Spotlight

Information Systems for Health Financing Reform Put into Place in Egypt

The Government of Egypt is committed to an ambitious health sector reform program designed to improve the health and well-being of its citizens by providing universal coverage for a set of basic health services. A basic package of priority services will be financed through a single social insurance entity, the Family Health Fund (FHF), combining public funds and user co-payments according to ability to pay. PHR assists with policy design and implementation, and with a pilot project that tests how best to turn the new primary care strategy into reality. This new strategy aims to use scarce resources efficiently and benefit people who are most in need: the underserved, the poor, and those at high risk, particularly women and children.

A key component of the reform strategy is a pilot test of a new primary care and financing system in the Governorate of Alexandria. Great advances have been made on the financing side to enable the FHF to establish performance-based contracts with the six pilot sites. Fund staff have developed position descriptions, a strategic and business plan, budgets, and a performance monitoring system. Most recently, two key information systems were completed and are now linked to serve the needs of both the facilities and the Fund.

The first is a new clinical information system that is used by the family practice clinics to gather and process patient encounter and cost data. This Arabic language system was adapted from software produced by a previous USAID-funded project which developed information systems for Egypt’s health insurance organization. By building on the existing systems, the project has saved time and leveraged resources.
Promoting Evidence-Based Policymaking: A National Priority in Jordan

Can you take the politics out of policymaking in the health sector? Never. But you can and should balance politics with empirical data, and to do so requires a pro-active approach. Jordan has taken several pro-active steps to foster the production and use of research in health policy, the latest of which was the Health Research and Policy Forum jointly hosted by the Ministry of Health (MOH), PHR, and the Royal Hashemite Court. The Forum, held July 31, was widely attended by the major health sector players in Jordan including Prince Firas Ra’aed, Health Advisor to HM King Abdullah, and representatives from the MOH, Royal Medical Services, Jordan University Hospital, universities, the private health sector, and the regional WHO office.

The Jordanian health system faces a serious sustainability issue. While the country spends more on health as a percentage of GDP (9.1) than many OECD countries and basic health statistics are comparatively good, demographic, epidemiological, and economic trends threaten these achievements. A high total fertility rate (4.3), longer life expectancy, and the rise of chronic diseases are placing mounting demands on the health system. At the same time, economic growth has been slow, limiting the public and private resources available to meet rising demand. Health officials and donors need reliable data to assist them make decisions regarding different macro and micro health reform approaches to contain costs, maintain quality, and eliminate inefficiencies. Research is needed to monitor and evaluate the impact of reforms.

Fortunately, Jordan has many health research resources available in the public and academic sectors, PHR is currently providing technical assistance in Egypt, Jordan, and Morocco in a wide range of health reform areas, including quality improvement, health information systems, National Health Accounts, primary care, health reform policies and processes, expansion of health coverage, sustaining family planning programs, and hospital autonomy. PHR is also working with the Asia and Near East (ANE) Bureau to establish a regional network of countries working on National Health Accounts and to support and expand regional networks of health economists.

The Oracle-platform software includes a component for beneficiary registration that establishes a unique patient identifier both to link families for treatment purposes, and to establish insurance eligibility by households. The system assists clinicians record detailed medical histories, track treatment by prompting for delivery of essential services including immunizations or chronic disease management, and capture routine patient encounter data. In addition, the system generates reports to track the use of specific services such as immunization, family planning, and communicable disease treatment that have traditionally been delivered by vertical programs and which are still monitored separately by the Ministry of Health and Population. Facility managers receive reports on primary care team efficiency, cost per patient per visit, and utilization of pharmaceuticals and laboratory and x-ray services.

A second new piece of software supports the FHF’s administration of performance-based contracts with the facilities. This MS-Access performance monitoring system accepts patient encounter data from facility-based clinical systems and enables Fund staff to prepare comparative reports on twelve indicators of cost, efficiency, and quality. The system allows the Fund, and the facilities themselves, to compare performance in terms of visit volume, trends in volume over time, patients with multiple visits, plan-to-actual volume performance, and utilization by diagnosis. Reports can be generated to assist Fund managers by presenting comparisons of clinical practice between primary care teams within a facility and across facilities in terms of diagnosis, prescription, laboratory, x-ray, and referral patterns. Basic cost and accounting data enables Fund and clinic managers to examine the direct, intermediate (prescription and x-ray), and overhead costs associated with care delivery. Initial reactions to the comparative data have prompted analysis and discussion within facilities about strategies to improve efficiency.

These two linked MIS systems will be used as a basis for performance incentive payments in the first stage of Egypt’s health financing reform. They are prototype systems that will provide experience in both insurance claims systems and clinical information systems. The National Technology Laboratory, financed by the World Bank, will then draw on these to design Egypt’s national health insurance information systems. The experience gained through these rapidly deployed prototype systems will improve the likelihood that larger systems will perform well and will meet user requirements.

Efficient computer-based systems for registering and referring beneficiaries and tracking their care, for registering providers, for provider billing and payment, and for monitoring and evaluation of health outcomes and resource use will contribute to the ministry’s strategy to provide all Egyptians with access to better quality primary care and preventive services. For more information, contact kathleen_poer@abtassoc.com.

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Fortunately, Jordan has many health research resources available in the public and academic sectors,
and from donor-funded sources. Examples include the MOH statistical yearbook, the Department of Statistics yearbook, National Health Accounts (NHA), household surveys, health facility surveys and registries, and issue-specific studies. But there is poor access to these resources and little demand for data among policymakers.

These access and demand issues were addressed at the Forum. At the Forum, current data sources and specific proposals for the improvement and standardization of key data sources were presented. NHA was used as a case study of evidence-based policymaking in practice. Then, specific proposals for creating a culture of evidence-based policymaking were outlined. Proposals included identifying and funding health research priorities, reactivating the Higher Health Council with a technical committee, holding an annual forum to present and discuss the latest research on national health issues, and establishing a national center for health research to serve policymakers.

The MOH and PHR are taking concrete steps to produce results. The access problem is being addressed by expanding the MOH website to include abstracts in English and Arabic of 500 publications related to the Jordanian health sector. Hardware upgrades will improve the speed and quality of the website. PHR has trained over 300 individuals from the public and private sectors in applied research methodology. PHR and the MOH will continue to work closely together to make the Forum proposals a reality. Health officials will have improved access to current health research and data to make informed decisions for an improved Jordanian health system. For more information, contact catherine_connor@abtassoc.com.

Focus on Africa

PHR provides technical assistance in Kenya, Malawi, Rwanda, Senegal, Zambia, and Zimbabwe in the areas of social insurance, health reform policies and processes, mutual health organizations and community financing mechanisms, hospital management, decentralization of health services, and cost recovery. PHR collaborates with USAID regional bureaus in West and Central Africa (WCA) and East and Southern Africa (ESA) to implement cross-cutting sub-regional activities in several other countries.

PHR Strengthens District-Level Financial Management Systems

Over the past several months, PHR has worked with the Malawi Ministry of Health and Population (MOHP) to strengthen district-level systems for planning and financial management as the government takes steps to decentralize the delivery of primary health care services. As part of the decentralization process, management and oversight functions for the operation of district hospitals, health centers, and rural health posts will be eventually transferred to newly created local government structures called district assemblies. In preparation for this transition, the MOHP is taking steps to build the capacity of district health management teams to perform monthly expenditure tracking and reporting, manage their own bank accounts, and maintain computerized accounting and inventory control systems.

As a first step, PHR carried out an assessment of current district-level systems for financial management and proposed ways to strengthen these systems in one district, Chikwawa. Extensive discussions were held with senior staff of the MOHP, the Office of Local Government, the USAID/Malawi Community Health Partnerships (CHAPS) program, and the Quality Assurance Project to discuss:

- The feasibility of computerizing the accounts of the District Health Office (DHO); and
- Resource availability/constraints in the DHO.

PHR conducted an on-site observation and assessment of accounting systems currently used by the Chikwawa district health management team and proposed a series of recommendations that included:

- Arranging for staff computer training;
- Establishing ledgers to control the budget by line item so that expenditures can be more efficiently tracked against the annual budget;
- Identifying an appropriate software package to handle the chart of accounts required under the government of Malawi Medium-Term Expenditure Framework (MTEF) structure; and
- Setting up a quality assurance team to assist in resolving the difficulties encountered in the implementation process.

USAID/Malawi has requested that PHR take part in upcoming high-level discussions with the MOHP decentralization task force regarding the development of a national-level plan of action for improving district financial management over the next twelve months. For more information, contact shirl_smith@abtassoc.com.

Communities Validate Household and Provider Survey Findings

PHR’s Equity Initiative Team (L’Initiative pour l’équité au Mali—IPE) held a series of community workshops in July and August to discuss and validate findings from household and provider surveys in Mali. Through the IPE, PHR surveyed more than 12,000 individuals and 500 health care providers to determine the root causes of strikingly low utilization of health care services.

PHR sponsored a series of community workshops in each of its two pilot sites—the rural district Bla and the city of Sikasso—in order to present the survey results and set local priorities for action. In each site, three days were devoted to validating the results of the household and provider surveys with PHR’s Equity Initiative Team (L’Initiative pour l’équité au Mali—IPE) held a series of community workshops in July and August to discuss and validate findings from household and provider surveys in Mali. Through the IPE, PHR surveyed more than 12,000 individuals and 500 health care providers to determine the root causes of strikingly low utilization of health care services.

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a diverse group of participants. These participants included health staff from both public and private facilities, NGOs, and associations of women and youth, pharmacists, traditional healers, village chiefs, radio stations, and local and regional government representatives. PHR, in partnership with the Quality Assurance Project, invited public and private health care providers to spend two additional days taking an in-depth look at survey results related to quality from the client, facility, and provider perspectives.

While the data presented were complex—including income quintile analysis, statistical concepts, and rich information on supply and demand for health services—participants actively discussed and debated results until they were validated by consensus. Participants received copies of all the data analyses presented. PHR staff set up laptops at the workshops to answer queries, run additional analyses, and verify data. Some findings provoked disbelief or surprised many health staff. For example, one survey found that pharmacies had experienced a stockout of chloroquine, the main remedy for malaria, during a particularly dangerous period for malaria infection. While the workshop agenda allowed for in-depth discussion of these findings as they were presented, the last day was dedicated to using the data to identify priority problems and propose solutions. Participants also conducted local feasibility analyses to set priorities for action.

Participants reached consensus on both key problems and solutions in each site. For example, PHR surveys found that very few providers offer (and very few people say they have benefited from) protection mechanisms for those who cannot pay in full at the point of service. Both pilot sites want to develop prepayment schemes / mutual health organizations as a solidarity mechanism to improve the population’s access to health services. Household surveys also showed that very few women (across income groups) use post-natal services, despite a relatively high use of prenatal services. Both communities want to initiate intensive information, education, and communication campaigns to improve women’s use of post-natal care.

A local radio program broadcast findings from the workshops, including in-depth interviews with participants and organizers. PHR will hold follow-on workshops in October to refine proposed strategies, begin their implementation, and develop monitoring and evaluation plans. For more information, contact allison_kelley@abtassoc.com.

Hospitals Undergo Reform in Malawi

The concept of hospital autonomy originated in countries where central health authorities have primary responsibility for the provision of curative inpatient care in addition to their traditional responsibility for planning and regulating health programs. As the cost of inpatient care rapidly increases, the role of governments in providing these services is being seriously revisited.

In Malawi, the government has made a clear choice to move towards hospital reform starting with the two largest public referral hospitals. This decision was motivated by the increasingly limited financial resources available and by the current state of operational and structural decay of the hospitals. Privatization of the public hospitals is not an option, as it would be perceived by the general population as reneging on the government’s past assurances to provide free and affordable inpatient care. A middle course has been chosen by which public ownership of the hospitals will be retained and organizational reforms to induce hospitals to operate more efficiently will be implemented. PHR, at the request of the MOH and USAID/Malawi, has assisted in assessing the present operational status of the two hospitals to devise a hospital autonomy implementation plan.

Malawi’s hospital autonomy strategy is based on a phased approach that ensures systematic implementation. To be successful, many systems and individuals, internal and external to the hospitals, will have to be in place and functioning properly prior to completing the final transfer of authority. The implementation strategy includes three phases to be performed simultaneously, all to be completed in four years.

Phase I – Initiate strengthening of hospital systems and outpatient health centers.

- Reinforce the current capacity of the primary care system by implementing a specialist rotation system whereby hospital physicians see patients at outpatient and rural health centers versus at the central referral hospital and by introducing an inventory management system for drug supplies.
- Introduce a referral system at the primary care outpatient clinics and at district and rural hospitals.
Implement full user fees at the hospital-based outpatient clinics to discourage primary care patients from using tertiary hospitals for routine illness treatment.

Implement in-depth assessment of personnel qualifications and determine training requirements.

Initiate administrative, financial, procurement, and personnel training.

Develop bylaws for hospital boards of directors detailing powers and responsibilities.

Appoint boards of directors.

Conduct needs assessment of administrative, financial, procurement, and human resource systems.

Initiate mobilization of political legislative support.

Compile a list of all laws and regulations that impact the transfer of operational autonomy to the hospitals.

Phase II – Strengthen the hospitals’ operational capacity.

Complete training of administrative, financial, and human resources personnel.

Implement detailed administrative, financial, purchasing, and human resource policies and procedures.

Initiate the transfer of authority and responsibilities to the hospitals in areas that do not conflict with existing laws.

Draft and present to relevant political stakeholders proposed changes in laws before full transfer of authority.

Phase III – Complete the transfer of operational autonomy to the hospitals.

Finalize implementation of hospital administrative, financial, procurement, and human resource systems.

Enact changes to laws that will formally create a legal entity for autonomous hospitals.

Design a monitoring and evaluating system that measures progress made and that examines the health outcome impact of the hospital reform process.

Over the next three months, PHR will work with the MOHP on designing the referral system and facilitating agreement with specialists on a rotation plan to provide specialist care at the district hospitals.

For more information, contact ibrahim_shehata@abtassoc.com.

Focus on Special Initiatives

PHR and USAID have jointly developed seven Special Initiatives, focusing on maternal and reproductive health, child survival (including activities in immunization financing, polio, vitamin A, integrated management of childhood illness [IMCI]), infectious diseases, the role of NGOs in health sector reform, National Health Accounts (NHA), and indicators for measuring results of health sector reform for system performance, and assessing the impact of health reform on HIV/AIDS service delivery.

National Immunization Programs Receive Financial Planning Training

In July 2000, immunization program representatives from over 30 countries participated in workshops focusing on key concepts in immunization financing. This was the first time immunization program representatives from these countries had a chance to focus on this increasingly important aspect of immunization provision programs.

The work of the Global Alliance for Vaccines and Immunizations (GAVI) in the international arena has served as a catalyst for an increased emphasis on immunization program financial management and planning for countries preparing funding proposals to the Global Fund for Children’s Vaccines. In response to requests from UNICEF regional offices in Africa, and the South-East Asia regional office of WHO, PHR facilitated sessions on immunization financing issues at UNICEF-sponsored training workshops in Douala, Cameroon, and New Delhi, India. The objectives of the PHR sessions were to:

- Introduce key concepts in costing, financing, and planning;
- Present illustrative findings of four immunization financing country case studies (Morocco, Côte d’Ivoire, Bangladesh, and Colombia);
- Present objectives, methodology, and applications of an immunization financing assessment tool; and
- Clarify how participants can use the tool to develop strategic plans and advocate for appropriate financing of immunization programs within their ministry of finance or other government entities and with partners such as GAVI.

The level of interest generated on these issues was significant. Several countries requested technical assistance in preparing their financial plans and others praised the relevance of the immunization financing assessment tool. Many country representatives commented that they had never received training in this aspect of their national immunization program. The response was positive, with many country representatives commenting that a better understanding of this information was essential to effectively manage their programs.

In addition to the presentations on the financial concepts, the workshop provided countries the opportunity to pose questions and concerns regarding GAVI and to offer suggestions on priorities, capacity-building, and sustainability issues.

Representatives from PHR will continue to provide technical assistance to countries as they prepare their financial plans for GAVI applications over the next five years. For more information, contact joanne_jorissen@abtassoc.com.

HIV/AIDS: Priorities and Challenges for the Health Sector

PHR presented key findings from studies focused on the organization, management, and financing of HIV/AIDS programs in July at the International AIDS Conference in Durban, South Africa. Presenters addressed how strengthening the health sector as a whole, through promoting efficient and cost-effective programming, can serve to enhance the sector’s ability to curb the HIV/AIDS epidemic.

As HIV/AIDS threatens to undermine the overall development of many countries, decision makers must be strategic in their resource allocation decisions. The challenge is how to make the best use of available resources to expand coverage, access, and quality of services while at the same time continue to combat pervasive diseases such as malaria, diarrhea, and respiratory infections.
In Durban, conference presenters and participants brought to the table multiple issues, all of which will place demands on the budgets of governments and donors alike. Among the topics widely discussed were: how to provide anti-retroviral therapy to those infected in developing countries, the financing and developing of an AIDS vaccine, the needs of AIDS orphans, preventing mother-to-child-transmission, and the debate over allocation of resources to expand coverage, access, and quality of care.

PHR researchers are developing tools and conducting analyses on how resources for HIV/AIDS programs can be most effectively allocated. Dr. Alexander Telyukov presented a study that addresses a pressing need for a uniform and replicable methodology of HIV/AIDS program costing. The approach, known as activity-based costing (ABC), enables the separation of various programs into common structural units, each one defined by an activity and a process. The standardized activity-cost matrix is instrumental for comparing costs of different HIV/AIDS interventions. Furthermore, the proposed terminology of activities and costs will be used to design new and evaluate ongoing programs and technical and budget proposals.

PHR worked with HIV/AIDS country program managers in Cambodia, which has the most serious HIV/AIDS epidemic in Asia, to design the activity-cost matrix. PHR also presented on alternative ways that donors and governments can provide HIV/AIDS services including contracting out to NGOs to deliver an array of services at a lower cost and typically have improved management of TB to reduce re-admissions. Lastly, PHR funded a small applied research (SAR) study to determine the costs of care at the primary level.

As the international community continues to focus attention and resources on this global epidemic, it is critical that lessons learned, tools developed, and data analyzed be brought to bear on policy decisions. PHR will continue to inform and add to the international dialogue on how to address the challenges and needs posed by HIV/AIDS. For more information, contact courtney_barnett@abtassoc.com.

Focus on Applied Research

The PHR Applied Research Program prepares and implements an agenda of research that advances knowledge about health sector reform at the global and individual country levels. The program has two components: Major Applied Research (MAR) and Small Applied Research (SAR). The MARs are intended to be cross-country studies using sophisticated research methodology to produce new information on health reform which is of value to a broad group of policymakers, while the SARs are intended to be more narrowly focused studies performed in a single country to evaluate a particular health policy or program and strengthen the country’s or region’s research capabilities.

Costing HIV/AIDS Services and Determining Perceived Quality of Care

With HIV prevalence at 22 percent among women attending public antenatal clinics, intensified use of public health facilities increasingly strains public resources in South Africa. In an effort to contribute to the fight against the HIV/AIDS crisis and in support of research among developing country researchers, PHR funded a small applied research (SAR) study on the costs and perceived quality of care of HIV/AIDS services in the Western Cape Province in South Africa.

Principal investigator Veloshnee Govender of the University of Cape Town and her team interviewed 350 HIV/AIDS patients to determine the costs of care at different stages of the illness and patients’ satisfaction with health services and medical staff. Of the respondents, the majority were women and a quarter of them were between the ages of 16 and 26. Forty percent of them lived in an informal dwelling, less than one-third had reached the primary education level, and almost half were unemployed. The average length of hospital stay was about eight days.

The study found that the average cost per hospital admission was approximately $760 at Groote Schuur hospital and $590 at Conradie hospital. The cost per inpatient day was $97 and $92, respectively, with specific inpatient costs (excluding drugs, laboratory, and radiology) comprising 85 percent of costs. For transportation expenses, patients paid an average of $6.30, and, in many cases, patients sought care further away from home for the sake of anonymity.

Overall, patients indicated that they were satisfied with the health services received. However, reasons for dissatisfaction cited included inadequate or ineffective drugs, poor staff attitudes, and the fear of being discriminated against or losing confidentiality.

The research suggests that a large number of terminal stage four inpatients could have been discharged sooner to hospice services and home-based care. Also, the study found that many patients presenting with tuberculosis (TB) as a co-infection with HIV were discharged and subsequently re-admitted with re-activated TB, suggesting poor compliance with TB treatment at the primary level.

Ms. Govender’s study recommends the development of standard treatment guidelines for the management of HIV-infected patients to ensure early diagnosis and appropriate treatment. Also, improved knowledge and awareness of the illness among the general population is essential in order to reduce or eliminate discrimination against HIV patients. Finally, the study recommends improved management of TB to reduce expensive secondary and tertiary inpatient costs. For more information, contact whitney_schott@abtassoc.com.
Focus on Latin America and the Caribbean

PHR provides technical assistance to USAID missions, ministries of health, and host-country counterparts in five countries in the Latin America and Caribbean (LAC) region: Bolivia, Dominican Republic, Ecuador, Guatemala, Honduras, and Peru. PHR also works with USAID’s LAC Bureau on the region-wide initiative that has trained a network of country counterparts in National Health Accounts (NHA) in eight countries, participated in the development of region-specific indicators of health system performance, and conducted research on the role of local NGOs in health reform efforts.

Dominican NGOs Learn from Ecuador’s Experiences

The Dominican Republic has been involved in an ambitious health reform program since 1996 led by the Ministry of Health and the Executive Health Sector Reform Commission (CERSS). Two large health reform projects, implemented by CERSS and funded through World Bank and Inter-American Development Bank (IDB) loans, are providing technical and financial assistance. In addition, USAID, PAHO, and the European Union provide support to the program. Despite broad cooperation, certain critical elements of the program such as decentralization, public-private partnerships, community participation, and service financing, among others, have presented a challenge. To facilitate conceptualization and implementation of these concepts, the CERSS-IDB project, with the assistance of PHR, organized a study tour to Ecuador to observe and learn from innovative health reform experiences there.

In July the Dominicans visited the APOLO/CARE project in Ecuador, a project sponsored by USAID since 1995 whose mission is to strengthen the organizational capacity of public and private entities. The purpose of the visit was to observe public-private partnerships in health reform, to examine NGO accreditation requirements and experience, and to learn about varied concepts and tools related to health reform implementation. Participants in the study tour included seven representatives of Dominican NGOs involved in the development of national guidelines for NGO accreditation, as well as two technical coordinators from CERSS.

The study tour began in Quito, with a general overview of the APOLO project and a description of health service delivery models developed. The group traveled to Cuenca to visit the Fundación Humanitaria Pablo Jaramillo, an NGO set up in the mid-1980s to provide affordable medical care to low-income neighborhood residents. With APOLO’s support, this NGO has improved its physical infrastructure, introduced modern health care management systems, and moved towards sustainability. This process of institutional strengthening has contributed to improved access and quality of care, and ultimately, to improved health status.

In Chordeleg, a small community located 100 miles north of Cuenca, the group observed a “comprehensive community development” model supported by APOLO. In this model, health services are run by the MOH, but report to a local board, with key decisions on coverage, user fees, subsidies, etc., made at the local level. There is active participation by the mayor’s office, the Catholic church, the MOH, and community groups, all of whom are involved at some level, in priority setting, planning, pricing of services, and program implementation.

In Santa Elena, a site visit was made to Fundación Cristo Redentor, an NGO started with support of the Catholic church. With APOLO’s support, Cristo Redentor improved its physical infrastructure and operations management, established working relations with the mayor’s office, and expanded service mix and coverage. The NGO has become the sole provider in an area where MOH services have historically been scarce. The community now relies on the NGO for high quality and affordable services. Likewise, health status indicators have improved.

On the last day of the study tour, the group visited CEMOPLAF, a reproductive health clinic in Otavalo, an indigenous community north of Quito. CEMOPLAF is one of the largest providers of reproductive health services in Ecuador, with clinics operating primarily in the highlands. The CEMOPLAF model is of interest because of its focus on diversification and sustainability. In this model, service mix was expanded to include some “cash cows” such as adult medicine, imaging services, and dental care. Revenue generated by these services provides a cross subsidy for provision of reproductive health services.

Participants in the study tour were exposed to several private-public models of health care organization and delivery. Key lessons gleaned that are applicable to the Dominican health system include:

▲ It is possible to improve health services with focused technical assistance interventions.
▲ Remarkable improvement in the quality and financing of health service delivery is possible with limited resources.
▲ Community participation in health service delivery program planning and implementation is a plus.
▲ It is important to be flexible and take advantage of opportunities. This is a key lesson given that the health reform process requires not only technical competence, but also political savvy.

All participants agreed that the study tour was highly successful and that observations and lessons learned will contribute positively to the health reform process in the Dominican Republic. Participants were impressed by the innovative management systems, social insurance schemes, level of community participation, and innovative financing strategies observed. For more information, contact kathleen_novak@abtassoc.com.

LAC Policymakers Discuss Social Health Insurance

Health systems in Latin America and the Caribbean (LAC) differ widely in terms of coverage, access, equity, effectiveness, financing, organizational structures, and outcomes. A significant relationship exists between high levels of poverty and poor health outcome. The challenge for health sector leadership in the region is to construct health systems that offer access to quality health care while facing severe budgetary constraints. Social health insurance issues have emerged as a central focus of current reform discussions in the LAC region as countries struggle to use scarce resources efficiently.

Key policymakers from five LAC countries came together at a workshop, “Expanding Social Insurance,” at
Montelimar, Nicaragua on July 11-13 to share successes and challenges in implementing social insurance programs. Sponsored by the Latin America and Caribbean Regional Health Sector Reform Initiative (LACSRH) and implemented by PHR, Family Planning Management Development (FPMD), and PAHO, representatives from Nicaragua, El Salvador, Honduras, Ecuador, and Jamaica, explored possibilities for expanding social insurance programs in each country.

At the beginning of the workshop it was clear that participants did not share a common definition of “social health insurance.” Social insurance systems within the region vary tremendously depending on the political, financial, and epidemiological characteristics of each country. To establish a common vocabulary, Dr. Matilde Pinto/PAHO gave an overview of social insurance describing basic characteristics, sources of funding, insurance mechanisms, and issues to consider during program design and implementation. The workshop was designed not to develop or propose a single model, but rather to provide country representatives with the necessary skills and tools to make informed decisions about expanding social insurance systems and to learn from mutual experiences.

Dr. Daniel Maceira/PHR presented a comparative study on the complexity and diversity of health care systems in the region providing participants with a basis to analyze and discuss common advantages and limitations. Dr. Rena Eichler/FPMD discussed the financing aspects of social insurance schemes and led participants through a role playing exercise in small groups to better understand the financial framework.

The workshop provided opportunities for participants to both formally and informally exchange information on experiences in implementing programs. Participants developed country-specific action plans for expanding social insurance in their respective countries. Follow-up interviews will be conducted in 3-4 months to check in with participants to learn what actions have been implemented as a result of the knowledge and experience gained in Montelimar. Copies of the publication, *Comparative Analysis of Social Health Insurance in the LAC Region* will be available from PHR in the fall. For more information, contact kathleen_novak@abtassoc.com.

**Inside PHR**

Vivian Aziz, the financial and administrative manager for the PHR Egypt office, is responsible for local finances, procurement, and administrative support for a team that included five expatriate advisors and a staff of nearly twenty Egyptians at the peak of the project’s activities. Vivian plays a critical role as the problem-solver who assists the chief-of-party and operations officer in defining solutions for complex administrative, personnel, and governmental issues. Her knowledge of Egyptian social insurance, salary, income tax, and labor laws, as well as USAID rules, and her professional contacts within the government of Egypt and the private sector, are an invaluable asset to the PHR Egypt team.

Vivian was instrumental in setting up the PHR Egypt office, which opened in September 1997. She established a rigorous financial system and procedures for the office, which have been adapted and used in a number of other PHR field locations. She holds a degree in business administration, with a major in accounting, from the American University in Cairo. Vivian has worked with USAID projects since the Camp David Agreement brought USAID into Egypt more than twenty years ago.

Mary Paterson, PHR Egypt’s chief of party, says of Vivian, “From my perspective, Viv is an indispensable member of the PHR team. She also handles the financial management for three other USAID projects in Egypt. Despite her busy schedule, she is always available to solve problems and assist team members. We couldn’t achieve our results without her. Vivian is very dedicated to her job and has a strong work ethic. She is a wonderful addition to the office.” Vivian replies, “It makes me very proud that people appreciate my work.”
PHR Presentations

As part of its ongoing dissemination efforts, PHR gave or sponsored the following presentations and brown bags between July 1 and September 30, 2000 for a variety of local, regional, and international audiences interested in the project’s work in health sector reform. In addition to reporting on PHR activities, a number of PHR staff were asked to provide their expertise or discuss the current state-of-the-art at a variety of fora in such areas as immunization financing and National Health Accounts. Presentations are listed below by the date they were given.

**July**
- Patricio Murgueytio, “Gestión de calidad para equipos de salud familiar,” Taller de Fortalecimiento Gerencial para Equipos de Salud Familiar, Bayahibe, Dominican Republic (July 1)
- José Durán, “Comunicación para la salud,” Taller de Fortalecimiento Gerencial para Equipos de Salud Familiar, Bayahibe, Dominican Republic (July 1)
- José Durán, “El uso efectivo del tiempo,” Taller de Fortalecimiento Gerencial para Equipos de Salud Familiar, Bayahibe, Dominican Republic (July 1)
- The following presentations were made in Durban, South Africa, at the IAEN International AIDS-Economics Symposium (July 7-8) and at the XIII International AIDS Conference (July 9-14)
- Pia Schneider, “Use and Expenditures on Outpatient Health Care by a Sample of HIV Positive Individuals in Rwanda”
- Sasha Telyukov in conjunction with Francesca Stuer from FHI/IMPACT, “Management Accounting for HIV/AIDS Program Planning and Implementation”
- Courtney Barnett, “The Relationship between Health Sector Reform and the Delivery of HIV/AIDS Services”
- Pam Putney and Courtney Barnett (in absentia), “Contracting NGOs in Guatemala: Greater Access, Expanded Coverage, and Improved Services”
- Catherine Connor, Pam Putney, Kathy Krasovec, and Courtney Barnett (in absentia), “Public Sector Contracting of NGOs to Deliver HIV/AIDS Services in Guatemala and Brazil”
- Miloud Kaddar, “PHR Immunization Financing Work,” Immunization Financing and New Vaccines Workshop, Douala, Cameroon (three presentations, July 10-14)
- Daniel Maceina, “Dimensiones horizontal y vertical en el aseguramiento social en salud de América Latina,” Workshop on Social Insurance in LAC, organized by LAC Initiative, Montelimar, Nicaragua (July 11-13)
- Ann Levin, “PHR Immunization Financing Work,” Immunization Financing and New Vaccines Workshop, Delhi, India (five presentations, July 24-27)
- Francisco Vallejo, “La reforma del sector salud y sus implicaciones en los procesos educativos: enseñanza de la salud pública y la educación en salud,” Postgrado Maestría en Salud Pública, Universidad Nacional Autónoma de Honduras, Tegucigalpa, Honduras (July 24)
- Lonna Milburn, “Promoting Evidence-based Policymaking in Healthcare: A National Priority,” Amman, Jordan (July 31)
- Allison Gamble Kelley, “Results from Household and Provider Surveys: The Equity Initiative in Mali,” Sikasso and Bla, Mali (July 25-27 and August 1-3)
- Atter Hannoura, “Developing Clinical Information Systems to Support Health Reform in Egypt,” Abt Associates, Bethesda, MD (August 16)
- Rossany Auceda, “Estudio de la situación de establecimientos públicos y privados de atención médica en Olancho,” Región Sanitaria No. 7, Juticalpa, Olancho, Honduras (multiple presentations, August 21-29)

**September**
- Francisco Vallejo, “Tendencias y modelos de planificación a nivel internacional,” Postgrado Maestría en Salud Pública, Universidad Nacional Autónoma de Honduras, Tegucigalpa, Honduras (September 7)
- Nena Terrell, “Family Care Models in Central Asia, Egypt, and Jordan: Applications of Advocacy and Marketing,” Morocco Study Tour, Commercial Marketing Strategies Project, Washington, DC (September 11)
- Nadwa Rafieh, “Family Care Models in Central Asia, Egypt, and Jordan: Quality Improvement and Health Sector Reform,” Morocco Study Tour, Commercial Marketing Strategies Project, Washington, DC (September 11)
- Pia Schneider and Francois Diop, “Final Evaluation Workshop of Prepayment Schemes in Rwanda,” Kigali, Rwanda (September 12-14)
**New Publications**

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- Prepayment Scheme in Rwanda Accepts Sero-Positive Members
- Facility Accreditation and Health Sector Reform in Egypt
- Special Initiative on Immunization Financing
- Initiative especial sobre el financiamiento de las imunizaciones
- Initiative spéciale sur le financement des vaccinations
- Costing Framework to Help HIV/AIDS Planning, and Management
- Brazil Public Sector Contracts to Fight HIV/AIDS

### Technical Reports
- Health Workforce Rationalization Plan for Egypt (TE 48) by Gary Gaumer, Wessam El Beih, and Samir Fouad
- Options for the Creation of a Monitoring and Evaluation Unit within the Ministry of Health and Population, Egypt (TE 47) by Alan Edmond and Erin Eckert
- Hospital Autonomy in Malawi: Assessment and Implementation Plan (TE 46) by Ibrahim Shehata and Gil Cripps
- Development and Implementation of Prepayment Schemes in Rwanda (TE 45) by Pia Schneider, François Diop, and Sosthène Bucyana

### Special Initiatives Reports
- The Impact of the Polio Eradication Campaign on the Financing of Routine EPI: Finding of Three Case Studies (SIR 27) by Ann Levin, Sujata Ram, and Miloud Kaddar
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- Health Finance Reform Model for Egypt Based on National Health Accounts (SIR 25 Vol III) by Afsar Akal and Katherine Burchfield
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**Partnerships for Health Reform**

July 1 - September 30, 2000