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SHS/NHP/94.5

English only

Distr.: Limited



HEALTH SECTOR REFORM

REPORT OF THE SECOND CONSULTATION

28 - 29 April 1994

Geneva

WORLD HEALTH ORGANIZATION

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1 BACKGROUND

In December 1993, a consultation on health sector reform was organised by the World Health Organization with the following objectives

- ▶ to share information about the scope and nature of current and planned activities related to supporting health reform;
- ▶ to review and discuss approaches to analysing the context, directions and outcomes of health reform;
- ▶ to review and discuss different agencies approaches to supporting the reform process in countries; and
- ▶ to consider next steps for concerted action in health reform.

In the discussions that took place, there was great convergence of interest in a number of topics. In particular, much of the debate centred around

- ▶ achieving a balance between rational design and analysis of organisational and political constraints;
- ▶ the need to critically examine donor conditionalities and impositions;
- ▶ the lack of adequate systems for monitoring and evaluating the process and outcomes of reform in a way that will allow comparative analysis and lead to the development of simple guidelines.

At the close of the meeting, participants agreed that valuable lines of communication had been opened and that the group should be maintained and continue to meet. A second consultation was, therefore, scheduled to take place in six months' time. Group members were asked to prepare short presentations on priority issues in health sector reform and on countries' and agencies' approaches to determining these priorities.

2 OVERVIEW OF PROCEEDINGS

The meeting was opened and introduced by Dr JP Jardel, ADG. Apologies were relayed from Dr Bichmann of the German Development Bank, Ms Thomason of the Asian Development Bank, the Vice Minister of Health of Kazakhstan, the Director of Policy and Planning from Ghana, and Dr Nordstrom of SIDA (represented at the meeting by Dr Höjer of the Karolinska Institute). The agenda of the meeting is attached as Annex A.

2.1 *Related Initiatives*

Two related initiatives were presented and briefly discussed on the first day of the meeting.

Partners for Health: A Network for Health Reform

Drs John Martin and Roberta Ritson reported on progress in formulating a proposal for creating a network to support people and institutions involved in implementing health development reform in countries. The objectives of the network are ambitious and include developing and promoting tools and processes for health reform and facilitating access by countries to technical and financial support, with emphasis on longer-term capacity building. It was made clear, however, that the initial emphasis would be on improving access to information through electronic mail. Risks with regard to lopsided development, given vast differences in access to information technology between countries, were discussed. The need for the network to link up with other relevant initiatives was also stressed. The current draft proposal sent to all participants in the Ottawa Conference on a Future Partnership for the Acceleration of Health Development in April is attached as Annex D.

The Foundations of the Future: Research for Global Gains in Health in the 21st Century

This is a major study, sponsored by WHO and the World Bank, supported by a number of foundations and agencies, and carried out under the aegis of the Ad Hoc Committee on Health Research Relating to Future Intervention Options. The study was initiated in response to requests for a broad-based review of opportunities for research and development in the health sector. The study builds on the World Development Report 1993 and endeavours to produce a document and a data base that would provide donors, aid agencies, health care providers and others with an analytical tool for decision-making - a broad sense of direction for research priorities, organization and funding at the beginning of the next century. It also aims to assist those involved in health sector reform to assess how research can help them achieve their goals more cost effectively¹.

Dr David Evans outlined issues and challenges with regard to the study, particularly concerning research on health systems. He discussed the apparent gap between the *What to do Group* and the *How to do it Group*. While the former tends to ignore the point that implementation of cost-effective interventions depends on the functioning of the health system, on coverage and compliance, the latter has made little attempt to analyse generic versus specific lessons. Dr Evans concluded that the what's and how's must interact more constructively, and invited participants to contribute in particular to the efforts of the initiative's Working Group on Population, Households and Systems.

¹ *The Foundations of the Future: Research for Global Gains in Health in the 21st Century*. Progress Report, May 1994.

2.2 Agency Perspectives

Each of the agency representatives made a presentation outlining the views and policies of their organisation on priority issues in health sector reform and on the approaches to provide support accordingly. The presentations by WHO, NORAD, ODA (UK), the European Union, DANIDA, SIDA, and the World Bank are appended (Annex B).

Experience with recurrent cost support and with non-project assistance was of particular interest. An emerging concern among agencies is the fit between donor policies to support broad-based health development and sector reform, and existing instruments for providing and disbursing aid.

IHPP presented a short draft paper proposing a Working Definition of Health Reform. The paper is attached as Annex C.

2.3 Financing Reform

The last item on the first day's agenda was a presentation and discussion of selected issues in financing reform by Andrew Creese. An outline of the presentation is attached as Annex F. A draft paper on financing aspects of health reform was distributed. A review paper on user charges is currently under preparation and will be made available to participants.

2.4 Country Presentations

On the second day, presentations were made by country representatives on Cameroon, Zambia and Mexico. Papers and overheads of the Cameroon and Mexico presentations are appended (Annex D). It became clear that to do justice to the range and complexity of the issues presented, more time was required for individual country presentations. It was, therefore, agreed that at future meetings, a half-day session would be reserved for one country presentation. Dr Kalumba, Vice-Minister of Health from Zambia, agreed to prepare a comprehensive analysis of the Zambian reforms for the next meeting.

A short presentation on work by WHO/EURO in Kyrgyzstan was also presented and is part of Annex D.

3 REVIEW OF KEY ISSUES

A review of issues that had emerged during this meeting for further exploration and discussion produced the following short list:

Tracking health reform process and outcomes

what are the indicators to monitor? who will do it and for what?

Creating internal markets and managing relations with the private sector

are these issues universally relevant? what about capacity for contracting, monitoring, regulation?

Financing

after the preliminary lessons, what agenda for health systems research?

Decentralization

what are the aims and trends of the current wave of decentralization? anybody recentralizing? what lessons are emerging?

Health and other sectors

what interactions with public sector and civil service reform? new approaches to intersectoral action on agriculture, education, the environment?

Capacity and capacity building

is there a formula? what have we learned so far? what are the priorities, the neglected dimensions?

Donor policies and aid instruments

is there a need for reform in agencies to achieve a better fit between policies to support the health sector and existing aid instruments?

4 THE FUTURE

As at the first meeting, there was unanimous agreement that the group serves a useful function and should be maintained. The following propositions were made:

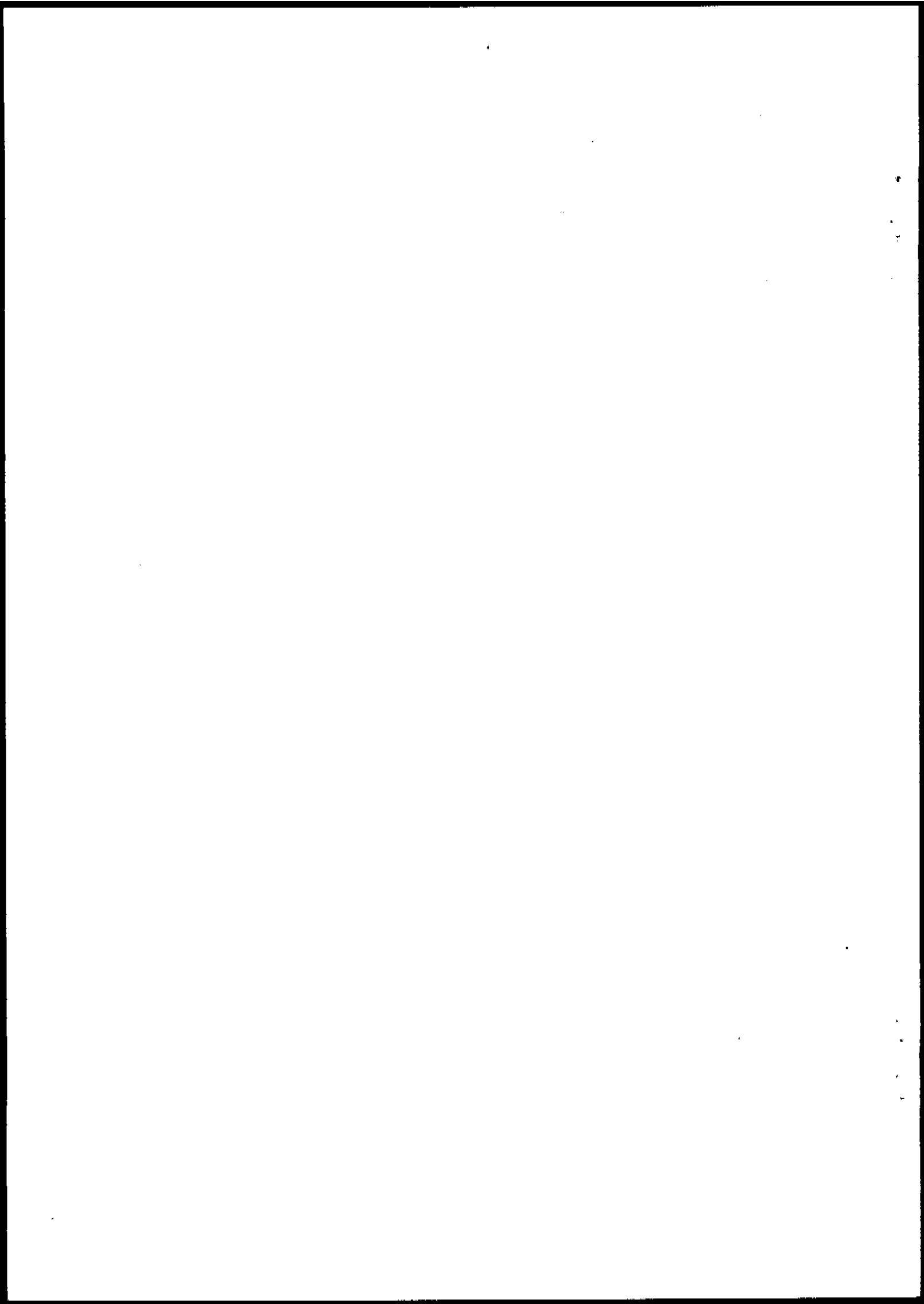
- 1 The group should be renamed *Forum for Health Sector Reform*. If possible, an attractive acronym should be found².
- 2 Clear terms of reference of the group outlining its purpose, products and membership should be prepared, based on the objectives of the first meeting and on subsequent discussions. The terms of reference should clarify linkages between this group and other ongoing and planned initiatives concerned with health sector reform.
- 3 The next meeting should be hosted by one of the other agencies in the group with a view to rotating future meetings between Geneva and other venues³.
- 4 The proposed dates for the next meeting were tentatively noted for the week of 19 September 1994.

² Propositions received to date include REFORUM, FOREF, FOREFO, FOHR.

³ A formal offer was made by the European Union to host the meeting in Brussels.

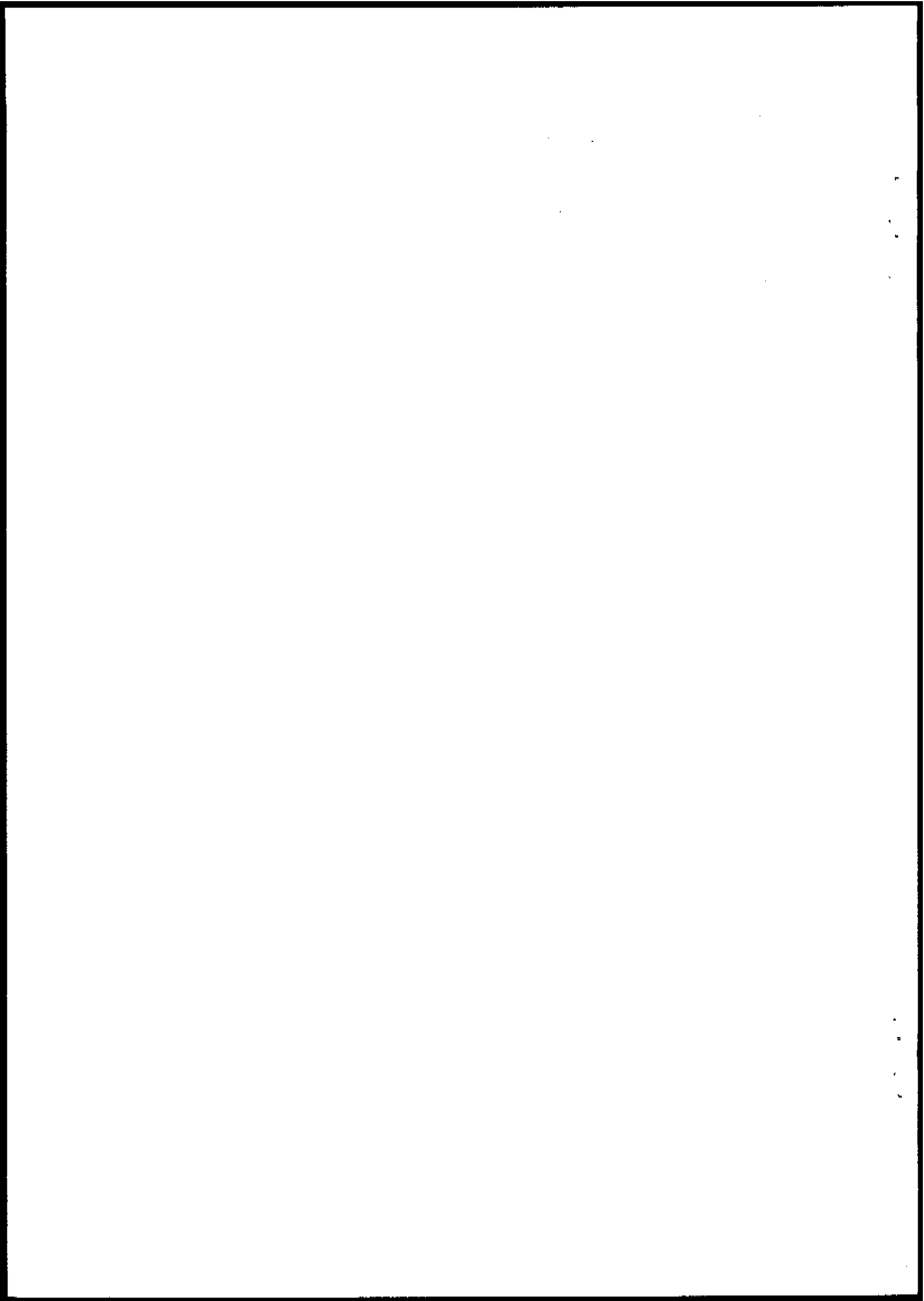
- 5 It was agreed that meetings should be limited to two days, given the time constraints of its members. To ensure the greatest possible benefit from the meetings, the agenda will need to be well documented and background materials distributed in advance. This will require cooperation of group members in the preparation of position papers on technical and agency issues and of country case studies. The possibility of commissioning joint work was briefly discussed⁴.
- 6 Future meetings' agenda could be usefully divided into 1) agency issues, 2) selected technical issues and 3) a country presentation which would outline the entire range of issues and experiences.
- 7 The coordinator will communicate with the members of the group to develop an agenda for the next meeting and ensure adequate preparation along the lines suggested.

⁴ Based on the model of the Inter-agency Group on Health Economics. In that group, discussion of expenditure analysis as a key concern led to an agreement among a number of group members to work together in preparing detailed terms of reference for a consultant to draft a manual on the subject, and for the group to review this work.



Annex A

Agenda



SECOND CONSULTATION ON HEALTH SECTOR REFORM

Geneva, WHO Headquarters, Conference Room M-605

28 - 29 April 1994

AGENDA

Thursday, 28 April 1994

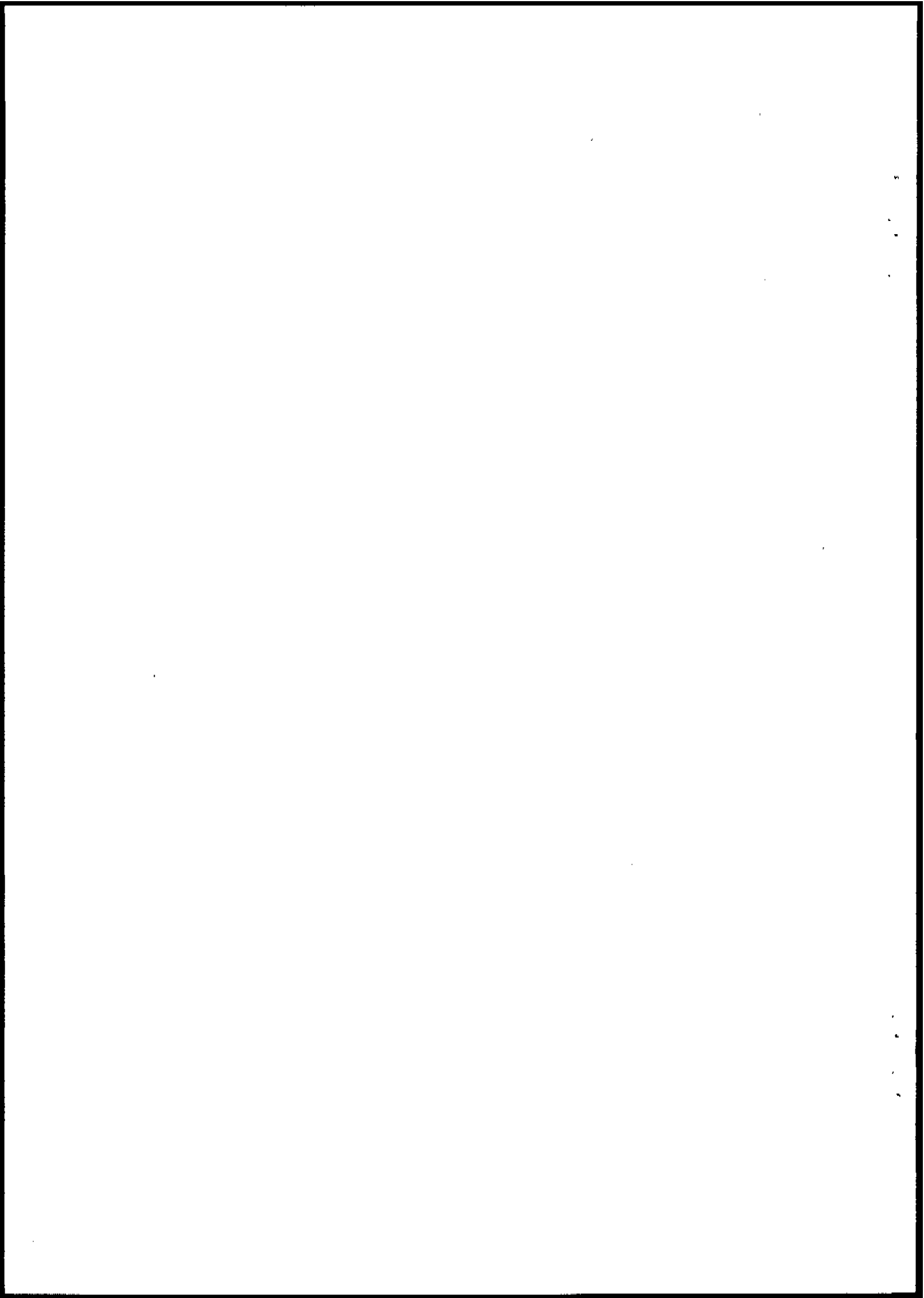
Morning session 09.30 - 12.30
Afternoon session 14.00 - 17.00
Reception 17.30 - 19.00

- 1 **Opening remarks**
Dr Jean-Paul Jardel, ADG
- 2 **Introduction and review of agenda**
Chair/Coordinator
- 3 **Brief update on Network for Health Reform**
Presentation by J Martin
- 4 **Priorities in health sector reform: Agencies**
Short presentations (5 minutes each) by agency representatives and discussion
What are priority issues in health sector reform? How are priorities for reform determined, for example, in non-project assistance/health sector aid?
- 5 **Challenges in research on institutional reform and implementation**
Presentation by D Evans, followed by discussion
- 6 **Selected issues in financing reform**
Presentation by A Creese, followed by discussion

Friday, 29 April 1994

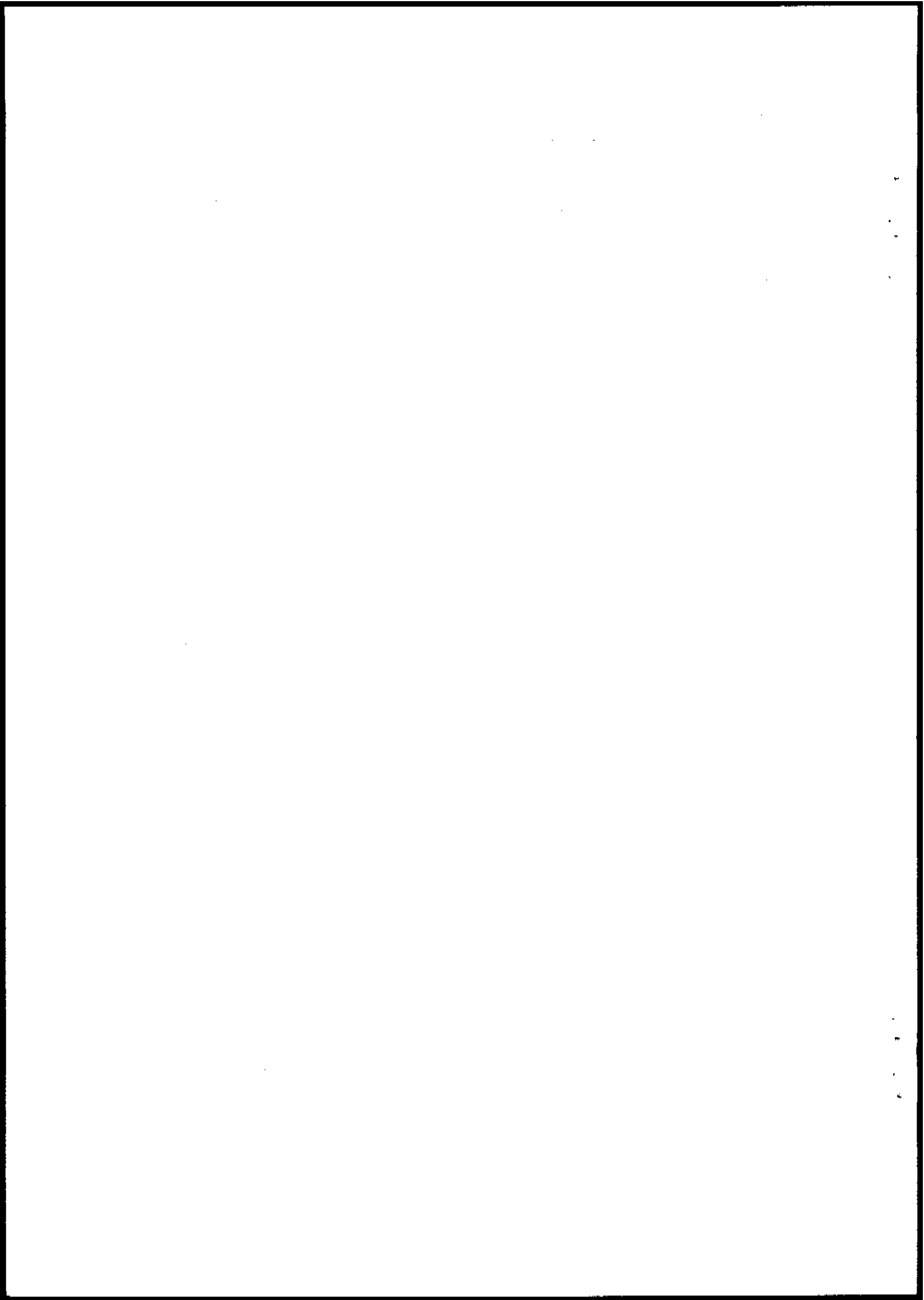
Morning session 09.00 - 13.00

- 7 **Agency presentations on country work**
World Bank, WHO/EURO
- 8 **Country experiences in health sector reform**
Presentations by Cameroon, Zambia and Mexico
- 9 **Discussion of topics for review at next meeting and agreement on preparatory work required**
Chair/Coordinator
- 10 **Recapitulation and closing**
Chair/Coordinator



Annex B

Agency Perspectives



PRIORITIES FOR HEALTH SECTOR REFORM: WHO PERSPECTIVE

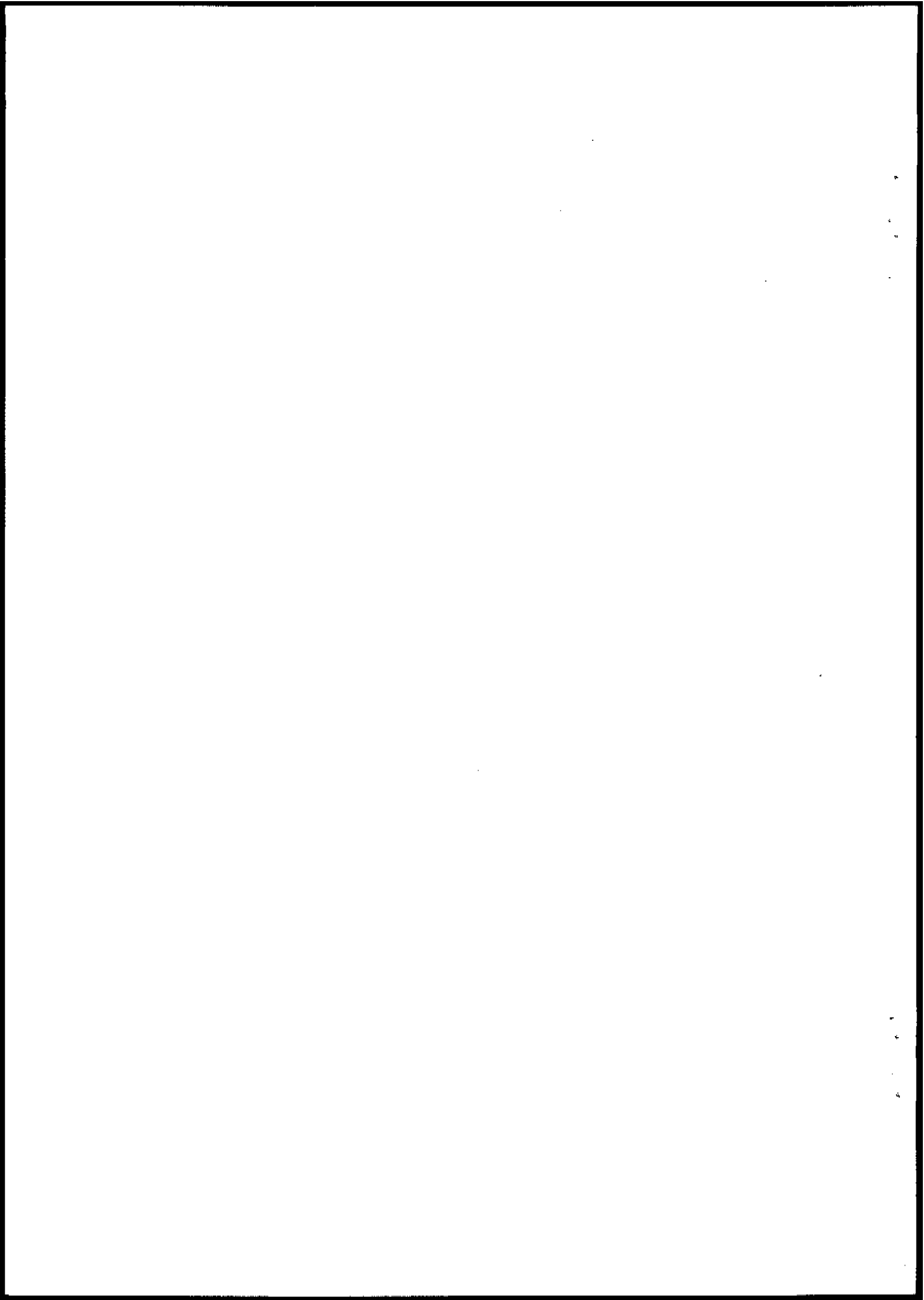
by Dr Jean-Paul Jarde¹

The process of health reform is country-specific. A blue print approach to reform would be inappropriate. Therefore, WHO takes the lead from countries in identifying priority issues for reform. In working with countries to diagnose problems in the first instance, the organization's support for health sector reforms can be more responsive and less normative in nature.

WHO support encompasses general assessment and orientation, facilitating exchange of ideas and experiences between countries, development of tools and guidelines, and building capacity in institutions and individuals for reform design and implementation. The emphasis is on improving access to information based on experiences of health reform, including comparative analysis of approaches to key issues.

Major issues to be dealt with concern health policy formulation; strategy development; identifying new financing options; redefining the role of government with regard to regulation, legislation, financing and provision of care; the need to strengthening management capacity; supporting effective decentralization; managing relations with the private sector and achieving an appropriate public/private mix, and developing the cost-effective packages of essential public health and clinical care.

¹ Assistant Director-General, World Health Organization, Geneva, Switzerland



PRIORITIES FOR HEALTH SECTOR REFORM: NORAD PERSPECTIVE

by Dr Rune Andreas Lea¹ and Dr Sigrün Mogedal²

In the Norwegian presentation during the first consultation on health sector reform in December 1993, it was pointed out that health systems development, management and reform are issues high on the priority list when considering cooperation in the health sector. It was also pointed out that in Norwegian development cooperation we seek to link up with and support national plans and priorities, and we are emphasising a partnership cooperation model within which the partner countries have the main responsibility for setting policies and directing and implementing programmes.

Hence, we welcome the emergence of country policy commitments to reform of the health sector, and the development of health reform framework plans which are being discussed internally and with donor partners. We have recently been exposed to such developments in Mozambique, Uganda, Ethiopia and Nicaragua; countries emerging from periods of unrest and stress. We believe that it is particularly important for donors to be openly aware of the reform processes actually taking place in many of our cooperating countries, and support these processes with a revised donor approach emphasising

- ▶ flexibility;
- ▶ country driven and country based donor coordination; and
- ▶ a realistic balance between short-term acute needs and long-term systems development and institutional capacity strengthening.

The need and openness for reform commonly arise out of perceived crisis at the country level, caused in different ways by changes in the social, political and economic context. Systems and structures have become dysfunctional in ways which cannot be rectified by more of the same. While in some countries the health sector appears to be in the forefront of reform, it is more often dragged into a broader and even more complex public sector reform process. In these cases, many choices with heavy implications for health care are made outside the sector itself. The ability to identify and analyse alternative options and implications of reform, both within the health sector and in the public sector at large, is however, in most countries limited, resulting in fragmented and inconsistent reform efforts.

A particular challenge in this situation is the multiplicity of poorly coordinated public sector reform initiatives which now seem to emerge within each country, often promoted and supported by different external support agencies, bilateral as well as multilateral, and sometimes also the larger NGOs.

¹ Health Adviser, Health Division, NORAD, Oslo, Norway

² Director, Centre for Partnership in Development (DIS), Oslo, Norway

The situation also calls for serious attention to clearer role definition between the external support agencies. It may not be possible to do this on an international level, as the status and potential of the agencies is so different from country to country. On the other hand, some general guiding principles may be required, so that agencies which are expected to carry a major role can strengthen their own capacity for undertaking such a cluster of tasks.

The menus and options presented by Dr Andrew Cassels during the December 1993 consultation on health sector reform, are in our view a useful common framework for approaching the reform process. We would however underline the need to further develop the framework to deal with *the relationship between the health sector and the political/administrative context within which health reform is taking place*. When, for example, decentralization is taking place, the local district administration and politically elected local bodies will be given an important role in deciding on health issues. In some countries, the Ministry of Local Government has been given an important role in planning and implementation of primary health care at local level. The division of roles and responsibilities between the health sector and the other parties involved in planning and implementation health services needs to be carefully analyzed, and we believe there is a need for further health systems research to cast light on these issues.

What are priority issues in health sector reform, from a Norwegian development cooperation perspective? Keeping in mind the common framework of menus and options mentioned above, some additional issues deserve particular attention:

- ▶ practicable mechanisms for country based donor coordination and aid management, controlled and driven by the partner country
- ▶ analytic capacity and the need for better indicators monitoring institutional capacity, both for its importance for the countries themselves and in light of the requirements of donor constituencies
- ▶ institutional cooperation, increased focus and priority given to create conditions for cooperation between partner country institutions and Norwegian resource institutions in areas where Norway may have something to contribute in health sector reform
- ▶ since a substantial part of Norwegian development cooperation is channelled through NGOs, the issues related to public/private mix are also of particular interest for us

Options available for Norwegian cooperation are the bilateral, multilateral and NGO channels.

The **multilateral channel** seems particularly relevant in the context of broad health reform programmes where countries are committed to a defined policy and a plan

framework. Also, these channels have an important role in the context of donor coordination.

In the cooperation and dialogue with the World Bank and UNICEF, Norway is increasingly giving emphasis to health reform issues. Also, we are emphasising the role and responsibilities of the agencies in response the reform process, with particular focus on the need for the organizations to better integrate program support into national structures and facilitate national institutional development and capacity strengthening; in other words, to allow the countries to be seated in the driver's seat.

The **bilateral channel** (which NORAD is responsible for in the Norwegian development cooperation), with its relatively high degree of flexibility, may be a useful tool in supporting specific reform issues and activities which otherwise would be under financed, supporting institutional cooperation, and district health development in specific districts.

Also, support through NGOs may have a potential in strengthening links between the public and private sector, and NGOs may very well contribute constructively in strengthening the district health administration.

NGOs should, however, be willing to analyze both their potentials **and** weaknesses, and be willing to meet the public sector efforts for reform with an open mind.

Generally a strong case should be made for the role of multilaterals in the question of supporting governments in a health sector reform process. WHO, UNDP, UNICEF and the World Bank are the key actors on this arena, and need to find their comparative advantage. There are many reasons why UN agencies such as WHO and UNDP should take a lead in accompanying governments through reform, to strengthen their ability to make informed choices, their negotiating power and co-ordinating capacity in relation to major funding agencies. This does not mean that WHO or UNDP need to be the main actors and sources for competence in undertaking reform, but rather that all actors respect and support the need for governments to have a "neutral" competent advisor as a critical corrective to pressures generated by funding or lending interests.

If so, WHO and/or UNDP need to get their act together so that they can build the required capacity for "Centre of Excellence" functions in this area. If such a development will be regarded undesirable or unrealistic, alternatives will need to be found to avoid fragmentation and general overload on the health system caused by strong and multiple reform initiatives launched by the donor community. In this context, there is also clearly a need for more discipline, transparency and coordination on the side of the bilaterals.

Increasingly, we see the need for using the various cooperation channels and options available together in a holistic approach. How can Norway best support health sector reform in specific country given the options/channels available, is the question we put forward.

This approach challenges us to improve our own capacity and competence in analysing country policies, plans and priorities, and assessing how Norwegian cooperation may insert itself in a holistic approach, taking national and various donor contributions to the health sector reform process into consideration. How may Norwegian and other bilateral cooperation support strategically important areas of activities within the framework of a national reform process? Which are the strategically important thematic areas of work that are currently under financed? And how does these strategically important priorities in the partner countries match Norwegian priorities? These are current questions which are becoming increasingly more important, yet also increasingly more difficult to answer in a context of many actors with unclear, overlapping and sometimes competing roles.

PRIORITIES FOR HEALTH SECTOR REFORM: ODA PERSPECTIVE

by Dr Andrew Cassels¹

1 Why does ODA give priority to health sector reform?

There have been many appeals for greater levels of spending on health in developing countries.

For several years donors have been asked to support countries' efforts to provide health for all by the year 2000.

More recently the WDR has presented the case for more -- and more rational -- investment in health.

Within the UK aid programme, as in other countries, there is a need to carefully justify expenditure. The overall budget and individual country aid frameworks are under pressure and spending departments are faced with requests for assistance in a number of priority areas, of which health is but one. Many spending departments regard health as a poor investment; the sector is poorly organised, it is well known that resources are used inefficiently, for the wrong things, to the benefit of few people. Aid managers often take the view that there are few signs that this situation is changing.

Although there is a need to show a return on investments in health, ODA has not been prepared to support vertical or intervention-specific approaches to the provision of health care. Although these programmes provide an opportunity to demonstrate quick results, their disruptive and distorting effect on the establishment of sustainable health has been clearly recognised.

ODA therefore accepts the need to address the more fundamental institutional issues involved in improving the functioning of the sector. To get long term results, it is necessary to address the difficult and often refractory problems that prevent ministries of health from ensuring that a range of good quality services are accessible to their populations -- particularly those most in need of care.

If countries can demonstrate the capacity to make tough strategic choices, can decide on clear priorities, and set and monitor standards of care, the sector will represent and monitor better candidate for increased levels of investment.

¹ Health Systems Development Consultant, Health and Population Division, ODA, London, England

Health sector reform is therefore one of ODA's four priority objectives in health and population. By helping countries to address policy and institutional reform issues the aim is to preserve or even increase spending on health and population, in an environment where the aid programme is under pressure. Spending in health and population has recently started to increase, and is currently about £100m pa (5% of aid expenditure).

2 How does ODA determine priorities for health sector reform?

There are no earmarked funds or spending targets for health. Priorities are determined by geographical spending departments according to jointly agreed country-specific strategies.

In relation to health sector reform ODA is concerned to see:

a clear link between reform in the health sector and reform in the public sector and civil service -- this is often a more effective way of ensuring that changes happen -- although there are exceptions where the health sector has taken the lead.

Priorities in the design of reform programmes include:

a shift from provider to managerial interests;

clear setting of objectives, standards and outcomes -- development of systems for tracking the use of human and financial resources;

clearer distinction of the role of those responsible for defining needs and commissioning services, from those actually providing them.

Beyond this, there is no clear-cut agenda or blue print. Rather, ODA is concerned to assist legislators and officials to analyze the implications of different options for institutional reforms. Having identified options appropriate to the circumstances of the country concerned, ODA will provide technical and financial assistance to those designing and implementing reform programmes.

The final content of specific reform programmes is influenced by a variety of factors: nationally-defined needs, the work of other donors (priority given to working in partnership with other bilateral and multilateral agencies), neglected areas in the health sector (eg, hospital management), and areas in which the UK has a comparative advantage in providing technical assistance.

ODA recognises the need for better analysis of international experience and information about the effects of different forms of institutional and policy reform. To this end a work programme has been established (by a consortium of groups led by the Liverpool School of Tropical Medicine) which will undertake research in this area.

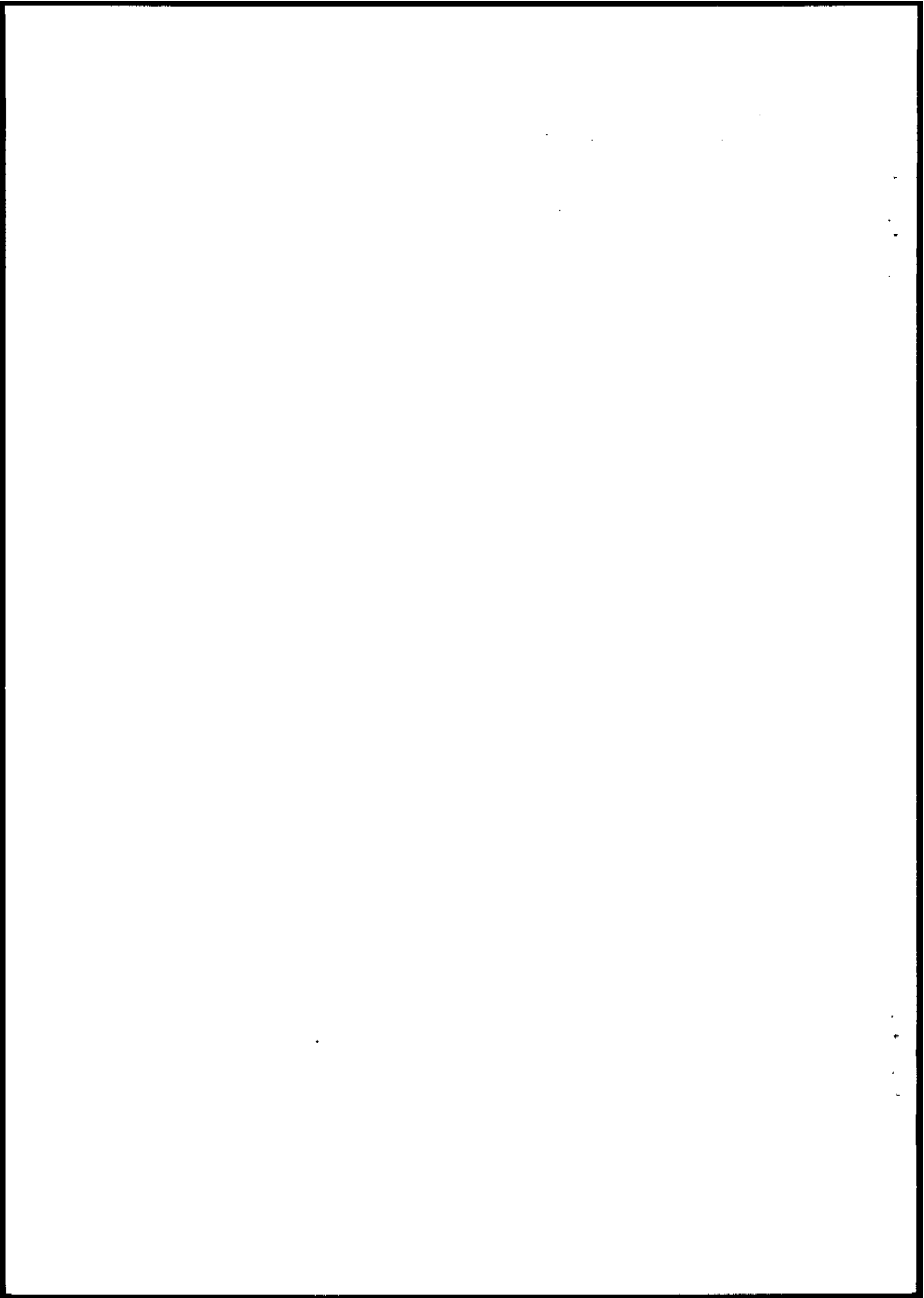
ODA recognises the need to access experienced consultants who can help national authorities review the implications of different options for reform. There are few of these people around. Following a process of competitive tendering, a Health Sector Reform Resource Centre will soon be established in the UK.

3 Forms and channels for assistance in health sector reform

There has been a trend away from specific projects to more broad-based sectoral support.

The term *sector aid* refers to the focus of ODA support, describing a more holistic concern for institutional issues in the sector. Although the term is also used to describe a specific set of aid instruments (which include different forms of budgetary support), there are few instances of this form of assistance being used in the health and population sector (in contrast, say, to USAID's non-project assistance or the EC's SAF). Thus support to the health sector is still largely managed as project aid.

Management systems for project aid are designed to ensure financial accountability. This can result in problems and lack of flexibility. ODA is therefore particularly concerned to assist countries to strengthen their financial management systems in order to avoid the need for parallel accounting mechanisms.



**COOPERATION ACP-CE DANS LE DOMAINE DE LA SANTE:
LE TOURNANT DES ANNEES 90**
par Dr François Decaillet¹

Sous Lomé IV, la coopération CE-ACP dans le domaine de la santé connaît une réorientation sensible de l'approche des problèmes et de leurs solutions, de la nature des interventions conduites et une augmentation très sensible des engagements.

Parce qu'elle n'est pas seulement une fin mais aussi un moyen, un moteur du développement, l'amélioration de l'état de santé des populations constitue un des principaux buts et une des premières priorités de l'aide au développement. Cependant, dans la coopération ACP-CE, la place de la santé est restée longtemps relativement limitée.

Conformément à l'esprit de la Convention de Lomé IV, à l'accent mis sur la valorisation des ressources humaines, les années 90 devaient, et doivent encore, être marquées d'un renforcement des dispositions relatives à la santé.

Une réorientation nécessaire

Pendant longtemps, les appuis communautaires dans ce secteur ont été limités en volume et centrés sur le développement des infrastructures sanitaires, d'abord hospitalières puis plus périphériques, sur la fourniture d'équipements et/ou de produits pharmaceutiques, dans le cadre de projets ponctuels, voire isolés et dispersés. Ces interventions ont été utiles, ont contribué à la constitution rapide des réseaux d'infrastructures, à l'amélioration de la couverture sanitaire.

Mais au cours des années 80, les limites d'une telle approche sont devenues de plus en plus évidentes. La crise des systèmes de soins, l'apparition du "syndrome des coûts récurrents" conduisaient à penser que la multiplication de projets d'investissement ne constituait plus une stratégie viable et efficace d'appui au développement sanitaire.

Une approche plus globale, sectorielle, devenait indispensable. Dès 1990, un processus de définition d'une stratégie de coopération et de réorientation des interventions dans le domaine de la santé était entamé.

Le souci de gagner en pertinence et en efficacité conduisait à rechercher un dialogue sur la politique de santé, une meilleure articulation avec les politiques nationales. Il fallait aussi proposer un cadre général pour les interventions, rechercher une meilleure cohérence dans l'utilisation des différents instruments d'acheminement de l'aide.

¹ Conseiller en Santé Publique, Commission des Communautés européennes, Bruxelles, Belgique.

L'augmentation de l'aide communautaire dans ce secteur ne devait pas venir ajouter à la confusion. Il fallait donc rechercher les moyens de faciliter la coordination des aides. En premier lieu cela passait par l'identification, en fonction des avantages comparatifs par rapport aux autres bailleurs de fonds, des "créneaux d'intervention". Mais en second lieu cela devait conduire à renforcer la concertation et la coordination opérationnelle entre partenaires européens.

Comment s'est opérée la réorientation?

Trois étapes:

- ▶ Définition (à partir d'une analyse générale de la problématique sectorielle) des principes, objectifs and priorités d'une "nouvelle" politique de coopération de la Commission dans ce domaine de la santé.
- ▶ Elaboration d'un schéma rationnel et cohérent d'utilisation des instruments.
- ▶ Sur cette base développement d'un dialogue de politique avec les États ACP bénéficiaires.

Action intermédiaire:

- ▶ Développement dans les services de la Commission de l'expertise en santé publique et construction progressive d'un dispositif d'appui technique. Mise en place des sessions de formation des personnels du siège et des délégations (dès 1992) et, en mai 1993, la création d'une unité spécifiquement chargée des dossiers santé et lutte contre le sida.

Un cadre général pour l'action communautaire

Trois principes essentiels:

- ▶ La coopération doit contribuer à la recherche d'une meilleure équité, d'une plus grande justice sociale, à rendre possible l'expression d'un droit individuel et collectif à une meilleure santé.
- ▶ La coopération n'a pas à se substituer aux efforts nationaux, n'entend pas répondre à tous les problèmes et à tous les besoins mais vise à aider les pays à satisfaire les besoins les plus fondamentaux, particulièrement ceux des groupes les plus vulnérables.

- ▶ Il n'est pas de modèle universel d'organisation des systèmes de santé, ou de leurs différentes composantes. Les spécificités comme les volontés nationales ou locales doivent être respectées.

Deux objectifs généraux pour l'aide de la communauté:

- ▶ Contribuer à la création d'un environnement favorable pour la santé.
- ▶ En appuyant la réforme des systèmes de santé, aider les pays à assurer la satisfaction des besoins fondamentaux de leurs populations.

Quatre objectifs intermédiaires:

- ▶ S'assurer d'une meilleure prise en compte de la dimension santé dans la définition des politiques de développement, tout particulièrement lors de la préparation et la mise en oeuvre des programmes d'ajustement.
- ▶ Contribuer à la correction des déséquilibres structurels des systèmes de soins, en orientant l'action vers le soutien et le renforcement des services de base.
- ▶ Faciliter la réforme institutionnelle en oeuvrant au renforcement des capacités au niveau central, en appuyant le processus de décentralisation, en favorisant le partage des responsabilités entre secteur public et privé.
- ▶ Aider les pays à développer des systèmes et interventions permettant de mobiliser et gérer de façon plus efficiente les ressources disponibles, tout particulièrement en développant des appuis à la programmation et à la gestion des budgets publics et des interventions visant l'amélioration des systèmes d'approvisionnement en médicament.

Un schéma d'utilisation des instruments: voir schéma en annexe.

Les résultats

Les nouvelles orientations pour la coopération dans le domaine de la santé ont été particulièrement bien accueillies et reçues par les ACP. Le nombre de pays intéressés à développer une coopération dans ce domaine a très sensiblement augmenté sous Lomé IV.

Un premier bilan, à mi-parcours, montre qu'en terme d'engagements, le volume global des interventions dans ce domaine a progressé très rapidement dans les premières années de mise en oeuvre du 7ème FED. Il dépasse à ce jour un demi-milliard d'ECU, représentant plus qu'un doublement des engagements santé par rapport au 6ème FED. Ce volume continue

encore d'augmenter et on peut raisonnablement penser que la coopération en matière de santé absorbera finalement plus de 7% du 7ème FED.

Les moyens dégagés au titre de la facilité à l'ajustement structurel constituent la moitié de ce total. Permettant un transfert de ressources rapide et direct, ils permettent de soutenir l'action des pouvoirs publics, de maintenir (voire augmenter) les ressources publiques allouées à la santé, d'éviter un effondrement des financements consacrés au fonctionnement des services publics de santé. La mise à disposition de ces moyens s'accompagne d'appuis à la programmation budgétaire permettant ainsi de faciliter la mise en cohérence entre budgets et politiques de santé énoncées.

Le nombre des interventions projets-programmes comme leur importance ont également sensiblement progressé ces dernières années. La moitié des ressources programmables portent directement sur des appuis aux secteurs primaires et secondaires, traduisant l'accent mis sur le renforcement des services de base. Les appuis aux systèmes d'approvisionnement en médicaments absorbent plus de 15% de ressources programmables, l'appui à la lutte contre le sida en absorbant plus de 10%. Les appuis institutionnels et à la formation représentent eux 10% du total de ces ressources.

Ils est encore trop tôt pour établir un bilan, mesurer réellement les effets de cette réorientation. Mais il ne fait pas de doute que, déjà, l'image et les réalités de l'aide communautaire à ce secteur ont changé.

Mais il reste encore beaucoup à faire pour développer encore et améliorer la coopération dans le domaine santé. Pour les prochaines années, et tout particulièrement pour l'exercice de programmation Lomé IV bis, trois axes se dessinent:

- ▶ poursuivre et approfondir la réorientation engagée;
- ▶ améliorer la pertinence, la viabilité, la qualité des interventions;
- ▶ mieux coordonner les actions communautaires avec celles des Etats membres de l'Union et des autres partenaires extérieurs.

Renforcer la coordination

La Communauté et les Etats membres consacrent près d'1,5 milliard d'ECU par an à la coopération avec les PVD dans le domaine de la santé, assumant plus de 40% du total de l'aide internationale à ce secteur. Une moitié de cette aide est acheminée par le canal des organisations internationales et des banques de développement. L'autre moitié au travers de l'aide bilatérale. L'Union Européenne est ainsi le premier partenaire des pays en voie de développement dans le domaine de la santé. De façon claire, la part la plus importante de cette aide va vers les pays ACP.

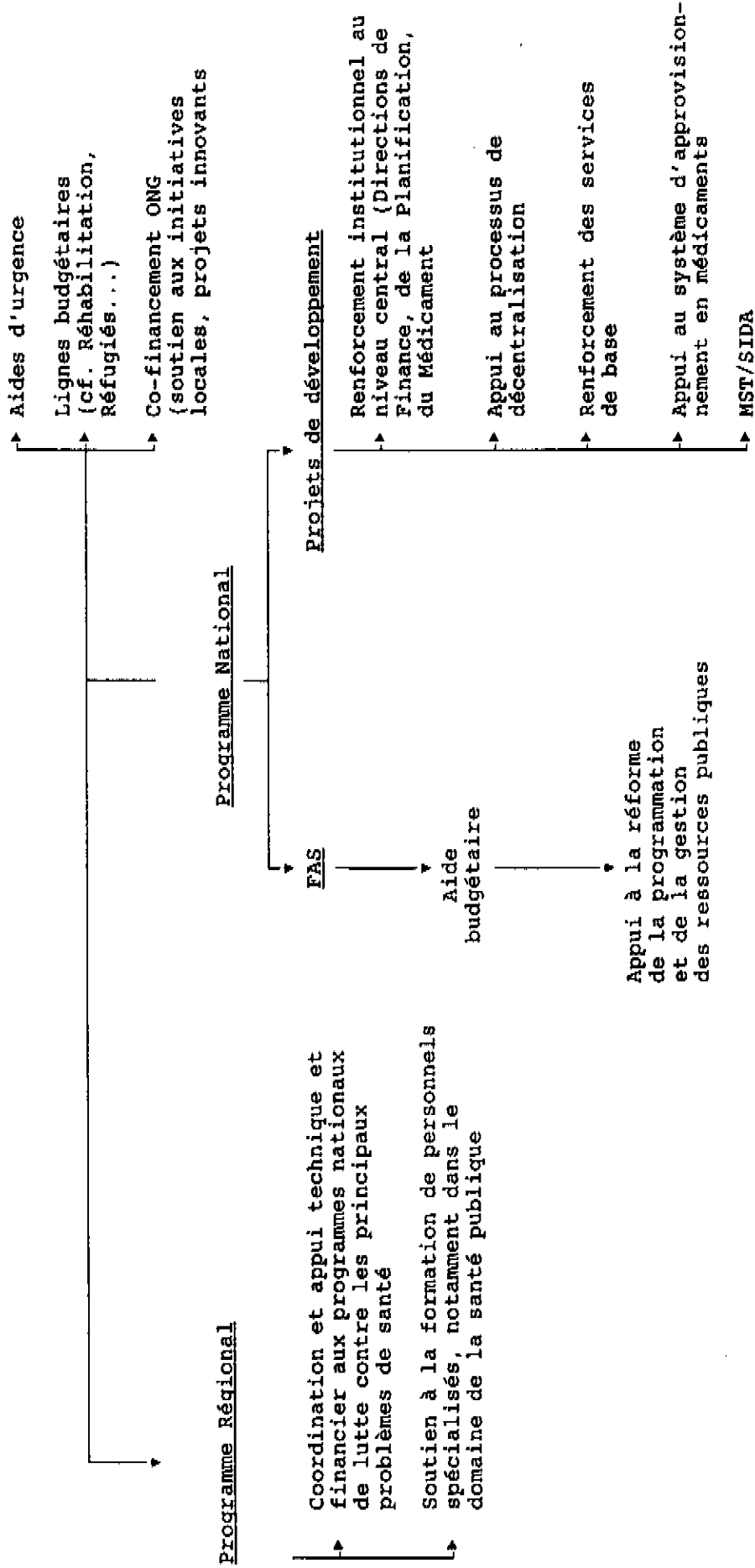
Du fait de la richesse de leurs expériences en matière de développement et de réforme des systèmes de santé, et de la diversité des approches suivies comme d'une longue expérience de terrain, les partenaires européens peuvent contribuer de façon très utile aux débats, apporter un appui méthodologique et technique à l'identification des scénarios pour le futur.

Mais l'aide européenne au secteur de la santé souffre d'une insuffisance de coordination. Des efforts ont donc été engagés pour améliorer la concentration sur les politiques et la coordination opérationnelle.

S'appuyant sur les travaux du groupe d'experts européens "santé et développement" mis en place et sur les propositions de la Commission, le Conseil a adopté, le 6 mai dernier, une résolution établissant les grandes orientations de politique de coopération avec les PVD dans ce domaine et les modalités pratiques pour la poursuite des efforts en matière de coordination opérationnelle.

Au niveau du terrain, les échanges d'information comme la concertation sur les interventions se développent. Il est prévu de suivre très attentivement ce processus de renforcement de la coordination dans sept pays: Côte d'Ivoire, Ethiopie, Mozambique, Zambie, Pérou, Bangladesh, Costa Rica.

SCHEMA GENERAL D'UTILISATION DES INSTRUMENTS -- STRATEGIE D'INTERVENTION -- SECTEUR SANTE



PRIORITIES FOR HEALTH SECTOR REFORM: DANIDA PERSPECTIVE

by Dr René Flamsholt Christensen¹

The views of DANIDA conform with most of what was said by the NORAD, ODA and EU representatives about health care reform.

Why do we perceive reforms to be essential? Basically, it has to do with three interlinked issues: the experiences with assistance in health over the last 15 to 20 years indicate the need for new ways of dealing with the health problems in third world countries; in order to confront concerns from the Danish 'constituency', including diminishing a certain, and understandable, 'fatigue', reforms are very much part of the agenda; and the need to consider our own internal resources induces us to place more emphasis on working with the countries in which we perceive a comparatively greater understanding of and commitment to reform.

This does not mean that DANIDA has a 'blueprint' for health care reform. Ideally, the reform elements should be the prerogative of the individual collaborating country. In the present situation, with global trends towards pluralism, liberalization and decentralization, the need for central government bodies to generate capacity for policy and institutional development, and for lower tiers of a public health systems' capability to deal i.a. with accountability and transparency issues, is very apparent. Also, in most developing countries with which DANIDA is cooperating in health, there is a need to shift resource allocation from tertiary services to more cost-effective, and more equitable, primary care, as well as to give up the 'verticalism' which has presently pervades health care delivery in many countries.

In our move away from vertical towards more integrated approaches an example merits mentioning. In Zambia, in a health sector support programme, undertaken in conjunction with other donors, DANIDA supports the development of district health administrations' capacity in budgeting and financial management, with a view to satisfying, for example, donors' demands for accountability, thereby hopefully preempting the need for future project-specific accounting systems.

As part of an assessment of DANIDA's strategy in general, currently ongoing, an attempt is being made to define, in more operational terms, the concept of sector support and sector programme support. This will have a bearing not only on Danish assistance in the health sector, but is meant to clarify the concept as an instrument for assistance in other sectors as well.

Much emphasis has been placed on the need for developing countries to embark on health sector reform. However, when looking at the way in which health systems have evolved and currently are configured in many developing countries, a share of the blame for failures undeniably falls on donor agencies. DANIDA, in its health sector guidelines currently being

¹ Technical Officer, DANIDA, Copenhagen, Denmark

drafted, is trying to take this into account by looking at what a health care reform in recipient countries implies on the part of donors in general (quoting from the draft guidelines):

This entails that donors:

- ▶ take an active part, and preferably jointly, in defining and clarifying the policy framework, to ensure consistency and avoid overburdening local administrations;
- ▶ are willing to support health systems development in terms of capacity building/institutional development at the different levels of the health care system, rather than propagating the weak, fragmented and unsustainable service delivery systems of questionable quality, currently often supported by donors;
- ▶ use systems and operational research as 'policy experiments', as well as opportunities and entry points for capacity and alliance building;
- ▶ in a number of instances are willing to provide recurrent budget support, for salaries, maintenance, spare parts, fuel i.a., to meet health systems-wide, rather than individual programme/project, expenditures;
- ▶ recognize the need for long-term commitment as a prerequisite for sustainable development, and are more ready to sacrifice short-term results and rapid performance improvements for capacity building;
- ▶ appreciate that there is not one single 'right' way of reforming health systems, and that attempts to reconcile varying positions between or among donors, whenever they arise, should have a high priority, rather than having conflicts place the reform process in jeopardy;
- ▶ work together also at the international level to share experiences, establish key principles, explore systems for monitoring and evaluating processes and outcomes, and develop guiding principles;
- ▶ increase assistance for health from the current 7% of total ODA, to at least 8%, over the next few years, as advocated by the WDR 193.

PRIORITIES FOR HEALTH SECTOR REFORM: SIDA PERSPECTIVE

by Dr Bengt Höjer¹

SIDA is in the process of focusing its assistance to the health sector in collaborating countries to two priority areas:

- ▶ sexual and reproductive health
- ▶ health planning and management, including policy development.

Hence, the issue of health reforms is definitely of immediate interest for the agency and also for my own department, where a small working group has now been constituted. SIDA is reducing its project-targeted support, including provision of long-term technical advisers and instead wants to assist in capability strengthening, if possible, by international collaboration within the framework of programme support.

After reading the documents from the first meeting of this group my initial comment will be, "Yes, health reforms are certainly needed – but for what?" In my experience a reform process is often initiated with very vague objectives, but with the feeling that something has to be done. Usually aims and objectives are not made clear to those who are supposed to implement the reforms – managers and health staff. This may have serious consequences for the outcome and leaves the floor open for different interpretations and modifications.

Rationales for health reforms have been given, for example, in the Investment in Health Report. Reforms in order to increase equity and protect vulnerable groups, as emphasized by Dr Jardele this morning, would be, I guess, the number one objective from a Swedish point of view, not forgetting a more gender-balanced functioning of the services; higher cost-effectiveness and quality of care; means to stimulate bottom-up planning whenever possible; avoidance of verticalization of programmes; and support to on-going decentralization processes.

But should these objectives be identified by a group like ours? No, of course they should be decided on by the national governments. But I think the health sector reform initiative should provide technical guidance and stimulate research work to address the issues mentioned. An initial step would be to describe the services by answering a few simple questions like: Who provides the services? Who utilizes them? Who finances them? Who makes the decisions? What kinds of services are given? If these variables were described and discussed it would certainly facilitate the identification of objectives.

From the experience we have from development of drug policies, I feel that it is extremely important that health reform work also considers tools for implementation. I do not mean that

¹ Associate Professor, International Health Care Research Unit, Karolinska Institute, Stockholm, Sweden

the group or the network should participate in the implementation. But policies on drugs, for example, will be useless unless systems for quality control, registration, inspectorate, etc, are elaborated. This holds true also for health reforms in general. I will also welcome a discussion on in what way appropriate health services reforms could also include the informal sector, practitioners, private pharmacies, etc.

From the discussions at home it seems clear that we would favour the development of a network between technical people or institutions, rather than aid agencies. The focus should be on information exchange and tools development. However, there may be serious problems for institutions in poor countries that really need support to join the network and use it continuously. It might be a good idea to adopt a two-stage strategy in those cases, which means that a Western collaborating institution should facilitate the dialogue during the initial phase. There seems also to be too strong a belief in technical solutions like E-mail and fax. Although facilities might be available in most countries, we know that time and some extra resources may be needed to get in operational. These points should be clarified.

PRIORITIES FOR HEALTH SECTOR REFORM: WORLD BANK PERSPECTIVE

by Dr Malonga Miatudila¹

HEALTH PROJECTS

Getting Results in the Field (GRIF)

- ▶ Involve stakeholders from the outside to ensure local ownership
- ▶ Emphasize process, not product
- ▶ Serve as a catalyst, not leader

HEALTH SECTOR REFORM

- ▶ Foster an environment that will enable households to improve their own health
- ▶ Reform the health care sector so as to improve its efficiency and effectiveness

BENIN: HEALTH SERVICES DEVELOPMENT PROJECT

Historical Background

- ▶ Loss of confidence by the public in the national health system.
- ▶ Centralized Marxist planning has rendered Benin's health care system ineffective in providing basic health care.
- ▶ No specific allocations in government budget for the health sector in 1987 and wages were not being paid.
- ▶ Decision making authority was heavily centralized and health staff were concentrated in the central units of the Ministry of Health.
- ▶ The government's pharmaceutical agency had gone bankrupt; private pharmaceutical business was banned and the parallel market for illegally imported drugs was the sole source of medicine for the general population.

Processes used to reform the health sector in Benin included the following:

- ▶ Identification of problems through a workshop which involved officials from the Ministry of Health and other ministries, health staff from the field, community representatives, and technical staff in donor-funded projects;
- ▶ Involvement of stakeholders in project preparation;
- ▶ Involvement of stakeholders in programme management through the creation of local management committees and enactment of regulatory framework and internal

¹ Public Health Specialist, Africa-South Central and Indian Ocean Department, The World Bank, Washington DC, USA

regulations for these committees giving them financial management authority and health facility maintenance responsibility.

In Benin the health reform process resulted in:

- ▶ New partnership among government, stakeholders and donors. This partnership was formalized in the creation at the national level of a technical coordination committee. The increased collaboration among donors attracted substantially more external funding to the sector through joint financing and bilateral funding;
- ▶ Institution of a programme budgeting system which involves a process initiated at the periphery;
- ▶ Creation of an independent agency responsible for procurement of essential generic drugs through ICB for public and private non-profit health facilities;
- ▶ Institution of cost recovery and new accounting system in all public facilities with accounts and drugs stocks managed by local management committees.

Problems encountered in Benin during the health sector reform process included:

- ▶ Resistance from some expatriate technical staff working on donor-financed projects who accorded little importance to consulting villagers;
- ▶ Resistance among some central ministry officials who realized that the process entailed sharing power with community representatives and decentralizing supervision function to regional organs;
- ▶ Annulment among some government officials to regain control of the essential drugs procurement agency and cost recovery funds which now belong to communities and are managed by their elected committees.

COSTA RICA: HEALTH SECTOR REFORM PROJECT

Project cost: US\$32 million, of which \$22 million from IBRD

Project background

- ▶ By allocating 7-10% of GDP in the past 30 years to providing health care for all its citizens, Costa Rica has brought about significant improvement in the health status of its population.
- ▶ In the recent years, however, inefficiencies have emerged in health care utilization patterns caused by distortions in both the supply and demand for health care.

The process used to reform Costa Rica's health sector design included:

- ▶ Definition of policy directions and guidelines for the project preparation groups by a high-level committee organized by the Cava Costarricense de Seguro Social (CCSS) which had taken the role of health care provider from the Ministry of Health;

- ▶ Organization of specific working groups responsible for the preparation of each of the components by the CCSS;
- ▶ Preparation of project component through seminars which involved the CCSS Board of Directors, CCSS Senior Managers, representatives from other agencies or interest groups (ministries of health, finance, private sector, legislators from main political parties, and universities).

In Costa Rica the process resulted in:

- ▶ Strong commitment from the government, technical staff, and political parties to implementing the reform;
- ▶ Great learning experience for the technical staff.

SIERRA LEONE: NATIONAL HEALTH PLAN

Background

- ▶ Following a change of government in 1992, Sierra Leone's Ministry of Health officials recognized that the country's health services had reached an appalling state of deterioration both in quality and in scope.

The process used to reform Sierra Leon's health sector included:

- ▶ Organization of site visits to assess the level of deterioration of health services;
- ▶ Organization of a one-week national seminar as a forum for frank and open discussion to assess the extent of the deterioration and form the basis for a national health policy. The seminar was attended by representatives from various national and international agencies and from public and private organizations;
- ▶ Development of a national health action plan through a participative workshop which involved officials from the Ministry of Health and other ministries, representatives from UN agencies and NGOs, and other stakeholders in the health sector. The national health policy which had been adopted served as a basis for the development of the action plan;
- ▶ Formal adoption of the national health action plan by the Cabinet and the National Provisional Ruling Council.

The process seems to have resulted in:

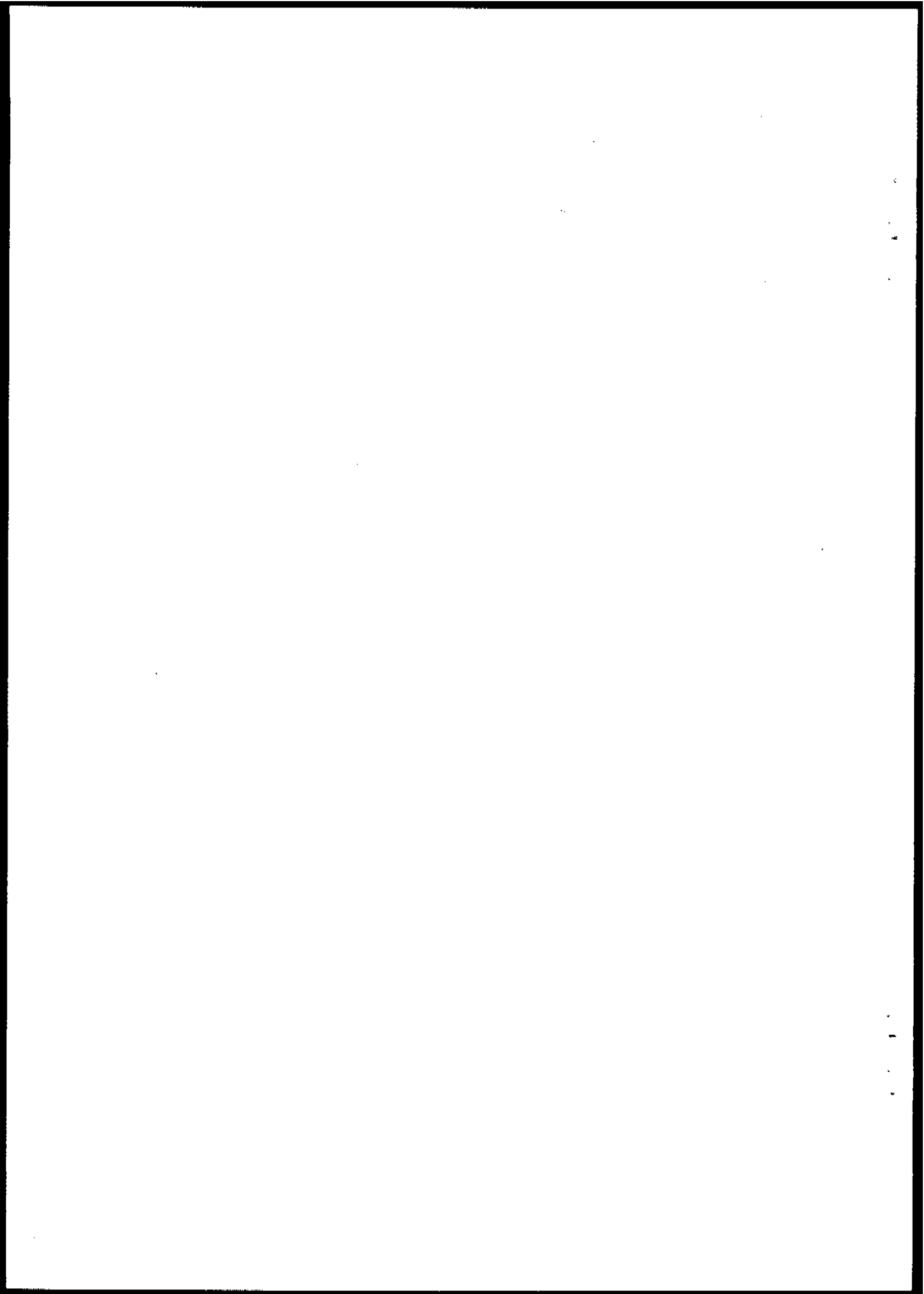
- ▶ Strong commitment from the government and technical staff to implementing the reform;
- ▶ Strong commitment from the government to increasing the amount of public financial resources;
- ▶ Great learning experience for the technical staff.

Notable among the conclusions that emerge from the discussions within the World Bank with regard to health reforms are the following:

- ▶ In many countries, significant and sustainable improvement in the health status of the population is dependent on the successful implementation of adequate health reforms.
- ▶ Health reform is a complex process. It must be country specific and include both technical and socio-political actions. While discussing reforms, one must remember that the power of rational argument is limited by that of ideology; therefore acceptable a proposal must fit with ideology.
- ▶ The expertise to understand the correctly describe local context and to design and implement adequate health reforms is limited both within countries and in the international community.
- ▶ The successful implementation of health reform is dependent on the scope and quality of partnership created before and during the process among the stakeholders in health.
- ▶ There is a need for ensuring national ownership through joint strategic planning. This requires that donors shift from playing a leading role to a more supportive or collaborative mode. This donors' conversion entails giving up some control of the process and working as a team with the recipient at all the stages of the process. A strategy that appears particularly promising is the provision of funds to countries to allow them to commission studies by national institutions on issues that they consider important.
- ▶ There is also a need for consensus-building on the health needs of the people and the most effective and affordable means to address them.
- ▶ Health reform always hurts some people's interests. Therefore it is important to identify the winners and the losers as a result of the reform.
- ▶ The power of inertia makes it difficult for health reform to dismantle some of the long-standing procedures and institutions in the sector.

Annex C

IHPP: Toward a Working Definition of Health Reform



TOWARD A WORKING DEFINITION OF HEALTH REFORM

by Dr Davidson R. Gwatkin¹

Health reform is a set of major changes in a health system with the objective of improving sectoral performance on one or more of the following dimensions: efficiency, equity, consumer satisfaction, health outcome².

The changes involved in health reform are many and varied. They are related to the objectives just noted and to one another through a web of often complex relationships. The changes most frequently referred to in connection with health reform include:

Financing

References to financial reforms in the health sector usually involve changes related to the structural transformation of health service systems from a state-directed toward a market orientation. Some of these issues are strictly financial: the introduction of users fees in public clinics, for example. Others also concern service delivery arrangements: for instance, greater reliance on private practitioners to provide services previously available through public facilities.

Services

Increased attention has recently been given to the identification of services that can produce greater outputs—particularly greater health status improvement—per unit of input; and on the allocation of more resources to such services. Particular emphasis is being placed on the use of cost-effectiveness techniques to define packages of services that deserve higher priority, in order to improve what economists call "allocational efficiency".

Outreach and Access

Those concerned with the objective of improved equity have long paid particular attention to population groups not reached by affordable health services, and to the extension of relevant services to them. Their emphasis has been a central element in the "health for all" movement and in efforts to develop primary health care for disadvantaged populations.

Organization

Governmental health services are commonly believed to suffer from many organizational defects. Prominent among them is over-centralization. To deal with this a strong interest in decentralization has emerged in recent years. The advocates of decentralization have had varying perspectives. For some, decentralization has been a necessary component of financial reform: to ensure that any resources raised through

¹ Director, International Health Policy Program (IHPP), Washington, DC, USA

² This draws heavily on a definition proposed by Helen Saxenian of the World Bank

cost-sharing remain at the local level in order to be available for service improvement, rather than reverting to the central treasury. Others consider it a key to improving efficiency, by providing local administrators with improved ability to design service packages tailored to local epidemiological and social conditions. Still others stress decentralization's anticipated equity benefits, believing that local leaders are more likely to emphasize programs serving the poor than are central administrators.

Orientation

Traditionally, health policy makers have thought primarily in terms of the health services for which they are directly responsible. This outlook is being challenged by proponents of a more outward orientation. The proponents argue for two types of change. One, often referred to as an "intersectoral" orientation, is based on recognition that the influence of health services on health status is much smaller than that of developments in such areas as education, rural development, and agriculture. This recognition leads many to emphasize the need for influencing overall development strategies rather than thinking primarily in terms of the health sector alone. A second type of outward change involves a greater emphasis on households and individuals. Households and individuals are viewed as the principal producers of good health, and priority is placed on enabling or empowering them to produce better health more efficiently. This means stressing such things as improved education and status for women, so that they can better care for their childrens' and their own health; and changes in the life styles and behaviour of individuals so that they feed themselves better, exercise more effectively, smoke less, and undertake other healthful practices.

Manpower

In most settings, implementation of many of the changes noted above will require a very different mix of health personnel than currently exists. This leads to a concern for basic reforms in health manpower training and deployment. Professionals concerned with outreach, access, equity, and decentralization emphasize the importance of more community health workers and other paramedical personnel relative to physicians. There is also interest in the training of physicians more concerned in community and household health issues than in traditional high-technology clinical medicine.

Legislation

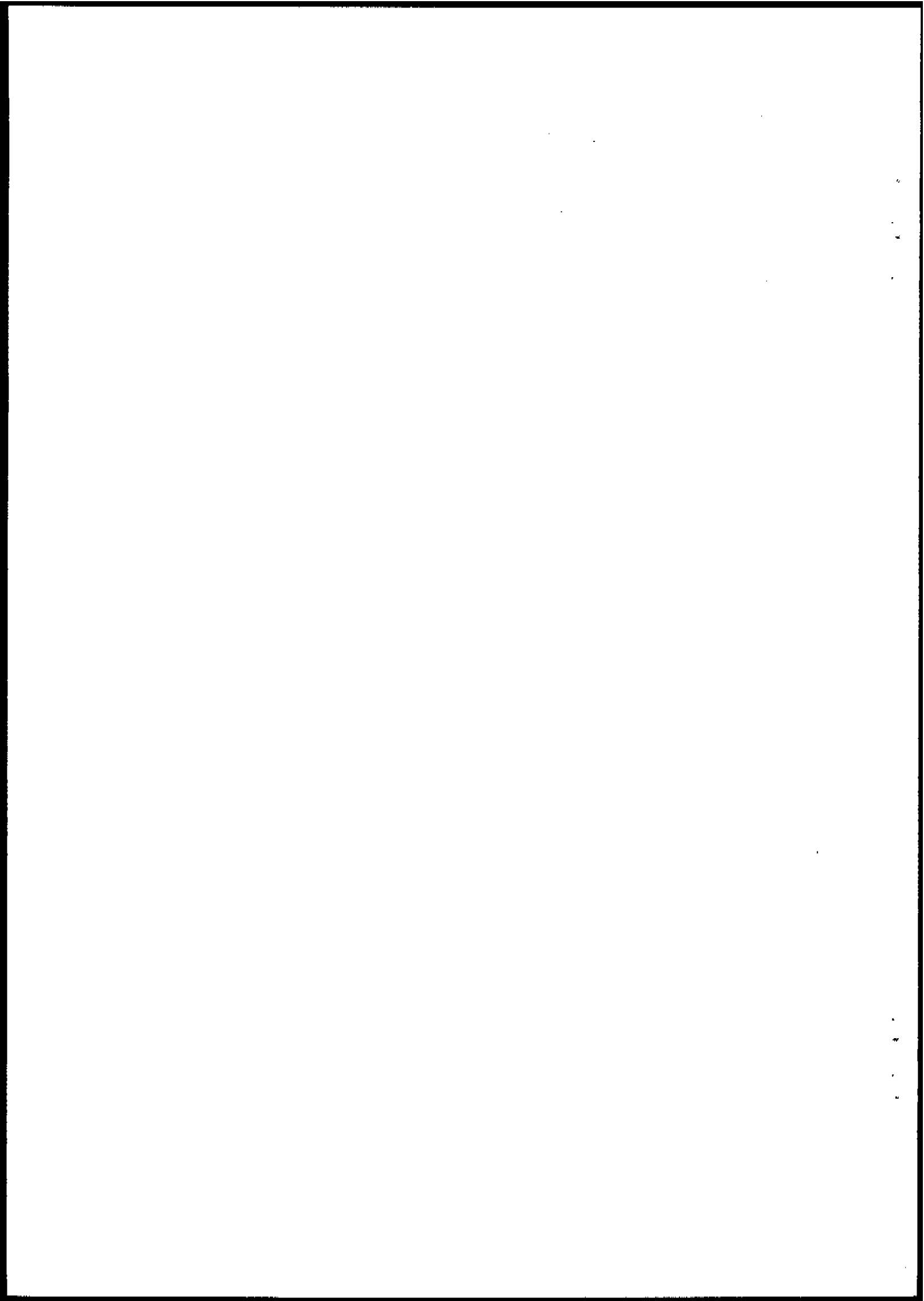
Implementation of many of the changes noted above will also require legislation. For example, governmental health budgets are normally established through legislation. So are many key health programs. In some countries there are umbrella legislative codes that provide a basic framework for health policy and must be revised in the course of any major reform.

NOTE

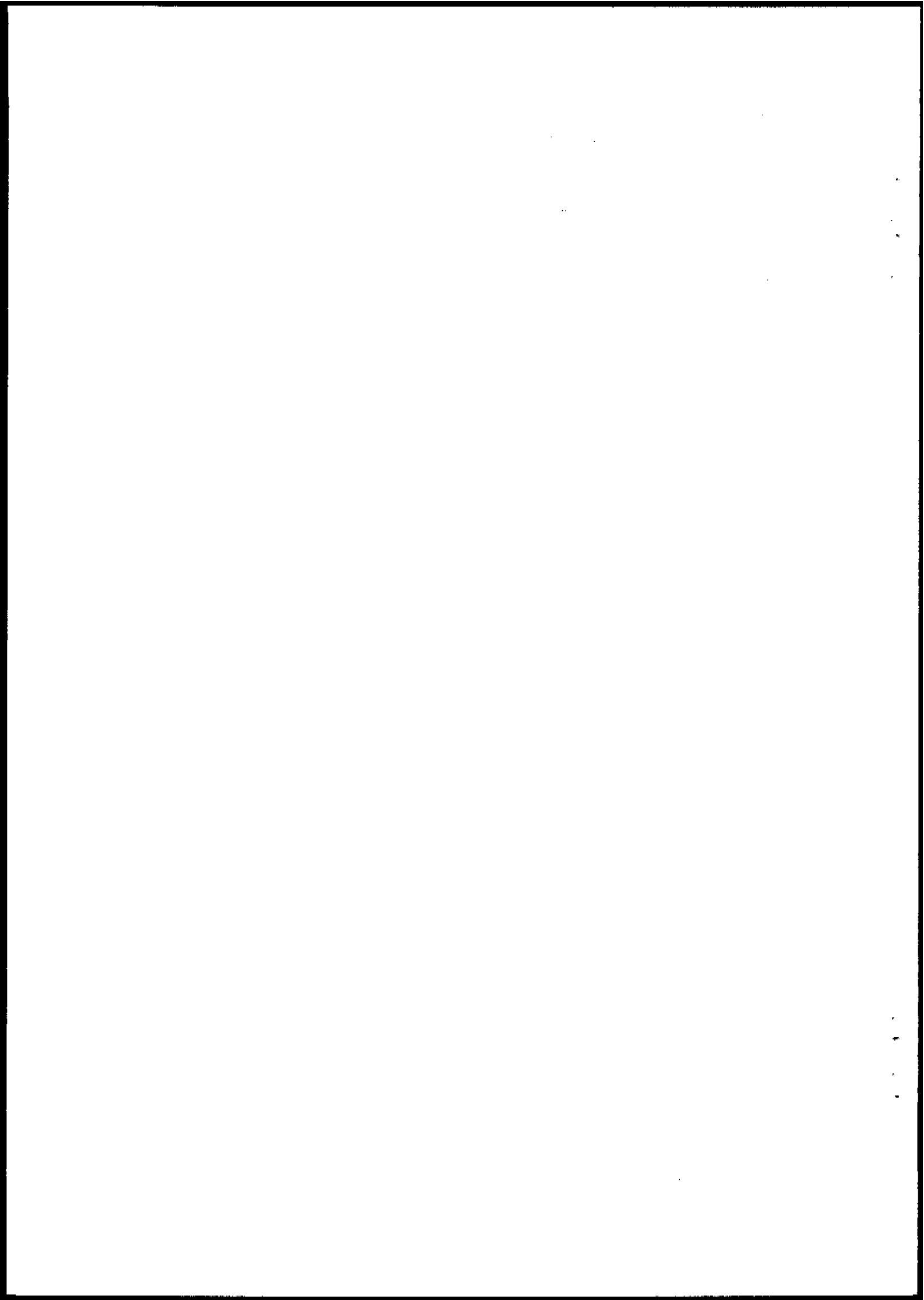
This paper represents an initial effort to present a definition of health reform for use as terms of reference in an incipient initiative to develop capacities to undertake such reform in Africa, Asia, and Latin America. The note's contents have been derived from two informal roundtable discussions. One was with staff members of the World Health Organization in March 1994. The second, held the following month, was with representatives of the World Bank. The ideas emanating from those meetings have been recorded as a starting point for the many discussions with others that are planned.

This initial version of the proposed working definition is intentionally broad. It consciously seeks to go beyond the standard focus on organized health services. In particular, by giving a central place to intersectoral and household issues, it tries to incorporate the principal elements of what is often known as health development.

There are two reasons for the current breadth. The first is procedural, reflecting acceptance of the argument that it is best to start broad and then narrow, rather than risk overlooking crucially important considerations by adopting a narrow outlook from the outset. The second reason is more substantive. It is based on the view that an internationally-established definition ought to be as broad as possible, in order to provide policy makers and analysts at the country level the freedom to choose those elements they consider most relevant to their situations.



Annex D
Country Presentations



CAMEROON EXPERIENCE

by Dr René Owona-Essomba¹

Since 1989, Cameroon has launched a Health Sector Reform Programme known as the Ministry of Public Health Reorientation of Primary Health Care (REO-PHC), the implementation of this very important and delicate programme is being conducted in six major areas:

- 1) Financing of health care services
- 2) Community participation and the decentralization of the management of health services in a system approach
- 3) Integrated pharmaceutical and medical supply system to support delivery of preventive, promotive and curative health services
- 4) Health management information system to promote local utilization of data and decision-making
- 5) Definition of a minimum package of health activities at each level of the National Health System including quality assurance
- 6) Human resources development to improve the performance of health workers, the relations between health personnel and to promote public/private sector collaboration.

The most important actors of our health system development are concerned:

- ▶ the university;
- ▶ the research organism;
- ▶ central and peripheral health services.

1 FINANCING OF HEALTH CARE SERVICES

The over whelming share of the recurrent budget of the MOH goes to salaries, which for political reasons the government was reluctant to cut. As in many developing countries, the budget category that has declined most sharply is non-personnel recurrent, ie largely material expenditures.

Health services without a minimum operating budget, and a modicum of material inputs, especially drugs, are both economically inefficient and unattractive to the population.

To solve this problem, the MOH adopted the co-financing of health services through the joint efforts of the government national budget international solidarity (multi- and

¹ Director of Rural and Preventive Health Services, Ministry of Health, Yaoundé, Cameroon

bilateral cooperations, NGOs) and the community. The development of co-financing approach has led to identify five key elements:

1.1 The producers of health care

These are physical or moral person who decide to finance investment costs and the first recurrent costs to the running of a health facility. There are two groups of producers.

Not-for-profit producers: Government, the community through different types of associations, missions NGOs, local councils, etc.

For profit producers: Communities, physicians, business men, private companies, etc.

1.2 The providers of health care

These are human resources recruited by the producer to run his health facility: physicians, nurses, pharmacists, administrative personnel and all the supportive personnel.

1.3 The purchasers of health care or clients

They are those who pay for health services given to a person, a family, or a community by the providers of health care. They pay to the producers. In this group, we find:

The government which can pay:

- ▶ either directly by financing all the costs of health services;
- ▶ or indirectly through direct or indirect taxes) subsidies to private producers.

Private insurances:

- ▶ social insurances found in traditional associations like Dja (tontine), elites associations, etc;
- ▶ local councils;
- ▶ the community through what is known as solidarity mechanisms
- ▶ the family, the patient himself.

1.4 The users of health services or the consumers:

the patient;
the person at risk;
the family;
the community.

1.5 The government

Beside the fact that the government is a producer and a purchaser of health care, it has also an important role of regulating health care services.

2 COMMUNITY PARTICIPATION AND THE DECENTRALIZATION OF THE MANAGEMENT OF NOT-FOR-PROFIT HEALTH CARE SERVICES IN THE NATIONAL HEALTH SYSTEM APPROACH

This is the co-management of health services by all those who participate to the co-financing of these services. This area of reform deals with:

- ▶ The reorganization of our health care system according to the African frame of development of health care known as the 3-level scenario: the district (optional level); the intermediary (technical support level); and the central (strategic level) levels.
- ▶ The development of partnership between the above 5 key elements of the co-financing approach.
- ▶ The development of a social dialogue between these 5 key elements.
- ▶ The public (private mix).

There is a very important aspect of Legal Frame of the health care system in this area.

3 PHARMACEUTICAL POLICY AS AN IMPORTANT SUPPORT OF HEALTH CARE POLICY

Drug has a triple role in the development of the REO-PHC:

- ▶ it is an economical factor in the financing of health services;
- ▶ it is a mobilizing factor for the users of health services;
- ▶ it is a very important element of curative medicine.

Seven important aspects have been identified to constitute the pharmaceutical area of our health sector reform programme:

- 1) The organization of drug supply system in relation with the REO-PHC.
- 2) Rational use of drug and promotion of the concept of essential drug.
- 3) Elaboration of a national pharmaceutical development plan.
- 4) Periodic revision of the national list of essential drugs and its promotion.
- 5) Reorganisation of the drug registration system.
- 6) Organization of drug quality control.
- 7) Formulation of the national pharmaceutical policy.

Many very powerful interested parties are concerned with any reforms in this area.

4 DEVELOPMENT OF A NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM ACCORDING TO THE THREE LEVELS HEALTH SYSTEM AND THE CO-FINANCING/CO-MANAGEMENT APPROACH

5 RATIONALISATION OF HEALTH SERVICES CONSUMPTION THROUGH THE DEFINITION OF MINIMUM PACKAGE OF HEALTH ACTIVITIES AT EACH LEVEL OF THE NATIONAL HEALTH SYSTEM INCLUDING QUALITY ASSURANCE

6 HUMAN RESOURCE DEVELOPMENT

In this area, we include human resources management and the relationships between the four most important actors of the development of our national health system:

- 1) Central services of the Ministry of Health in charge of strategic development of health care
- 2) Peripheral health services in charge of operational aspects of health care
- 3) The university in charge of training of health personnel
- 4) The research ORGANISM in charge of development of health care strategies.

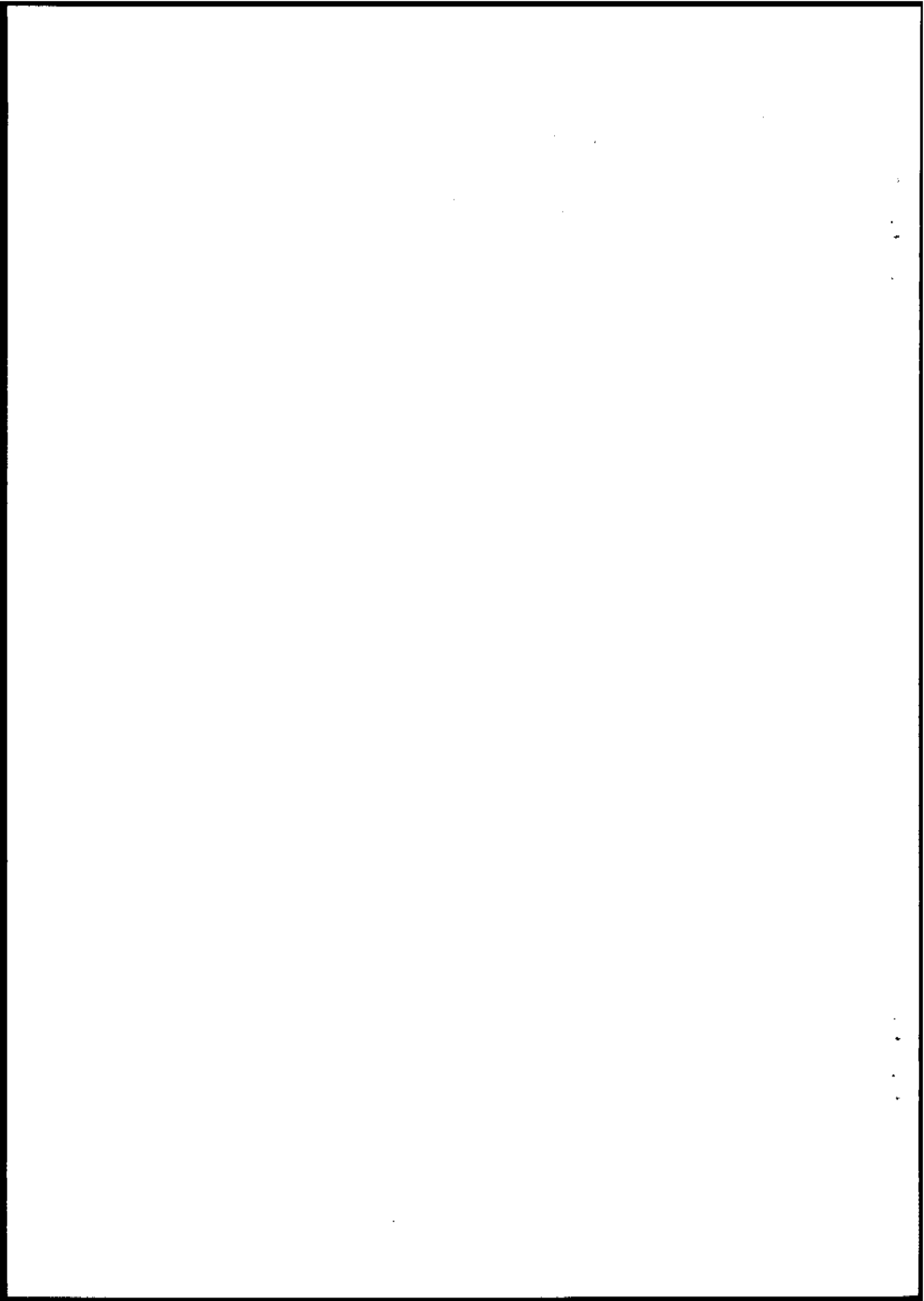
We have noticed that there are strong relationships between:

- ▶ central services of the MOH and the peripheral services and
- ▶ university and research organisms,

but very weak relationships, if at all, existing between:

- ▶ central services of the MOH and university,
- ▶ central services of the MOH and research organisms,
- ▶ university and peripheral health services, and
- ▶ research organisms and peripheral health services.

These are the six important areas of our national programme of health sector reform still going on.



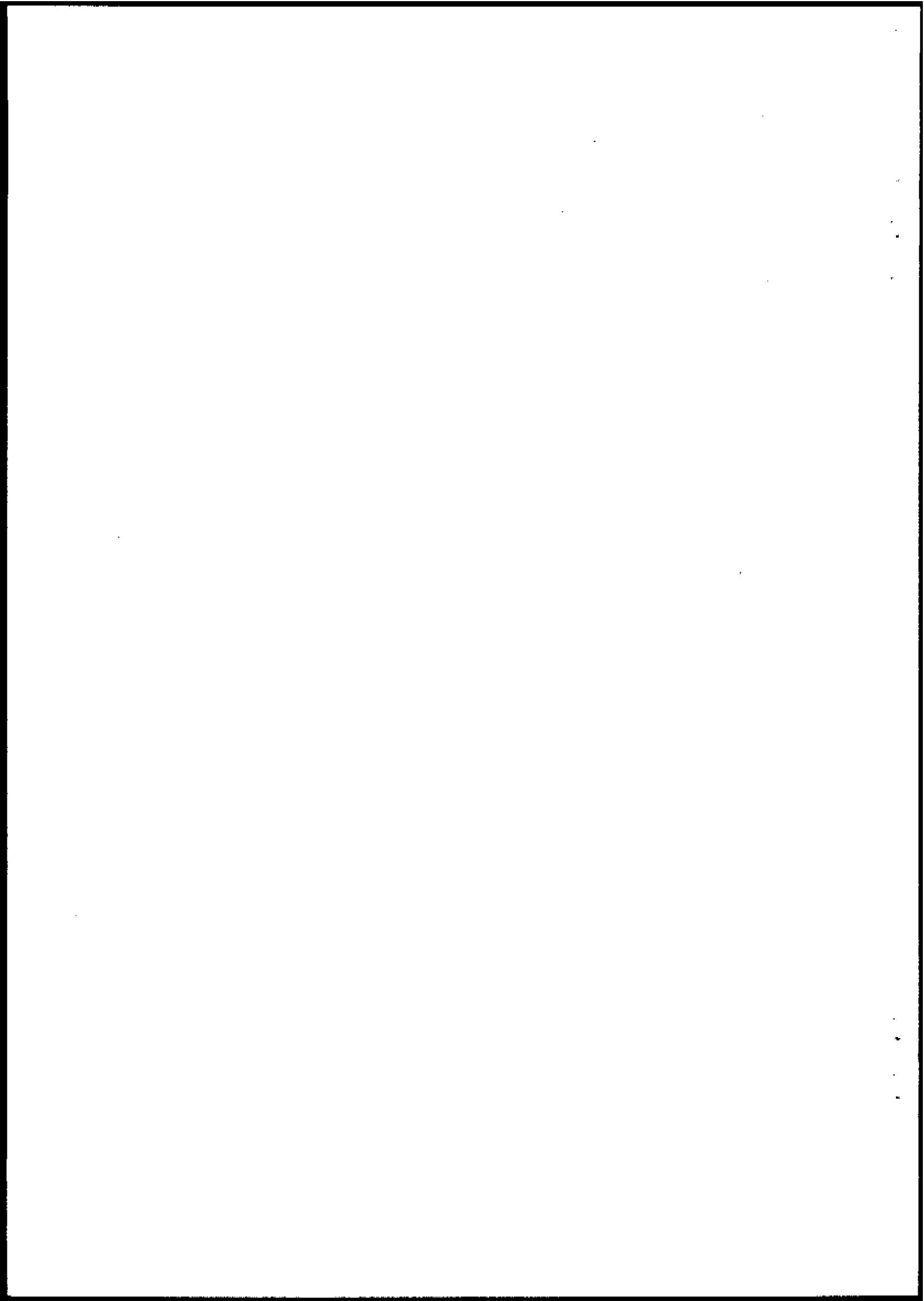
HEALTH SECTOR REFORM IN MEXICO

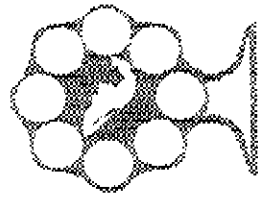
by Dr Beatriz Zurita¹

The following are overheads of Dr Zurita's presentation based on a paper by Dr Julio Frenk, "Hacia la reforma del sistema de salud: una propuesta estratégica", FUNSALUD, Mexico, D.F. 1994.

Written permission has been received from FUNSALUD to publish this material. The English translation of the overheads in Spanish will be available at the next meeting.

¹ Head, Unit for the Study of Quality and Costs of Health Care, National Institute of Public Health, Cuernavaca, Morelos, Mexico





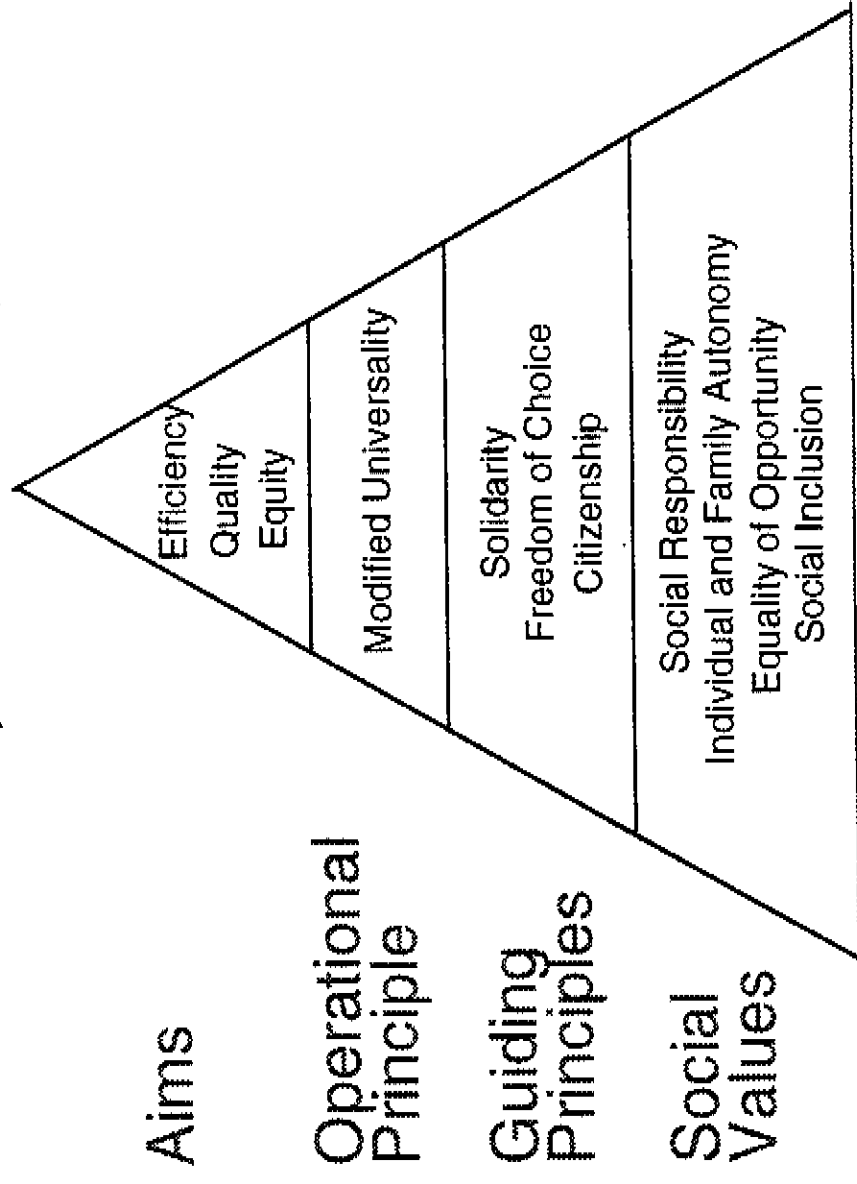
Fundación Mexicana para la Salud

Health System Reform in Mexico

Options for Financing and Delivery of
Health Services

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VALUES, PRINCIPLES, AND AIMS



Aims

Operational Principle

Guiding Principles

Social Values

Health System Reform: Policy Levels, Objectives, and ISSUES

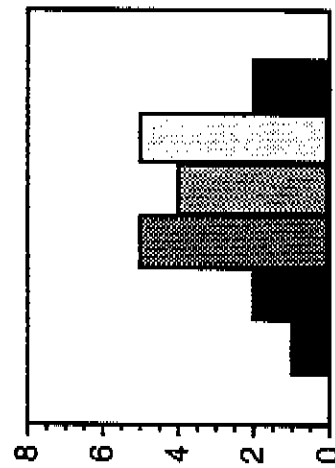
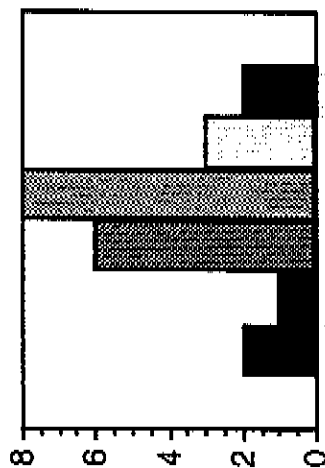
<u>POLICY LEVEL</u>	<u>MAIN OBJECTIVE</u>	<u>ISSUES</u>
Organizational	Technical efficiency	<ul style="list-style-type: none">• Productivity• Quality of care
Instrumental	Institutional intelligence for performance enhancement	<ul style="list-style-type: none">• Information systems• Scientific research• Technological innovation• Human resource development• Physical infrastructure

Health System Reform: Policy Levels, Objectives, and Issues

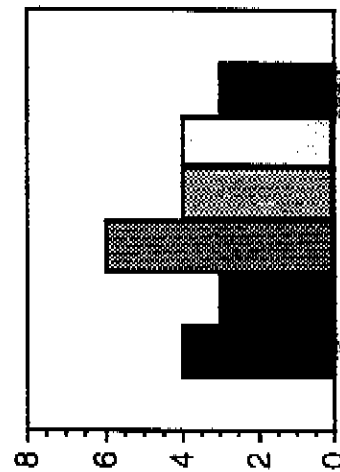
POLICY LEVEL	MAIN OBJECTIVE	ISSUES
Systemic	Equity	<ul style="list-style-type: none"> ● Basis for population eligibility ● Institutional arrangements: <ul style="list-style-type: none"> ◇ Public agencies involved in health care ◇ Levels of government ◇ Public/private mix ◇ Population involvement ◇ Resource generators ◇ Other sectors with effects on health
Programmatic	Allocational efficiency	<ul style="list-style-type: none"> ● Priority setting ● Cost-effectiveness of interventions

CHALLENGES FOR HEALTH SYSTEMS REFORM

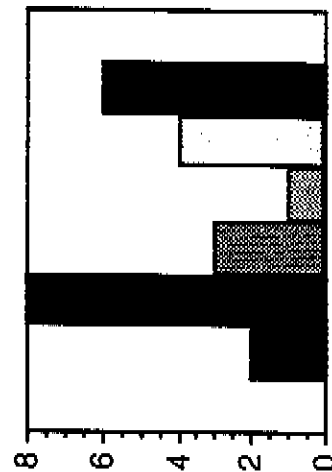
Established Market Economies Formerly Socialist Economies of Europe



Middle-Income Economies



Low-Income Economies



Challenges

- Inequity
- Insufficiency
- Inefficiency
- Inflation
- Insatisfaction
- Insecurity

FIGURA 1

Opciones para la reforma del sistema de salud
Fase I. Fortalecimiento interno y federalización
de las instituciones públicas

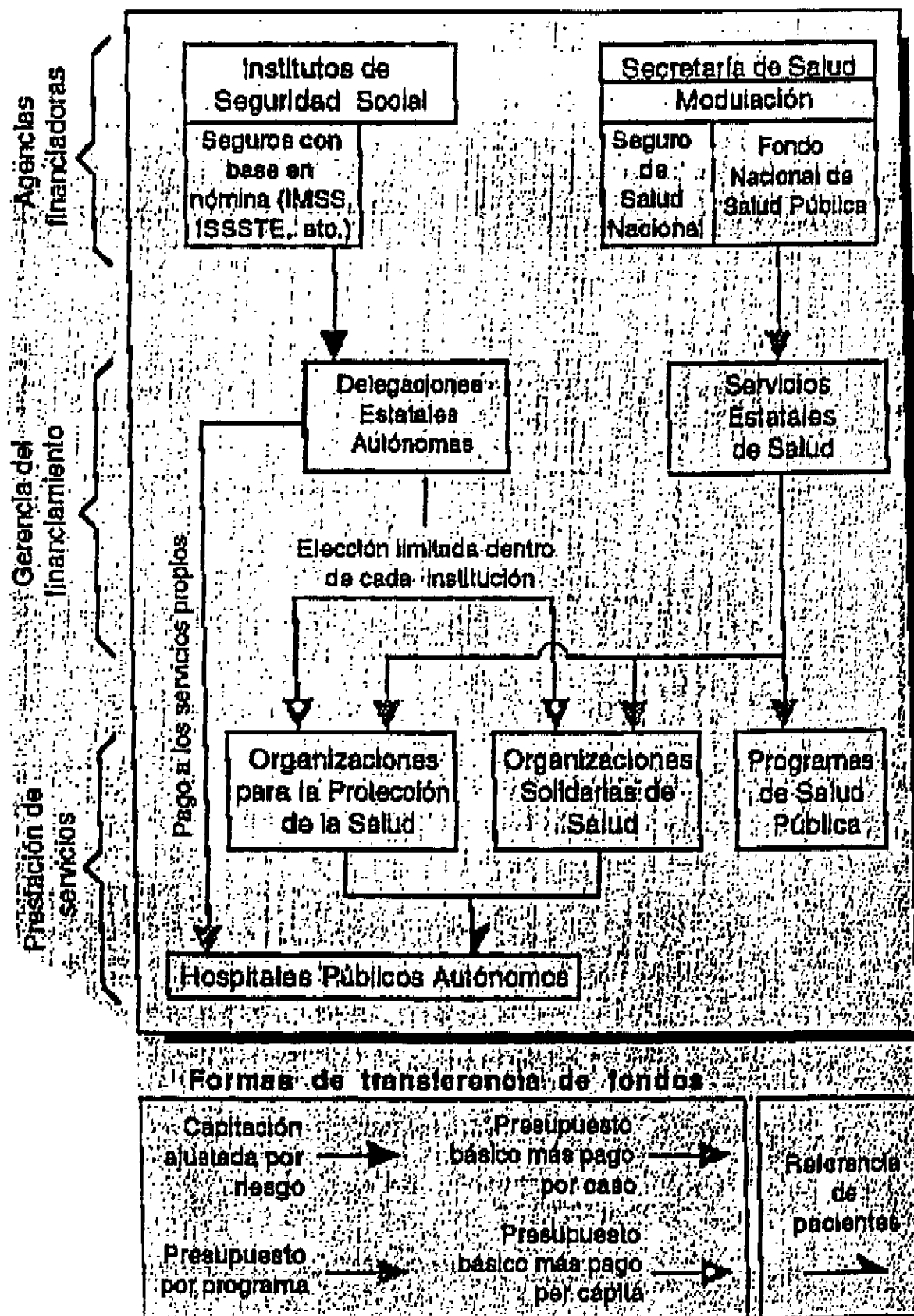


FIGURA 2

Opciones para la reforma del sistema de salud
 Fase II. Apertura inicial de las instituciones públicas
 y preparación de las organizaciones privadas

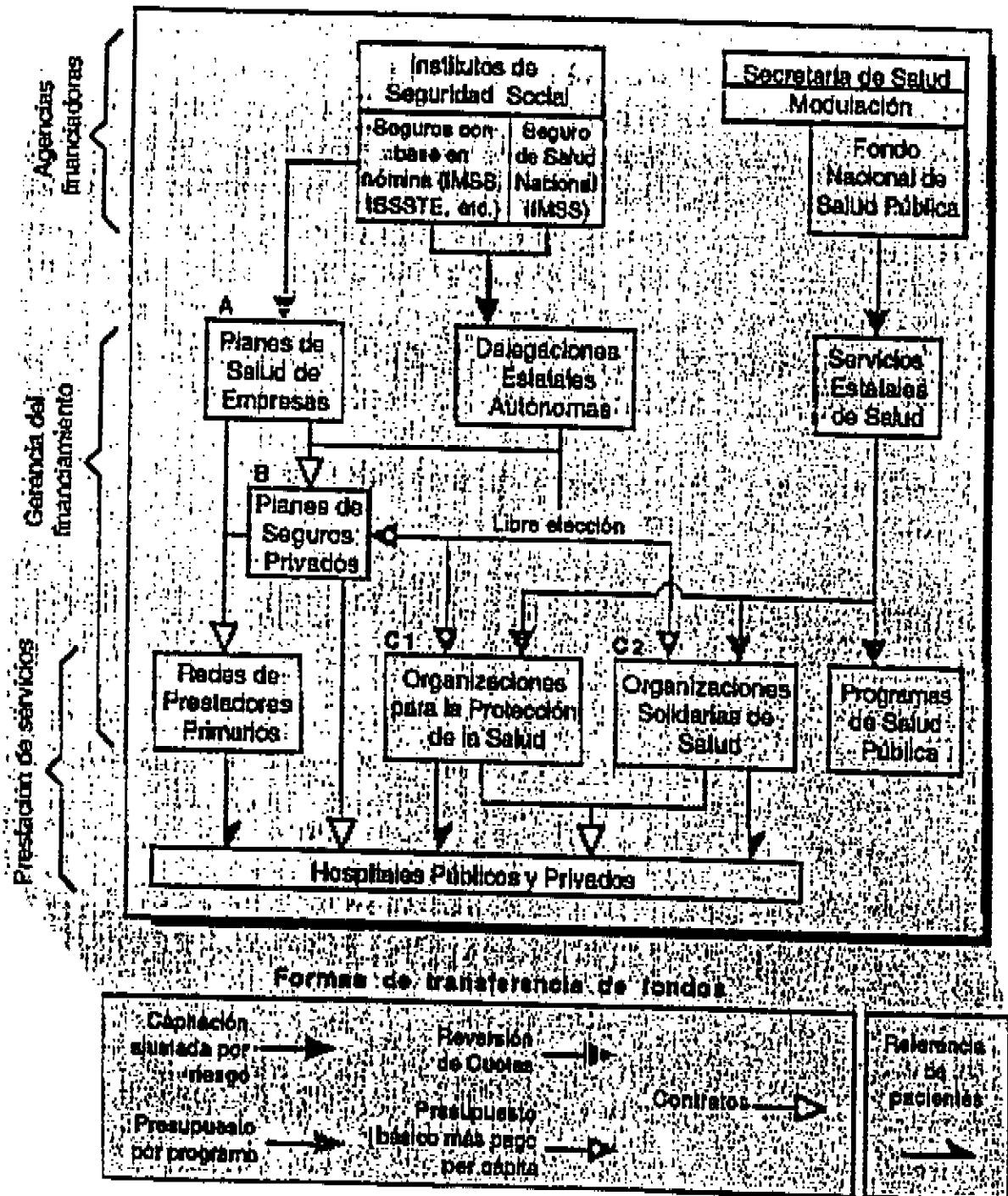
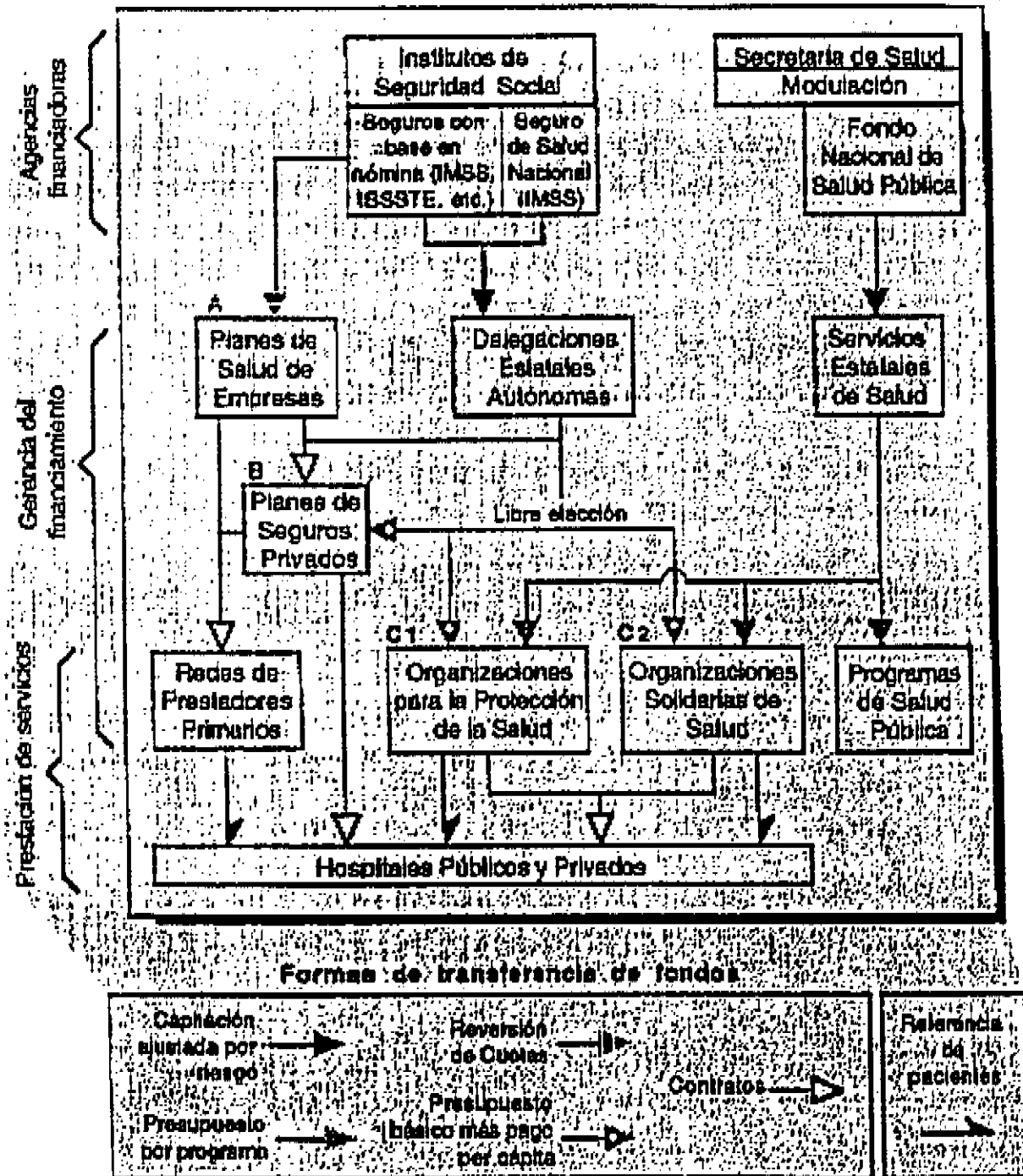


FIGURA 3
 Opciones para la reforma del sistema de salud
 Fase III. Ampliación del pluralismo y
 de la libertad de elección



HEALTH CARE REFORM IN THE REPUBLIC OF KAZAKHSTAN

by Dr Maksut Kulzhanov¹

The Republic of Kazakhstan is currently undergoing a complex process of transition towards political and economic independence associated with profound socio-economic changes. Difficulties of this period such as disintegration of old industrial, financial and trade systems, building-up of a new political and economic system, have resulted in deep economic, financial and social crisis, production decline, high inflation, falling of population's living standards.

Naturally, these affected all spheres and sectors of society's life including health care. Crisis in the health care system involved its organization, management, financing, and, eventually, resulted in decline of level and quality of care.

Like all other former USSR republics, Kazakhstan has inherited from the Soviet era a chronically neglected and under-funded health care system with highly centralized management, strong orientation towards curative care and emphasis on quantity rather than quality.

Although the ratio of medical personnel and hospital beds per population is very high (135 hospital beds, 40,6 doctors including dentists and 104,5 nurses per 10,000 population), and coverage and accessibility is practically universal, the quality and appropriateness of care is rather low.

In recent years, the level of the real government spending for health has fallen dramatically and accounts now only for 2-2,5% of GNP compared with the estimated minimum requirement of 6-8%. The situation with financing, budgeting and planning is hampered by continuing rapid inflation, decline in purchasing power of health budget and inexperience of staff, particularly managers at all levels, to operate under new circumstances.

Until now, financing of the health sector comes exclusively from the state budget. Financing of the hospital care is based on the number of beds, and financing of polyclinics on the number of visits.

Chronical under-financing of the health sector determines the volume and quality of services provided to the population. Consumers has no economic incentives for promotion of their health because they receive free care. Health personnel has no incentives as well because they receive fixed salaries which do not depend on the volume or quality of service provided. There is no incentive in improving quality because, in any case, the allocation from the central budget, although very low, is fixed and guaranteed.

¹ Deputy Minister of Health, Almaty, Kazakhstan.
Unable to attend the meeting, but forwarded these notes.

The only way out of crisis is in the introduction of the wide-scale reform in health sector. It should involve deep policy and management changes, restructuring of the system, decentralization, reorientation towards primary health care and other measures. The core of the reform is seen in development of new financing and management mechanisms.

After 70 years of a centrally planned and directed system, there is now an opportunity to review health care priorities and approaches in Kazakhstan. There is a strong political will in the country to solve the existing problems in providing quality care to the entire population through finding the most appropriate ways of using effectively our limited resources, achieving efficiency and equity in allocation and reallocation of resources and in delivery of services.

The adopted concept of the health sector reform includes, first of all, the development of a legal basis and framework, the reorganization of the system and its management based on decentralization, shift from a strict vertical structure to flexible horizontal links and delegation of more power and responsibilities to local health authorities, and the introduction of new financing policy including introduction of compulsory health insurance and finding the appropriate public/private mix.

Today, centralized model of financing and allocation of resources does not correspond with the socio-economic realities of the transition to the market economy. Because of that we are now trying to introduce the elements of health insurance with a view to shifting the whole system to health insurance. Funds generated through insurance will be complementary to the state financing, the latter going primarily to the support of most vulnerable groups.

It is envisaged that health sector financing will come from general state revenue, compulsory insurance by employer, user charges, voluntary insurance, voluntary contributions from industrial enterprises, donations from charity organizations, international agencies, etc.

We have started with the experiment in two oblasts, namely South Kazakhstan (Chimkent) and Zheskazgan.

It involves not only introduction of new financing mechanisms but also new methods of management. First experience of using economic methods of management is very positive, particularly with regard to final outputs of health services. The practice of costing for various medical procedures is being introduced, and health facilities are becoming partially self-financed through charging for services according to their quantity, quality and effectiveness.

The logical development of those new mechanisms became realization of necessity of financing health sector according not to the number of beds or visits but per capita. The Ministry of Health has developed a scheme for such per capita financing taking into

consideration demographic and health indicators and state of health services in various regions of Kazakhstan.

This approach to financing was supported by the Parliament and the Government, and has been approved by the Ministry of Finance. However, the difficult economic situation, inflation, unstable state budget do not allow to fully realise this policy.

Currently, a voluntary insurance becomes widely spread with more than 100 insurance companies of various forms of property operating in Kazakhstan.

Ministry of Health proposes the following health insurance scheme:

- ▶ it will be compulsory;
- ▶ it will be introduced not at once for the whole country but region by region depending on the preparedness of new management structures;
- ▶ state will be responsible for compulsory health insurance, and only state-run companies will be involved in it;
- ▶ resources received from compulsory insurance will be collected in the specially created regional insurance funds;
- ▶ relationships amongst various, e.g. employer, employee, health care purchaser and health care provider, will be strictly fixed in the insurance contract;
- ▶ the role of the government and local authorities in developing and controlling the insurance system will be very important.

Apart from the government, the health sector will be managed by state insurance companies, professional associations, various non-governmental organizations, consumer associations.

At this stage, we are trying to keep free health care for most of the population, however, at later stages we are planning to introduce more widely user charges covered by health insurance.

Last March, we have organized a seminar involving representatives of all oblasts' health authorities to discuss the experiment in Chimkent and Zheskazgan. A statement defining further steps has been adopted.

Another meeting is being planned for the beginning of June where we will discuss the results of the analysis of the experiment made by a team of USAID experts currently working in two experimental oblasts as part of a major USAID-sponsored project.

An important issue for us is the problem of allocation, reallocation and use of resources at a hospital level. We look forward to become a part of a WHO intercountry comparative study on this subject.

We are now in the process of profound changes and introducing various approaches and mechanisms which are completely new for us. Our resources are limited and we have to ensure that we are using them as efficiently as possible because we can not allow ourselves to make mistakes which in our circumstances would be too costly.

Based on the analysis of international experience, we have to choose the model or to combine parts of different ones in a way which is the best for our specific conditions and realities.

We need the support from international organizations in expert advice, consultancy services, human resources development, information, particularly in the field of organizational change, decentralization, health economics, financial management, etc. in order to strengthen our institutional capacity for future self-assessment and introduction of required organizational and managerial change. We view a health care reform network for the Central Asian Republics planned by WHO as a follow-up to the meeting held in Almaty last December as an important mechanism in this regard.

THE KYRGYZ "MANAS" HEALTH CARE REFORM PROJECT

by Dr Serdar Savas¹

Introduction

Due to the transition away from a centralized socialist health system to a more market-oriented approach, the Ministry of Health of Kyrgyzstan has, over the past two years, managed increased responsibilities in maintaining the day-to-day functioning of health services, while undertaking the burden of planning for a comprehensive health care reform. Several international and donor agencies (eg, UNDP, WHO/EURO, UNICEF, World Bank, TICA (Turkish International Cooperation Agency), ODA, USAID, DANIDA) have expressed interest in assisting the Kyrgyzstan Health Authorities with its health care reform.

In February 1994, the Ministry of Health declared that the proposed health sector reform should be expanded over a ten-year period, beginning in 1995 and should comprise short-term (1995-96), mid-term (1995-2000) and long-term strategies. This ten-year reform process is entitled "MANAS" Health Project, named in honour of the Kyrgyz national hero whose first commemorative millennium will be in 1995.

Coordination of international donor assistance on the Kyrgyz health care sector

In the existing socio-economic climate of change, external assistance is required from both the pure funding and technical expertise viewpoints. This is due to the fact that the financial and technical capacity of Kyrgyzstan does not currently allow for the development and implementation of a project of this magnitude. Despite the fact that different international and donor organizations are presently bringing resources to the health sector to meet various needs, additional resources are required to coordinate these inputs and ensure that the delivery of the same create synergy for the health sector reform in that country. In addition, although a minimal amount of equipment not available in the country is required (eg, computer equipment and teaching materials) to develop the immediate objectives of the project. Again, this will require external assistance.

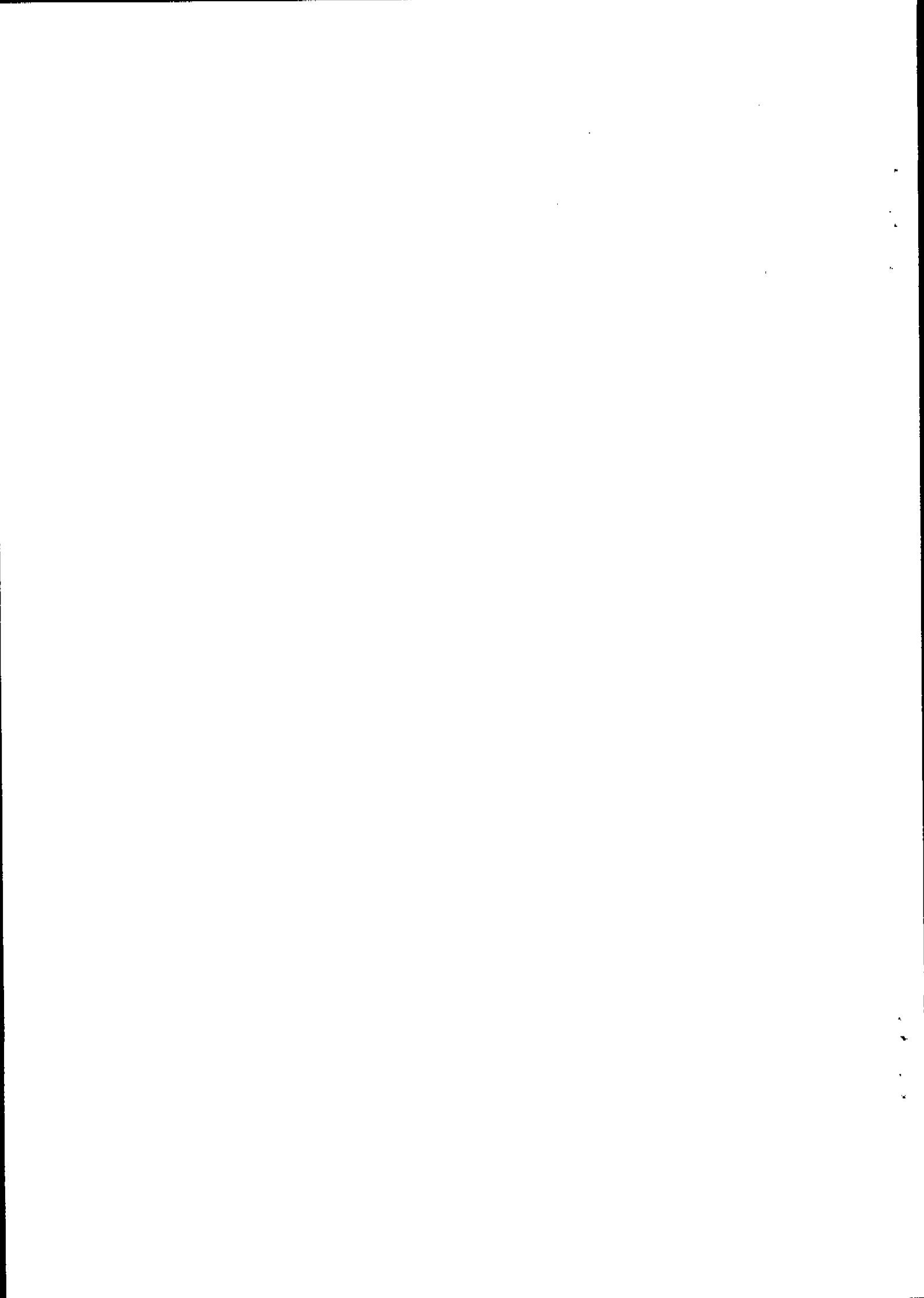
Resources to support technical assistance are not lacking. There are many international and bilateral technical cooperation agencies who are assisting or willing to assist Kyrgyzstan in the MANAS Health Project. These agencies include WHO, UNDP, World Bank, TICA, USAID, and ODA. There are also other agencies interested in the Kyrgyz health sector, such as GTZ, DANIDA, Swiss Red Cross, Dutch Ministry of Foreign Affairs, UNFPA, and UNICEF. The effective coordination of donor organizations would increase the impact of the assistance to Kyrgyzstan and will ensure preventing duplication of work while satisfying the country's needs.

¹ Consultant, Health Care Policies, World Health Organization, Regional Office for Europe, Copenhagen, Denmark

In relation to the MANAS Project, a Memorandum of Understanding was formalized between the Ministry of Health of Kyrgyzstan and the World Health Organization Regional Office for Europe (WHO/EURO). The terms of this document call for the assistance of WHO/EURO in a dual capacity: in an advisory role in health service policies, health sector reforms and management, as well as in assisting the Kyrgyz Ministry of Health to ensure the effective coordination of donor organization inputs to increase the impact of this assistance to the health care sector in Kyrgyzstan.

Annex E

Draft Document: Partners for Health



PARTNERS FOR HEALTH: NETWORK FOR HEALTH REFORM

Why a new network?

Many countries are in the process of undertaking ambitious reforms to achieve better health. The design and implementation of health reform entails difficult analysis of policy options and managing complex institutional change.

People implementing change face a number of problems. They feel isolated, lacking interaction with colleagues to help them solve difficult problems. They have limited access to information about current approaches to the many aspects of health reform. Often the required information is not available in time and in user-friendly form.

Overall, there is a poor match between the demand for and the supply of technical and financial resources for health. Achieving such a match is difficult, given the complexity of the reform process, the varied nature of requests and the often limited repertoire of available responses.

In order to address these problems, it is proposed to establish a network among partners in health reform at the local and global level.

The scope of the network

The basic mission of the network is to support people and institutions involved in implementing health reform. Specific objectives are:

- ▶ to improve access to information based on experiences of health reform, including comparative analysis of approaches to key issues;
- ▶ to support informed choice of approaches to health reform in countries;
- ▶ to develop, refine and promote utilization of tools and processes for health reform;
- ▶ to serve as a forum for advocating action for health reform in countries;
- ▶ to facilitate access by countries to technical and financial support, with emphasis on longer-term capacity building.

The network will address issues related to health development, health care, institutional and global change.

Examples of how it might work

1. The Ministry of Health in country X would like to know what the experience has been with decentralization in other regions. He/she sends off an electronic mail enquiry which is disseminated through the network. Responses are sent via E-mail or fax. The secretariat monitors the exchange, and if no responses are forthcoming, either provides information directly, or contacts members in specific countries to ask them to contribute their experience.
2. In conversation with a member of the secretariat of the network, a ministry of health official complains about the approach being taken by an international development agency in a project. The member of the secretariat channels that complaint to the relevant unit in that institution.
3. Field trials of new malaria vaccines are successful enough to warrant discussion of "what next"? The network forms a subgroup of interested parties. This working group clarifies the issues and options, and proposes a strategy for a collective response.

Network architecture

The network will consist of members, a secretariat and an advisory group.

Members

- ▶ Network members will be the owners of the network. They will be both users and providers of knowledge, technical and financial resources.
- ▶ Membership will be open to individuals acting in their personal capacity or on behalf of their institutions. The possibility of different types of membership with access to different types of information and support will be reviewed by the advisory group.
- ▶ Members must agree to adhere to the basic objectives of the network and observe the operating principles to be defined by the advisory group.
- ▶ Members must be accessible by E-mail or fax.

Secretariat

Functions

- ▶ Facilitate access to the network by individuals and institutions, especially in developing countries.
- ▶ Facilitate exchange of information between members.
- ▶ Provide access to information already available and easily retrievable.
- ▶ Support the production of information not currently available or available but not in user-friendly form.
- ▶ Act as intermediary among network members to ensure that requests for technical support receive appropriate responses.
- ▶ Monitor events which have a critical impact on countries' capacity to implement health reforms.
- ▶ Challenge current practices and directions which affect health reform and development and advocate change accordingly.
- ▶ Ensure adherence to the operating principles defined by the advisory group.

Structure

- ▶ The secretariat will consist of a small core technical and administrative support group to be established at WHO and of focal points (with their own administrative support) in the World Bank and UNDP.
- ▶ The secretariat, in carrying out its functions as described above, will draw on existing groups and networks, and, in some cases, create new working groups.
- ▶ Financial resources required for the secretariat and its activities will come initially from WHO, the World Bank and UNDP.

Advisory Group

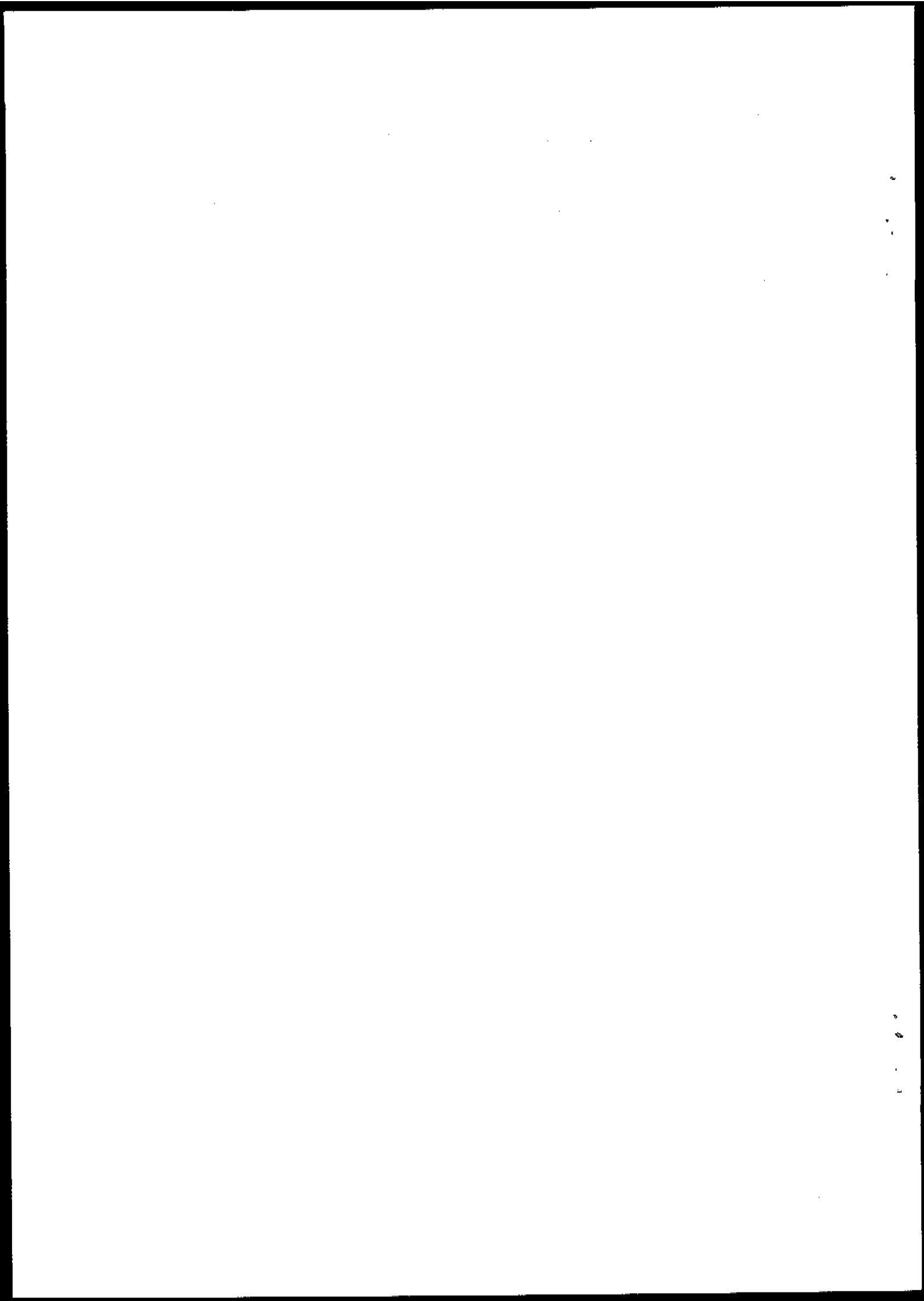
There will be up to twelve advisory group members. One place each is reserved for the core members (WHO, World Bank, UNDP). Other members will be elected by the network members from among themselves.

Advisory group members will:

- ▶ liaise with their own and other relevant organisations in the network to ensure appropriate institutional response to needs and requests emerging from the network members;
- ▶ develop guidelines on membership, access to information and other operating principles of the network;
- ▶ orient activities and review achievements of the network and the secretariat, including quality and timeliness of technical information and support.

Annex F

Outline of Presentation: Health Financing



EXPERIENCE WITH REFORM IN THE FINANCING OF THE HEALTH SECTOR¹
presented by Andrew Creese²

USER CHARGES AND ACCESS

Expected benefit: Money generated can be used to extend services to the poor

Experience: Potential equity gains not realized because

- fees dissuade poor persons more than rich
- income-based exemptions difficult to implement.

Lessons: Evidence of large and prolonged drop in utilization follow fee increase. Charging patients and using revenue to improve quality can raise utilization by poor (Cameroon) by reducing non-fee costs of access to care of acceptable quality.

- Must lower costs to users of access to effective care.
- Revenue retention at health facility or district.
- Management capacity to convert revenue/service quality.
- No evidence of workable exemption mechanisms.
- Costs of cost recovery.

USER CHARGES AND VALUE FOR MONEY/EFFICIENCY

Expected benefit: Consumers and providers will behave better

- frivolous use reduced
- cascading fees and by-pass charges to encourage appropriate use of referral system.

Experience: No evidence that reduced use is 'frivolous' (Canada)

- probable that non-fee costs of access are sufficient to dissuade "unnecessary" utilization in most developing countries

a) Consumers

No evidence of cascading tariffs improving referral system because of low quality at first contact level. Charges for STD treatment (eg, Ethiopia, Ghana, Jamaica, Mali, Niger, Zimbabwe) may be inefficient because of the external benefits associated with such treatment.

¹ Paper prepared by Joseph Kutzin, Health Economist Consultant

² Chief, National Health Systems & Policies, Division of Strengthening of Health Services, WHO, Geneva

b) Providers

China - fees important and costs relatively high - provider induced demand (drugs, CT Scans, ultrasound, renal dialysis.)

Drugs and demand - similar patterns of increase without evidence as to 'appropriateness'.

- Lessons:**
- Non-fee costs often high, but where these are low (urban areas) fees may have allocative role - though no evidence this is being effectively done.
 - Coordinated price signals (fees) should be part of a policy package to support referral; but pricing policy alone is not sufficient.
 - Decentralized management/budget in response to population - based care
 - Finland (not facility based) would help develop coordinated policies.
 - Need better evidence about institutional arrangements that facilitate efficiency

USER CHARGES - REVENUE-RAISING

- Experience:**
- National levels modest
 - Facility/local level higher and community finance can raise productivity
 - Willingness to pay for drugs, hospitals greatest
 - Costs of cost recovery underestimated
 - Marginal productivity gains from fee revenues can be high (eg, when used to purchase drugs)

- Lessons:**
- Revenue retention at collecting facility
 - Waste and inefficiency must be reduced to keep costs (and fees) down
 - Periodic adjustment - for inflation
 - Financial management/accountancy/audit/committees
 - Local banking
 - Fee retention does not automatically raise quality.

GENERAL LESSON FROM EXPERIENCE WITH USER CHARGES

Without other accompanying reforms, charging users of government health facilities is unlikely to lead to progress towards goals of equity and efficiency.

INSURANCE AND ACCESS/EQUITY

- Experience:** A number of countries (Germany, Japan, Korea, Canada) have secured universal access through insurance.

- Expected benefit:** Many claim that even in countries with small employment base, insurance could improve access for poor by "freeing up" government resources (insured use private care).
- Experience:** BUT: frequent capture of public subsidies by insured groups - double subsidy - Indonesia, Burundi - civil servants.
Rural prepayment schemes can address seasonal income fluctuation and thus reduce access barriers presented by user charges. But such schemes still exclude the poor who cannot afford to prepay.
- Lessons:** Mandate universal cover where feasible.
Limit cost-sharing by poor (although targeting is difficult).
Voluntary insurance leads to problems in ensuring access for poor. Effective regulation of private insurers depends on government capacity.
In poorer countries, insurance for formal sector workers has "generally led to greater inequity".
Rural prepayment can reduce influence of seasonal income variation, but sufficient management skills must be in place to implement this effectively.

INSURANCE AND VALUE FOR MONEY/EFFICIENCY

- Experience:** Allocation of resources between levels of care.
Effects of insurance on appropriate medical technology.
Allocation - expansion of insurance coverage in Brazil 1960-1980s led to decline in priority for prevention; the share of curative care rose from 36 to 85% of spending between 1965 and 1982.
New Zealand has slowed growth in hospital expenditure by integrating funding. "Service managers".
Technology/China: Most of the insured have no cost sharing - providers use profitable technologies. In Korea, competition based on perceived quality has led to a proliferation of technology. For example, there is a CT scanner in every hospital with at least 200 beds and more lithotripters than in Germany or Canada.
- Lessons:** Preventive/primary and secondary/curative care should be financed and managed by some single entity: "integrated service purchasing". Integrated service management steps taken in New Zealand, Hungary, Finland, many HMOs. Efficiency is made much worse by fee for service reimbursement. Gatekeepers - service manager needed to separate financial incentives to provider from decisions on treatment.

INSURANCE AND REVENUE-RAISING (SUSTAINABILITY)

Experience: Rapid expansion of insurance coverage fuelled cost increases (eg, Brazil, China, Korea, USA), especially when third party payers reimburse providers on a retrospective fee-for-service basis. Cost sharing can limit this, but even so, the Korean experience with co-payment at very high levels was still not sufficient to stem rapid cost escalation. Provider payment mechanisms vary: fee for service, daily rates, case basics, capitation, salary, budgets.

Lessons: Strong gatekeeper to limit access to referral services - provider focused incentives more effective than consumer based ones - make insuring institutions financially at risk.
Provider payment mechanisms - capitation - global budgets
Management capacity.

GENERAL LESSONS FROM EXPERIENCE WITH HEALTH INSURANCE

An array of institutional characteristics; not solely particular reimbursement mechanisms determines whether insurance will contribute to health objectives.

Strong role for government in setting rules.

Use market mechanisms for incentives for quality and cost containment, but avoid third party fee-for-service reimbursement.

If insuring institution is simply a financing intermediary, volume of services goes up; where insurer is also purchaser, cost may also be kept down.

Insurance should be considered a strategy for improving technical efficiency, not merely for raising funding.

PUBLIC FINANCE OF PRIVATE PROVISION: EXAMPLES

Contractual relationship.

Subsidy of not-for-profit providers.

PUBLIC FINANCE/PRIVATE PROVIDER AND EQUITY

Experience: Aim is usually to improve quality/quantity; no evidence that this can be used to improve equity.
But subsidies to NGOs - remote areas could be mechanized for maintaining access.

Lessons: Incentives for NGOs - equity conditions can be included in formal/informal contract.

PUBLIC FINANCE/PRIVATE PROVIDER: EFFICIENCY AND SUSTAINABILITY

Experience: Contracting of clinical services in USA has generated savings of up to 35%. Autonomy for some urban hospitals, but so far (eg, Zimbabwe, Burundi) no evidence of any impact on efficiency or cost containment.

Lessons: Competition for contracts necessary (contestability)
Establishing and supervising contracts needs skills (eg, to specify performance criteria).
Information systems.

CONCLUSIONS

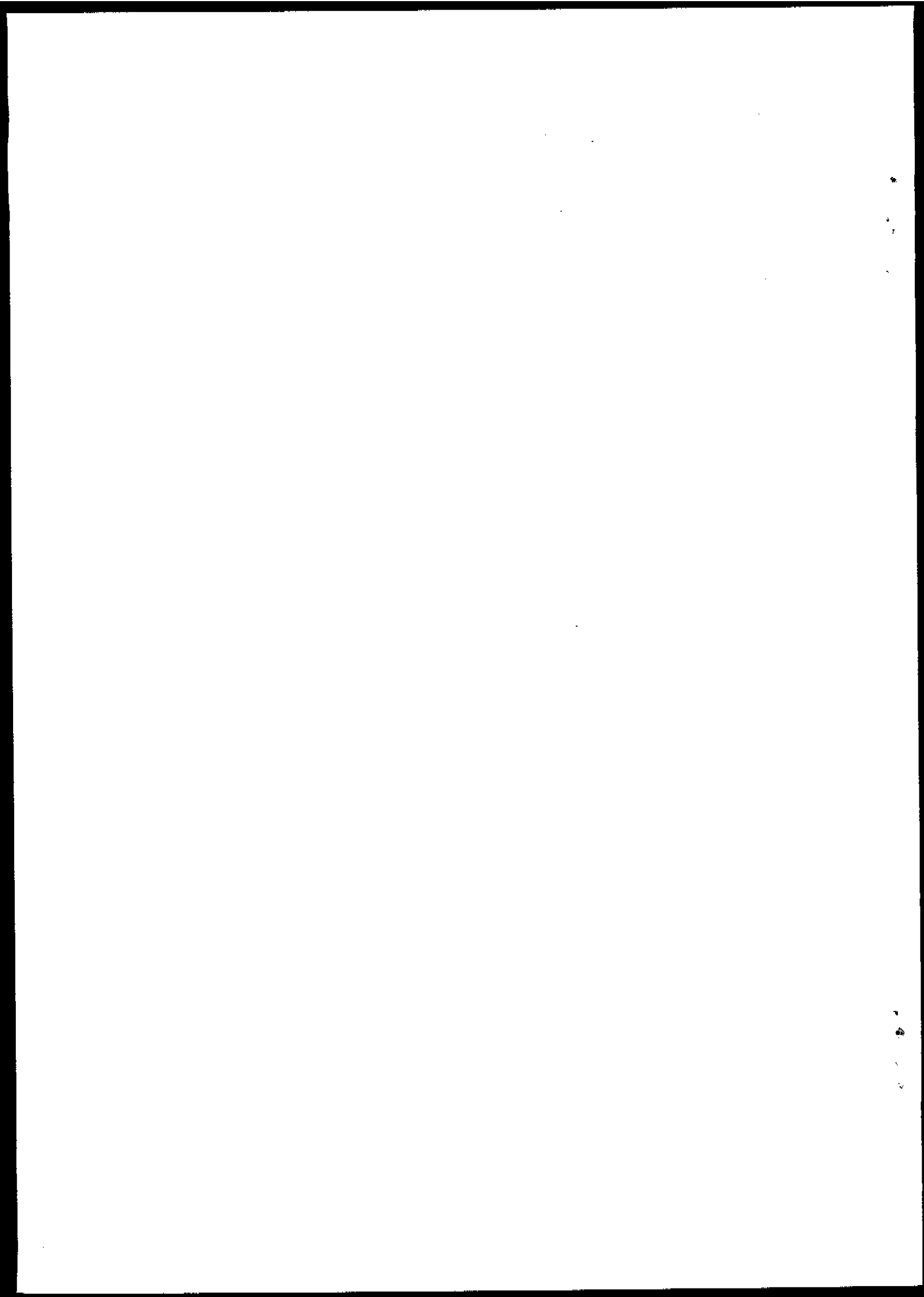
1. Partial role of financing - organizational/institutional issues matter, too (incentives).
2. Importance of government setting rules.
3. Focus of finance and organizational design on provider rather than consumer behaviour.
4. Trade-offs among objectives - quantify.

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3

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5
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Annex G

List of Participants



SECOND CONSULTATION ON HEALTH SECTOR REFORM

Geneva, WHO Headquarters, Conference Room M-605

28 - 29 April 1994

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