

⮝ *Child Survival*

Case Study on the Costs and Financing of Immunization Services in Morocco

Special Initiative Report 18

Miloud Kaddar, Sangeeta Mookherji, Denise DeRoeck, and Denise Antona

135 pages (September 1999) · Order No. SIR 18

The government of Morocco has built a strong immunization program over the past 12 years and has seen impressive gains in immunization coverage. The Partnerships for Health Reform Project, in collaboration with the World Health Organization and the Ministry of Health, conducted an in-depth study of the costs and financing of immunization in Morocco, culminating in this report. This study was conducted in the fall and winter of 1998-1999 and is one of a series of four country case studies on immunization financing. The objectives of the study are to estimate the current and future costs of the country's immunization program, to assist the ministry with program planning, to provide

recommendations to the Moroccan government on ways to improve its financing strategies, and to draw lessons learned from Morocco's immunization financing strategies for the international health community at large. Financing strategies for immunization have become increasingly important due to Morocco's heavy reliance on external funding through donors such as the World Bank; and the analysis and recommendations in this study are presented in the context of prospects for financial sustainability. Costs and financing data used in the analysis were obtained through government documents and through government and private sector interviews. The financial analysis is based on estimated costs rather than expenditures recorded to provide a more inclusive accounting of costs. The analysis also provides estimated for projected expenditures for the next five years. The report concludes with a set of options in the areas of program planning, management, evaluation, research, vaccine procurement and supply, and financing structures to improve the financial sustainability of Morocco's immunization program.
Available in French: ***Étude de cas sur les coûts et le financement des services de vaccination au Maroc*** **(Order No. SIR 18F)**
Le gouvernment du Maroc a mis en place un solide programme de vaccination au cours des 12 derinères années. Il a enregistré des progrès impressionnants dans la couverture vaccinale. Le Projet Parternariats pour la réforme de la santé (PHR), en collaboration avec l'Organisation mondiale de la santé et le Ministère de la santé, a effectué une étude approfondie des coûts et du financement de la vaccination au Maroc, dont ce rapport est l'aboutissement. Cette étude a été réalisée durant l'automne et l'hiver de 1998-1999. Elle fait partie d'une série de quatre études de cas-pays qui sont centrées sur le financement des vaccinations. Les objectifs de cette étude sont les suivants: estimer les coûts actuels et futurs du programme de vaccination du pays; aider le ministère dans la planification du programme; fournir des recommandations au gouvernement marocain sur les moyens d'améliorer ses stratégies de financement; et dégager des leçons des stratégies marocaines de financement des vaccinations pour la communauté sanitaire internationale dans son ensemble. Les stratégies de financement des vaccinations sont devenues de plus en plus importantes, étant donné que le Maroc dépend largement de financements extérieurs par l'intermédiaire de la Banque Mondiale. L'analyse et les recommandations de cette étude sont présentées dans la perspective d'une meilleure pérennité financière. Les données relatives aux coûts et aux financements utilisées dans cette analyse proviennent de documents officiels et d'entretiens menénes par l'équipe PHR dans le secteur publicet privé. L'analyse financière se base sur des coûts estimés plutôt que sur les dépenses enregistrées afin de mieux tenir compte de l'ensemble des coûts. Cette analyse donne aussi des estimations des dépenses projetées pour les cinq prochaines années. Le rapport s'achéve en proposant une série d'options dans les domaines de la planification du progreamme, de la gestion, de l'évaluation, de la recherche, de l'approvisionnement en vaccins, et du financement, avec pour objectif d'améliorer la pérennité du programme d'immunisation du Maroc.

Review of Financing Immunization Programs in Developing and Transitional Countries
Special Initiative Report 12
Denise DeRoeck and Ann Levin
93 pages (December 1998) · Order No. SIR 12
This paper presents a review of selected issues related to immunization financing in developing and transitional countries. Information for this review was obtained through an extensive literature search and through an E-mail survey sent to all United Nations Children's Fund (UNICEF) and Pan American Health Organization (PAHO) country offices. Information is presented in four main areas: (1) the costs of immunization programs, with a focus on the costs of introducing additional vaccines; (2) financing of immunization services, including trends in government vs. donor funding, financing of new vaccines, and the use of cost recovery for immunization services; (3) the effects of a changing health sector on immunization financing, including the impact of decentralization, the role of the private sector in providing immunization, and the impact of disease eradication programs; and (4) country experiences with international mechanisms to facilitate vaccine financing, such as the Vaccine Independence

Initiative, the PAHO Revolving Fund, and the European Union Initiative. In addition to summarizing existing information and lessons learned on the financing and costs of country-level immunization programs, this paper identifies critical gaps in information in immunization financing. Further information will be obtained through a series of country case studies on immunization financing that the Partnerships for Health Reform Project is conducting in collaboration with the World Health Organization and PAHO.

Expanded Program on Immunization in Bangladesh: Cost, Cost-Effectiveness, and Financing Estimates

Special Initiative Report 6

M. Mahmud Khan and Richard A. Yoder

61 pages (September 1998) · Order No. SIR 6

The Bangladesh Expanded Program of Immunization (EPI) began in 1979 as a means of reducing vaccine preventable morbidity and mortality. Widely recognized as having achieved significant gains since its beginning, some concerns have been expressed recently over the financial sustainability of the EPI, diminishing donor support, competition for scarce resources within the government budget, as well as plateauing immunization coverage rates. Partly in response to such concerns, a comprehensive EPI review was conducted that includes, among other things, this assessment of costs, cost-effectiveness and financing issues. The assessment found that the total cost of the EPI for the current year will approximate $18.3 million while fully immunizing approximately 1.56 million infants under one year of age, resulting in a cost per fully immunized child of $11.76. The immunizations are estimated to prevent 134,000 deaths during the current year, at a cost of $136 per death prevented. As a broad picture, it is estimated that some 1.15 million deaths have been averted since 1987 due to immunization activities. At the current level of costs, the gap between total resources needed ($18.3 million) and the resources provided through government funding ($8.3 million) approximates $10 million. This gap must be closed through generating additional resources, through cost containment, or both. As an indicator of the Government of Bangladesh's ability to finance EPI activities, current EPI costs represent approximately 0.06 percent of GDP, 0.5 percent of GOB revenue, and 4.95 percent of the budget of the Ministry of Health and Family Welfare. In general, the EPI program was found to be relatively cost-effective, particularly when compared to similar countries and to the opportunity cost of treating the sick child. Thus, one of the best ways to generate savings in the entire health sector is to reduce the needs in the highly visible curative sector by reducing its demand—precisely what a strong immunization program does.

The Nepal National Vitamin A Program: A Program Review and Cost Analysis

Special Initiative Report 5

John L. Fiedler

71 pages (May 1997) · Order No. SIR 5

Vitamin A deficiency is a significant public health problem and a major cause of child mortality and morbidity in Nepal. The Nepal National Vitamin A Program (NVAP), begun in 1993 in 32 of the country's 75 districts where vitamin A deficiency rates are highest, has been considered by many to be a highly successful, model program. The program consists primarily of distributing high-dose vitamin A capsules to all children 6 to 60 months of age during twice-yearly campaigns. The campaign is complemented by on-going treatment of clinical zerophthalmia and other acute infections in health facilities throughout the country. The capsule distribution is carried out by a previously existing network of Female Community Health Volunteers (FCHVs) that has been reinvigorated by the highly visible and universally acclaimed success of the National Vitamin A Program. These volunteers are generally illiterate women who have been selected by their communities. Much of the program's activities have thus far been devoted to training health and community workers in vitamin A promotion and distribution. An important strategy of the program has been the empowerment of the FCHVs, which has been accomplished by organizing, training, and motivating community workers and other representatives from education, agriculture, and other sectors, as well as political representatives, to support the FCHVs. Estimates of average rates among targeted children range from 53 to over 90 percent. The United States Agency for International Development (USAID) in Nepal, which has provided much of the program's funding, requested the Partnerships for Health Reform (PHR) Project to conduct a detailed cost analysis of the program to determine how USAID's investment was spent, the

annual recurrent costs of the program, and how much it will cost to expand the program nation-wide. The analysis shows that, assuming different coverage rates, the cost of the program per child ranges from US$0.81 to $1.09 for one capsule, and from US$0.68 to $1.65 for two capsules. Program development and administration costs make up an estimated 38 percent of the overall annual, recurrent costs of the program, and the costs of training make up 30 percent. The analysis estimates that the cost of expanding the program nation-wide will be US$6.5 million over five years. Once the program is national, the estimated incremental recurrent costs will be around US$1.3 million per year. The report ends with a discussion of key issues regarding the sustainability and institutionalization of the program.

➢ *Monitoring and Tracking Health Sector Reform*

Measuring Results of Health Sector Reform: A Handbook of Indicators

Special Initiative Report 1

James Knowles, Charlotte Leighton, and Wayne Stinson

66 pages (September 1997) · Order No. SIR 1

This handbook presents indicators for five key dimensions of health system performance: access, equity, quality, efficiency, and sustainability. These performance measures are considered within a framework that maps the linkages between health sector reform, changes in health system performance, and ultimately, changes in health status. It also provides a rationale for focusing on system performance as one of the principal ways to measure results of health sector reform. Through definitions and discussion of each of the five key dimensions, and then presentation and explanation of the indicators themselves, the handbook attempts to make the indicators understandable, accessible, and usable in a way that will bring the intended results. The indicators focus on health system performance—as opposed to specific health services, programs, or health status, for which general consensus about indicators already exists—as a way to measure the results of health care reform in low- and middle-income countries. The handbook brings together what is known and practiced in these countries. It makes no value judgement about approaches to health reform, which may vary widely from country to country, system to system. Rather, it is intended to enable local health professionals and donor organizations to design and implement, and then evaluate and refine health sector reforms based on empirical evidence in order to achieve desired results; and to compare the range and type of results that health sector reform is achieving internationally. Finally, the handbook presents a methodology to select most relevant indicators, depending on intended use in individual countries.

Available in Spanish: ***Medición de resultados de la reforma del sector salud en cuanto al desempeño del sistema: Guía de indicadores*** (Order No. SIR 1S)

En esta guía se presentan indicadores sobre cinco dimensiones clave del desempeño del sistema de la salud: acceso, equidad, calidad, eficiencia y sustentabilidad. Estas mediciones del desempeño se consideran dentro de un marco que relaciona los vínculos entre la reforma del sector salud, los cambios en el desempeño del sistema de la salud y, en definitiva, los cambios en el estado de la salud. En este trabajo se entregan los fundamentos para analizar en el desempeño del sistema como uno de los principales medios para evaluar los resultados de la reforma de este sector. A través de definiciones y análisis de cada una de las cinco dimensiones clave y la presentación y explicación de los indicadores, el objetivo es hacerlos comprensibles, accesibles y factibles de usar, de manera tal de obtener los resultados deseados. Los indicadores se centran en el desempeño del sistema de salud como una forma de medir los resultados de esta reforma en países de ingresos medianos y bajos. Estos indicadores no tienen por objeto analizar el desempeño de servicios y programas de salud específicos o el estado de la salud de la población, sobre los cuales ya existe un consenso general. La guía reúne lo que se sabe y aplica en estos países. No emite juicios acerca del valor de los métodos utilizados en la reforma, donde hay grandes variaciones entre países y sistemas. Más bien busca capacitar a los profesionales locales y a

las organizaciones de donantes en el diseño e implementación, y luego evaluación y perfeccionamiento, de las reformas de este sector, basándose en una evidencia empírica que permita obtener los resultados deseados. Asimismo, el presente trabajo busca comparar los niveles y tipos de resultados que se están logrando con este tipo de reformas a nivel internacional. Finalmente, la guía se presenta una metodología apta para seleccionar los indicadores más importantes en base al uso que se les pretenda dar en cada país.

Available in French: ***La mesure des résultats de la réforme du secteur de la santé pour évaluer la performance du système: manuel des indicateurs*** (Order No. SIR 1F)
Ce manuel présente une série d'indicateurs qui sont les plus couramment utilisés pour cinq dimensions essentielles de la performance des systèmes de santé: l'accès, l'équité, la qualité, l'efficacité et la durabilité. Il place ces mesures de la performance dans un cadre qui illustre les liens entre la réforme du secteur de la santé, l'évolution de la performance des systèmes de santé et l'évolution de l'état de santé. Il apporte aussi une justification à l'importance accordée à la performance du système comme stratégie principale pour mesurer les résultats de la réforme du secteur de la santé. Les indicateurs ont été conçus pour pouvoir suivre certains des résultats de la réforme de la santé; ils ne cherchent pas à formuler des jugements de valeur à propos d'approches, de politiques, de stratégies ou de techniques spécifiques pour procéder à des réformes. Alors que l'un des objectifs majeurs de la réforme du secteur de la santé dans de nombreux pays est d'améliorer la performance du système de santé, l'interprétation de l'impact d'un indicateur particulier sur les performances, peut varier selon le point de départ du pays concerné, les buts de ses réformes et sa vision de ce que devrait accomplir le système de santé. Dans ce contexte de politiques et de systèmes très différents, la définition de l'expression "réforme du secteur de la santé" et les résultats que pourrait engendrer cette réforme sont très variables. Il y a tout autant d'incertitudes concernant la mesure des résultats et les indicateurs qui sont valables pour suivre les progrès accomplis par rapport aux objectifs fixés pour la réforme du secteur de la santé. Ce manuel a pour but de servir de support à une discussion et à l'obtention d'un consensus à l'échelle internationale sur ces points - sur la performance du système en tant que mesure des résultats des réformes du secteur de la santé, sur les catégories principales d'indicateurs pour la performance du système de santé et sur une série d'indicateurs spécifiques qui illustrent ces dimensions de la performance du système.

Applied Research Papers

PHR applied research studies seek to address key policy questions in health care reform and to improve understanding in the areas of health policy, management, financing and service improvement. The applied research program consists of two components: Major Applied Research (MAR) studies and Small Applied Research (SAR) grants.

First Year Literature Review for Applied Research Agenda

Applied Research Paper 1

Ravindra Rannan-Eliya, Tisna Velduyzen van Zanten, and Abdo Yazbeck

58 pages (November 1996) · Order No. AR 1

This first year PHR Applied Research Review has been developed as part of the process to select activities for the Applied Research component of the PHR Project. The document reviews current policy issues in all the core health sector reform areas, which are the concern of the project and relevant to achieving USAID strategic objectives. It also identifies information gaps and other ongoing research work, and proposes potential areas for research under the PHR AR component. A comprehensive review of all material and literature in the various health reform areas would have been an enormous task, requiring many person-months. A number of reviews of certain areas, however, have recently been completed by agencies such as WHO, World Bank, and other USAID projects. It was decided at the beginning that, to ensure rapid implementation of the AR activities, the PHR AR review would focus on assessing these other external reviews, supplemented by additional research where necessary. The compilation of the document involved preparation of draft sections, which were then reviewed by two meetings of the AR Steering Committee. These meetings were attended by representatives of USAID/Office of Health and senior management of the PHR project to allow for their substantial advice and input. The Steering Committee also consulted with the other USAID strategic objective groups. This document was compiled in a relatively short period of time, as required under the PHR contract and First Year Workplan, to support selection of first year applied research activities. It therefore should not be regarded as a final or definitive review of all relevant applied research issues. While it is an adequate document upon which to base the first year's activities, it is expected to be revised and modified in the future, as time allows for more substantial effort and as the priorities of the PHR project itself change in coming years. It should thus be viewed as an organic document, which will be improved with time and modified with changing circumstances.

Applied Research Agenda

Applied Research Paper 2

58 pages (March 1996) · Order No. AR 2

This document presents the Applied Research Agenda for the Partnerships for Health Reform (PHR) Project, a global five-year USAID project which began in October 1995. The purpose of the Project is to support health sector reform and to advance knowledge about health sector problems in Africa, Asia, Latin America and the Caribbean, the Middle East and Eastern Europe. PHR concentrates on supporting reform initiatives that make the health sector more effective in improving health status, with an emphasis on the priority child health, maternal health, family planning, and HIV/AIDS services that USAID's Population, Health and Nutrition (PHN) Center has identified in its Strategic Objectives. The project offers long and short-term technical assistance, training, research, and information services in

three core areas: health policy and management, health care financing, and health service improvement. The Applied Research Program consists of two components: Major Applied Research (MAR) and Small Applied Research (SAR). The main priority for PHR Applied Research is to demonstrate, through field-based interventions or targeted data analysis, how reform activities and/or new policy, financing, management, and service delivery approaches can be successful in achieving PHN Strategic Objectives and related program results. The Applied Research Program also emphasizes producing findings for the 15 PHN Priority Countries (which are primarily in Anglophone Africa, the Near East and Asia, and the countries of Eastern and Central Europe), or as they relate to typical conditions prevailing in Priority Countries. The Project will seek opportunities to hold regional conferences for local researchers and policy makers on both MAR and SAR findings. PHR will also disseminate the results of the Applied Research Program in relevant languages and in several forms, including written materials, workshops, and conferences, to the broader international health community.

Available in Spanish: ***Temario de investigación aplicada*** (Order No. AR 2S)
Este documento presenta el temario de investigación aplicada para el Partnerships for Health Reform (PHR) Project, un proyecto global quinquenal de la USAID que comenzó en octubre de 1995. La finalidad del proyecto es apoyar la reforma del sector salud y avanzar el conocimiento acerca de los problemas del sector salud en África, Asia, América Latina y el Caribe, el Oriente Medio y Europa del Este. El PHR se concentra en apoyar iniciativas de reforma que hacen que el sector salud sea más eficaz en mejorar el estado de salud, con énfasis en la salud prioritaria del niño, la salud materna, la planificación familiar y los servicios de VIH/SIDA que el Centro de Población, Salud y Nutrición (PHN) ha identificado en sus objetivos estratégicos. El proyecto ofrece asistencia técnica a largo y corto plazos, capacitación, investigación y servicios de información en tres áreas básicas: política de salud y gestión, financiamiento de la atención de salud y mejora de los servicios de salud. El Programa de Investigación Aplicada consiste en dos componentes: Investigación Aplicada Principal (MAR) e Investigación Aplicada Menor (SAR). La principal prioridad para la Investigación Aplicada del PHR es demostrar, mediante intervenciones basadas en el terreno o análisis concentrados de datos, cómo reformar las actividades y nuevos enfoques de política, financiamiento, gestión y provisión de servicios que puedan contribuir al logro de los objetivos estratégicos del PHN y resultados programáticos afines. El programa de Investigación Aplicada también subraya la formulación de conclusiones para los 15 países prioritarios del PHN (que se hallan principalmente en el Africa de habla inglesa, el Oriente Próximo y Asia, y los países de la Europa del Este y Central) o en cuanto se relacionan con las condiciones típicas que prevalecen en los países prioritarios. El proyecto tratará de aprovechar oportunidades para celebrar conferencias regionales para investigadores y ejecutivos locales en las que se tratarán las conclusiones emanadas de los MAR y de los SAR. El PHR también divulgará los resultados del Programa de Investigación Aplicada en idiomas pertinentes y en varias formas a la comunidad internacional de salud en general.

Available in French: ***Ordre du jour de la recherce appliquée*** (Order No. AR 2F)
Ce document présente l'Ordre du jour de la recherche appliquée pour le Projet partenariats pour la réforme de la santé (PHR), un projet mondial de l'USAID qui a débuté en octobre 1995. Le but de ce projet est d'appuyer les réformes dan le domaine la santé et de faire progresser les connaissances au sujet des problèmes qui se posent dans le secteur de la santé en Afrique, en Asie, en Amérique latine et dans les Caraï bes, au Proche-Orient et en Europe de l'Est. Le PHR cherche avant tout à fournir un soutien aux initiatives de réforme pour renforce l'efficacité de ce secteur en améliorant l'état de santé des populations. L'accent est mis sur la santé de l'enfant, la santé de la mère, la planification familiale et les services VIH/SIDA que le Centre pour la population, la santé et la nutrition (PHN) de l'USAID a choisis comme objectifs stratégiques. Le projet offre une assistance technique à long et à court terme, des services de formation, de recherche et d'information dans trois domaines essentiels: politique et

gestion de la santé, financement des soins de santé et amélioration des services de santé. Le Programme de recherche appliquée comporte deux volets: les Grands project de recherche appliquée (GPR) et les Petits projets de recherche appliquée (PPR). Le principal objectif de la recherce appliquée du PHR est de démonter, par des interventions de terrain ou par des analyses de données ciblées, comment des activités de réforme et/ou de nouvelles approches de politique, de financement, de gestion et de prestation de services peuvent permettre d'atteindre les Objectifs stratégiques du PHN et autres résultats connexes du programme. Le Programme de recherche appliquée vise aussi à dégager des conclusions pour les Pays prioritaires du PHN (qui se situent essentiellement en Afrique anglophone, au Proche-Orient et en Asie, ainsi qu'en Europe de l'Est et du Centre), ou des points qui s'appliqueraient aux conditions particulières qui prévalent dans les Pays prioritaires. Le projet recherchera des occasion d'organiser des conférences régionales, à l'intention des chercheurs et des décideurs locaux, sur les conclusions des GPR ainsi que des PPR. Le PHR disséminera aussi les résultats du Programme de recherche appliquée dans les langue appropriées et sous diverses formes à l'ensemble de la communauté internationale de la santé.

Major Applied Research Papers

- ***MAR 1: Analyzing the Process of Health Financing Reform***

Implementing and Evaluating Health Reform Processes: Lessons from the Literature

Working Paper 1
Lucy Gilson
26 pages (November 1997) · MAR 1/WP-1
Health reform is a process of organizational and financial changes based on the social and political values of reformers. This report reviews the literature on past reform experiences and discusses the lessons learned. A key finding is the importance of understanding the underlying factors at play during reform implementation. One of the report's conclusions is that these factors (the level of organizational capacity among reformers, for example) play a critical role in shaping and affecting the success of a reform package. Finally, this report reviews evaluation methods and strategies including the key problems of evaluating public/health sector reform, approaches for evaluation that address these key problems, and critical aspects of the overall strategy of evaluation.

- ***MAR 2: Impact of Alternative Provider Payment Systems***

A Review of Health Care Provider Payment Reform in Selected Countries in Asia and Latin America

Working Paper 1
Ricardo Bitran and Winnie C. Yip
29 pages (September 1998) · Order No. MAR 2/WP-1
To explore opportunities for research and assist in research design, the Partnerships for Health Reform undertook the research for this report, which reviews the current status of provider payment reform in selected Asian and Latin American countries, as well as possible research questions and research approaches. Provider payment method, the mechanism for transfering financial resources from the payers of health services (the government, insurers, and/or patients) to the providers, influences providers' behavior (in terms of the types, amounts, and quality of services they offer) and financial performance. The research found that reforms in Asia are largely national level reforms affecting the whole of the social security system, reforms in Latin

America tend to be less centrally driven and uniform.

Provider Payment Mechanisms in Health Care: Incentives, Outcomes, and Organizational Impact in Developing Countries

Working Paper 2

Daniel Maceira

25 pages (August 1998) · Order No. MAR 2/WP-2

This paper assists with development of a research design for a study exploring the impact of alternative methods of provider payment mechanisms in developing countries. The paper sees provider payment as a form of contract between purchaser and provider and draws upon the economic literature on agency contracts to consider the problem of how best to develop appropriate payment mechanisms. In addition, the paper suggests the need to study the effects of payment mechanisms on the organization of the health care system, not only in terms of market structure, but also in the way providers are organized internally. It is argued that changes in payment mechanisms provoke realignments in the mode of service delivery through risk shifting, specialization, competition, integration, etc., which in turn affect health care outputs. At the same time, different basic conditions in the health care sector may affect the impact of new incentive mechanisms. The main payment methods and the incentives inherent in them are discussed. A brief overview is given of main payment structures in OECD countries. The paper then discusses the impacts of provider payment reforms on the structure of health care markets and the internal organization of providers. The paper also presents several examples of empirical research that help explain the impact of provider payment reforms on intermediate outcomes (such as health care provider organization) and on final outcomes (such as health outcomes, expenditures, utilization, and quality). The paper concludes with a list of issues that should be taken into account in the research design on provider payment systems.

Available in Spanish: ***Mecanismos de pago a prestadores en el sistema de salud: Incentivos, resultados e impacto organizacional en países en desarrollo*** (Order No. MAR 2/WP-2S)

El objetivo de este trabajo es contribuir al desarrollo de un modelo de investigación que analice el impacto que producen métodos alternativos de pago a prestadores de servicios de salud en países en desarrollo. El presente trabajo considera la estructura de pago a prestadores como una forma de contrato entre éstos y los compradores y a fin de abordar el problema acerca de cuál es la mejor manera de desarrollar mecanismos de pago adecuados, se recurre a la literatura económica sobre contratos de agencia. Además, en el trabajo se sugiere la necesidad de estudiar cómo influyen los mecanismos de pago en la organización del sistema de salud, no sólo en términos de la estructura del mercado, sino también de la organización interna de los prestadores. Se argumenta que los cambios en los mecanismos de pago causan reestructuraciones en la modalidad de prestación de los servicios, ya sea por transferencia de riesgo, especialización, competencia, integración, etc. que, a su vez, influyen sobre el rendimiento de la asistencia médica. Al mismo tiempo, distintas condiciones básicas en el sector salud pueden afectar la magnitud del impacto provocado por nuevos mecanismos de incentivos. En este trabajo se tratan los principales métodos de pago y los incentivos inherentes a ellos. También se ofrece una perspectiva general de las principales estructuras de pago en los países de la OCDE. Luego, se debate la influencia que ejercen las reformas en el pago a prestadores sobre la estructura del mercado de la asistencia médica y la organización interna de los prestadores. Asimismo, se presentan diversos ejemplos basados en investigaciones empíricas que sirven para explicar el efecto de estas reformas en los resultados intermedios (tales como la organización de la prestación médica) y finales (tales como niveles de gasto, utilización, calidad y resultados en el área de salud). Para finalizar, se propone una lista de temas que deberían ser tomados en cuenta en el momento de desarrollar un modelo de investigación sobre sistemas de

pago a prestadores.

MAR 3: Revenue Generation

Equity of Health Sector Revenue Generation and Allocation in Guatemala
Working Paper 1
Ricardo Bitrán, Gloria Ubilia, and Lorena Prieto
55 pages (May 1999) · Order No. MAR 3/WP-1
This paper presents methods and results from the Partnerships for Health Reform Project's empirical work on equity carried out in four departments of Guatemala, using government-supplied data as well as household survey information on health care spending. It is part of a larger study that will provide more in-depth analysis. Section 2 of the paper presents an overview of the health sector in Guatemala; Section 3 provides basic information on government health care financing in that country; Section 4 describes the household survey used in the analysis; Section 5 presents the results; and Section 6 offers policy conclusions. This analysis found significant inequity in health care delivery in the departments studied, particularly for curative health care delivery, and recommends increased public health spending either through direct investment in government health facilities or through income subsidies for the poor.

Equity of Health Sector Revenue Generation and Allocation in Paraguay
Working Paper 2
Ricardo Bitrán, Gloria Ubilia, and Lorena Prieto
55 pages (June 1998) · Order No. MAR 3/WP-2
This paper presents methods and results from the Partnership for Health Reform's (PHR) empirical work on equity carried out in six departments of Paraguay. Its findings, based on government supplied data on health spending and household survey information on health care spending and consumption, will contribute to a more in-depth PHR major applied research study on equity. The paper opens with an overview of the health sector in Paraguay, provides information on government health care financing in the country, describes the methodology and findings of the household survey, and presents results and policy conclusions. Paraguay has a mixed health system, where public, social security, and private agents participate in health care financing and delivery. Public sector financing accounts for one-half of total health spending. The data illustrate that neither public nor total (public and private) health care resources are evenly allocated among study sites. The analysis reveals that illness incidence, as measured by self-perception, is highest among the poorest, rural households, yet consumption of health services in lowest among this group. The paper concludes with recommendations for improvement of equity in the allocation of resources on the part of the government through higher investment in infrastructure, health personnel and social programs, such as housing and nutrition.

Equity of Health Sector Revenue Generation and Allocation: A South African Case Study
Working Paper 3
Di McIntyre, Lucy Gilson, Nicole Valentine, and Neil Söderlund
69 pages (May 1999) · Order No. MAR 3/WP-3
This report is a case study of the Partnerships for Health Reform Project's empirical work on equity in health care financing in South Africa. The study uses government-supplied data on health spending and hosuehold survey information to analyze private and public sector health

care delivery. This paper will contribute to the larger equity study which will provide more in-depth analysis. Section 2 of the paper presents an overview of the health sector in South Africa; Section 3 provides basic information on government health care financing in the country; Section 4 describes the household survey used in the analysis; and Section 5 presents the result and implications for policy. Despite substantial economic resources relative to other African countries, South Africa suffers substantial inequalities of health care spending and delivery and has relatively high poverty levels. Approximately 60 percent of health care expenditure is attributable to the private sector, however only 23 percent of the population have regular access to private sector health care in terms of coverage by a third-party payer mechanism. Closing the gap in health care spending and access will require policy innovations that reallocate financial and human resources, improve access to care, especially for residents of rural area; and improve quality of primary, maternal, and pre-natal care. To make informed decisions, a more detailed analysis of the public/private health sector mix, health sector revenue allocation, and service delivery reform is recommended.

Health Spending Inequalities and Goverment's Role in Zambia

Working Paper 4

Marty Makinen

13 pages (May 1999) · Order No. MAR 3/WP-4

Government health spending patterns and household survey data in Zambia permit analysis of the effects of government funding and resource allocation reforms on inequality in the system. The country's health sector reform program includes dividing responsibilities between the Ministry of Health (policy development and regulation) and the Central Board of Health (service delivery, decentralization, and instituting cost-sharing and pre-payment schemes). Reforms to decrease the share of resources devoted to hospitals and increase resources for primary care services has contributed to a small decrease in inequality. Lower-income quintiles make greater use of primary care and higher-income quintiles make greater use of hospitals. Government spending on health increases inequality in absolute terms but decreases inequality in relative terms; despite government spending's being skewed towards richer quintiles, it is less skewed than is personal spending. Roughly 2.4 times as many total health resources reach the top quintile as the bottom; this would be 2 to 1 if government subsidies were equally distributed. Other means to better target subsidies include: charging more to the rich and urban for government delivered services; improving access to hospital services by the poor and rural; and decreasing use of hospital services by the rich and urban populations.

MAR 4: Economics of Using Private Providers to Extend Coverage of Priority Services

A Model for Analyzing Strategic Use of Government Financing to Improve Health Care Provision

Technical Paper 1

Peter Berman and Mukesh Chawla

33 pages (April 1999) · Order No. MAR 4/TP-1

This paper contributes to the debate over public vis-a-vis private provision of health care services in low- and middle-income developing countries with a framework and methods intended to help governments analyze the costs and benefits of different health care financing

and provision scenarios, and thus design policy appropriate to their health care goals. It takes into account government interests of health care coverage, equity, and efficiency; provider interests in issues of public and private production of services; and consumer interests of cost, quality, and health benefits. This paper develops an estimable model to help governments decide how best to use scarce resources to achieve priority health goals. Focusing on a single intervention, the model incorporates the separation of financing and provision functions and explicit behavioral assumptions about four key actors: government, public providers, private providers, and consumers. Government can allocate funds between four types of expenditures to increase health outcomes: educating potential users, improving access to public services, improving public service quality, and subsidizing private providers.

Extending Coverage of Priority Health Care Services through Collaboration with the Private Sector: Selected Experiences of USAID Cooperating Agencies

Working Paper 1

Christina M. Skaar

58 pages (February 1998) · Order No. MAR 4/WP-1

As it has become apparent in most regions that developing countries' public sectors lack the resources to meet the health care needs of their populations, the United States Agency for International Development (USAID) has sought increased collaboration with the private sector in the last decade. This paper presents an overview of the variety of activities cooperating agencies (CA) have undertaken in collaboration with the private sector to extend coverage of priority health services. USAID has defined priority health care services to include maternal and child health, reproductive health, family planning, and sexually transmitted diseases/acquired immunodeficiency syndrome services. The general methods of collaboration employed, types of private providers and services involved, and geographic regions and populations covered are described. An assessment of the collaboration is also included, incorporating an analysis of how the different aspects of these projects are combined. Information was gathered largely through CA annual reports, outside evaluations, discussions with project staff, and other materials produced and disseminated by the CAs. The review was constrained by time and availability of

documents and is not an exhaustive survey. It presents the most up-to-date portrayal of ongoing public-private partnerships.

- ***MAR 5: Health Worker Motivation***

Public Sector Health Worker Motivation and Health Sector Reform: A Conceptual Framework

Technical Paper 1

Sara Bennett and Lynne Miller Franco

28 pages (January 1999) · Order No. MAR 5/TP-1

This paper offers a conceptual framework for considering the many layers of influences upon health worker motivation. It suggests that worker motivation is influenced not only by specific incentive schemes targeted at workers, but also by the whole range of health sector reforms which potentially affect organizational culture, reporting structures, channels of accountability, ect. In addition, the impact of such organizational reforms will be further mediated by the social and cultural context. By drawing attention to the broad range of influences, the paper aims to help policymakers develop and implement health sector reform policies that promote worker motivation and understand better the potential of specific incentives to induce higher worker motivation. Two themes run persistently throughout the paper: (1) the need to broaden understanding of motivational determinants beyond simply financial incentives to other, often less tangible, non-financial instruments (such as organizational culture and feedback from community); and (2) the need for methods to increase alignment of individual, organizational, and reform goals.

Measuring Health Worker Motivation in Developing Countries

Working Paper 1

Ruth Kanfer

20 pages (January 1999) · Order No. MAR 5/WP-1

A conceptual framework of motivation processes is presented and used to identify strategies and options for the measurement of health worker motivation in developing countries. Measures of motivation are broadly organized into determinant and consequent categories, and determinants are further distinguished in terms of measures that influence worker–organization goal congruence ("will do" motivation) and those directed toward goal striving ("can do" motivation). Strategic considerations in the use and development of measures appropriate for the target population are discussed and advantages/disadvantages of various measurement options in each category are described. General guidelines for developing a conceptually based and practically useful measurement system are offered.

Summary Proceedings: Workshop on Health Worker Motivation and Health Sector Reform

Working Paper 2

Sara Bennett and Lynne Miller Franco

31 pages (October 1998) · Order No. MAR 5/WP-2

These proceedings summarize the discussions at a workshop on Health Worker Motivation and Health Sector Reform convened by the Partnerships for Health Reform (PHR) Project, and held on October 14-16, 1998 in Bethesda, Maryland. The purpose of the workshop was to (i) review a conceptual framework for considering the impact of health sector reform upon health worker motivation and specific country experiences in this respect; and (ii) develop an agenda for future research in this area. Participants at the workshop included authors of country papers; experts in anthropology, the psychology of motivation, and human resource management; representatives of international organizations and USAID; and PHR staff members. During the first part of the workshop the overarching conceptual framework and individual country experiences were presented and discussed. A number of key themes emerged from this discussion. In order to help develop a research agenda, the workshop participants reviewed other research activities in the field of human resource management in the health sector, and heard a presentation on approaches to measuring health worker motivation. Through a process of small group discussions, agreement was reached on key, policy relevant, research topics in the area of health worker motivation in the developing country health sector context.

Reform of Primary Health Care in Kazakhstan and the Effects on Primary Health Care Worker Motivation: The Case of Zhezkazgan Region

Working Paper 3

Rosa Abzalova, Cheryl Wickham, Askar Chukmaitov, and Tolebai Rakhpbekar

27 pages (October 1998) · Order No. MAR 5/WP-3

This paper reports the experiences of primary care reform in the Zhezkazgan region of Kazakhstan. After the collapse of the Soviet regime, Kazakhstan undertook a radical program of reform to restructure the health sector, making primary care the centerpiece of their health reform agenda. The reforms included the creation of independent family group practices financed on a capitation basis directly from the Ministry of Health, allowing free choice of primary care providers through open enrollment, and creating a non-governmental primary care physician association. This program has had remarkable success in improving motivation among primary health care workers. Part of this success can be explained by the multiple strategies adopted, including communicating and preparing providers and communities for changes, providing stronger financial incentives for performance, ensuring strong feedback mechanisms from the community to care providers, and engendering a stronger sense of professionalism among primary care providers. The paper describes how changes in the overall organizational relationships and economic incentives have led to increased interest in primary care among physicians, increased attention to quality and patient satisfaction, more rational and creative use of resources, and stronger commitment of physicians' personal time and resources.

The Impact of Health Sector Reform on Public Sector Health Worker Motivation in Zimbabwe

Working Paper 4

Dorothy Mutizwa-Mangiza

28 pages (November 1998) · Order No. MAR 5/WP-4

During the past decade the economic situation in Zimbabwe has deteriorated significantly. Public sector health care workers have gone from being high status and relatively well paid members of the community to workers struggling to get a living wage from their jobs. This paper describes the specific policy measures that the Zimbabwean government has recently implemented to try to improve health sector performance, and promote higher levels of motivation amongst public sector health care workers. The overall reform package is to include financial reforms (user fees and social insurance), strengthening of health management, liberalization and regulation of the private health sector, decentralization, and contracting out. Unfortunately, the process of reform implementation in Zimbabwe and the government's poor communication with workers, combined with a conflict between local cultures and the measures being implemented, has undermined the potentially positive effect of reforms on health worker motivation. Workers perceived reforms as threatening their job security, salaries, and training/career advancement opportunities, and feared ethnic and political influence on new employment practices under a decentralized system. Worker demotivation has been expressed in terms of strikes, unethical behavior, neglecting public sector responsibilities to work in private practice, and high turnover.

Small Applied Research Papers

PHR awarded a total of 16 SAR grants that focus on a specific national health policy topic and are designed to build in-country analytical skills and policy research capabilities.

Targeting Public Health Expenditures in Peru: Situation and Alternatives

Small Applied Research Paper 1

Pedro Francke

25 pages (February 1998) · Order No. SAR 1

El presente artículo aborda el tema de la focalización del gasto público en salud en el Perú desde

una doble perspectiva. En la primera parte, se realiza un análisis de la distribución del gasto público en salud, entre regiones y entre estratos sociales, mostrándose que el mismo no se efectúa de una manera equitativa. Particular énfasis se pone en los cobros por tarifas realizados a los usuarios, que se demuestra no aportan a la focalización, debido a que no se concentran entre quienes tienen más recursos. Una segunda parte es propositiva: plantea una estrategia de múltiples facetas para mejorar la focalización del gasto público en salud, que incluye la priorización de servicios dirigidos a madres y niños, la adaptación de los servicios a los requerimientos culturales de los grupos indígenas, la reasignación geográfica del gasto en forma paulatina a las zonas más pobres y necesitadas, la auto - selección mediante la promoción y

adecuada regulación de servicios privados y la identificación individual de los pobres y necesitados mediante “proxy means tests” o indicadores socio-económicos.

User Fees in Government Health Units in Uganda: Implementation, Impact, and Scope

Small Applied Research Paper 2

Joseph K. Konde-Lule

19 pages (May 1998) · Order No. SAR 2

The objective of this cross-sectional study, which was conducted both at the Ministry of Health headquarters and in three districts of Uganda namely Mukono, Mpigi and Jinja, was to investigate and outline the implementation and impact of user fees on government health services in Uganda and to explore their scope in the future. The study includes qualitative and quantitative data, which were obtained through questionnaires administered to administrators, patients and health workers and focus groups conducted in the community. We found that despite an unclear government position on cost sharing, user fees are levied at all government health units in the study districts. Among health workers, there is widespread acceptance of user fees. Health workers report that their morale is better because of the user fees. Other outcomes of the user fees include money available to rehabilitate buildings, improve supplies of drugs and other consumables, expand the presence of health workers at health units and provide better quality medical care at government health units. The public is beginning to reluctantly accept user fees. The patients who were interviewed generally dislike the fee. While some of them acknowledge the positive outcomes of user fees, the proportion of the public acknowledging the benefits is significantly lower than that of health workers. Many patients also complain about rude staff and corruption in the health units. The patients and the community in general had little knowledge about the operational details of cost sharing or the roles of the health unit management committees. The communities are uninformed about both the selection process for committee members and committee members’ roles and responsibilities. Many of the complaints from community members related to cost sharing may be attributed to ignorance of the system. The health workers aggravate this by withholding information, which they fear could lead to less money being collected, such as exemption criteria for people who cannot afford to pay user fees. The implementation of cost sharing has been problematic largely because of unclear policies and corruption in the health units. Our assessment of the scheme is that user fees have had some positive impact on the quality of health care in many government health units in Uganda. Drugs and supplies are now more easily available, and health workers spend more time working at the health units. A low level of community awareness about the management committees has created negative feelings about their roles. The public needs to participate more in decisions related to user fees. With increased transparency and decreased corruption, user fees are likely to play a larger and more positive role in the future.

An Essential Hospital Package for South Africa: Selection Criteria, Costs, and Affordability

Small Applied Research Paper 3

Neil Söderlund and Enoch Peprah

80 pages (May 1998) · Order No. SAR 3

The Committee of Enquiry into National Health Insurance (NHI) in South Africa recommended in 1995 that formally employed individuals and their employers be required to fund at least a minimum package of hospital coverage for workers and their dependents. This has recently been echoed in a Department of Health Policy paper on Social Health Insurance. This research aims

to define and cost a minimum package of essential hospital care for competing (public and private) health insurers in South Africa. Based on the objectives implicit in the NHI Committee report, the following criteria were used to define the essential package: the extent to which there was another appropriate responsible party who should pay for treatment, the degree of discretion in deciding whether or not to provide treatment; and the costs and effectiveness of treatment. Of 598 possible hospital interventions, 396 were included in the package based on the above criteria. Using local mine hospital and private sector utilization rates and mine hospital cost data, the research estimates that an essential inpatient package for a person of working age and his or her dependents would cost around R502 per enrollee per year in 1998 prices. The research estimates that age-sex standardized outpatient care costs in the mine hospital population studied would be R183 per person per year. Thus, the total inpatient and outpatient hospital package would cost around R685 per person per year. The results presented in this paper are intended to inform the process of defining a national essential hospital benefit package. Assuming that contributions were proportionally related to income, and that costs should not exceed 6 percent of payroll, the package should be affordable to all of those earning above R20,000 per year. Significant additional work is required—first, at a technical level to assess the appropriateness of the prioritization approach used in this study, and second, to take the debate around essential hospital benefits to broader political and public fora.

Hospital Financing in Georgia

Small Applied Research Paper 4

Akaki Zoidze, David Gzirishvili, and George Gotsadze

77 pages (July 1999) · Order No. SAR 4

A variety of payment methods are used for financing hospital care in Georgia (Caucasus): fee for service (FFS), per diem, and a variation of diagnostic related groups (DRGs), the latter method being the dominant one. During the last three years of health reform, major difficulties in the macro-financing of the health system, a decreased ability of the population to pay for health services, shortcomings in payment methods, and the inability of hospital managers to adjust to the new reality have all posed serious threats to the financial sustainability of the hospital sector. In order to determine the extent of the problems in hospital financing, data on the financial performance of 34 hospitals nationwide were collected, based on a standardized questionnaire. Patient surveys, focus group discussions with hospital administrators, and interviews with leading policymakers were also employed. The results of the study have provided a description of: 1) the existing hospital financing system; 2) the efficiency of financial management within hospitals; 3) the real costs per unit of hospital care for the hospital itself; the patients, and third party payers; 4) the total financial requirements of hospitals; 5) patient satisfaction with hospital care. The main finding of this study is that the actual financing rates and amounts are significantly below the cost. This resulting under-reimbursement, while hurting all the hospitals and production inputs, is also distributed unevenly by region, facility level, and kind of hospital-based activity. A more in-depth study of the survey data will aim to specify the distortionary effects that severe under-financing exerts on the structure and productivity of the national hospital sector. Policy recommendations have been developed regarding the improvement of hospital finance management and the refinement of reimbursement mechanisms for inpatient care that ultimately leads to increased efficiency and the long-term sustainability of hospitals.

Characteristics and Structure of the Private Hospital Sector in Urban India: A Study of Madras City

Small Applied Research Paper 5

V.R. Muraleedharan

57 pages (May 1999) · Order No. SAR 5

This paper examines India's private hospital sector, focusing on urban hospitals. Data collected for the study from a sample of hospitals in Madras City was used to analyze the size, infrastructure, and distribution of private hospitals, the range and pricing of services offered, and the various payment schemes for private hospitals, diagnostic centers, and physicians. The study also identifies strategies to improve the performance and accessibility of the private hospital market. Policy issues discussed include the process of deregulation, the interaction between the public and private health sectors and the question of over-provision of services. The paper concludes that there is a need for improved data on the growth and distribution of private sector health professionals and for policies beneficial to both public and private health sectors. Creation of a separate state agency concerned with the development of the private health sector is also recommended.

Special Products

Executive Summary Series

Bolivia Maternal and Child Health Insurance

Tania Dmytraczenko and Susan Scribner
8 pages (May 1999) · Order No. ESS 1
High maternal and child mortality have been two of the most persistent health problems confronting Bolivia over the past several decades. The maternal mortality rate is more than twice that found in an average Latin American country and infant mortality rates are also higher than in most other Latin American countries. The Bolivian Insurance for Mothers and Children (SNMN) is the government's most recent attempt at resolving critical health issues affecting this important segment of the population. The SNMN program focuses on reducing economic barriers to health care access for a variety of services provided by Ministry of Health facilities, some social security hospitals and a small number of private not-for-profit organizations. This summary describes the insurance program, its financing, and the lessons learned from implementation. Programmatic recommendations are also made.

Available in Spanish: ***Reducción de la mortalidad materno-infantil en Bolivia*** (Order No. ESS 1S)
La alta mortalidad materno-infantil es uno de los problemas de salud más persistentes que ha enfrentado Bolivia durante las ultimas décadas. La tasa de mortalidad materna es más alta que el promedio para los países de ingresos bajos y medios a nivel mundial. Las tasas de mortalidad infantil son inquietantes mientras que las tasas promedio de la región y para países con un ingreso similar. El Seguro Nacional Boliviano de Maternidad y Ninez (SNMN) es el intento más reciente del gobierno por resolver temas críticos de salud pública que afectan a este importante segmento de la población. El programa del SNMN se centra en la reducción de las barreras económicas al acceso para una variedad de servicios prestados por establecimientos del Ministerio de Salud y Previsión Social, algunos hospitales del seguro social y un pequeño número de organizaciones privadas sin fines de lucro. Este resúmen describe el programa de seguro, su financiamiento, y las lecciones aprendidas en su implementación. También se ofrecen recomendaciones programáticas.

Primer for Policymakers Series

Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery

Annemarie Wouters
12 pages (June 1999) · Order No. PPS 1
Provider payment methods are important to consider any time a government or a payor wants to improve the efficiency and the quality of health services with the use of its funds. Changes in provider payment methods are often pivotal to broader health reform measures to contain costs and use existing resources effectively, and also to improve quality of care and equitable financial access to care. This primer describes the alternative payment methods developed over the last twenty-five years—their advantages and disadvantages, the incentives they create for providers, payors, and consumers, how they operate—and offers policy guidance gathered from experiences in diverse countries and health systems.

Available in Arabic: ***Bad'il Sidad Taqdeem al-Khadamat: Mahfuzat li-Rufa' Mistawa Taqdeem al-Ri'ayat al-Sahiyyat*** (Order No. PPS 1A)

Available in French: ***Méthodes alternatives de paiement des prestataires: incitations pour l'amélioration de la qualité des soins*** (Order No. PPS 1F)
Les méthodes de paiement des prestataires sont importantes à envisager chaque fois qu'un gouvernement ou un organisme payeur veut améliorer l'efficience et la qualité des services de santé au moyen de ses propres fonds. Des changements dans les méthodes de paiement des prestataires sont souvent essentiels dans le cadre de mesures de réforme de la santé visant à maîtrises les coûts et à utiliser efficacement les ressources existantes, ainsi qu'à améliorer la qualité des soins et à les rendre plus abordables. Cette Note décrit des méthodes de paiement alternatives mises au point au cours des vingt-cinq dernières années, leurs avantages et leurs inconvénients, les incitations qu'elles créent pour les prestataires, les organismes payeurs et les consommateurs, et leur fonctionnement. Il propose aussi des conseils tirés de l'expérience de divers pays et systèmes de santé.

Available in Spanish: ***Métodos alternativos de pago a proveedores: Incentivos para mejorar la prestación de los servicios de salud*** (Order No. PPS 1S)
Cuando un gobierno o ente pagador desea mejorar la eficiencia y calidad de los servicios de salud utilizando sus propios fondos, los métodos de pago a los proveedores son un aspecto importante que hay que considerar. A menudo, la modificación de estos métodos es la base para aplicar medidas de reforma de salud más amplias, destinadas a frenar costos y usar los recursos existentes de manera más eficiente, y también para mejorar la calidad de la atención y asegurar un acceso equitativo en términos financieros. En esta cartilla se describen los métodos de pagos alternativos desarrollados en el transcurso de los últimos 25 años, sus ventajas y desventajas, los incentivos que crean para los proveedores, entes pagadores y consumidores, y sus modos de operación. Además, la cartilla sirve de orientación sobre las políticas recopiladas a partir de experiencias en diversos paises y sistemas de salud.

Health Reform and Priority Services

Charlotte Leighton, Mark McEuen, Kathleen Lynch, and Maureen Berg
26 pages (Summer/Fall 1999) · Order No. PHS 1
Sector-wide health reforms that many countries around the world are undertaking pose both challenges and opportunities for priority health services that strike at major causes of maternal and child mortality, inadequate family planning practices, rapid spread of HIV/AIDS, and other infectious diseases. Reforms can affect many aspects of the health system, including the organization and financing of health systems and the decision to include priority services in government-sponsored "essential care packages." This journal explores various aspects of health reform initiatives in particular countries, focusing on the policy implications of the reforms on health system organization and management, the policy process, and health care financing. This issue of the journal includes articles on reforming maternal and reproductive health care, improving maternal health care efficiency and financing in Uganda, improving the sustainability of immunization services in Bangladesh, assessing Bolivia's National Mother Child Health Insurance Program, and the use of stakeholder analysis in health system planning in India.

About the Partnerships for Health Reform Project

PHR Quarterly Report (October 1999) · Order No. QR 4/99

Strategic Plan for the Use of Electronic Connectivity
Connectivity Initiative Report 1
Bhavya Lal and Nena Terrell
64 pages (February 1998) · Order No. CIR 1
The objectives of the PHR electronic communications and connectivity (ECC) initiative are to: disseminate PHR information, tools, and publications quickly and cost-effectively; promote the use of connectivity to supplement field-based technical assistance and research; increase access to information about health systems and options for reform among stakeholders; and facilitate networking and communication among health reform actors. The strategy stresses the use of connectivity, not the provision of connectivity. PHR's three-pronged strategy focuses on three sets of constituents differentiated by their degree of connectivity: for unconnected constituents, use of connectivity will begin through the introduction of E-mail and CD-ROM; for those using basic Internet services but without full web access, communication and dissemination will occur via E-mail and listservs, text-only WWW access, and document distribution through FTP and CD-ROMs; and for those fully connected, connectivity initiative activities and products will use the worldwide web for training, information searches, networking, conferencing, and information dissemination. The PHR ECC objectives prompt five types of ongoing activities: designing and maintaining a PHR Web site; developing production protocols for rapid dissemination of PHR products via the Web site and CD-ROM, as well as in traditional print formats; planning and implementing ECC activities focused on enhancing specific PHR programs; providing connectivity and Internet orientation and training to enable full, efficient use of technology; and monitoring and evaluating the above activities to improve and expand, as appropriate.

PHR Resource Center

The Resource Center distributes PHR publications and serves as an information broker to increase and facilitate access to information on all aspects of health reform. The Resource Center provides reference services to PHR staff and counterparts and to USAID. A monthly bulletin announces new acquisitions and highlights websites of particular interest.

Bibliographic Database on Health Sector Reform
The PHR Resource Center bibliographic database cites books, papers, gray literature, videos, CD-ROMs, and journal articles related to health sector reform and the work of PHR. The database contains over 3,000 entries, primarily from 1990 to the present. The database can be searched by title, author, publisher, organization, date, country, region, language, and subject. To facilitate access to PHR constituents around the world, ordering information for documents is provided with each entry as available. The database can be accessed on the PHR website at *http://www.phrproject.com*.

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