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Contents

- Executive summary** 1
- Introduction** 3
- Financing and payment reforms** 4
 - Resource mobilization 4
 - Resource pooling 5
 - Resource allocation 5
 - Payment and purchasing: private sector and public policy 6
- Organizational reforms** 9
- Human resources development** 10
- Achieving equity** 12
- Gaps in knowledge and priority research topics** 15
 - Financing and payment reforms, including public–private mix 17
 - Decentralization and organizational reforms 18
 - Human resources development 18
- Breakaway discussion groups** 19
 - Effects of health sector reforms on other priority health programmes: what can reproductive health learn from their experience? 19
 - Evidence and health sector reform: the role of health information systems 19
- Conclusions** 20
- Annex 1. Agenda 21
- Annex 2. List of participants 25
- Annex 3. Papers presented 31

Executive summary

Health sector reforms in almost every country are implemented as a means of increasing the effectiveness, efficiency, quality, equity and financial soundness of health systems. A great deal is known about the theoretical underpinnings of reform, and there is broad experience with the implementation of health systems. There are large gaps, however, in the empirical evidence base on the impact of many types of health sector reform, in particular concerning the effects of most reforms on reproductive health services and health outcomes. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction and the Department of Reproductive Health and Research (RHR) in the Family and Community Health Cluster of the World Health Organization (WHO) organized a high-level Technical Consultation on Health Sector Reform and Reproductive Health from 30 November to 2 December 2004 in Geneva, Switzerland, in collaboration with several departments from WHO's Evidence and Information for Policy Cluster, and with support from the MacArthur Foundation, in order to explore contemporary trends in reform and their effects on reproductive health services. Key topics, salient comments and important gaps in knowledge are summarized in this report. All papers and presentations are available at the meeting's web site: <http://www.who.int/reproductive-health/tcc/meeting.html>.

Financing and payment reforms, including public–private mix

In general, research on the *process of reform* is as important as studying effects related to output and outcome. A few examples drawn from the discussions illustrate this point.

- Many of the financing reforms discussed during the meeting are based upon new public management roles.
- Targeted action by civil society groups is required to ensure that priority-setting exercises and resource-pooling reforms adequately value reproductive health services.
- Public–private partnerships necessitate not only the development of administrative skills related to contracting for services, but also stewardship and regulatory oversight competencies required to ensure equity and quality in private practice settings. In each case, the process through which these actions are implemented is not clearly understood or documented.

Reforms related to *resource allocation* are an innovative area of work, but fundamental questions surrounding allocations to sexual and reproductive health services remain unanswerable in many settings today because mechanisms for tracking expenditure are under-utilised. Substantial advances in National Health Accounts reviews now need to be expanded into sub-account reviews for reproductive health. Definitions and standardized approaches to the collection and reporting of National Health Accounts results should be strengthened.

There is a pressing need to develop the evidence base on *payment reforms*. Different conceptual frameworks were presented during the meeting, including The World Bank's output-based aid and the Partners for Health Reform plus (PHRplus) models, which show promise for generating useful findings and guiding the design of reforms. Basic research on the magnitude and characteristics of the private sector (in general) and reproductive health (in particular) are needed in many settings, such as private sector assessments. More evidence is needed to develop understanding of the effects of contracting out on sexual and reproductive health services, concerning both supply-side and demand-side mechanisms. Integrating this research into an approach that strengthens government capacity to monitor contracts and regulate quality of care will substantially contribute to both the implementation of reforms and their evaluation.

The development of sustainable targeting mechanisms that ensure access by the poor and disadvantaged groups in the population to private sector reproductive health services is another understudied area. The study of equity has advanced considerably through the pro-poor focus of contemporary reforms, and the development of wealth quintiles has greatly increased understanding

of access to and use of health services. The meeting's discussions were directed towards expanding the measurement of equity, through the use of the benchmarks of fairness methodology and a new conceptual framework that maps the sociocultural dimensions of a country onto the functions of its health system.

Decentralization and organizational reforms

Decentralization processes highlight the effects of political influences, human resources development and local institutional capacity on the implementation of reforms. The decision-space approach to investigating the effects of reform on sexual and reproductive health is a promising area of enquiry and should be pursued. In addition to studying such questions as whether more local choice results in better programme performance, information on the process of constructing the decision space is required. For example, among the range of options within a decision space, which ones are favourable to sexual and reproductive health and how can they be influenced by local actors? Because decentralization processes are pervasive, research is needed on the interaction of decentralization and other reforms (e.g. those concerning financing and payment), with context-specific indicators included in the study.

Human resources development

The mounting crisis in human resources within the health sector is a cause for alarm worldwide. The consultation made this point forcefully. The principal research recommendation that emerged from the discussions is that the development of human resource impact assessments is a necessary element of any health sector reform initiative. Additionally, implications for human resources need to be explicitly incorporated into the study of reform's effects on reproductive health services.

Introduction

Health sector reforms in almost every country are implemented as a means of increasing the effectiveness, efficiency, quality, equity and financial soundness of health systems. Reforms have typically involved significant changes in the financing, payment, organization and regulation of health systems. A great deal is known about the theoretical underpinnings of reform, and there is broad experience with the implementation of health systems. There are large gaps, however, in the empirical evidence base on the impact of many types of health sector reform, in particular concerning the effects of most reforms on reproductive health services and health outcomes. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research (RHR) in the Family and Community Health Cluster of the World Health Organization (WHO) launched a new initiative to respond to this need for more information on health sector reforms. Such evidence will be used to guide the formulation and implementation of future reforms so as to maximize the positive results for reproductive health care.

One of the first substantive activities of HRP's health sector reform initiative was the organization of a high-level Technical Consultation on Health Sector Reform and Reproductive Health from 30 November to 2 December 2004 in Geneva, Switzerland. Conducted in collaboration with several departments from WHO's Evidence and Information for Policy Cluster, the meeting assembled approximately 70 leaders in the field of health sector reform and reproductive health from academic institutions in the United States of America, Europe and developing countries; donors including The World Bank, the United Kingdom Department for International Development (DFID), the Dutch Foreign Office, the German Technical Cooperation Agency (GTZ), the Swedish International Development Cooperation Agency (Sida) and the United States Agency for International Development (USAID); representatives from ten developing country governments and nongovernmental organizations; and officials from the United Nations Population Fund (UNFPA) and the International Labour Organization (ILO). The list of participants is reproduced as Annex 2. The meeting included several original papers, a synthesis of the findings from different global literature reviews, new perspectives from recent conferences on health sector reform and reproductive health and reports from countries drawn from each region of the world. These background papers and the presentations during the meeting were developed to focus on the following two objectives:

- to identify contemporary trends in health sector reform initiatives, including undocumented areas of effects and leading-edge interventions;
- to discuss key research issues, critical gaps in knowledge, and priority topics for better understanding the implications of reform for reproductive health programmes.

During the first two days of the consultation, a series of panels explored contemporary trends in reforms on the following topics: financing and payment; private sector and public policy; organization and decentralization; human resources development; equity and its measurement; and existing evidence on the effects of reform on reproductive health. The agenda is reproduced as Annex 1.

Three round-table discussions were organized during the third day, which covered the following topics: (i) sustainable financing, (ii) the effects of health sector reforms on the Millennium Development Goals (MDGs), and (iii) the role of health information systems. This report presents a summary of each paper and the discussions that were stimulated by its presentation during the meeting and highlights key topics, salient comments and important gaps in knowledge. Inevitably, the report will exclude the full range of topics and omit information contained in the original papers: readers are referred to the meeting's web site, where all papers and presentations are available: <http://www.who.int/reproductive-health/tcc/meeting.html>. The insights from the round-table discussions are also summarized. The results from the round table on sustainable financing are

¹ The term "reproductive health" is used in this report as shorthand for "sexual and reproductive health".

integrated into the summary of the meeting's session on financing and payment reforms, while the feedback from the other two round tables is presented in the closing section of the report.

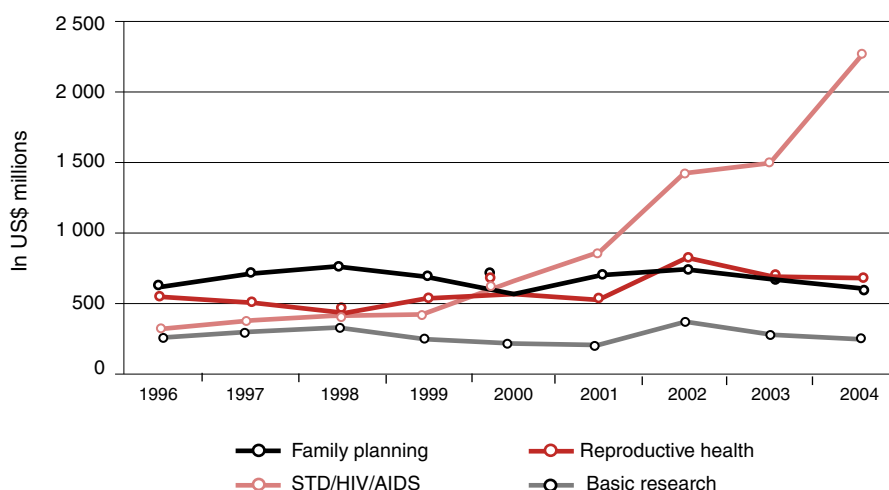
Financing and payment reforms

Financing and payment are central functions for any health care system, and they figure prominently in reforms worldwide. Deconstructing the term *financing and payment* reveals four different functions that every health system carries out but will organize differently (in response to its specific institutional structures). The interaction between the specific aspects of each financing and payment function also reflects the organizational context, making comparisons of different reforms across sites or even across institutions difficult. Shorthand terms, such as social health insurance, appear in the literature and discourse and add to the confusion. Peter Berman clarified definitions and set out a now well-established framework for organizing the meeting's discussion of financing and payment reforms, based on the following functions: resource mobilization, resource pooling, resource allocation, and payment and purchasing.

Resource mobilization

The emergence of new international funding sources (e.g. the Global Fund to fight AIDS, Tuberculosis and Malaria), new private foundations (e.g. the Bill and Melinda Gates Foundation) and major bilateral initiatives (e.g. the United States President's Emergency Plan for AIDS Relief, PEPFAR) have mobilized significant new resources for health, even if not entirely at the level that was promised or planned. Evidence on the global effects of these funds on reproductive health reveals that the increases have almost entirely been accorded to HIV/AIDS activities, and (at the aggregate level) may have resulted in a small reduction of external funding for population and reproductive health (see Figure 1). The effects of these different sources of external assistance on national reproductive health programmes and outcomes are largely unknown, partly because of the limited ability to analyse government expenditure on reproductive health.

Figure 1 Expenditure on ICPD-costed population-package categories, 1996–2004a



^a Data for 2003 and 2004 are estimates

Source: <http://www.resourceflows.org/index.php/articles/c78>

Because of the severe constraints on government spending in low-income countries, little improvement in the amount of funds for sexual and reproductive health programmes can be anticipated in these settings. Reforms in public financing initiatives in poor countries generally have been of small scale and community driven, with very little evidence on how these increased resources have affected reproductive health outcomes. In middle-income countries, public financing initiatives (such as social health insurance schemes) have expanded the amount of resources available for health care, including reproductive health. Overall, the evidence base on how domestic resource mobilization efforts have improved the availability of resources for reproductive health is limited; more work is required on country-level expenditure tracking to answer this question.

Resource pooling

The high burden of out-of-pocket spending on health in many countries reflects a disorganized pooling of resources that negatively affects progressivity, increases the number of people with catastrophic expenditures and contributes to impoverishment. David Evans' comments drew attention to the stated goals of WHO financing policy which are oriented towards achieving universal coverage that will prevent or minimize these effects. The realization of a universal coverage policy takes time to develop and is very much a work in progress for many countries. Reforms in the Commonwealth of Independent States (CIS) were presented by Ainura Ibraimova and Joseph Kutzin to illustrate how the elimination of pool fragmentation has played an important role in reform efforts designed to scale down health systems while improving access. For example, data from Kyrgyzstan were presented during the meeting to show how increased utilization rates of primary care services were accompanied by decreased rates of hospital admissions. However, these promising results are not linked to reproductive health services. The social insurance programme in Mexico was also discussed, showing how insurance packages combine together to create circumstances promoting universal coverage (see Table 1). Finally, it was noted that in many settings, innovations with resource pooling have been hampered by weak public-sector management and resource constraints.

Table 1 New structure for universal financial protection in Mexico

Public insurance scheme	Contributions			
	Beneficiary	Co-responsible contributor	Federal government	
IMSS (private sector, salaried employees in the private sector)	Employee	Private employer	Social contribution	
ISSSTE (salaried employees in the public sector)	Employee	Federal employer	Social contribution	
Popular health insurance (non salaried workers, self employed and families outside of the labour force)	Family	Solidarity contribution		Social contribution
		State-level government	Federal government	

Source: Matus CR. *Sustainable Financing for Reproductive Health in the Context of Health Sector Reform. The Case of Mexico.* Presentation at the Technical Consultation on Health Sector Reform and Reproductive Health. WHO, Geneva, 2004.

Resource allocation

Peter Berman noted that, in contrast to the slow pace of innovation in resource mobilization and pooling, important reforms related to resource allocation have been observed in many countries. Three dimensions were developed in his paper: functional allocations to and within reproductive health, allocation reforms related to decentralization, and distributional allocation strategies to reach the poor. Although substantial progress has been made with National Health Accounts (NHA) reviews, progress with reproductive health sub-account reviews has been slower. In part this is because of definitional complexities of reproductive health services (as opposed to other services), in addition to other difficulties such as failures to classify expenditures by function consistently over time. Thus, fundamental questions on whether countries are actually increasing their allocations on reproductive health or how the government's share is changing within an overall pattern of resource allocation for reproductive health remain largely unanswerable. Reforms that affect the distributional allocation of health resources are attracting increased attention, as analytical methods have highlighted socioeconomic and gender differences in health-related outcomes. The development of allocation mechanisms, however, including the means to periodically identify the poor, have lagged behind the development of analytical methods that measure equity.

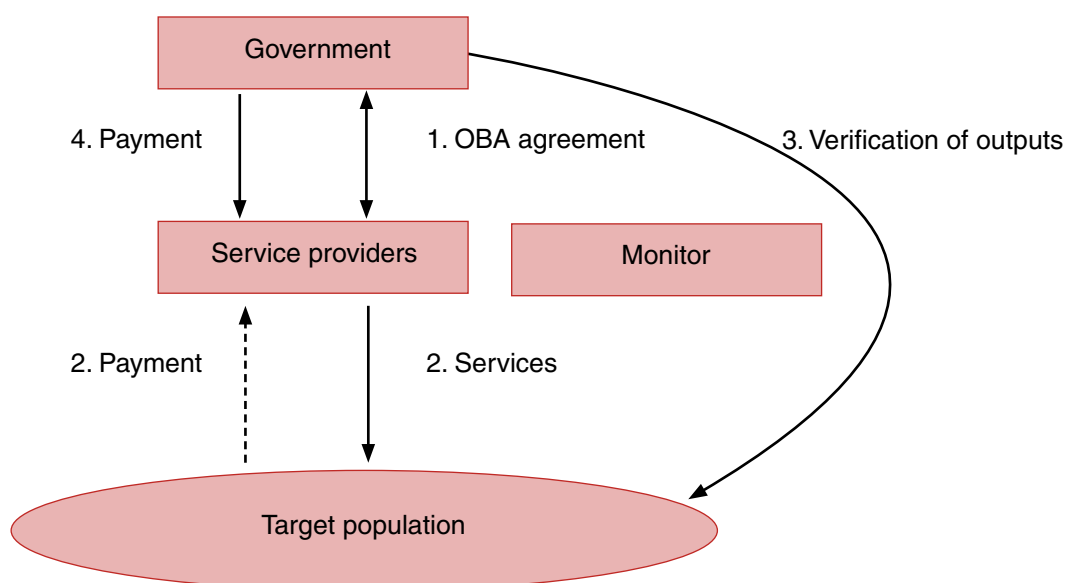
Payment and purchasing: private sector and public policy

Financing and payment reforms related to expanding the mix of public and private health services have received a great deal of attention in recent years. Chiaki Yamamoto's paper reviewed the history of this area, noting that it represents an expansion into the health sector of reforms undertaken in other areas that separated public sector financing from provision (e.g. energy and transport). Experience from developed countries with new forms of public sector management of health services is also influencing the introduction of these reforms. Groups engaged in promoting reforms that separate financing from provision point to the slow progress made by the public sector in delivering health interventions proven to be effective and affordable. Inadequate public provision has caused large segments of the population in many countries (including the poor) to utilize private-sector providers, increasing the amount of out-of-pocket spending on health care and raising concerns about progressivity and quality. The meeting explored this important area of reform in some detail, principally focusing on a conceptual organization for contracting-out services. Attention was then turned to the existing evidence base supporting the several assumptions that underpin the movement towards diversifying the role of the public sector, and identifying areas of particular importance for reproductive health.

Output-based aid (OBA) is the delegation of service provision responsibilities to a third party under contract, and ties disbursement of public funding to services or outputs actually delivered (see Figure 2). Originally developed in the energy and transport sectors, OBA models are being applied to designing health sector reforms worldwide. Chiaki Yamamoto identified four potential contributions of OBA:

- The design process of the OBA approach forces government to clearly specify outputs, not inputs, for the allocation of public funds.
- By tying disbursement of public funding to specific outputs, the OBA transfers performance risks from the government to service providers.
- The link between disbursement and outputs provides stronger incentives for innovation.
- OBA can be used to mandate service quality standards and, through contractual monitoring processes, strengthen the regulatory oversight and stewardship role of the public sector.

Figure 2 Output-based aid in development



Source: Yamamoto C. *Output-based Aid in Health: Reaching the Poor through Public-Private Partnership*. Washington, DC, The World Bank, 2004.

There are a number of design issues in the successful application of OBA, despite its conceptual simplicity. Although results-oriented budgeting processes guide the approach, the amount of funds needs to be balanced with considerations of affordability and positive externalities. The identification of the funding source and channels for ensuring the flow of funds are critical, particularly in settings where the government is perceived to have weak payment capacity. The prioritization of beneficiaries and procedures for identifying the recipients of any subsidized services are a central element of contracts. For example, payments to ensure demand (e.g. vouchers) may work better than supply-side contracts for some reproductive health services. A key element in all cases is government willingness to accept experimentation with innovative financing and service delivery processes.

The monitoring function (to ensure that payments are linked to achievement of performance indicators) and the development of other contractual management and administrative functions can be new roles for government. An introductory period can be anticipated, during which time various bottlenecks and other constraints to implementation can be anticipated. In fact, the possibility of high transaction costs associated with contracting out a service may override the potential benefits, particularly if government capacity to manage this new role does not develop quickly. Other pitfalls of contracting out include the low contractibility of many health care services (because of their inherent complexity, limited competition and high asset specificity).

Christopher Allison's commentary drew attention to the importance of accountability and trust in the development of functional public–private partnerships (see Box 1). The transition to new partnerships between public and private sectors can be difficult, reinforcing misgivings and inhibiting further development of OBA initiatives. From this perspective, the importance of credible monitoring systems extends beyond oversight of the contract's outputs and contributes to better accountability vis-à-vis the public and donors.

The paper by PHRplus, presented by David Hotchkiss, provided the meeting with a conceptual model for the evaluation of contracting out programmes (see Figure 3) and an extensive review of the existing evidence base on the impact of contracting out health services. This review indicated that, in general, insufficient evidence exists for drawing firm conclusions on outcomes related to equity, quality and efficiency of health care services delivery. In part this can be attributed to a lack of methodological rigour in studies on contracting out of health care services, as the literature is dominated by donor-sponsored papers and reports. The literature is replete with reports that employ an incomplete selection of indicators and study designs inappropriate for demonstrating attribution of effects. Very few external evaluations of the OBA approach are reported.

Box 1 Accountability

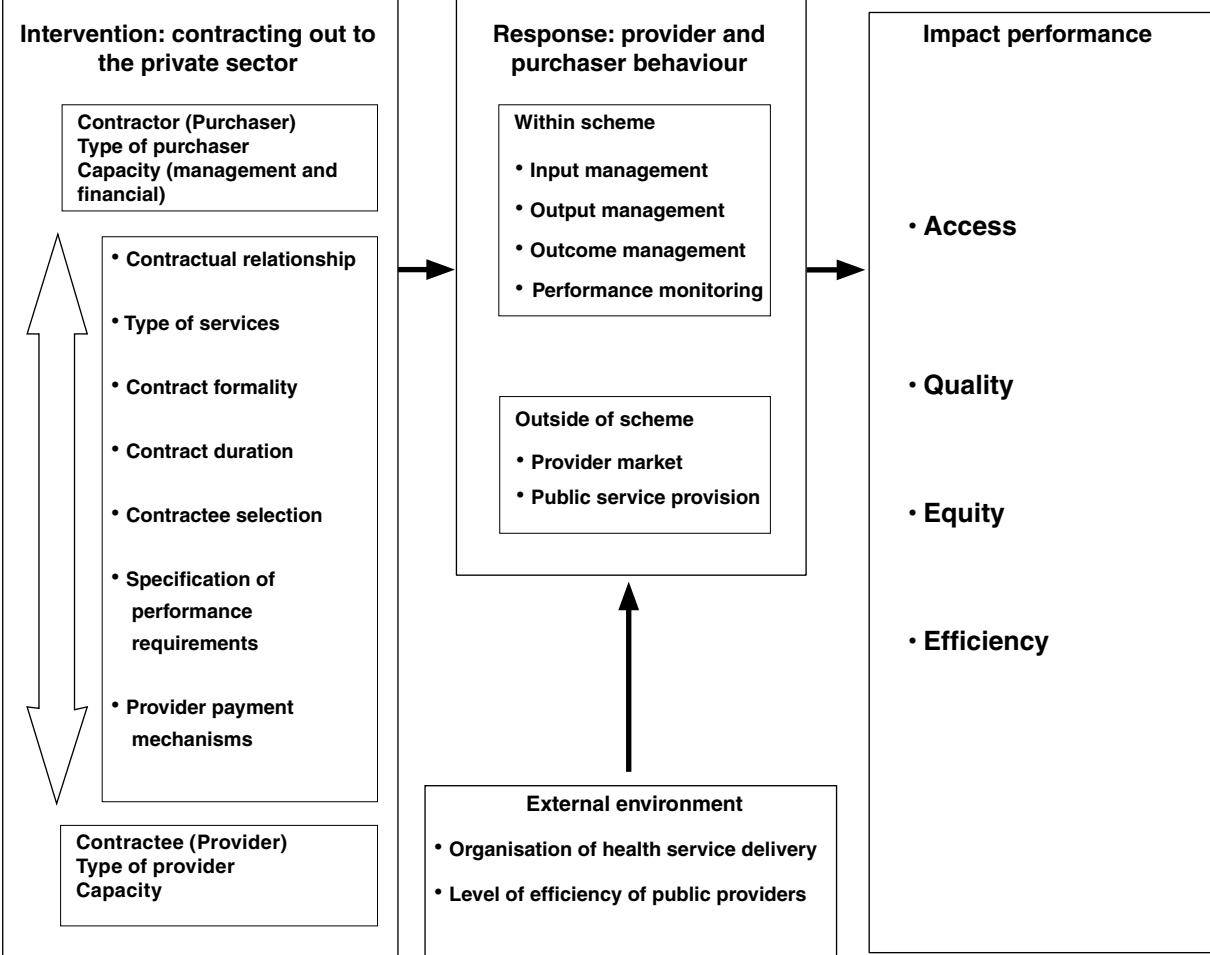
Accountability in the provision of reproductive health services can be addressed by examining three dimensions. Whereas much attention has been paid to operationalise and evaluate the accountability pressure between policy makers and service providers, few effective mechanisms exist to hold policy makers accountable to people. Democratic elections are not always effective in opening channels for accountability promoting reproductive health, since it is not always considered a “vote winner” (compared to other economic and social issues). Information asymmetries also hinder the development of accountability. Despite the high rate of out-of-pocket spending for health services by the poor, service providers are not accountable to these patients, in part because the poor are *unable to make choices of where to seek services*.

Source: Comments by Christopher Allison.

Not all of the research on contracting out of health services is of limited value, however, and the PHRplus paper carefully identified those studies from which sound conclusions can be drawn. There is substantial evidence that contracting out primary health care services can increase access to these services by increasing their provision, utilization and coverage. However, the impact of OBA model reforms on outcomes related to equity, quality or efficiency is less conclusive. From the available literature, it appears that contracting out health services has the potential to improve

equity in both access and financing if poor people and the services that benefit them are well targeted. There is a dearth of comparative studies, so no conclusions can be drawn as to whether private providers are better able than public providers to improve equity.

Figure 3 Framework for evaluating primary health care “contracting-out” initiatives



Source: Liu X et al. *Contracting for Primary Health Services: Evidence for its Effects and a Framework for Evaluation*. Partners for Health Reform Plus. Bethesda, 2004.

Similarly, there is little evidence showing the relative advantage of the private sector to provide better quality services than the public sector, partly because of the difficulty in measuring quality of care. The PHRplus review noted several limitations in the literature on the effects of reform on quality of care, including the absence of comparison groups and an incomplete or undefined range of indicators. In settings where quality has been well defined, with appropriate indicators included in the contract, and where there is well-documented association between use of the contracted health services and health outcomes, contracted-out projects have improved quality and outcomes. These studies are relatively few and do not include reproductive health services.

Interestingly, the PHRplus paper concluded that very little evidence exists on the impact of contracting out on efficiency. Few studies have examined this outcome directly as most evaluations report on improvements in access as a result of the contracted service. The impact of contracting out on efficiency is suggested by results that show that contracted providers deliver services at lower unit cost than their public sector counterparts, or that the contractor was able to deliver health services effectively given a similar level of resources. These findings suggest efficiencies with contracting out primary health care at both the provider and the health system level, a conclusion

that should be interpreted cautiously as other studies indicate that contracted services can actually be more costly than direct provision. Most studies do not provide information on the actual costs of managing the contracted services or other expenses such as the government's transaction costs. In addition, the PHRplus paper noted that there has been little effort to conduct cost-effectiveness analysis of contracting-out initiatives. The comparative efficiency of private versus public health care sectors is, in general, an understudied area of health services research – despite widespread assumptions regarding the efficiency of the private sector.

The material presented in this session and the meeting's discussions reflected the vibrancy of this area of health sector reform, as well as the many unknown factors. The generalized lack of hard evidence (with notable exceptions) is hindering the development of these reforms and is a source of much debate. Broader issues concerning the development of effective regulatory procedures were not explored in detail during the meeting, but do constitute an essential element of successful public–private mix initiatives.

Organizational reforms

During this session, discussion focused principally on decentralization, with reference made to integration and reorganization of ministries of health (topics that were also examined later in the context of human resources development). Decentralization has been a major reform initiative in many countries throughout the world, often involving several ministries in government-wide reforms or broader public-sector management change. For this reason, the point was made that studies responding to the question of whether decentralization should or should not occur are less relevant than are studies on the best management of decentralization processes. For example, Azrul Azwar reported how the decentralization process in Indonesia is a driving force behind the health sector's paradigm shift towards developing a stronger community-based primary health care programme. The Indonesian Health Development Programme is working through the government's broad decentralization policy to achieve the objective of reducing disparities in health status and human development between provinces and districts in the country.

The study of decentralization processes and effects is extraordinarily complex, reflecting the broad range of influences and determinates that emerge, as conceptual models are constructed to describe the outcomes. Tom Bossert's paper explored two major approaches to decentralization of health systems: public administration and decision space. Through the use of the well-known four-fold typology of different forms of decentralization (deconcentration, devolution, delegation and privatization), the public administration approach identifies different patterns of who gets new responsibilities, authority and powers from the organizational reforms.

The public administration framework is contrasted with a decision-space approach to understanding decentralization, which analyses the functions and range of choices available to decision-makers at each level of the administration. This analysis answers the questions of what functions and how much power are transferred. Based on the principal–agent theory, the decision-space approach can be used to analyse the dynamics of how specific objectives as established by a principal (either an individual or an institution) are implemented by different agents. From this perspective, the ministry of health can be viewed as the principal who sets the reform objectives of efficiency, equity, quality, client responsiveness and sustainability. Local authorities are the agents who receive resources to implement the reforms. This framework captures the interactions between the local authorities and the centre's policy-makers, and the range of choices available to each party.

The decision-space approach builds on the principal–agent theory to distinguish two mechanisms that central authorities can use to influence the choices of local officials: (i) rules that define the choices open to the local authorities, and (ii) incentives that encourage the desired actions to be made. Although decentralization inherently implies the expansion of choice at the local level, the amount of choice will vary depending upon the issue and the setting. The space within which that choice operates is called the decision space and it can be characterized as being narrow, moderate or wide (depending upon the latitude available to the local agent in defining how to implement the

principal’s objectives). By examining a set of key programmatic functions over which local officials have a defined range of discretionary authority (e.g. finance, service organization and human resources) the decision space can be used to identify constraints to implementation related to the decentralized management structure (see Table 2). Tom Bossert laid out the conceptual guidelines for constructing a study using this model to assess the impact of decentralization on reproductive health services.

Table 2 Map of decision space

Functions	Range of choice		
	Narrow	Moderate	Wide
Finance Sources of revenue Allocation of expenditures Income from fees and contracts			
Service organization Required programmes/norms Hospital autonomy Drug supply and logistics systems Insurance plans Payment mechanisms to institutions Contracts with private providers			
Human resources Salaries Contract staff Civil service			
Access rules Targeting			
Government rules Local elections Facility boards Health offices Community participation			

Source: Bossert T. *Organisational Reforms and Reproductive Health: Decentralisation, Integration and Organisational Reform of Ministries of Health*. Harvard School of Public Health, 2004.

The comments by Mushtaque Chowdhury and U Than Sein and ensuing discussion drew attention to the conflicts that can occur when some functions are decentralized and others remain centralized, and also how influences other than centrally directed rules and policies act upon the decision space of local officials. This is particularly the case in highly devolved settings where local branches of government have received wide authority and responsibility for health programmes (e.g. municipal governments). In such settings, the definition of principal is expanded beyond the central ministry, and the dynamics of various influences upon the local agents become multi-directional. Analysing the forces that act to either expand or contract the decision space, so as to identify characteristics that facilitate or impede the implementation of reproductive health programmes in highly decentralized settings, is leading-edge research on the effects of decentralization on health care programmes.

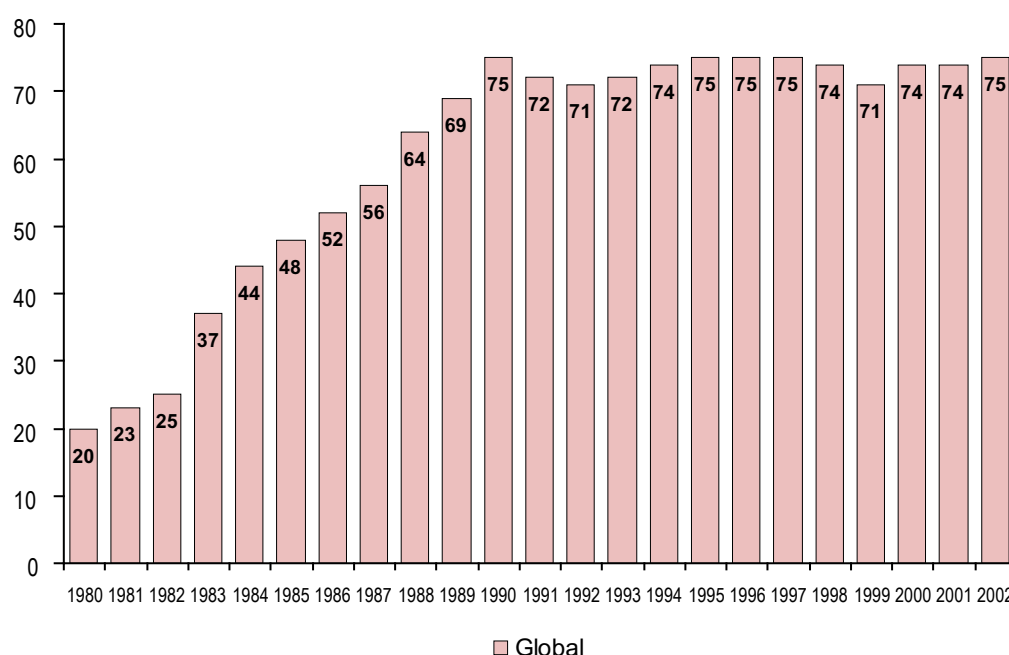
Human resources development

Health care delivery is labour intensive: personnel costs account for the major part of recurrent expenditure in health systems worldwide, so any change that is introduced to a health care system will necessarily involve changes in the deployment of human resources. Reforms that seek to improve the quality of clinical services, prioritize health services, alter financing and payment mechanisms and work through increasingly decentralized management structures will intersect

with ongoing crises of a depleted and, in many settings, dispirited workforce. Whether or not the reforms resolve broader human resources development questions or aggravate problems is critically important. The paper by David Sanders and colleagues explored these and other matters, such as the brain drain phenomenon that is depleting the health sector’s human resources in many countries. This report draws out some of the implications for human resources development in three areas of reform: efficiency, public–private mix and decentralization.

In many settings, health sector reform initiatives have focused on selecting the most efficient package of services that responds to the health care needs of the population. The long-standing trend towards prioritization of services, as in the selective primary health care associated with the child survival programmes of the 1980s, continues to motivate health planners in the 21st century. Health sector reform efforts in many settings use cost-effectiveness analysis (CEA) and disability-adjusted life years (DALYs) to set priorities, though these methodologies have been shown to undervalue reproductive health services, including maternal care. David Sanders discussed several implications for human resources associated with priority-setting actions, illustrating them with examples from Africa to show how narrowly conceived interventions have contributed to the erosion of local capacity to plan and manage comprehensive health services. Besides having negative effects on human resources development, categorical interventions have diminished gains made in primary health care in many settings. He cited the example of how increases in global immunization coverage for DTP3 flattened out in the 1990s, as the prioritization of primary health services took effect (see Figure 4).

Figure 4 Global immunisation 1980–2002, DTP3 coverage



Source: Sanders D, Ferrinho P. *Health Sector Reform: Some implications for human resources*. Presentation given at the Technical Consultation on Health Sector Reform and Reproductive Health, WHO, Geneva, 2004. WHO/UNICEF estimates 2003.

The profound implications of decentralization processes for human resources in most settings have impeded the progress of reform, as staff struggle with the new roles and responsibilities that accompany the transfer of resources, functions and authority. In part, these problems may be the result of poor planning for the introduction of decentralized procedures, or caused by shocks associated with abrupt macroeconomic or governance change. The lengthy period of administrative instability associated with decentralization in many settings has created conditions

of “transformational fatigue”, as staff become frustrated with continual change and the incomplete introduction of new procedures and policies. In her comments, Susan Maybud reported on evidence gathered by the International Labour Organization (ILO) that shows how the administrative instability of prolonged transformations can exacerbate already difficult working environments. For example, 25% of all workplace violence occurs in the health sector, which is particularly troubling given that this workforce is dominated by women. Increased efforts are required to initiate dialogue between government and health workers to improve working conditions, even in settings where regulation limits collective bargaining. The meeting’s discussions drew out examples of how health worker motivation is a complex challenge and difficult to deal with, because it is multifaceted and context-bound. The existing evidence base is largely anecdotal, and systematic studies of the different dimensions of health worker motivation are needed.

Central management systems have been slow to react to decentralized processes, only partially devolving their functions related to human resources. For example, the responsibility to carry out tasks has devolved to local managers but the authority over key functions such as salaries, recruitment or disciplinary procedures remains centralized. A holistic definition of capacity development includes all four functions: responsibility, authority, control over resources, and possession of the requisite knowledge and skills. David Sanders’ presentation suggested that health sector reforms too often focus on developing legal frameworks, administrative structures and technical skills, and not enough on developing the human resource skills associated with their implementation. Developing local leadership and management capacity was emphasized (see Box 2), and comments by Mario Dal Poz included reforming the regulatory environment governing the health sector’s human resources. More evidence from effective interventions is needed, particularly in view of the challenges associated with new forms of public management that accompany many reforms.

Box 2 Leadership, oversight and training

Leadership at the local level is critical for a well-functioning health system and decentralisation of management functions should be accompanied with the necessary training and capacity building of health facility managers. Governments need to pay more attention to training on leadership and oversight in medical schools since doctors are often the managers of health facilities. Management training should be accompanied with social and economic incentives to improve recruitment in rural areas.

Source: Comments by Malik Afzali.

The growth in private health services is having dramatic effects on human resources development, including brain drain and dual practice among public sector providers. Negative effects of dual practice include the development of predatory behaviour (self-gain pursued to the detriment of patients, services or colleagues), conflicts of interest, absenteeism in the public sector, and redirection of publicly provided diagnostic and therapeutic resources to private practice. Innovative solutions have been found to mitigate these negative effects where reform

has explicitly focused on dual practice. For example, in some settings, policies that permit dual practice have resulted in high public-sector retention of skilled professionals, offsetting trends of brain drain from the public sector to purely private practice. Research on dual practice is necessarily highly context-specific, and additional studies are needed that provide in-depth descriptive analysis from which implications for cross-cutting issues can be drawn out. Too often, case study reports on dual practice provide limited contextual information, constraining in-depth analysis of the findings.

Achieving equity

The goals of health sector reform and reproductive health programmes clearly converge on equity. Gender equity is emphasized by the ICPD Programme of Action and has been championed by reproductive health programmes for decades. Within the health sector reform field, the measurement of equity-related outcomes has developed in response to the pro-poor focus of development assistance: index scores based on wealth, categorized into quintiles, reveal striking disparities in access to and use of health services and health outcomes. Building on the history of gender-related research from reproductive health programmes worldwide, the papers presented

in this session urged studies of reform to go further into the measurement of equity, broadening its conception beyond income and assets.

Jeanette Vega presented a paper written with colleagues in the Health Equity Team of WHO that placed the discussion of measuring equity within a health systems model (see Box 3). This paper views health systems as a special category of a larger social system, characteristics of which will govern the structure and functioning of the health services. The four key functions of a health system identified in The World Health Report 2000 – Health systems: improving performance (service provision, resource generation, financing and stewardship) are mapped onto four other dimensions that capture critical influences on equity: sociopolitical characteristics, economic development, health status level and social determinants of health. The resulting bi-dimensional matrix that crosses the four key functions of a health system with each of the four key societal influences is proposed as a useful conceptual framework for deepening our understanding of health system performance – particularly for equity-related determinants and outcomes.

An example of how this matrix can assist in narrowing the field of enquiry and deepening the analysis of equity within reforms is given by examining the interactions of the health system with sociopolitical influences: the underlying social values and political organization of a country will affect each of the four functions of its health system in unique ways. In societies that are characterized as being highly individualistic, the state will assume minimal responsibility for individual welfare. In contrast, state responsibility for the individual will be broader in societies with high communal values and dense social capital.

The stewardship function will also be quite different in each of these settings. Silvia Salinas Mulder's comments expanded upon this point, discussing how the social and cultural construction of sexual and reproductive health makes assessments of equity-related outcomes particularly context specific.

Jeanette Vega's presentation drew attention to the pitfalls of making cross-national comparisons using this approach, because of the importance of local historical influences on the development of the social system in a country and the organization of its health system. Pursuing this line of enquiry further, the paper discussed how certain health system impact indicators of equity may be more closely related to the historical development of the society and health system than to actual performance at a specific point in time. This raises the question of what is a reasonable level of impact that any health sector reform can have on equity, particularly in the absence of larger movements within a society towards improvements in equity and social justice.

Cultural barriers to gender equity were discussed by Silvia Salinas Mulder. An unresolved tension exists in many settings between preserving cultural traditions and the movement towards greater gender equity. This dynamic is most likely to be expressed in reproductive health care, and study on the impact of health sector reforms on equity within the reproductive health field must be cognizant of these larger forces that act upon, or constrain, the improvement of equity.

Box 3 Evaluating equity in health systems

The monitoring and evaluation of equity performance of health systems should focus on health outcomes and how reforms affect the most vulnerable and socially excluded groups. However, the exclusive use of outcome measures is insufficient and studies need to include intermediate and process indicators to better advantage, particularly with respect to measuring equity

All dimensions of the health system functions should be addressed including stewardship, resource generation, financing and service delivery and organisation of resources. The contexts in which health systems develop must not be absent from the analysis

Given that persistent health inequities are primarily rooted in the influence of social and environmental determinants of the population, monitoring of interventions for the achievement of equity should not be limited to the health sector. Exogenous influences from other sectors, such as education, labour, social security, transport, should be considered for a more comprehensive understanding of how equity is improved by reform.

Source: Solar O, Irwin A, Vega J. *Equity in Health Sector Reform and Reproductive Health. Measurement Issues and the Health Systems Context*. WHO, 2004.

Norman Daniels and Walter Flores presented the “Benchmarks of fairness” approach to conceptualizing and measuring health systems performance on equity-related outcomes. This analytical framework designed to assess the overall fairness of health sector reforms – originally developed within the context of evaluating health insurance reforms in the United States during the first Clinton administration – has been used in several developing countries for a variety of purposes related to improving national capacity to deliberate about health care reform efforts.

Fairness is a broad ethical term that has much to do with social justice and is conceptualized by this method through three dimensions: equity, efficiency and accountability. Nine benchmarks are specified, each covering a main goal of fairness in health system performance and design.

Benchmarks of fairness indicators

	Benchmark	Dimension of fairness measured
1.	Intersectoral public health	Equity
2.	Financial barriers to equitable access	
3.	Non-financial barriers to access	
4.	Comprehensiveness of benefits	
5.	Equitable financing	
6.	Efficacy, efficiency and quality improvement	Efficiency
7.	Administrative efficiency	
8.	Democratic accountability and empowerment	Accountability
9.	Patient and provider autonomy	

Source: Daniels et al. *Benchmarks of Fairness for Health Care Reform*. Oxford University Press, June 1996.

Five benchmarks capture different aspects of equity, two focus on clinical and administrative efficiency, and two examine accountability and autonomy. Emphasizing the point made by Jeanette Vega, Norman Daniels stressed that the benchmarks are not intended for cross-country comparisons, because local contextual factors will influence the scoring criteria for each benchmark. The scores that result from an assessment using these benchmarks are intended to reveal the complex pattern of the effects of reform on fairness and to provide a tool for understanding changes over time for each aspect of fairness tapped by the nine benchmarks. Accordingly, there is no attempt to rank the nine benchmarks for their importance, nor is an overall index score produced.

Benchmarks of fairness constitute an analytical methodology, not a prescriptive reporting plan. The adaptation process of the generic benchmarks is a critical step in the application of the methodology. Walter Flores discussed this process in reference to work done in Guatemala and Mexico: in both settings, the studies worked through a series of consultation meetings that involved a broad range of stakeholders. An evidence-based process reached consensus on specific indicators for each benchmark and scoring rules for assessing the fairness of each. A range of possible, illustrative indicators is available to guide this process, but ultimately the final selection depends on local conditions and purposes and includes consideration of existing data sources: the analysis relies on secondary data analysis, meta-analysis and literature review techniques to as large an extent as possible (even exclusively). A critical element of the development process in both sites was achieving broad agreement on how to evaluate changes in the indicators for each benchmark.

Jane Cottingham’s comments drew attention to the importance of internationally recognized legal agreements that encode agreed definitions and standards of human rights, and specify a number of reproductive rights. These covenants and treaties provide a basis for holding states accountable,

and cut across discussions of cultural relativism and avoiding cross-national comparisons. Such a human rights analysis was suggested as a tool for assessing how health sector reforms comply with underlying legal frameworks supporting equity. Points brought up in the discussion noted that aspects of the rights-based approach to assessing the impact of reforms are included in the equity measures discussed by Jeanette Vega, Norman Daniels and Walter Flores (e.g. principles of accountability, non-discrimination and participation). The addition of assessing a state's legal instruments governing reproductive rights and the adoption of domestic legislation in response to international law can provide new insights into the meaning of the stewardship function of health system development.

Gaps in knowledge and priority research topics

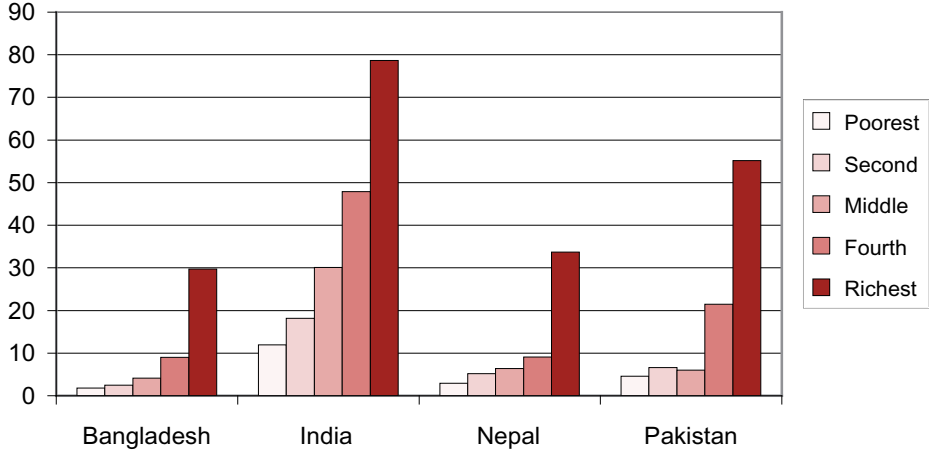
This session comprised three papers, each taking a different perspective on how health sector reforms have affected reproductive health. Ranjani Murthy presented a summary of a global literature review targeting research on the implications and impact of health sector reforms on sexual and reproductive health. The larger work from which she and her co-authors drew was originally produced by the Rights and Reform Initiative, coordinated by the Women's Health Project of the University of Witwatersrand, South Africa, and implemented by women's advocacy groups from Africa, Asia and Latin America. Meera Chatterjee presented a preliminary analysis of an ongoing World Bank analytical project in five South Asian countries that will produce a comprehensive analysis of women's reproductive health within the context of national goals and policies, including health sector reform. She shared results from this study that reviewed the utilization of reproductive health services, the quality of care provided and health outcomes. Susannah Mayhew reviewed key issues that arose from a conference on health sector reform, "Making the link", held in Leeds, United Kingdom, in 2003, which brought together specialists on sexual and reproductive health and health sector reform; the conference considered how changes in health systems affect sexual and reproductive health, and identified appropriate strategies for tackling unresolved questions and shortcomings. Her paper built on a body of published work that preceded and arose from the Leeds conference.

Each of these papers contained a wealth of information, including explicit identification of gaps in knowledge and suggestions for important areas of enquiry. A few key points drawn from these important works launched the discussions on critical areas for research.

The Rights and Reform Initiative Global Literature Review drew attention to the importance of disaggregating the different components of sexual and reproductive health care. Some sexual and reproductive health services are socially and politically "safer" than others (e.g. perinatal care) or have been targeted as a high development priority (e.g. family planning). In contrast, the controversy surrounding the provision of services for abortion, sexually transmitted infections and some adolescent health care in many settings has created a special set of circumstances surrounding their implementation. The paper by Ranjani Murthy and colleagues termed these "heaven and hell" services. Although the final determination of what constitutes a "heaven" or a "hell" service is dependent upon local contextual factors, in general the categorization provides a useful perspective for viewing the impact of health sector reforms on reproductive health. The review suggested that reproductive health services from "heaven" are more likely to be valued in priority-setting processes, included in financial reforms covered in public-private partnerships, and supported in decentralized programmes or community health structures. There are clearly important exceptions, particularly in decentralized settings; for example, national family planning may not be supported by local government units. This point was explored further in the discussions, as the evidence on how decentralization has affected reproductive health services is very mixed, reflecting the diversity of local influences on the determination of the "heaven" or "hell" services. The important advocacy role for civil society groups in ensuring that value is given to reproductive health services is critical in highly decentralized settings.

Meera Chatterjee’s presentation was based on five propositions drawn from The World Bank’s South Asian Women’s Health Study. The importance of targeting reproductive health care services by socioeconomic criteria emerged from these five topics as a defining characteristic for the meeting’s discussion on analytical approaches to studying the effects of reform. The field of sexual and reproductive health has traditionally been driven by demographic analyses, leading to groupings by age, parity or sex. The contribution of the life-course approach to defining the range of appropriate services and policies supporting reproductive health has been substantial, and the paper did not call for a reconsideration of its importance. The analysis by Meera Chatterjee clearly showed, however, that socioeconomic targeting of reproductive health services is now essential and may exceed the importance of biological categories (see Figure 5). Evidence from the five-country study indicates that, for a wide range of health outcome and service use indicators, the differentials by social characteristics (such as education, religion, caste or poverty) are greater than those by biological characteristics (such as age, parity or birth order), with some notable exceptions. Research on the distributional effects of reforms should be guided by these findings, as should programme implementation.

Figure 5 Attendance of delivery by a medically trained person by economic quintiles, four countries



Source: Chatterjee, M. *Inequalities in Women’s Reproductive Health in South Asia: Some Implications for Reform*. The World Bank, 2004.

The imperative of using economic targeting to improve sexual and reproductive health outcomes notwithstanding, Meera Chatterjee also emphasized selective use of demographic characteristics, particularly where adolescents are concerned. The social curtain drawn around poor women, cutting them off from many services – including sexual and reproductive health services – has not been adequately dealt with to date by reforms in South-East Asia. The South Asian Women’s Health Study’s findings show that the exclusion of younger women from health services is a problem that must be given priority. The paper concluded that the neglect of the poorest women can also be characterized as neglect of adolescents, both married and unmarried, because of the demographic structure of these countries. For example, recent population-based surveys from India show high marriage rates among 15–19-year-olds living in rural areas (approximately 38% overall, increasing to 45% among the poorest). Other findings show that this age group’s need for sexual and reproductive health services is great: approximately two-thirds of young women who marry between 15 and 19 years of age had their first birth before reaching 20 years; yet adolescent use of health services is significantly less than use by older groups. These and other findings led the South Asian Women’s Health Study to highlight the need to develop reforms targeting adolescent women, in addition to targeting the poor.

In many respects, the limitations of available evidence on the effects of health sector reforms on reproductive health reflect the scanty evidence of reform's impact on any priority health service. The review produced by Susannah Mayhew brought this point to the meeting's attention, particularly in reference to conducting more rigorous evaluations of public–private partnerships (echoing the conclusions of David Hotchkiss and the PHRplus paper). The converse of the above generalization is also true: where evidence exists on the overall impact of reforms, supporting research on outcomes related to reproductive health is more likely to be identified. For example, evaluations of health care financing schemes in Bolivia and Thailand have produced evidence of increased utilization of maternal and child health services, and where effective targeting mechanisms are included within a financing reform there is some evidence of increased use by the poor (e.g. in Rwanda). Important shortcomings in the valorization of reproductive health vis-à-vis other health services clearly exist and have affected priority-setting exercises. The application of CEA and DALYs were repeatedly identified during the meeting as being problematic for reproductive health. Thus, where reforms may have achieved some measure of success with other health services, their impact related to reproductive health is likely to be minimal. In his comments, Vincent Fauveau suggested prioritizing work on developing alternatives to CEA and DALY methods, as the use of alternative indicators might lead to better valorization of reproductive health.

The reorganization of services was extensively discussed by Susannah Mayhew, elaborating upon points identified by David Sanders. The ICPD Programme of Action's emphasis on integrated reproductive health care can best be operationalized through a health systems approach that links services across different levels of care and across different settings. Isabelle de Zoysa in her comments drew attention to the need to consider integration not only at the service or system level but also at the resource mobilization level, as different approaches to pooling inputs into the health system will have profound effects on all allocations and operations of the health system. John Worley commented on the need to generate evidence that is explicitly linked to the expansion of ongoing reforms and policy dialogue. Drawing upon the broad review of the papers from this session, as well as the points raised during the review of different reform areas, three general categories can be used to guide the formulation of priority research topics: financing and payment reforms, decentralization and organizational reforms, and human resources development.

Financing and payment reforms, including public–private mix

In general, research on the *process of reform* is as important as studying effects related to output and outcome. A few examples drawn from the discussions illustrate this point: (i) many of the financing reforms discussed are based upon new public management roles; (ii) targeted action by civil society groups is required to ensure that priority-setting exercises and resource pooling reforms adequately value reproductive health services; and (iii) public–private partnerships necessitate not only the development of administrative skills related to contracting for services, but also stewardship and regulatory oversight competencies to ensure equity and quality in private practice settings. In each case, the process through which these actions are implemented is not clearly understood or documented. There is an important learning opportunity in these and other similar examples, while working towards increasing the evidence base on the impact of reforms on sexual and reproductive health.

The round-table on sustainable financing discussed reforms related to resource pooling, focusing on the need to develop understanding of out-of-pocket expenditure. Although aggregate levels of out-of-pocket expenses are reported, assessments of the value for money spent by the poor (in particular) on health care is largely anecdotal. More information is required, and could be collected from national household sample surveys (e.g. Demographic and Health Surveys) through the introduction of a module on health expenditure. The round-table also identified the need to better understand social participation in the formation of health insurance systems, particularly community-based schemes.

Reforms related to resource allocation are an innovative area of work, but fundamental questions surrounding allocations to reproductive health services remain unanswerable in many settings today

because mechanisms for tracking expenditure are under-utilized. Substantial advances in National Health Accounts reviews now need to be expanded into sub-account reviews for reproductive health. Definitions and standardized approaches to the collection and reporting of National Health Accounts results should be strengthened further.

There is a pressing need to develop the evidence base on payment reforms. Different conceptual frameworks were presented during the meeting, including the OBA and PHRplus models, which show promise for generating useful findings and guiding the design of reforms. Basic research on the magnitude and characteristics of the private sector (in general) and reproductive health (in particular) are needed in many settings, such as private sector assessments. More evidence is needed to develop understanding of the effects of contracting out on sexual and reproductive health services, concerning both supply-side and demand-side mechanisms. Integrating this research into an approach that strengthens government capacity to monitor contracts and regulate quality of care will substantially contribute to both the implementation of reforms and their evaluation.

The development of sustainable targeting mechanisms that ensure access by the poor and disadvantaged groups in the population to private sector reproductive health services is another understudied area of reforms associated with resource pooling and health insurance schemes. More research on accountability (and trust) is required, including methodological development and designs for demonstrating attribution of effects to reproductive health outcomes.

Decentralization and organizational reforms

Decentralization processes highlight the effects of political influences, human resources development and local institutional capacity on the implementation of reforms. The decision-space approach to investigating the effects of reform on sexual and reproductive health is a promising area of enquiry and should be pursued. In addition to studying such questions as whether more local choice results in better programme performance, information on the process of constructing the decision space is required. For example, among the range of options within a decision space, which ones are favourable to reproductive health and how can they be affected by local actors? Because decentralization processes are pervasive, research is needed on the interaction of decentralization and other reforms (e.g. those concerning financing and payment), with context-specific indicators included in the study.

Other organizational reforms were discussed by Susannah Mayhew, principally those related to providing an integrated package of reproductive health care services. The limited evidence that is available on the effects of other reforms (notably resource allocations to a limited set of priority programmes or disease-specific services) on primary health care, including sexual and reproductive health, is suggestive of declining coverage and reduced impact. More information is required on how to effectively integrate priority programmes, including the cost-effectiveness of holistic service delivery structures.

Human resources development

The mounting crisis in human resources within the health sector is a cause for alarm worldwide. The consultation made this point forcefully. The principal research recommendation that emerged from its discussions is that the development of human resource impact assessments is a necessary element of any health sector reform initiative. Additionally, implications for human resources need to be explicitly incorporated into the study of reform's effects on reproductive health services. For example, studying the effects of decentralization on local capacity development needs to include gender-sensitive indicators related to health worker motivation. Public-private partnerships that are constructed around contracting for a specific set of priority programmes can be studied for their effects on health worker capacity to provide non-priority health services. As suggested above, investigations of the transaction costs associated with output-based aid are directly related to building the evidence base on how reforms have interacted with the development of human resources for reproductive health.

Breakaway discussion groups

Effects of health sector reforms on other priority health programmes: what can reproductive health learn from their experience?

Country presentations from Ghana, the Republic of Moldova, the Philippines and the United Republic of Tanzania reviewed experiences with health sector reform and other priority health programmes, drawing out implications for reproductive health. The discussions began with what makes reproductive health care different from other areas of priority, acknowledging some of its inherent complexities that set it apart. For example, the holistic approach to providing comprehensive sexual and reproductive health services articulated in the ICPD Programme of Action sometimes runs counter to the need for presenting an easily comprehensible package of services to non-specialist decision-makers. In this respect, other priority programmes such as tuberculosis and malaria have been more successful than reproductive health. Additionally, indicators of reproductive health are not as well matched to priority-setting methodologies, or to monitoring systems, as are other priority health programmes. The life-course approach to defining a tailored package of reproductive health services and related indicators presents a framework for segmenting different populations and clarifying their reproductive health care needs.

Public–private partnerships have proved to be invaluable in extending the coverage of other priority health programmes, and the experience of private sector collaboration with national tuberculosis control programmes was emphasized as an important learning area for reproductive health. External benefits accrued as the private sector’s involvement increased, as the dialogue and sharing of resources furthered the development of government regulatory functions, enhancing systems of accountability. The important role of national leadership was emphasized, even in settings characterized as highly decentralized. Linked to strong policy support are budgetary safeguards for priority programmes, including the earmarking of funds. The breakaway discussion group indicated how value is added when a priority health intervention is linked to what are considered to be core public health functions of government, such as the establishment of norms, financing, human resource functions, and monitoring.

Evidence and health sector reform: the role of health information systems

The ability to monitor the implementation of health sector reform programmes and to track effects on reproductive health is dependent, to a large extent, on improvements in health information systems. Although there is clearly a need for population-based surveys, active sentinel surveillance systems and other methods for monitoring changes in health status and health system performance, the ability routinely to collect, analyse and disseminate information is a core public health function of government worldwide. The production of health information cuts across all reform efforts, intersecting issues of human resources development as capacity-building is envisaged. Decentralization processes have substantially complicated the implementation of health information systems, creating a mix of functions at different and sometimes multiple levels of the health care system. The consultation’s working group explored these and other areas of health information system development, with country presentations by Brazil and the Islamic Republic of Iran serving to place the discussions in two different contexts.

The need to engage the private sector effectively in a system of routinely collected health statistics was discussed at length, particularly given the important role of the private sector in some reproductive health services, such as sexually transmitted infections. The means of expanding the passive surveillance systems of highly communicable disease reporting into other priority health topics has not been successfully demonstrated, except in the context of government monitoring of health outcomes specified in a contractual agreement. Linking the provision of routinely collected statistics to certification renewals and other licensing regulations is possible, but in practice depends on enforcement of penalties for non-compliance.

Building upon Ranjani Murthy’s analysis, the distinction between reproductive health services from “heaven” and “hell” is useful in characterizing the likelihood of a service being included in a health information system’s reporting. The cultural influences that create circumstances of

sensitivity around certain reproductive health services will also inhibit the collection of information. Information on a number of reproductive health indicators will need to be collected in the community, in addition to the health facility. How to manage this collection in a sustainable and ethically sound manner is a challenge for health information system development in many settings. When health reform initiatives engage local communities, the information retrieval function needs to be considered and incorporated in the reform's design.

Conclusions

The technical consultation's presentations and discussions provided many examples of how health sector reforms can further the advancement of reproductive health, while also providing insights into the differences characterizing the two disciplines. The broad-based definition of reproductive health, encompassing both public health and human rights paradigms, proved at times to be ill-matched to the analytical frameworks used in the discourse of health reform. The goals of improving equity, quality and client responsiveness (among others) provide a large degree of commonality, and the meeting advanced understanding of priority areas for research that will facilitate the introduction of reforms that value sexual and reproductive health.

In general, research on the process of reform is as important as studying effects related to output and outcome. Many of the *financing and payment reforms* are based on government assuming new public management roles, even if they are implemented in settings characterized by weak governance. There are important opportunities for learning about these transitions, while research seeks to monitor progress and demonstrate impact. Reforms related to resource allocation are an innovative area of work, but fundamental questions surrounding allocations to sexual and reproductive health services remain unanswerable in many settings because mechanisms to track expenditures are under-utilized. Definitions and standardized approaches to the collection and reporting of National Health Accounts should be strengthened to cope with this pressing need. Despite great progress with the development of payment reforms, the existing evidence base is actually quite weak on the effects of contracting out on reproductive health services. The development of sustainable targeting mechanisms to ensure access by the poor and disadvantaged groups in the population is another priority area related to resource allocation.

Decentralization processes bring to the forefront the effects of political influences, human resources development and local institutional capacity on the implementation of reforms. The decision-space approach to investigating the effects of reform on sexual and reproductive health is a promising area of enquiry and should be pursued. In addition to studying such questions as whether more local choice results in better programme performance, information on the process of constructing the decision space is required. For example, among the range of options within a decision space, which ones are favourable to reproductive health and how can they be affected by local actors? Because decentralization processes are pervasive, research is needed on the interaction of decentralization and other reforms (e.g. those concerning financing and payment), with context-specific indicators included in the study.

The mounting crisis in *human resources development* within the health sector is a cause for alarm worldwide. The consultation made this point forcefully. The principal research recommendation that emerged from its discussions is that the development of human resource impact assessments is a necessary element of any health sector reform initiative. Additionally, implications for human resources need to be explicitly incorporated into the study of reforms on reproductive health services.

The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction and the Department of Reproductive Health and Research will be working to move this research agenda forward, in collaboration with several departments in the Evidence and Information for Policy Cluster and external partners. It is hoped that this report will stimulate similar research in other institutions and advance progress towards reaching the goals of ICPD's Programme of Action.

UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and
Research Training in Human Reproduction

Department of Reproductive Health and Research,
Family and Community Health Cluster, in collaboration with the Evidence and
Information for Policy Cluster

TECHNICAL CONSULTATION ON HEALTH SECTOR REFORM AND
REPRODUCTIVE HEALTH: DEVELOPING THE EVIDENCE BASE

Geneva, 30 November–2 December 2004
WHO/HQ, Salle B

Agenda

30 November 2004

Opening remarks: 09:00–09:30 Tim Evans, Assistant Director-General,
Evidence and Information for Policy, WHO

Contemporary trends in health sector reform

Morning Chair: Assia Brandrup-Lukanow

Financing and payment reforms

Invited paper:	09:30–09:55	Peter Berman (1) ¹
Commentaries:	09:55–10:05	Joseph Kutzin
	10:05–10:15	David Evans
Discussion:	10:30–11:15	

Organizational reforms

Invited paper:	11:15–11:45	Tom Bossert (2)
Commentaries:	11:45–11:55	U Than Sein
	11:55–12:05	Mushtaque Chowdhury
Discussion:	12:05–12:30	

¹ See Annex 3 for a list of papers presented.

Afternoon Chair: Ellen Starbird

Public–private mix

Invited papers:	13:45–14:15	Chiaki Yamamoto (3)
	14:15–14:45	David Hotchkiss (4)
Commentary:	14:45–15:00	Christopher J. Allison
Discussion	15:00–15:40	

Human resources development

Invited paper:	16:00–16:30	David Sanders (5)
Commentaries:	16:30–16:40	Susan Maybud
	16:40–16:50	Abdelhay Mechbal
Discussion:	16:50–17:30	

1 December 2004 – Gaps in knowledge and priority topics

Morning Chair: Pär Svensson

Invited papers:	09:00–09:30	Ranjani K. Murthy (6)
	09:30–10:00	Meera Chatterjee (7)
	10:00–10:30	Susannah Mayhew (8)
Commentaries:	10:45–11:00	John Worley
	11:00–11:15	Vincent Faveau
	11:15–11:30	Wim Van Lerberghe
	11:30–11:45	Isabelle de Zoysa
Discussion:	11:45–12:30	

Afternoon Chair: Elly Leemhuis-de Regt

Achieving equity

Invited papers:	13:30–14:00	Jeanette Vega (9)
	14:00–14:30	Norman Daniels (10)
Commentaries:	14:30–14:45	Jane Cottingham
	14:45–15:00	Silvia Salinas
Discussion:	15:00–15:30	

2 December 2004 – **Country perspectives – Round Table discussions**

Morning Chair: Ariel Pablos-Mendez

Plenary session:	09:00–09:30	Introduction of Round Tables
Round Table 1:		Effects of health sector reforms on other MDGs: what can reproductive health learn from their experience?
Round Table 2:		Sustainable financing for reproductive health in the context of health sector reforms
Round Table 3:		Evidence and health sector reforms: the role of health information systems
Discussions:	10:45–12:30	Round Table 1 (Salle B) Facilitator: Diana Weil Rapporteur: Mustaque Chowdhury
		Round Table 2 (M105) Facilitators: Joe Kutzin, Peter Berman Rapporteur: Susannah Mayhew
		Round Table 3 (X10) Facilitators: Ties Boerma, U Than Sein Rapporteur: Ritu Sadana

Afternoon Chair: Ariel Pablos-Mendez

Reports and Discussions:	14:00–14:30	Round Table 1
	14:30–15:00	Round Table 2
	15:00–15:30	Round Table 3
Closing remarks:	15:30–15:45	Dale Huntington, Department of Reproductive Health and Research, WHO

UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research
Training in Human Reproduction

Department of Reproductive Health and Research, Family and Community Health Cluster, in
collaboration with the Evidence and Information for Policy Cluster

TECHNICAL CONSULTATION ON HEALTH SECTOR REFORM AND REPRODUCTIVE
HEALTH: DEVELOPING THE EVIDENCE BASE
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WHO/HQ, Salle B

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Department of Reproductive Health and Research, Family and Community Health Cluster, in
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TECHNICAL CONSULTATION ON HEALTH SECTOR REFORM AND REPRODUCTIVE
HEALTH: DEVELOPING THE EVIDENCE BASE
Geneva, 30 November–2 December 2004
WHO/HQ, Salle B

Papers presented

1. *Financing and payment reforms relevant to reproductive health programmes: global trends and recent experience in India*
Peter Berman, The World Bank, New Delhi
2. *Organizational reforms and reproductive health: decentralization, integration and organizational reform of ministries of health*
Thomas Bossert, Harvard School of Public Health
3. *Output-based aid in health: reaching the poor through public–private partnership*
Chiaki Yamamoto, The World Bank
4. *Contracting for primary health services: evidence on its effects and a framework for evaluation*
Xingzhu Liu, Abt Associates; David Hotchkiss, Tulane University; Sujata Bose, Abt Associates; Ricardo Bitran and Ursula Giedion, Bitran and Asociados
5. *Health sector reform: some implications for human resources*
David Sanders and Uta Lehmann, School of Public Health, University of the Western Cape, South Africa; and Paulo Ferrinho, Associacao para o Desenvolvimento e Cooperacao Garcia de Orta and Health Systems Unit of the Institute of Tropical Medicine and Hygiene, Universidade Nova de Lisboa, Portugal
6. *Health sector reforms and sexual and reproductive health services*
Ranjani K. Murthy with Helen de Pinho, Sundari T.K. Ravindran, and Mariana Romero, Initiative for Sexual and Reproductive Rights in Health Reforms coordinated by the Women's Health Project, South Africa
7. *Inequalities in women's reproductive health in South Asia: some implications for reform*
Meera Chatterjee, The World Bank, New Delhi
8. *Acting for reproductive health in reform contexts: challenges and research priorities*
Susannah Mayhew, London School of Hygiene and Tropical Medicine
9. *Equity in health sector reform and reproductive health: measurement issues and the health systems context*
Orielle Solar, Alec Irwin and Jeanette Vega, Health Equity Team, WHO
10. *Benchmarking fairness in reproductive health*
Normal Daniels, Harvard School of Public Health; Walter Flores, Universidad de San Carlos de Guatemala; and Jesica Gomez-Jauregui, National Institute of Public Health, Cuernavaca, Mexico

Note: All papers and presentations from the meeting are available on <http://www.who.int/reproductive-health/tcc/meeting.html>.

