Using National Health Accounts to Improve Allocation of HIV/AIDS Funds

To understand financing for HIV/AIDS-related programs, country teams from seven East and Southern African (ESA) nations met in February to discuss expanding their National Health Accounts (NHA) to include data on expenditures for HIV/AIDS and tuberculosis activities. NHA tracks the flows of health care spending – “from sources to uses.” Its findings can be used to institute policy changes to correct imbalances in health spending and to determine the efficiency of the present financing system. The framework can be further adapted to incorporate analysis of a subsectoral policy concern. For example, adaptations are being made for estimation of HIV/AIDS and TB-specific expenditures in the ESA nations, and have been made for maternal and child health expenditures in Morocco. Over the years, repeated NHAs also allow policymakers to conduct trend analysis of expenditure data and thereby monitor and evaluate the impact of their interventions.

The 28 participants hailed from Ethiopia, Kenya, Malawi, Swaziland, Tanzania, Zimbabwe, and Zambia, most of them countries that have done a first round of NHA estimations. Many arrived at the PHRplus-sponsored meeting in Livingston, Zambia, expressing reservations about the cost and time needed for disease-specific studies. They left convinced that the moderate incremental cost would have enormous value for the development and implementation of new policies targeted at improving the equity and efficiency of HIV/AIDS-related funding.

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Focus on Africa

(Continue Using NHA...)

disproportionate extent of households’ contribution (93 percent) to total HIV/AIDS expenditures in 1999. Because 70 percent of the households live below the poverty line, HIV/AIDS care further exacerbates the burden on poor families. Also revealed was the amount spent on treating symptoms and opportunistic infections (79 percent) vis à vis ARV treatment (14 percent) and prevention (7 percent).

The Rwanda experience, described in a PHR report and a UNAIDS “best practice” case study and used as a training tool at workshops sponsored by other donors, was particularly useful at the Livingstone meeting, the first of a two-workshop series by PHRplus on “Estimation of HIV/AIDS and TB Expenditures Using the NHA Framework.”

Also significant about the meeting was that each country team comprised a national-level policymaker, an NHA representative, an HIV/AIDS expert, and a TB expert, in contrast to earlier meetings for NHA teams only. In addition to progress made at the meeting, work groups formed will adapt International Classification for Health Accounts to make them more applicable to the ESA network. Issues and terminology to be refined include points such as:

- How to disaggregate AIDS-related costs from those of integrated STD/AIDS programs?
- How to distinguish expenditures on HIV-related health interventions from those on broader social programs?
- Is it feasible to incorporate malaria into the HIV/AIDS study?
- How should the network define “hospital” and “clinic”?

The inclusion of policy, NHA, and clinical experts on teams will permit fine-tuning of the NHA framework so that countries will more assuredly use findings to:

- Estimate how much is being spent by public, private, and donor sources and the extent to which different interventions, such as prevention, treatment of HIV/AIDS and opportunistic infections, and palliative care, are supported by these funds;
- Target policy to improve access to programs and efficient resource allocation.

Two workshop countries – Kenya and Ethiopia – have since committed to carrying out HIV/AIDS NHA studies.

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Adapting Integrated Disease Surveillance Guidelines for Ghana

Ghana is one of the first countries in Africa to finalize Guidelines for Integrated Disease Surveillance and Response (IDSR) for implementation by public health authorities. The guidelines aim to improve the capacity of health workers and communities to detect, report, and respond to outbreaks of the 23 “priority” diseases in the country.

PHRplus worked with the Ghanaian Ministry of Health (MOH), WHO/Africa Regional Office (AFRO), and the U.S. Centers for Disease Control and Prevention (CDC) to adapt the generic guidelines created by the latter two institutions to reflect Ghana’s country-specific policies and priorities. PHRplus will continue to support the MOH’s National Surveillance Unit (NSU) in IDSR implementation.

While the generic guidelines provide a comprehensive overview of an entire surveillance system, they are a basic framework intended to be made “user friendly” for the facilities, district health management teams, and national surveillance units of individual countries. The guidelines espouse the integration of individual surveillance systems that vertical programs now employ in an
 Highlight 

Partners for Health Reform plus, May 2002

Interviews were conducted with CHF members and non-members. Key findings from the assessment are:

▲ Enrollment rates are fairly low. Across the CHF facilities visited, the household membership rate in 2001 ranged from 2 percent to 13 percent, with the average being 5 percent. District-wide membership is estimated at 3 percent.

Initially, CHF members received free health services; in 1998, coincidentally the year the CHF was established in Hanang district, user fees were introduced. In Hanang, CHF refers to the combination of membership and user fees collected. In 2001, the Community Health Fund Act established the CHF as the official health plan at the local/community level to be rolled out in all districts by 2003.

Given this potential role in financing primary health care, there was agreement on the importance of improving the CHF’s performance and maximizing its effectiveness. The PHRplus assessment in Hanang is the first of a series of activities aimed at accomplishing this.

The assessment included all levels of the CHF (central, district, ward, and health facility). Information was gathered through semi-structured interviews with individuals involved in the administration of the CHF at all levels and providers and managers at participating and non-participating health facilities. Facility and district records and reports were also reviewed. Focus group discussions and facility exit interviews were conducted with CHF members and non-members.

Key findings from the assessment are:

▲ Enrollment rates are fairly low. Across the CHF facilities visited, the household membership rate in 2001 ranged from 2 percent to 13 percent, with the average being 5 percent. District-wide membership is estimated at 3 percent.

▲ Financial management and information systems require improvement. There were many inconsistencies in membership, utilization, and financial data between the national and district level, district and facility level, and records within the facility. Assistance to rationalize and simplify the record-keeping at the facility and district level is needed.

▲ Management of CHF funds varies from ward to ward. In areas where the ward health committees were not functioning, the facility in-charge and district medical officer made decisions regarding the use of funds.
Improving Quality of Care in MHOs in Africa

Although there are sometimes obstacles or delays in accessing the funds, CHF funds are being used to improve the health facilities and services. Total CHF funds constituted 10 percent of the 2001 district budget through the end of October, with user fees representing 77 percent of total funds. While membership fees account for a small portion of the total fees collected, CHF member utilization accounts for a significant portion of total utilization (38 percent–58 percent). There is some evidence of significant amounts of unused CHF funds.

Knowledge of the CHF is high and general perceptions of the CHF are positive. People believe that the CHF has led to an increase in the supply of drugs and improved services at participating facilities. Managers at facilities visited do not believe that CHF members are overusing health services. Many communities felt that they were represented in the management of the CHF, although few people were able to explain how the CHF is managed. The most common reason cited for not joining was that it was difficult to pay the membership fee all at once.

Currently, there are no mechanisms in Hanang district to ensure that the poor have access to care. Few people are being exempted from user fees and no households have been exempted from CHF membership fees.

PHRplus, together with key stakeholders, will develop a workplan that prioritizes the areas to be addressed and designs strategies for improvements. Longer term, PHRplus will provide technical assistance to implement this workplan, document the results of strategic changes, and disseminate tools and lessons learned that can be applied throughout Tanzania in an effort to improve community-funded PHC service delivery.

Improvements in actual and perceived quality of health care offered through mutual health organizations (MHOs) – community-level mechanisms for covering the costs of primary care – is an important element in ensuring client participation and long-term MHO financial viability. PHRplus currently is developing manuals to build the capacity of MHO managers to assess, improve, and monitor the quality of care delivered by the health care providers whom they contract.

In collaboration with the U.N. Population Fund-led Stronger Voices for Reproductive Health project, PHRplus conducted a field study of MHOs and the priority they give to the issue of quality. The study gathered data from October to December 2001 in three countries: Ghana, Senegal, and Tanzania. Data collected included descriptions of the structure of MHOs, the services they cover, how they select providers and manage their relationships with providers, and the role of quality of care.

The study sample comprised 24 MHOs – eight in Ghana, nine in Senegal, and seven in Tanzania – that ranged in size and age. Fifty-two percent of MHO managers felt that ensuring quality of care is the most important aspect of their work. Thirty-six percent felt that their clients believed this to be the most important aspect of an MHO’s work. When asked what they thought was the most important thing that their members consider when seeking care, 29 percent of MHO managers overall felt that provider effectiveness was the deciding factor and 16 percent stated that provider competency was the most important factor. However, this finding varied by country. In particular, in Tanzania, interviewees stated that clients were more concerned with drug availability (29 percent) and service affordability (29 percent).

The study highlights that, while aspects of quality vary in priority, the overall issue of ensuring quality of services and quality assurance is important to MHOs. PHRplus’s continued support will provide tools for MHOs to measure quality of providers and ensure better services for their clients.

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PHRplus, together with key stakeholders, will develop a workplan...
Study Tour Sparks National Forum on Decentralization in Benin

To demonstrate lessons from the experience of a fellow West African nation, PHRplus led two groups of Beninois government officials to study decentralization in the Senegalese health sector. The study tours helped to clarify the roles and responsibilities of all levels within a decentralized system and to reinforce political support for decentralization of Benin’s health sector. As a result, the minister of health in Benin recognized the critical importance of

advancing both discussion and implementation within the country.

Among the 24 study tour participants were the minister of health, the secretary general of the Ministry of Health (MOH), five MOH national program directors, the advisor to the president in charge of administrative affairs and decentralization, as well as the secretary general of the decentralization unit within the Ministry of the Interior.

Participants returned to Benin convinced of the need to organize a national forum to share the lessons learned from the Senegal experience and to garner support for decentralization from all stakeholders not able to participate in the tours. PHRplus consultant Cheikh Mbengue returned to Benin to assist the MOH develop the forum, held in April 2002.

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Focus on ANE/EE

Improving Health Care Delivery in Jordan

After nine long months, the contractions and the baby are finally coming. Your husband is a civil servant working for the government of Jordan, paying 3 percent of his salary for health insurance. So off you go to the government hospital. But instead of showing you to the delivery room, the hospital staff is showing you to the door! No obstetrical beds are available and you are being transferred to a private maternity hospital. As you are hurried into the taxi, you wonder if you will get there in time and who will deliver your baby.

With private hospitals operating at 40 percent occupancy and the major public hospital of Amman overcrowded, the Ministry of Health (MOH) turned to contracting private hospitals to deal with this mismatch of supply and demand. However, in the case of maternal care, the contracts cover only deliveries, no prenatal care. They encourage emergency referrals like the one described above. The contracts pay on a fee-for-service basis, which encourages extra charges and possibly unnecessary C-sections.

PHRplus is assisting the central MOH and the Health Insurance Directorate to design a new contracting system, so both the MOH and patients get more for their money. The process is overseen by an Advisory Board consisting of policymakers from the MOH. During this quarter, the design of the contracting system was reviewed with the Advisory Board and met their approval. To date, the design includes bundling reproductive health services so a patient can be followed by the same provider throughout her pregnancy, delivery, and postnatal care to improve the continuity of care delivered.

The new contracting system calls for the use of clinical practice guidelines at the contracted hospitals so quality standards are clear and can be monitored. The system will also shift to a capitated payment system whereby payment is made directly to the provider. The capitated payment, combined with monitoring of quality, will encourage providers to deliver the right care, and avoid unnecessary services and charges. This design will be piloted this year in Amman with approximately 200 beneficiaries and several private hospitals. Upon enrollment, baseline information will be collected on the beneficiaries so the impact of the new system on patient satisfaction can be measured.

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Examining the Health Care Costs on Aging in Asia and the Near East

USAID and aging? Aging is not a traditional issue for USAID, but that is changing. The Asia/Near East (ANE) Bureau targeted aging as a regional issue last year, and USAID Administrator Andrew Natsios is considering it as a priority issue for the entire agency – for good reason. In the past 50 years, the number of people age 60 or older in the world rose by 350 million (to 550 million); this number will increase by 1.5 billion in the next 50 years, and more than 70 percent of those elderly will be living in developing countries by 2050. This demographic shift will put severe pressure on public finances, and policy responses will have to be both radical and relatively swift.

For the ANE Bureau, PHRplus proposed the development of a methodology to estimate the impact of aging populations on a country’s health expenditures and health system. Development of the methodology will be done in collaboration with the East West Center (EWC) in Hawaii, and case studies will be produced for two countries in the ANE region – Jordan from the Near East and the Philippines from Asia. Technical experts from PHRplus and the EWC are working with researchers and policymakers from the case countries to build capacity at the country level and give the U.S.-based team a critical link to data sources and policymakers in each country.

On March 1, the team held its first Experts Meeting at PHRplus headquarters in Bethesda. Country counterparts – Dr. Hani Brosk of the Ministry of Health of Jordan and Ms. Thiel B. Manaog, representing Dr. Mario C. Villaverde of the Health Policy Development Planning Bureau of the Philippines Department of Health – shared findings from the data collected to date. Two external technical experts – Kevin Kinsella of the U.S. Census Bureau and Laura Shrestha of the National Institute on Aging – gave feedback on the data and on a variety of methodological issues. The entire group reviewed previous studies on projections of health expenditures on the elderly and agreed on a series of methodological issues for estimating baseline health expenditures. The country teams are now developing and applying the estimation methodology in their countries. The teams will meet again at the end of May 2002 to share results and begin to look at the policy implications of rising health expenditures on older populations.

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Software Facilitates Patient Data Collection to Improve Services

PHRplus is working with counterparts in Albania and several other countries to create simple programs to track primary health care service utilization and costs.

These programs rely on manual patient encounter forms that capture patient demographic information, key provider data, and information about the encounter. PHRplus-created scanning protocols enable these manual forms to be scanned into an Access database. In this way, data collected in patient encounters at even the most remote clinic can be computerized by scanning at a district health office or other central location.

Understanding utilization patterns enables systemic improvements – clinical guidelines, infrastructure improvements, budget strategies – that will enhance quality of care, provider support, and resource allocation. The patient encounter software also has a simple cost module that collects basic cost data from clinics on a quarterly basis. The cost and utilization data can be provided to central as well as district health officials and providers themselves to support evidence-based local decisions about resource allocation, quality of care, and demand for services.

The PHRplus software is based on a system that was developed to support the Egyptian Family Health Fund demonstration project completed under the previous PHR project. The software is easily adapted to other country settings.

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MENA Health Officials Coordinate NHA Institutionalization

Senior health policymakers and National Health Accounts (NHA) teams from eight Middle East and North African (MENA) nations recently committed their countries to work together toward institutionalization of NHA. Their commitment was manifested in several concrete steps, including adoption of a common Institutionalization Framework and establishment of a regional coordinating center for NHA network activities.

Nearly 50 representatives, including five deputy ministers of health, from Egypt, Jordan, Iran, Morocco, Oman, Syria, Tunisia, and Yemen participated in the MENA Regional NHA conference in Marrakech, Morocco, March 18-21. The conference, co-sponsored by PHRplus with support from USAID’s Asia/Near East Bureaus, was the fourth meeting of the network since 1999. The World Health Organization (WHO)/Eastern Mediterranean Regional Office (EMRO) and World Bank co-sponsored the event. The European Commission attended for the first time and expressed interest in supporting NHA in MENA countries.

Having high-level policymakers and NHA technicians deliberate together allowed each group to better understand the needs of the other and thus take specific steps toward NHA institutionalization, including regularly carrying out the NHA process and using the findings to make policy. It also helped to build relationships and cross-country teamwork. Hisham Bedeir, Monitoring and Evaluation Officer at Egypt’s Ministry of Health and Population, said, “I…appreciate all negotiations… [am] hoping to keep in touch.” The Omani Deputy Minister of Health arrived expressing reservations about NHA, but departed committed to the activity and to searching for a full-time NHA technician.

In addition to the satisfaction expressed by participants, concrete objectives were achieved:

▲ Encouraging policymakers to recognize and support the utility of NHA. Policymakers emphasized that they can utilize NHA if it produces reliable data that are appropriately applied to policy development. They asked NHA technicians to consult with them in the design of the NHA activity to ensure it would produce information to inform key policy issues.

▲ Discussing appropriate strategies for institutionalizing NHA at the country level. Participants exceeded this objective by generating a common Institutionalization Framework for sustaining NHA in network countries. The framework was developed by the group, building on a design brought to the meeting by Dr. Taissir Fardous of the Jordan NHA team.

▲ Determining the future of the MENA NHA network. Participants elected WHO/EMRO as a regional coordinating center for network activities proposed by a committee of NHA team representatives from each country and interested donors. The network will serve as a forum to exchange experiences and support national efforts to implement NHA. In addition, participants agreed upon “Next Steps,” specific directives that reflect their vision for NHA in the region.

Participants also praised the ongoing contribution of USAID, through PHR and PHRplus, to regional NHA development and the excellent coordination among the sponsoring donors, and they emphasized the need for continued support in institutionalizing NHA and strengthening the MENA network.

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Focus on LAC

Costing HIV/AIDS Treatment Services in Mexico

It is estimated that 100,000 to 150,000 people live with HIV/AIDS in Mexico. Since 1992, the Mexican Institute of Social Security has been providing antiretroviral (ARV) treatment, a therapy regime that slows the progression of AIDS, to its contributors, but they represent less than 40 percent of the population. The Mexican Ministry of Health, which covers approximately 60 percent of the population, approved in January a strategic plan to expand ARV treatment services to all uninsured people living with HIV/AIDS by 2006. However, Mexican policymakers lack information on the incremental costs of scaling up...
ARV treatment services in order to advocate for funding to implement the strategic plan.

A study being conducted by PHRplus, in collaboration with the National Institute of Public Health, draws on Mexico’s experience of treating HIV/AIDS in the public sector to estimate incremental costs of scaling up such treatment programs in a developing country setting. The study will provide policymakers in Mexico and, subsequently, in the broader Latin American and Caribbean region, the information necessary to assess the utilization of ARV services and costs of care for HIV/AIDS patients in the public sector; guide planning and development of comprehensive HIV/AIDS treatment programs; estimate the total costs of antiretroviral treatment programs, including non-drug costs; and advocate for program funding.

The study takes a comprehensive approach by costing various aspects of the program, including ARV and other drug purchases, human resource training, laboratory testing, and voluntary counseling and testing, among other program components. Results are expected in July 2002.

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Most team members felt they played a leadership role in some way but recognized they could improve in this area.

Both regions identified the need for a formal performance evaluation system as well as a system to identify staff training needs.

The team recognized the need to improve communication from the lower levels of the health system (health post, health centers) to the regional level and vice versa.

PHRplus regional advisors will provide technical assistance in the development and implementation of improvement strategies. By improving their management capacity, regions will be better positioned to support and implement decentralized systems of health care.

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Focus on Applied Research

Learning from Fieldwork on Community-Based Insurance in Africa

PHRplus field staff visiting Bethesda for the project retreat (see related story) exchanged experience gained in their work with increasingly popular community-based health insurance (or mutuelles, in Francophone Africa). Field representatives from Ghana, Mali, Senegal, and Tanzania as
well as headquarters staff also used the one-day workshop to identify gaps in knowledge and discuss how PHRplus in general – and its Knowledge-Building component in particular – might address some of these gaps.

West Africa staff, including Chris Atim, Patrick Apoya, Abdoulaye Ba, Bocar Daff, Ousmane Sidibé, and Cheick Simpara, described the remarkable growth in mutuelles in that region during the past few years. PHRplus staff have developed standard approaches to conducting situation analyses, training scheme managers, and helping establish and monitor the schemes. Headquarters’ Grace Chee described the assessment of the Community Health Fund she carried out in Tanzania. Increasingly, PHRplus is engaged in policy-level work with some particularly interesting examples of this in Ghana. In the Ashanti region, the project is advising on the establishment of a fund to support a variety of health sector development aims including the pooling of risks among CBHI schemes to cover tertiary hospital care.

The second half of the workshop focused on ways to learn more from and synthesize knowledge about field experience in this area. Three policy-relevant topics were identified for further research work:

▲ Equity and community-based financing schemes;

▲ Financial sustainability and the role of reinsurance in such schemes; and

▲ Understanding how community financing fits into the broader health care financing context.

The group also agreed that there is a need to share knowledge between practitioners in this field on an ongoing basis. As a first step in this direction, PHRplus will establish a special page devoted to community-based risk pooling schemes on its website.

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Focus on Global Leadership

PHRplus Launches World Bank’s CBHI Technical Series

Increasingly, international debates about health financing have been shifting to discussions about a second generation of community-based health financing (CBHF), and specifically community-based health insurance (CBHI). CBHI refers to a non-profit health insurance scheme for the informal sector, formed on the basis of an ethic of mutual aid and the collective pooling of health risks, in which members may or may not participate in its management. Several national governments, particularly in sub-Saharan Africa, have started to explore CBHI as a means to enhance the financial accessibility of services while maintaining some form of user fees and cost sharing. Others see it as a bridge toward national social health insurance programs. Several international organizations have touted CBHI as a promising mechanism for extending health insurance coverage to the informal urban and rural populations.

Given the extensive field experience with CBHI under the earlier PHR project and now with PHRplus, the Health, Nutrition, and Population sector office of the World Bank’s Africa Region invited the project to deliver the first seminar in a Bank-sponsored technical series that will explore the evidence and implications of the CBHI mechanism for financing strategies in the region. The project’s experience with CBHI has been built over the past six years through extensive reviews and field inventories; technical assistance in design and implementation for mutuelles (CBHI schemes in West and Central Africa); technical assistance, evaluations, and development of operational manuals for CBHF organizations in East Africa; and assistance with pilot efforts in Rwanda and Mali.

The session was introduced by Charlotte Leighton, who presented an overview of CBHI in Africa. Country and regional experience were presented by Chris Atim (mutuelles in West and Central Africa), Stephen Musau (CBHF schemes in East Africa), Grace Chee (Community Health Funds in Tanzania), and François Diop (CBHI pilot in Rwanda). Sara Bennett ended the panel with a discussion of research issues and PHRplus’ planned program of research, analysis, and evaluation on the CBHI movement.

PHRplus presenters identified strengths and weaknesses as well as implementation and policy issues for each case they discussed. Among the most striking aspect of the presentations was the great diversity of these CBHF endeavors across the region. Schemes differ in terms of services covered, initiator, role of the government and public health facilities, member payment mechanism, provider relations and
payment mechanisms, target population, membership rules, and size. As the discussion pointed out, this diversity, plus the limited evidence on performance and impact, makes broader policy issues difficult to untangle.

Financial sustainability, benefit package, and membership design issues emerged from discussion about the Community Health Fund in Tanzania and several other East Africa CBHF schemes. Household survey data available for the Rwanda pilot provided evidence of the improvements in utilization that a well-designed and strongly participatory prepayment scheme can have. It also illustrated ways that CBHI can be used as a vehicle for making health care services more financially accessible for lower income populations. But much remains to be done in all of the CBHI schemes discussed to develop them as specific targeting mechanisms for protecting the poor against unaffordable health care costs.

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PHRplus Contributes to Global Leadership on Vaccine Fund Task Force

PHRplus played a leading role in the development of innovative indicators of financial sustainability proposed for consideration by the Global Alliance on Vaccines and Immunization (GA VI) Vaccine Fund and its Financing Task Force (FTF).

PHRplus chaired an FTF technical committee that proposed the indicators based on a preliminary set developed at a June 2001 meeting by delegations from the Vaccine Fund beneficiary countries of Bangladesh, Benin, Ukraine, and Zimbabwe. Results of that meeting were: (1) a proposed definition of financial sustainability (see box); (2) a preliminary set of indicators relating to the definition; and (3) input to the FTF on the desirability of setting performance targets for financial sustainability for immunization programs in the 74 poor countries that benefit from the fund.

Building on work at the meeting, the committee, chaired by PHRplus, crafted four “global” indicators proposed for application to all Vaccine Fund countries and 19 “national” indicators from which individual countries may choose to use in monitoring their programs. The indicators correspond to the dimensions of financial sustainability spelled out in the definition: mobilization of resources domestically and externally, reliability of resources, and efficient use of resources.

GA VI’s Definition of Financial Sustainability

Although self-sufficiency is the ultimate goal, in the nearer term sustainable financing is the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve target levels of immunization performance, including goals for access, utilization, quality, safety, and equity.

The first two global indicators, national operating and capital expenditures on immunization program-specific costs relative to available GDP, address domestic resource mobilization and reliability, as a function of the country’s ability to pay. The third, vaccine wastage, addresses a key element of efficiency, and the fourth, donor expenditures on immunization program-specific costs, refers to the mobilization and reliability of external resources.

The committee’s proposal to focus on domestic resource mobilization in relation to available national income (GDP less debt service) represents an innovation, measuring domestic “effort” relative to “ability.” Traditional indicators measure financial sustainability in terms of domestic resources used as a percent of program costs. In contrast, GA VI sees financial sustainability as a joint responsibility of the Vaccine Fund beneficiary countries and their external partners, with the external support as complementary to the domestic “effort” to mobilize resources. Hence, the approach required the committee to find a measure of “good effort” in mobilizing and using domestic resources for immunizations.

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Inside PHRplus

Staff Retreat and TAG Meetings Offer Unique Opportunities for Exchange

More than 75 PHRplus staff members representing eight partner groups and hailing from 15 countries gathered in Bethesda, MD, for meetings in early February to discuss the implementation of project work and to gain field perspectives. The retreat was unique in that it also included field
representatives from 11 other Abt projects funded primarily by USAID. They joined PHRplus staff and provided additional insights into ways to improve efficiency and strengthen communications with the field. Ample opportunity for discussion and learning was provided during the two-day retreat.

In assessing the retreat, headquarters staff noted that the group presentations by field staff working with mutuelles (community-based health insurance organizations in Francophone Africa) was especially helpful in providing a clear picture of the work and its impact; field staff appreciated the opportunity to learn lessons from related projects activities in different regions.

**PHRplus TAG Meeting**

Immediately prior to the Staff Retreat, the project convened its first Technical Advisory Group (TAG) meeting. At the two-day meeting, project and USAID staff briefed the TAG on the organization of the project, its missions and goals, research agenda, and selected project activities. TAG members represent both private and public organizations including the Gates Foundation, Rockefeller Foundation, World Health Organization, World Bank, Inter-American Development Bank, Self Employed Women’s Association, and the Tufts Health Plan. Valuable insights provided by the TAG included:

▲ Recognizing the project serves multiple clients, there is a need to balance diverse demands, notably those of Global Bureau teams, regional bureaus, and missions. The TAG recommended adequate core budget funds be allocated to support cohesiveness and learning across the diverse activities of the project.

▲ The TAG commended USAID on its foresight in including infectious disease surveillance (IDS) in a broad health systems project. They believe there are considerable benefits to be derived, providing there is sufficient interaction between the IDS team and the rest of the project.

▲ PHRplus requested the TAG help identify areas for project technical assistance (TA) responses and for global leadership. Three areas were identified:

▲ Community-based health insurance, which may provide opportunities for complementary TA and research activities and could be useful in terms of policy impact.

▲ Accountability, which the TAG thought was an intriguing new area. A particular challenge will be to advise on reforms that use strengthened accountability to improve service delivery.

▲ Human resources, a challenging area that is receiving growing interest. Given PHR’s work on health worker motivation, this could be an area where PHRplus could make significant contributions.

**HIV/AIDS Technical Advisor Joins Project**

Gilbert Kombe, MD, MPH, has joined PHRplus as HIV/AIDS senior technical advisor. Dr. Kombe will shape the overall technical approach for health systems and HIV/AIDS and provide leadership to regional and country teams in determining achievable, sustainable short- and long-term strategies to strengthen health systems’ capacity to provide effective HIV/AIDS prevention and service interventions.

Dr. Kombe comes to PHRplus from the George Washington University School of Public Health and Health Services in Washington, DC, where he taught international health classes for seven years. In addition to regular academic responsibilities, he conducted several trainings for international health projects for primary health care managers from developing countries. During this period, he also provided hands-on technical assistance to several multinational donors and international organizations on topics such as HIV/AIDS, maternal and child health, health systems, and infectious disease prevention. He has served as a technical advisor for the U.N. Economic Commission on Africa, where he helped to formulate an HIV/AIDS prevention strategy for that continent. A native of Zambia, Dr. Kombe completed medical training in China and then served as senior resident physician for three years in Zambia. His MPH is from the George Washington University.

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Partners for Health Reformplus

Partners for Health Reformplus is USAID’s flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR’s focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services.

PHRplus will focus on the following results:

▲ Implementation of appropriate health system reform
▲ Generation of new financing for health care, as well as more effective use of existing funds
▲ Design and implementation of health information systems for disease surveillance
▲ Delivery of quality services by health workers
▲ Availability and appropriate use of health commodities

Bibliographic Database on Health Reform

Looking for the latest information on health reform issues? The PHRplus Resource Center bibliographic database on the project website contains nearly 5,000 entries, primarily from 1990 to the present. The database citations include books, papers, gray literature, videos, CD-ROMs, and journal articles on health reform and related issues. The user-friendly database can be easily searched by title, author, publisher, organization, date, region, language, and subject. Although the Resource Center does not provide photocopying services, many of the resources in the bibliographic database can be found at local university or medical libraries. Ordering information is provided with each entry as available. Where live links are available, they are included as well (the database currently includes over 800 live links). Visit the site at: http://www.PHRproject.com/resource/index.htm.