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***Health Sector Evaluation
1995-2005***

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ACRONYMS

IFIs	International Financial Institutions
IPES	Report of Economic and Social Progress in Latin America
LAC	Latin America and the Caribbean
LSMS	Living Standards Measurement Survey
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
NPM	New Public Management
PBL	Policy-Based Loan
PHC	Primary Health Care
PPMR	Project Performance Monitoring Report
SDSt	1996 Social Delivery Strategy
SUS	Sistema Único de Saúde (Unified Health System, Brazil)
WB	The World Bank
WHO	World Health Organization
WDR	World Development Report

EXECUTIVE SUMMARY

This report presents an evaluation of the conceptual and empirical basis of the key reform measures promoted by the Bank in its health sector interventions between 1995 and 2005. These measures depict the approach followed by the Bank to confront the problems of the sector. In this sense, the projects themselves, and the health sector reforms implemented by the countries during this period, are not evaluated individually or in isolation, but discussed in their relationship to such approach.

Since the approach followed by the Bank through its projects were related to the pursuit of three main objectives, improvement in efficiency, quality and equity or coverage, this report assesses the likelihood in which they have contributed to the achievement of such goals.

A. Portfolio and execution

In its history, the Bank has approved 63 stand-alone health sector loans totaling approximately US\$4.5 billion (in 2005 dollars). Even though these operations have represented a small share of Bank approvals – 3.4% of the number of projects and 2.3% of the amount – the pace of health sector approvals and the median size of health loans have increased since the nineties, particularly since 1995, surpassing the median Bank project. The period of focus of this evaluation (1995-2005), constitutes the most important period of the Bank’s involvement in the sector, representing 48% of the number of projects and 57% of the total amount approved by the Bank since its first stand-alone health loan in 1973.

In general, health projects approved between 1995 and 2005 took longer to approve and disburse than the average Bank project or education projects. The preparation and execution problems observed appear to be related to the complex nature of the health sector reform processes that most of our operations were supporting, and the political difficulties inherent to such processes. Comprehensive economic and public sector reforms, including those in the health sector, have imposed substantial political and transaction costs on politicians, decision-makers and the population in general. These costs have led to what has been called reform fatigue.

A comparison with the health sector projects approved by the World Bank in Latin America and the Caribbean (LAC) during the period, indicate that the Bank is competitive in the sector and that there are two major differences between the two institutions: (i) the World Bank has concentrated a much larger proportion of its lending on the bigger (“A”) countries than the IDB; and (ii) the World Bank has “dominated” the HIV/AIDS topic in the Region, approving 11 AIDS-related loans covering the entire LAC Region while the Bank has not approved any stand alone AIDS-related loan.

B. Health sector reform and the Bank’s framework in the sector

The nineties, and particularly the second half of the nineties, represent a major change in the direction of Bank’s financing for the health sector. While during the seventies and eighties the health sector operations approved by the Bank were fundamentally directed

at financing the sector's infrastructure and equipment, during the nineties the Bank shifted the *focus* of its financing in the health sector towards a systemic approach aimed at introducing structural changes and reforms to the sector as a whole. This change mirrored the trend of public sector reforms that were being implemented in the countries.

The reforms of the health sector were part of a general context of structural reforms initiated during the eighties, and were based on the views and policies of the "Washington Consensus." These views dominated the development thinking of the period and were incorporated by those working with the health sector, both in the countries themselves and in the International Financial Institutions. In this regard, the policy intervention areas supported by the Bank were intrinsically connected with and reflected the discussions and concerns of the countries of the Region.

This evaluation shows that a set of key reform measures, largely based on market instruments and incentives, defines the approach followed by the Bank during the 1995-2005 period: (i) the promotion of primary health care services and/or the definition of a basic (or essential) package of services; (ii) the contracting of private sector providers; (iii) the design and implementation of performance-based incentives ("contratos or convenios de gestión"); (iv) the introduction of user fees; and (v) the decentralization of the sector.

The evaluation also shows that these measures and the projects approved by the Bank during this period were essentially related to the pursuit of three main objectives: (i) to improve efficiency; (ii) to improve the quality of care and/or of the system; and (iii) to improve equity or increase coverage.

C. Evaluating the Bank's key reform measures

OVE has evaluated the theoretical and empirical basis underlying the key reform measures supported/implemented by the Bank in order to assess whether they were likely to have contributed to the achievement of the three main objectives for the sector.

The conclusions and findings derived from each of the main reform measures supported by the Bank indicate that they contain sufficient limitations and drawbacks to suggest that, as a whole, this set of measures was unlikely to have been able to improve efficiency, quality or equity of the health systems of the Region.

1. Primary health care and basic package of services

The comprehensive primary health care approach promoted at the 1978 Alma-Ata Conference was viewed as vague and financially unrealistic and has been replaced by an alternative primary health care framework that asserted that primary care interventions should contemplate a small number of cost-effective interventions: a basic package of care.

In this sense, the analysis of primary care needs to distinguish between the integrated PHC approach – used as a basis for organizing the health system, as in Canada and the U.K. – and the basic package services, that have been the most common form of policy

interventions in developing countries, including those promoted by the Bank. Fifteen of the 21 operations with primary care-related interventions supported the implementation of basic packages, and approximately 80% of those were limited basic packages.

While the idea of implementing selective interventions may make economic sense, the gains found in cost-effectiveness studies of PHC interventions have rarely been demonstrated in practice, i.e. the theoretical estimates of cost-effectiveness analysis do not take into consideration the limitations and constraints of health care systems. One of the few assessments from LAC shows that the limited scope of services offered by the basic package, particularly in the case of public outreach services of the type financed by the Bank in Central America, led to underutilization of services. A mid-term evaluation of a Bank experience with basic package shows mixed results. The experiences of some developed countries, on the other hand, indicate that a comprehensive primary care approach might be an effective strategy for organizing the sector.

As opposed to hospital care, which was viewed as mostly benefiting the middle and upper income groups, PHC was seen as pro-poor. This pro-poor perception of PHC has been made explicit in the Bank, which automatically classifies primary care health projects as poverty-targeted. However, the positive equity impact of primary care is not a certainty.

2. Contracting

Contracting was not only related to many of the other key reform instruments promoted by the Bank, but was also the most direct expression of the pro-market approach that was at the core of the reform proposals of the nineties. Contracting was expected to contribute to all three objectives: efficiency, quality, and coverage. The data available suggest that the contracting model most commonly implemented by the Bank has been unable to achieve the objectives of improving efficiency and quality, and although it may have achieved coverage goals for certain types of services, its adequacy and sustainability is questionable.

The success of the contracting model rests in the fulfillment of a series of assumptions and pre-requisites that were generally not satisfied: (i) the existence of a competitive environment; (ii) the greater quality of care delivered by private sector providers; (iii) the provision of services under lower costs; and (iv) the existence of adequate technical capacity covering all aspects of regulation, from contract design to monitoring and evaluation, to the ability of imposing penalties and sanctions.

The results derived from three Bank contracting experiences suggest that, in general, there are no major differences in performance between the contracted out and the publicly provided services, and that the unit costs of the contracted out model are greater than those under the public service arrangement.

3. Performance-based incentives

The Bank has supported the implementation of supply side performance-based incentives in 70% of the projects approved between 1995 and 2005. These measures aimed at improving the efficiency and quality of service delivery.

Contrary to economic intuition, evidence demonstrating the success of performance-based incentives is still weak or only peripherally relevant for the LAC context. Reviews of developed countries experiences find little evidence to support the assumed effectiveness of provider financial incentives and few positive net outcomes for the health system. Furthermore, these studies also point out the high design and administrative costs of these instruments.

The majority of Bank projects that support the implementation of performance-based incentives see them as instruments for improving quality. However, the Canadian experience shows that there is little reliable evidence to understand the effects of incentive systems on the health of patients in general and quality of care in particular.

Performance-based payment systems require a level of sophistication from regulatory and monitoring systems that might not be present in most LAC countries. This is particularly important, since incentive schemes that reward/penalize institutional performance, such as those supported by the majority of Bank projects, can potentially have a negative impact on the population that depends on the service. The “penalties” that might result from poor performance – e.g. smaller transfers or reduced budgetary allocations – are likely to affect mostly the local population that depends on services that can become underfunded.

4. User fees

Even though only 7 of the 30 projects approved between 1995 and 2005 supported the implementation of user fees, the fact that any Bank project would be proposing this type of measure is a striking finding in itself. The overwhelming evidence accumulated shows that, in practice, user fees have negative impacts on equity, access, efficiency and revenue collection. Furthermore, mechanisms to protect the poor (fee waivers and/or fee-scale arrangements), are generally ineffective; first because they cannot fully prevent patients from deterring care; and second because such systems are costly and difficult to implement and administer.

Two other issues need to be noted: first, projects that supported user fees were approved as late as 2001, even though the World Bank, who first promoted user fees in their African programs, had distanced itself from the measure by the mid-nineties. In addition, user fees were being implemented in countries (with one exception, all of them in Central America and the Latin Caribbean) that were not only among the poorest in the Region, but also were among those with the lowest tax efforts.

5. Decentralization and hospital autonomy

Decentralization has been the measure most commonly supported by Bank projects and reflects the general belief of the countries of the Region that decentralization was a key tool to improve the sector’s efficiency and coverage/equity.

However, decentralization, *per se*, does not guarantee improved health sector efficiency or access. Decentralization processes depend on the successful implementation of a series of measures (e.g. accountability systems and transparent legal frameworks and

transfer mechanisms), on the presence of adequate managerial and technical capacity at the local level, and on the existence of sufficient funding. Without these elements, decentralization may lead to increased costs and the multiplication of administrative and bureaucratic structures, and therefore greater inefficiency. Finally, if appropriate mechanisms for community control and oversight do not exist or are ineffective, there is an increased likelihood that resources will be misallocated or used for political purposes.

While rigorous empirical evaluations of decentralization efforts are difficult to conduct, the evidence available suggests mixed but somewhat encouraging results. Data on the impact of decentralization on (technical) efficiency is limited, but the international evidence suggests a worsening in allocative efficiency due to a decline in the provision of resources to public goods activities and an increase towards private health goods.

The Bank also supported, in 10 projects, country efforts to increase hospital managerial and financial autonomy as part of the decentralization process. The (limited) data on hospital autonomy in developing countries suggest few gains in terms of efficiency and quality of care. The experiences of developed countries show that hospital autonomy does not automatically enhance hospital performance. Finally, many of the assumptions implicit in the conceptual model of hospital autonomy are not likely to be met in practice. Decentralized public hospitals are instruments for two potentially conflicting objectives: to improve the sector's overall "efficiency and productivity," and to contribute to social policy goals. This is particularly true in the many instances in which public hospitals are the only source of care for certain areas. These facts, and their ultimate dependence on public resources, imply that hospitals are not likely to be as autonomous as assumed by the conceptual models.

D. Conclusions and recommendations

The Bank's interventions in the health sector were part of a general framework of structural reforms anchored on fiscal deficit reduction and market-based policies that dominated the development thinking of the period and permeated those working with the health sector, whether in the countries themselves, whether in the International Financial Institutions, including the Bank.

The conclusions and findings derived from each of the main reform measures supported by the Bank between 1995 and 2005 show the presence of important empirical and conceptual limitations. These limitations suggest that, as a whole, the approach followed by the Bank may not have been able to improve the efficiency, quality or equity of the health systems of the Region, as intended by the projects approved during the period.

The evidence available indicates that market-based instruments are not *necessarily* superior alternatives. The health sector is in fact characterized by both market failure and government failure, and the context-specific characteristics of the countries are critical for proper policy recommendation and implementation. These results, in turn, imply that health sector interventions were and will be largely experimental and the Bank should analyze different alternatives. Uncertainty is indeed inherent to the sector's policy

context. Developed countries like New Zealand that were strong adopters of New Public Management policies have been revising their strategies.

However, one of the main findings of this evaluation is that Bank reform actions were not evidence-based; they have, to a large extent, followed a set of consensual assumptions of the time that resulted from the belief that market-based mechanisms and incentives were the only solution to the problems and inefficiencies observed in the sector. Despite the lack of empirical and sometimes conceptual support, these assumptions were not seriously questioned: they were judged to be right because they were based on the “right premises.”

For all these reasons the evaluation efforts and the analytical and empirical work required to *support the Bank’s operational activities* need to be strengthened.

With regard to the need to strengthen evaluation efforts, this report has shown that that primary care is an area of significant relevance and potential impact on the organization and functioning of health systems that displays a remarkable paucity of empirical evaluation.

As shown by the analysis of the contracting experiences, several of the pre-requisites and assumptions required for the contracting of private sector providers have not been fulfilled. Accordingly, the Bank needs to assess the conditions in the countries in which it has financed similar approaches, formulate measures necessary to correct or mitigate existing limitations (if any), and analyze the set of conditions that can increase the likelihood of success.

The regulatory capacity of a country has been pointed out as critical for the successful implementation of many of the measures supported by Bank projects. This issue raises an important question that needs to be explicitly tackled by the Bank: Should (or can) policy makers wait for an optimal regulatory system to introduce certain interventions? However, since it appears that the regulatory limitations have not been adequately addressed, the Bank should prioritize evaluations of the existing regulatory capacity in those countries that have Bank-financed operations aimed at implementing contracting mechanisms, performance-based incentives, and hospital autonomy.

OVE has also found that the majority of the Bank’s economic and sector work is unrelated to the key measures discussed here or to the main objectives of Bank projects. In fact, there were only four studies related to the five key reform measures, eight studies related to reform in general, and only two to the objectives of efficiency, quality and equity/coverage.

In that respect, the implementation of “knowledge resource links” – website pages presenting main conceptual definitions, thematic reviews, applied research papers developed in-house or financed by the Bank, and links and references to the academic and policy-related literature – could be a tool that would serve both as a source of information and a catalyst for further research and exchange of ideas.

It is also clear that more sector work and analysis is needed. OVE strongly recommends that the Bank's applied research agenda should be driven by the needs of the Operations Departments. Recently approved projects suggest that the countries of the Region are seeking a still unclear but somewhat different path; therefore, the relevance of the Bank's assistance relies upon its capacity to identify the themes and areas that need further research.

It should be pointed out that the problems found by this evaluation do not invalidate the Bank's focus on systemic issues. IDB's comparative advantages rely on its ability to understand, prescribe and intervene upon system-related issues, which does not necessarily mean reform measures. It must also be remembered that the Region is unique in the sense that it has a United Nations technical agency, the Pan-American Health Organization, to support the countries on disease-specific and epidemiological issues.

Examples of (non-reform) systemic issues that present potential for future Bank involvement include: (i) interventions aimed at improving the (epidemiological and health) surveillance capacity of the countries, an area that is closely related to regulatory and institutional systems, which as discussed throughout this document, are still weak in the Region; (ii) the design and implementation of health systems networks (the Bank has supported interventions in this area during the period analyzed, and continues to do so to this date); and (iii) human resources: the health sector is essentially labor intensive. While in developed countries it employs up to 10% of the formal workforce, in developing economies it uses large proportions of voluntary and informal labor. Furthermore, human resources are, perhaps, the most important factors in determining the quality and efficiency of any health service, since they are the final actors and decision-makers in the health care delivery process. Despite these facts, the development of the sector's human resources has not received adequate attention from the Bank or other agencies.

Finally, as indicated by the comparison with the World Bank, the Bank is competitive in the sector. The Bank's very positive health sector program in Colombia is an example of its competitiveness and the lessons that can be drawn from this experience should serve as a basis for the Bank in the future.

I. INTRODUCTION

- 1.1 Starting in the early 1990s, but particularly since 1995, the Bank's interventions in the health sector were part of a general framework of structural reforms anchored on the fiscal deficit reduction and market-based policies that dominated the development thinking of the period. This reform framework was translated into a set of health reform measures designed to induce, or at least mimic, market-like behavior by public and private agents.
- 1.2 This report presents an evaluation of the conceptual and empirical basis of the key reform measures promoted by the Bank in its health sector interventions between 1995 and 2005. These measures depict the approach followed by the Bank to confront the problems of the sector. In this sense, the projects themselves, and the health sector reforms implemented by the countries during this period, are not evaluated individually or in isolation, but discussed in their relationship to such approach.
- 1.3 This evaluative methodology, as opposed to an evaluation of individual projects, has been chosen by OVE because (i) the number of fully-disbursed investment projects approved between 1995 and 2005 are few; (ii) most projects had evaluability problems lacking appropriate indicators and/or targets;¹ and (iii) evaluations of individual projects without the general framework provided by a conceptual and empirical context – such as the one here presented – would not allow for wide-ranging lessons learned, thus being of limited relevance to the Bank and the countries of Region. Accordingly, this report represents OVE's first attempt to analyze the sector and, as such, provides a background for future project evaluations.
- 1.4 Since the approach followed by the Bank through its projects were related to the pursuit of three main objectives, improvement in efficiency, quality, and equity or coverage, this report assesses the likelihood in which they have contributed to the achievement of such goals.
- 1.5 The main period of analysis not only represents the most important cycle of Bank activities in the health sector, but also marks an important shift of emphasis in terms of Bank actions: from projects that were almost exclusively directed at financing the infrastructure and equipment of health care facilities, to interventions that were aimed at introducing structural changes (reforms) to the sector as a whole.
- 1.6 The next chapter frames the health sector within the Bank, and presents a brief description and analysis of the health sector loans approved by the IDB. Chapter III discusses the direction of the Bank's interventions since the nineties and delineates the Bank's intervention framework. In this context it discusses the underpinnings of health sector reform in Latin America and the Caribbean (LAC) and how they were incorporated into the Bank's interventions.

1.7 Chapter IV analyzes the conceptual and empirical basis for the key reform measures implemented by Bank projects. Finally Chapter V presents the report's main conclusion and recommendations.

II. A BRIEF ANALYSIS OF THE BANK'S HEALTH SECTOR PORTFOLIO

- 2.1 This chapter provides a general overview of the size and evolution of the Bank's health sector portfolio in both absolute and relative terms. It has the objective of providing the reader with an understanding of the sector's importance in the context of the IDB and to position it in relation to the World Bank's health actions in Latin America and the Caribbean.
- A. The health sector in the IDB**
- 2.2 The IDB approved the first of its 63 stand-alone health sector loans in 1973.² This classification excludes other projects approved by the Bank that have components financing interventions in this area (e.g. social investment funds, conditional cash transfers, and non-health policy-based loans), as well as water and sanitation operations that knowingly have major health impacts. Since then, there have been health sector projects approved in practically every year, and to every member country with the exception of The Bahamas. Of the 63 projects approved, 3 were policy-based loans (PBLs).³
- 2.3 The original amount approved by the Bank throughout these 33 years total approximately US\$4.5 billion (in dollars of 2005), with a median project size of US\$48.1 million (see Table 2.1, which – as all tables and graphs – is presented in this report's Annex 1).⁴ The data also show that the greater number of approvals (42% more) and the larger projects of the last 16 years, i.e. between 1990 and 2005, led to a total approval that was approximately twice as big as that of the previous 17 years (between 1973 and 1989).⁵
- 2.4 This report focuses its analysis in the period between 1995 and 2005, which constitutes the most important phase of the Bank's activities in health.⁶ Even though these 11 years represent one-third of the total time in which the Bank has been involved with health sector operations, 48% of the number of projects (i.e. 30 operations) and 57% of the total amount (equivalent to US\$2.6 billion) were approved during this period (Table 2.2). Table 2.3 presents some basic information about the projects approved in these years.
- 2.5 Since the nineties, and particularly after 1995, the pace of health sector approvals and the median size of health sector loans have surpassed the overall Bank's, increasing the sector's share of Bank projects (Graphs 2.1 and 2.2 and Table 2.4).⁷ Still, historically, stand-alone health sector loans have represented a small share of Bank approvals, 3.4% of the number of projects and 2.3% of the amount approved by the Bank since 1973.
- 2.6 Even though twice as many loans have been approved between 1973 and 2005 to the sector's closest comparator, the education sector (Table 2.4), the data in the table indicate that the pace of health approvals observed after 1995 also surpasses that of the education sector, a fact that is particularly noteworthy, and somewhat surprising, given the Bank's stated intention of prioritizing investments in education during the late nineties and first years of the new millennium.⁸

2.7 Box 2.1 in Annex 2 provides a brief discussion of the efficiency in which health sector projects have been prepared and executed. It shows that, in general, health projects approved between 1995 and 2005 took longer to approve and disburse than the average Bank project or education projects. It also shows a recent improvement in execution. As discussed in Chapter III, these results might be related to the type of health project approved during this period.

B. Comparison with the World Bank

2.8 Between 1995 and 2005, the World Bank (WB) approved 38 health sector operations totaling almost US\$4.5 billion (in constant dollars of 2005) to those countries that are member of the Bank.⁹ As shown in Table 2.2, the IDB approved 30 projects and approximately US\$2.6 billion during the same period. Even though the average WB health project is significantly larger (in real terms) than the Bank's (US\$118 million and US\$86 million, respectively), the IDB's median project is larger than the WB's (respectively, US\$48 million and US\$33 million in real terms). Two large WB adjustment loans, one of US\$700 million approved for Mexico in 1998, and another of US\$750 million for Argentina in 2003, explain these differences. If these two projects were to be excluded, the maximum amount approved by the IDB in a single year (almost US\$500 million in 1996 and 1999), would also be similar to the maximum annual approval of the World Bank (US\$436 million in 1995).

2.9 It is interesting to note, that the number of IDB health specialists working at headquarters has generally been substantially smaller than at the World Bank's LAC Region. While the IDB has had since the mid-nineties no more than 9 health specialists in the three Regional Departments, the World Bank has had close to 20 health specialists.¹⁰

2.10 The WB has concentrated a much larger proportion of its lending on the bigger ("A") countries than the IDB (47% and 13%, respectively),¹¹ while the IDB approved health loans to more countries that can borrow from both institutions than the WB (respectively, 22 compared to 17, out of 25 countries).^{12, 13}

2.11 Another noteworthy difference between the World Bank's and IDB's portfolios relates to the approval of AIDS-related programs. The World Bank has approved 11 such loans covering the entire LAC Region,¹⁴ while the Bank has not approved any stand-alone AIDS-related loan.¹⁵

III. HEALTH SECTOR REFORM AND THE BANK'S FRAMEWORK IN THE SECTOR

A. The context of change: The basis for the health sector reforms of the nineties

- 3.1 The focus of health sector interventions financed by the Bank has changed substantially since 1973. The operations of the 1970s and 1980s were fundamentally directed at financing the sector's infrastructure and equipment, i.e. the construction and equipment of health care facilities: healthcare posts, healthcare centers, and hospitals. As stated by a 1985 External Review and Evaluation Office (ORE) report (RE-127), "*Bank funds have gone almost exclusively to the building of facilities and the provision of equipment*" (Inter-American Development Bank (1985), p. 3).
- 3.2 However, by the mid to late eighties, two main sets of factors were combining to bring about changes to the direction in which the Bank – as well as the other International Financial Institutions (IFIs) and bilateral agencies – would finance health sector interventions during the nineties. The first element was the recognition that the experience with infrastructure projects presented many serious problems such as the incompatibility between project design and the needs of the population; design and construction flaws; equipment deterioration due to delays in delivery and installation; incompatibility between the equipment acquired and epidemiological or medical priorities; and the rapid deterioration of the infrastructure and equipment investments due to the lack of adequate maintenance. The lack of counterpart resources brought by the economic crisis further compounded these problems by hampering project execution and threatening the sustainability of investments.¹⁶
- 3.3 The second element was the emergence of the "Washington Consensus" set of economic and institutional adjustment policies, consequence of the debt crisis of the 1980s and the political/ideological changes brought by the end of the Cold War. These reform policies were anchored on the reduction of fiscal deficits and private sector participation and market-based policies, including in areas that had been the domain of the public sector, such as the social areas.
- 3.4 The health systems of the Region were obvious "candidates" for adjustment programs: they were not only a major source of public expenditure, but also generally perceived as inefficient and as providers of poor quality services.¹⁷ Public systems were seen as fundamentally inefficient and inequitable and were criticized for spending most of their resources on hospital services that tend to benefit mostly the influential urban middle and upper classes, instead of making basic services easily accessible to the poor (Birdsall and James (1990, 1992)).¹⁸ Their performance problems were evidenced by the lack of access by the poor to healthcare, by the lack of accountability, and by the low quality of public services.
- 3.5 The health sector reforms of the period had as conceptual basis the agency theory¹⁹ and "New Public Management" (NPM), a conceptual framework that emerged in the early nineties:²⁰ "*The core of NPM has been described as government moving from 'a concern to do, towards a concern to ensure that things are done'* (Kaul, 1997). *While the state may play a role in development,*

this role is not necessarily one of direct service provision, but rather policy-making, purchasing and regulating” (Mills, Bennett and Russell (2001), p. 5). In this context, according to NPM, responsibility for service provision should shift from the state to the private sector, and therefore from hierarchical modes of organization to market mechanisms (Blaauw, et al. (2003)).

- 3.6 Kettl (2000) identifies six core ideas central to the changes in public management that were occurring during the nineties:²¹ *“the search for greater productivity; more public reliance on private markets; a stronger orientation toward service; more decentralization from national to subnational governments; increased capacity to devise and track public policy; and tactics to enhance accountability for results”* (p. v). Accordingly, regulation, sanctions, and incentives, were all part of this new framework’s toolkit.

B. The diagnosis of the health systems of the Region and the Bank

- 3.7 The prevailing diagnosis of the nineties argued that despite the significant improvements in many of Latin America and Caribbean (LAC) health indicators,²² and the important contribution attributed to healthcare systems in achieving these results,²³ serious problems still persisted in the Region.²⁴
- 3.8 The health systems of the Region were seen as *“segmented and fragmented”* (Inter-American Development Bank (1996a)).²⁵ This fragmentation generally involved three tiers or subsystems: (i) the private sector subsystem providing services for those with higher income levels that could afford their charges and/or insurance premiums; (ii) the social security subsystem that covers the formally employed population; and (iii) the services provided by ministry of health facilities were the only source of care for the remaining (majority) population.
- 3.9 In addition, the Region was generally viewed as an “underperformer”, presenting health outcomes that did not correspond to its level of development – *“given its levels of education and income, the Region should be enjoying much better health status”* (Inter-American Development Bank (1996a), p. 301) – and expenditure. At 6.2% of its GDP, the Region’s total (i.e. public and private) health expenditure of the early nineties was estimated to be the highest outside the developed world.²⁶ These problems would only be compounded by the aging of the population and by the epidemiological transition facing the countries of the Region.²⁷
- 3.10 The diagnosis described above led to the conclusion that the health systems of the Region needed structural reforms that could tackle the causes of their low performance, *“without addressing the causes of poor performance, external financial support provides only temporary redress for the underlying problems that will reemerge”* (Inter-American Development Bank (1996b), p. 8).
- 3.11 By the mid-nineties the Bank was part of the health reform “tide”. Operationally, the move towards the support of structural reforms effectively begins in 1995 with the approval of the “Health Sector Support Reform Program” for Colombia (CO-0088, 910/OC-CO).^{28, 29} In this sense, 1995 marks the beginning of a new (third) generation of projects aimed at *“confronting sector-wide issues,”* as defined by the 1996 Social Delivery Strategy (GN-1932-1). Inter-American Development

- Bank (1996b)). The change of focus is also evidenced in the names of the operations: all pre-1995 projects have titles related to service improvement – e.g. Improvement (or Strengthening or Rehabilitation) of Health Services – while post-1995 loans generally have names that refer to the health system or sector: e.g. Health Sector Reform Program, Health Sector Modernization and Restructuring Program, Reorganization of the Health System, etc.³⁰
- 3.12 It is worth noting that the move towards reform loans did “no[t] call for an automatic censorship of operations which do not directly confront sector-wide issues” (GN-1932-1, p. 8). In fact, given the general lack of public resources available for investments, the Bank has continued to finance infrastructure and/or equipment in its projects throughout the entire 1995-2005 period (see Table 3.1).³¹ There was, however, an important change in perception inside the Bank during the nineties: “pure bricks and mortar” operations should not and would not be approved by the Bank.³²
- 3.13 This perception was grounded not only upon the lessons learned from the sector’s previous experience with infrastructure projects, but also upon the changes that were also occurring inside the Bank. Nancy Birdsall, the Bank’s Executive Vice-President (EVP) between 1993 and 1998 had had large experience in the field, and publications that were influential in establishing the general principles of health reform (see the next section). In addition, the Bank’s 1994 reorganization initiated a process of substituting the health specialists, who previously were mostly from the medical field, by economists or professionals with experience in health services administration.
- 3.14 All these changes were occurring during a period in which the Bank did not have a health strategy *per se* providing a framework for its actions in the sector. A social strategy was approved, however, in 1996 (the above-cited 1996 Social Delivery Strategy, GN-1932-1) and even though not specific for health, it was the institution’s reference document. The reform of social services was at the core of the three areas for Bank support defined by the strategy: a) “getting incentives right”³³ – “the Bank should support initiatives which help countries develop good organizational structures with sound incentives working towards effective and efficient delivery” (p. 11, emphasis in the original); b) “assessing reform readiness: working with existing institutions” – “the Bank’s role is fundamentally to support these processes initiated by the countries themselves” (p. 17); and c) “focus on implementation” – “in order for [reform] programs to be successful, they must be both designed well and implemented well.” (p. 17).
- C. The reform framework and the Bank’s health sector interventions**
- 3.15 As discussed, the reforms of the health sector were part of a general context of structural reforms initiated during the eighties, and were based on the market-based views and policies of the “Washington Consensus.”³⁴ These views dominated the development thinking of the period and permeated those working with the health sector, whether in the countries themselves, whether in the IFIs, including the Bank.

- 3.16 The 1993 publication of the World Bank's first World Development Report (WDR) dedicated entirely to health (World Bank (1993)), marked a turning point for the sector and established the main principles that would guide health sector reform efforts around the world, including LAC, during the nineties and established a dominance of economic approaches in the analysis of health systems. Table 3.2, reproduces the WDR's Table 3, which summarized the report's general main policy framework.
- 3.17 The Bank's views for the sector were consolidated and articulated in the above-mentioned 1996 Social Delivery Strategy (GN-1932-1), and in the special section "Making Social Services Work" of the 1996 Report of Economic and Social Progress in Latin America (IPES, Inter-American Development Bank (1996a)).³⁵ These documents present a consistent and coherent view of the sector, and the directions to be followed by the Bank.^{36, 37}
- 3.18 The policy framework that was developed from this context was clear and called for the public sector to reduce or eliminate its role as service provider, and concentrate in its leadership, policy-making and regulatory roles:^{38, 39}
- improve health spending and reduce (or contain) its growth: *"unless immediate steps are taken to rein in health expenditures and to use available resources more efficiently, the Latin American countries will soon face the same problems of exploding health care costs currently confronting the developed world"* (Govindaraj, Chellaraj and Murray, 1997, p. 169). In particular, reduce public expenditures with higher-cost services such as hospitals, which are difficult to access by the poor and, therefore, tend to benefit the middle and upper classes (WDR; Birdsall and James, 1990), and concentrate public expenditure in less expensive and cost-effective interventions that benefit mostly the poor (i.e. primary health care) (WDR);
 - limit government actions to those cases in which market failures are present, i.e. public goods or externalities (WDR);⁴⁰
 - introduce sector financing mechanisms that consolidate the different providers/subsystems through insurance schemes (WDR; IPES);
 - promote private sector participation in the provision of healthcare services and introduce competition to the sector (WDR; IPES, GN-1932-1);⁴¹
 - introduce incentive systems that reward performance and outcomes (GN-1932-1; IPES); and
 - decentralize responsibilities from the central government to local governments and/or semi-autonomous institutions (WDR).
- 3.19 From a more operational stand-point, this framework was translated into a set of five health reform measures designed to induce, or at least mimic, market-like behavior and reduce inefficiencies:
- a. the contracting of private sector providers;

- b. the promotion of primary health care services and/or the definition of a basic (or essential) package of services;
- c. the design and implementation of performance-based incentives and/or contracts (“contratos or convenios de gestión”).

On the supply side, and in order to increase coverage, the public sector should contract out private providers to deliver a basic package of cost-effective services to the poor – to ensure technical efficiency and improve the quality of services these contracts should be based on performance and competitive criteria.

- d. the introduction of user fees and cost-recovery mechanisms; and
- e. the decentralization of the sector, giving autonomy to sub-national entities and/or services (i.e. hospitals).

On the demand side, introduce cost-recovery mechanisms to provide the right incentives, avoid the misuse of services, and increase the sustainability of the services, in order to improve the allocative efficiency of the system. Finally, devolving responsibilities to local governments – which are closer to the population and therefore more responsive to their demands and concerns – and/or increase the financial and administrative autonomy of more complex institutions, such as hospitals, would also contribute to improving quality and (technical and allocative) efficiency.

- 3.20 In addition, the proponents of health reform were also promoting a transformation of the sector financing, away from systems based on general taxes, and towards mandatory payroll-based systems (i.e. social insurance), in which a proportion of revenues collected could be allocated to subsidize those that cannot contribute (e.g. Colombia), in order to remove financial access barriers and system fragmentation (WDR, IPES).
- 3.21 Table 3.3 shows the extent in which Bank projects approved between 1995 and 2005 have incorporated these five key reform measures. The data show that IDB projects tend to include about 60% of these reform components, indicating that perhaps the Bank and its member countries were, by and large, not “packaging” the same types of measures into all their interventions and, as such, not following a formulaic approach. The exception seems to be the countries/projects of Central America and the non-English speaking Caribbean, which tend to have followed much more closely the blueprint of health reform. In fact, of the six projects that contain every one of these key reform elements, five were implemented in this Region.
- 3.22 Even though the Bank and its member countries were, in general, not implementing the “full reform package,” these reform measures were being adopted by the majority of projects, and therefore do represent the way in which the Bank approached the health sector problems during this period.⁴² The only one of these measures that was not implemented by most Bank projects was the introduction of user fees. Although a key element of the health reforms of the nineties, few Bank operations – six in Central America and the non-English

- speaking Caribbean, and one in Paraguay – promoted their implementation or backed those already in place (see Section D in the next chapter).
- 3.23 The reforms to implement social insurance mechanisms were supported by Bank projects in Belize, Bolivia, Colombia, Dominican Republic, and Peru, and studies to assess their appropriateness were financed in Jamaica, and Trinidad and Tobago. A more detailed analysis of these reform elements and their conceptual underpinnings are presented in the next chapter.
- 3.24 The two clear outliers in Table 3.3, BR-0305 (1215/OC-BR) and GY-0068 (1120/SF-GY), were projects that financed very specific interventions unrelated to the usual reform measures being implemented during the period: human resources development in the Brazilian case, and nutrition in the Guyana case.
- 3.25 OVE has also compiled and analyzed the distribution of the 164 indicators of purpose (or their equivalents) defined for all the 27 non-policy-based loans approved between 1995 and 2005. These indicators can be classified as being related to five broad categories of objectives: (i) improvement of health status; (ii) increase in efficiency; (iii) improvement of equity or increase in coverage; (iv) quality improvement; and (v) other (Table 3.4).^{43, 44} See also Box 3.1 in Annex 2 for a discussion on the definition of access and coverage.
- 3.26 As Graph 3.1 shows, 3 main categories of objectives – improving efficiency, equity/coverage, and quality – are present in the majority of projects, and as such summarize the goals set up by the Bank’s interventions.⁴⁵ Given that the concepts of health sector reform framed the Bank’s thinking and operational intent of the period, it is not surprising that these objectives faithfully reflect the health reform approach of the nineties, the “*sustained and purposeful changes to improve efficiency, equity and effectiveness of the health system*” (Berman (1995)).
- 3.27 The fact that only 15% of projects present indicators related to health objectives, does not necessarily mean that Bank loans were designed without taking such issues into considerations. In fact, 85% of all investment projects approved between 1995 and 2005 have goals that are health-related.⁴⁶
- 3.28 Because a reform measure can be related to more than one objective – reimbursement incentives may be introduced, for example, as means for improving quality and efficiency; or the contracting of private providers might be aimed at increasing coverage and improving the quality of services provided – the majority of projects (63%) contain indicators related to three or four of the five objectives, as the data in Table 3.4 show.⁴⁷
- 3.29 Even though it is true that certain measures may impact various objectives simultaneously, in practice this fact has led to very ambitious program objectives without priorities and, therefore, difficult to be achieved if taken at face value. This is particularly true if one takes into consideration the small proportion that Bank financing generally represents in relation to a country’s health budget and/or a health system’s needs.⁴⁸

3.30 These considerations make even more surprising the fact that health projects have seldom been reported as presenting low probabilities of achieving their development objectives (see Box 2.1 in Annex 2). Furthermore, from an operational perspective, the pursuit of several objectives simultaneously increases the complexity of a project and might be related to the execution problems discussed in the same chapter.

D. A new direction?

3.31 The data in Tables 3.1, 3.3 and 3.4 consistently show that the 1995-2005 period contains two different phases, one spanning the years between 1995 and 2001, and another between 2002 and 2005, with the first one characterized by a much greater presence of reform elements and, as such, representing the peak reform years. Table 3.3 shows that the projects approved before 2002 were proposing to implement about four of the five reform measures, while those approved during the second phase contain only two reform measures.⁴⁹

3.32 The data suggest that the projects approved since 2002 are simpler. Their average preparation times (from pipeline to approval) of approximately 11 months were significantly shorter than the ones approved between 1995 and 2001 (32 months). Graphs 3.2 and 3.3 clearly show that the indicators of purpose of these projects were concentrated on fewer objectives. Table 3.4 shows that among the three key Bank objectives for the sector (efficiency, equity/coverage and quality), the goal of improving efficiency – perhaps the major new fundamental introduced during the nineties – was the one to present the sharpest decline since 2002 (more than 50%). The sharp reduction of Bank-financed activities related to strengthening managerial capacity observed after 2001 (Table 3.1), is consistent with this decline.⁵⁰

3.33 There are several factors that might explain these changes: (i) comprehensive economic and public sector reforms, including those in the health sector, have imposed substantial political and transaction costs on politicians, decision makers and the population in general. These costs have led to what has been called reform fatigue,⁵¹ thus reducing the willingness of countries to borrow for – or to enter, continue, or expand existing – reform processes; (ii) related to the previous point, the execution problems encountered by many of the more ambitious reform programs may have generated some type of reform fatigue also inside the Bank;⁵² ⁵³ (iii) the limited absorptive capacity of countries restricts the ability of the sector to continue requesting large credits. With the exception of Colombia, that has requested large policy-based loans and continues to invest heavily in its health sector with Bank support, the loans approved after 2001, particularly for those countries that have had reform-type of projects during the nineties, are significantly smaller; and (iv) the introduction of new Bank lending instruments, such as Sector Facilities, Innovation, and Performance-Driven Loans, that offer alternative approaches that may require a different project structure.

3.34 Even though not enough time has passed to affirm that these changes indeed represent a new trend for the Bank towards different and simpler approaches.⁵⁴ Data collected over the next few years will be needed to indicate the extent in

which these changes towards fewer objectives and less reform measures explain the recently observed improvement in project execution noted in the previous chapter (see also Box 2.1 in Annex 2).

- 3.35 It appears, however, that there might be a disconnect between these *de facto* changes in Bank actions, and the recently approved (2003) Social Development Strategy (GN-2241-1).⁵⁵ Despite the introduction of a life-cycle perspective in its human development agenda, in what relates to the health sector, the strategy continues to be very much centered around the reform process: “*the Bank will continue assisting countries in promoting reform processes, aimed at the goals of universal and more equitable access to social services*” (p. ii). In fact, in general, the recommendations of the new strategy do not differ much from its predecessor: “*The principles presented in the Bank’s 1996 “Strategy for Supporting Reform in the Delivery of Social Services” remain sound and the Bank will continue to promote them*” (pp. 14-15).⁵⁶

IV. EVALUATING THE BANK'S APPROACH

"Economists are often in error, but never in doubt"

Borrowing from a phrase attributed to Lev Landau, Nobel Prize in Physics⁵⁷

- 4.1 The last chapter shows that a set of five key reform measures implemented by the health projects approved between 1995 and 2005 depicts the approach followed by the Bank during this period. These measures were: (i) the promotion of primary health care services and/or the definition of a basic (or essential) package of services; (ii) the contracting of private sector providers; (iii) the design and implementation of performance-based incentives ("contratos or convenios de gestión"); (iv) the introduction of user fees; and (v) the decentralization of the sector. The data also show that the indicators defined by the projects were fundamentally related to the improvement of three main categories of objectives: (i) efficiency; (ii) quality; and (iii) equity/coverage.
- 4.2 This chapter examines the conceptual and empirical basis underlying the set of systemic measures implemented by the Bank with the intent of achieving the three main objectives that were being pursued during the period under analysis.⁵⁸
- A. Was Latin America really lagging behind?**
- 4.3 As discussed in Chapter III, one of the arguments used during the nineties to justify the need for structural changes to the health systems of the Region was that its health indicators, such as life expectancy and infant and child mortality, were below its level of income and development (e.g. IPES and the 1996 Social Delivery Strategy, GN-1932-1).⁵⁹
- 4.4 The data indicate, however, that in relation to these general indicators of population health, the performances of the countries of the Region in the early nineties were not significantly different than expected, given their levels of income. The assertions that the Region presented health indicators that were worse than expected, were based on aggregate estimates that were most likely skewed by the figures of some of the larger countries – particularly Brazil – that had below-average indicators. In fact, while it may be true that the health status observed in *some* countries might have been lower than expected, given their levels of development and/or health expenditure, the empirical evidence available *at the time* did not appear sufficient for a generalization to the entire Region, as was done as part of the rationale for the reforms (e.g. IPES and GN-1932-1). See Box 4.1 in Annex 2 for a more detailed discussion of the data and these issues.
- B. Primary care and the basic package of care**
- 4.5 Primary Health Care (PHC) *"involves four interrelated aspects: a set of activities, a level of care, a strategy for organizing health care, and a philosophy that permeates health care provision . . . and can be defined as the immediate — and often continuing — medical and health management of a child, adult, or family*

when the patient first presents to the formal health system” (Tollman, Doherty and Mulligan (2006), p. 1193).

- 4.6 Primary health care came to the forefront of health and development policy discussions after the International Conference on Primary Health Care sponsored by WHO and UNICEF at Alma-Ata, Kazakhstan, in September 1978. PHC was viewed as the means for achieving the objective “Health for All by the Year 2000.”
- 4.7 The “enthusiasm” with PHC as an effective tool for improving the health conditions of the poor received a boost by the “Good Health at Low Cost” conference sponsored by the Rockefeller Foundation in 1985 where the experiences of China, Costa Rica, Sri Lanka and the Indian state of Kerala were discussed. As the conference title indicates, these cases showed that life expectancy and child mortality improvements in developing regions could be achieved with low levels of expenditure.

1. Conceptual issues

- 4.8 It is important to note that the PHC approach originally conceived at Alma-Ata was more than a delivery model but rather *a strategy for organizing health care, and a philosophy that permeates health care provision*, to use the terminology quoted above. Under Alma-Ata, primary care services should, in contrast to the prevailing hospital-centric model, be the main focus of a country’s health system and, as such, universally accessible. Alma-Ata’s conception of primary care also involves other sectors and variables that may affect a person’s health condition (e.g. water and sanitation, education, housing, etc.) as well as community participation (see Box 4.2 in Annex 2 for Alma-Ata’s definition of PHC).
- 4.9 The Alma-Ata principles were criticized for being too ambitious, and “*while draped in moral language to which no one can object, were from the start technically vague and financially unrealistic, hence impossible to implement*” (Irwin and Scali (op. cit.), p. 17, summarizing the criticism towards Alma-Ata. In fact, PHC has been more commonly defined “*by what it is not: it is neither secondary nor tertiary curative care but could be all other activities related to health, from nutrition, to sanitation, information, and education, to clinic-based curative care*” (Filmer, Hammer and Pritchett (2000), p. 200).
- 4.10 These criticisms and the constraint of public resources generated by the economic crisis of the eighties led to the emergence of an alternative PHC framework in which efforts were to concentrate on a *small number* of cost-effective interventions: a basic package of services.⁶⁰ The emergence of the basic package implied an even more radical move away from PHC as an integrated approach to organizing the system, and towards PHC as a set of activities or services.
- 4.11 The basic package was at the core of the 1993 WDR,⁶¹ and its implementation was promoted in 15 of the 21 Bank operations with PHC-related interventions. The other operations emphasized interventions aimed at the primary level of care (i.e. services provided by clinics and health centers), as opposed to hospital care (see subsection 3, below).

- 4.12 Although the package contents of Bank projects were not always clearly described in loan documents and their content – and therefore “degree of selectivity” – varied, most appear to have been limited in scope, and all included services focused on maternal and child health, as well as preventive measures (see Box 4.3 in Annex 2).^{62, 63}
- 4.13 Even though the concept of a basic package is specific – i.e. a set of priority, cost-effective interventions – it has been applied in two different contexts: to define the services financed by (social) insurance mechanisms, and to define the services to be financed under contracting arrangements (see Box 4.4 in Annex 2 and this chapter’s Section G). The recent proposal of “*universalismo básico*” that is being discussed at the Bank (Filgueira et al. (2006), Medici (2006)), also evolves directly from the concept of the basic package.⁶⁴ The Panama project (PN-0076, 1350/OC-PN) summarizes well the rationale used in most Bank projects for the implementation of basic packages: “*la entrega de un paquete de intervenciones altamente costo-efectivas, orientado a las poblaciones más pobres, especialmente los niños y mujeres, se constituye en un esquema de focalización de gasto público que ataca simultáneamente los problemas de desigualdad en el acceso y de ineficiencia en la asignación de los recursos*” (document PR-2608, executive summary, p. 4).
- 4.14 Basic packages have also been criticized by their disease-oriented approach and tendency to verticalization, rather than horizontally integrated programs. In fact, the incentive structure of donors and governments tend to favor the implementation of narrowly defined programs, since these are easier to monitor (Doherty and Govender (2004)).

2. Empirical evidence

- 4.15 Filmer, Hammer, and Pritchett (2000) point out that the gains found in cost-effectiveness studies of primary care interventions have rarely been demonstrated in practice, i.e. the theoretical estimates of cost-effectiveness analysis do not take into consideration the limitations and constraints of health care systems: “*Because cost-effectiveness estimates are based on the presumed effective delivery of primary care services, it can be argued that implicit in the estimates have been overly optimistic assumptions regarding key constituents (staff, drugs, equipment, monitoring and evaluation, and so forth) of the primary care level and their functioning*” (Tollman, Doherty, and Mulligan (op. cit.), p. 1204).⁶⁵ Lewis, Eskeland, and Traa-Valerezo (2005) also call attention to the fact that “*despite declarations of the cost effectiveness of PHC the approach has received virtually no evaluation . . . of either costs or impacts*” (p. 4).⁶⁶ According to Filmer, Hammer, and Pritchett (2000), it was never very clear whether the success cases discussed at the “Good Health at Low Cost Conference” were explained by health systems characteristics or by social and political factors.
- 4.16 The El Salvador data from Lewis, Eskeland, and Traa-Valerezo (op. cit.), show that the limited scope of basic services offered, particularly in the case of public outreach services, leads to underutilization of services: “*most find them of marginal*

- use partly because they have little in the way of diagnostic or treatment services”* (p. 33). It must be recalled that the Bank has supported the provision of outreach services in Central America, including El Salvador (see also Section C).
- 4.17 Bitrán et al. (2005) provide mid-term evaluation data for the IDB-financed basic package program in Honduras (HO-0032, 1005/SF-HO). As will be discussed in more detail in the next section, this program financed the contracting of outreach services to provide a basic package of services to rural communities. The results are somewhat mixed. On the one hand, there was a significant positive difference in child immunization coverage and weight monitoring of children for those population groups receiving the basic package, as compared to those receiving these services from public clinics (the comparison group). On the other hand, those pregnant women receiving the package were significantly less likely to receive birth deliveries in medical facilities. Women receiving the basic package were also more likely to have screenings for cervical cancer and to receive the supplemental tetanus vaccination, but less likely to be examined during the last month of pregnancy, a critical measure to reduce infant and maternal mortality.
- 4.18 While the data from the Honduras project indicate that the basic package of services has been delivered with some positive results, some issues still require further analysis: (i) the strategy seems to present significant administrative costs (23%) (see Section C for further discussion on sustainability); (ii) there are no data on health outcomes to properly assess its cost-effectiveness; and (iii) as with other reform measures (e.g. contracting and performance-based incentives, see also Sections C and D), the basic package intervention performs particularly well in terms of immunization, a very important area with demonstrated and undisputed health benefits; but nonetheless an area in which LAC has achieved great progress with the use of relatively inexpensive mass immunization campaigns. In this sense, the latter represents one of the benchmarks against which the basic package needs to be compared in order to assess its cost-effectiveness.
- 4.19 In her comparative studies of developed countries, Starfield (1994, 1998) finds a positive association between the primary care orientation of health systems and positive health indicators and lower costs. The experiences of Costa Rica (particularly until the eighties) and Cuba in LAC suggest that an integrated set of primary care interventions, as opposed to the delivery of selective basic packages of services might be an effective strategy for organizing the sector. Only one Bank project (AR-0120, 1193/OC-AR) proposed the full reorganization of the sector around a PHC approach.⁶⁷

3. Primary care, hospital care, and equity

- 4.20 The belief in the cost-effectiveness of basic care interventions (i.e. non secondary and tertiary services) implied that resources should be reallocated from curative care in public hospitals and toward preventive and basic primary care services in order to generate health gains and cost reductions. In addition, as opposed to hospital care, which was viewed as mostly benefiting the middle and upper income groups, basic care services were seen as pro-poor. This pro-poor

perception has been made explicit in the Bank, which automatically classifies projects that promote basic, non-hospital services as poverty-targeted (PTI).

- 4.21 It is worth noting, however, that the perception of anti-poor bias of hospital care largely came from the context of poorer and largely rural countries in Africa and Asia. Since hospitals tend to be located in cities, their services were seen as largely directed at the urban populations and their health problems, and difficult to be accessed by the (rural) poor.⁶⁸ The LAC context is, however, fundamentally different: the countries of the Region tend to be not only more urbanized but also with large urban poor populations, with the “typical” urban health problems (chronic diseases, accidents and violence), constituting the main causes of morbidity and mortality.
- 4.22 Furthermore, public hospitals serve an important role of “insurers” of the poor against catastrophic expenditures, an issue recognized in the design of the Jamaica project (JA-0051, 1028/OC-JA). Accordingly, the welfare impact of public hospitals services may be significant (even with lower health impacts), particularly in the absence of an appropriate insurance system for the poor Filmer, Hammer, and Pritchett (2002).
- 4.23 In this sense, the reallocation of resources from public hospital services to basic services implies a potential loss of welfare benefits (particularly to the poor) generated by publicly financed inpatient care (Filmer, Hammer, and Pritchett (2002)), thus implying that the expected positive equity impact of such reallocation is not a certainty, particularly in the LAC context.⁶⁹ Data for the U.S., however, indicate that primary care can attenuate the adverse impact of income inequality on population health.⁷⁰

4. Summary

- 4.24 It is clear that any analysis of primary care needs to distinguish between the integrated PHC approach – used as a basis for organizing the health system – and the delivery of a basic package of services, the most common form of primary care interventions in developing countries, including the Bank. In fact, it could be argued that the original vision of PHC has not been effectively implemented in most LAC countries. While the idea of implementing a package of selective interventions may make economic sense, its cost-effectiveness has not been demonstrated *in practice*. The experiences of developed countries, on the other hand, indicate that an integrated primary care approach might be an effective strategy for organizing the sector.
- 4.25 The move away from PHC as an organizing principle and towards a set of basic services may render true the fears expressed by of Almeida et al. (2001) that primary care may be declared a failure without proper implementation and evaluation.
- 4.26 Finally, basic care and hospital care serve different objectives within the system, and as such, the policy recommendation of prioritizing basic care expenditures instead of hospital care, as promoted by the Bank, entails equity trade-offs that need to be carefully evaluated.

C. Contracting

- 4.27 Contracting is not only related to many of the other key reform instruments promoted by the Bank, but is also the most direct expression of the pro-market approach that was at the core of the reform proposals of the nineties.
- 4.28 Contracting can be defined as “*a purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period.*”⁷¹ See also Box 4.5 for a description of contracting.
- 4.29 Contracting was expected to contribute to all three categories of objectives: efficiency, quality, and coverage. The contracting-in of private providers to operate and/or manage a government service was expected to generate an improvement in efficiency due to the private sector’s greater flexibility and less bureaucratic procedures. If, on the other hand, private providers were contracted-out to operate simultaneously with, or in substitution to, public services, it was assumed that competition between providers, the higher quality and efficiency of the private sector, and the greater transparency brought by contracts and their enforcement would ensure an increase in access to care and quality improvement.⁷² In developing countries, and particularly those emerging/recovering from internal conflicts or with weak states, contracts for primary care services was also seen as a relatively rapid way to increase the coverage for underserved populations (Palmer (2000)).
- 4.30 Seventeen of the 30 projects approved between 1995 and 2005, and 70% of the projects approved between 1995 and 2001 financed the implementation of contracting measures (Table 3.3). Table 4.1 presents a brief description of the types of contracting supported by these operations. This section focuses its discussion on issues related to the contracting of public and private providers to supply a basic (or essential) package of primary care services, which was the type of intervention financed by the majority of Bank projects.
- 4.31 This contracting model was first financed by the Bank in its 1995 loan for Guatemala (GU-0023, 890 and 891/OC-GU) and has continued throughout the entire period. The Bank’s experience shows that contracting was not viewed as an isolated measure but one that was closely related to and/or complemented by other reform actions such as the definition of a basic package and the adoption of performance-based criteria (or “*contratos de gestión*”) for the reimbursement of providers, which was first introduced by the 1998 El Salvador project (ES-0053, 1092/OC-ES).

1. Conceptual issues

- 4.32 The basic argument for contracting derives from a simple question: “*In most low- and middle-income countries the private sector is already very active. . . . If such private providers already exist, why not use them rather than engage in public production of services that are often of low consumer and clinical quality, unresponsive to patient expectation, and costly in terms of associated informal payments that patients have to make to providers?*” (Preker (2005), p. 36).

- 4.33 Unfortunately, even acknowledging the problems and limitations of the public sector, the answer to this simple question is not a trivial one. Contracting is in fact a complex process: even developed countries are still struggling with contract designs; *“the design of efficient contracts in health care has eluded policy makers worldwide”* (Maynard (2005a)).
- 4.34 In fact, the success of the contracting model rests in the fulfillment of a series of assumptions and pre-requisites: (i) the existence of a competitive environment; (ii) the greater quality of care delivered by private sector providers; (iii) the provision of services with lower costs; and (iv) the existence of adequate technical capacity covering all aspects of regulation, from contract design to monitoring and evaluation, to the ability of imposing penalties and sanctions (see also Box 4.6 in Annex 2). This implies that the contracting is a path-dependent process.
- 4.35 Contracting has also been closely associated to a call for the separation of the provision of health care services from their financing. This concept reflects the commonly held view that the public sector should concentrate in its leadership, policy-making, coordination and regulatory roles, and move away from the tasks and responsibilities related to the delivery of care. In fact, 12 (40%) of the projects approved between 1995 and 2005 explicitly refer to the need to introduce such measure. However, the separation of provision and financing is neither a necessary nor a sufficient condition for contracting (see Box 4.6 in Annex 2).

2. Empirical results

- 4.36 The empirical evidence available raises important questions regarding the validity of the assumptions of the contracting model and resulting interventions (see also Box 4.6 in Annex 2).
- 4.37 **Competitive environment.** Competition and choice are at the core of the contracting approach, they are expected to induce efficiency and quality gains in the public sector itself, or in the private provision of care. However, the existence of a sufficiently large number of suitable private providers does not appear to be a reasonable assumption for the context of remote and poor populations for which several Bank projects were designed. The Colombian reform, perhaps the most structured and cohesive reform effort of the nineties, has clearly demonstrated the difficulties of establishing a competitive environment in remote and/or poor areas. Few private providers and/or insurers have offered their services in the more remote areas of the country covered by the “subsidized regime.” Estimates of Herfindahl-Hirschman Index (HHI) made by the Universidad Javeriana show that in the year 2000, i.e. seven years after the beginning of the reform, the insurance markets outside the major metropolitan areas were essentially monopolies, or at best oligopolies (Ruiz (2001)).⁷³ Public hospitals still remain the only sources of care in some of the remote areas of the country, a fact that was a contributing factor to the recent hospital crisis.
- 4.38 Furthermore, recent evidence from developed countries raises questions regarding the assumed inherent and necessarily positive impact of competition on quality: Propper, Burgess and Green (2004) find a negative relationship between

- competition and quality of care in U.K. hospitals, and Scanlon's et al. (2005) study of 341 Health Maintenance Organizations (HMOs) show that greater competition, as measured by the Herfindahl-Hirschman Index, was associated with inferior health plan performance on several quality dimensions. In his recent review of the literature on U.S. hospital competition, Gaynor (2006, p. 27) points out that "*economic theory does not provide an unambiguous answer to the question of whether competition is welfare enhancing in markets with product differentiation,*" as is the case in the health sector. He concludes that "*the results of these studies don't allow us to make inferences about whether their estimated results imply that competition increased or decreased social welfare*" (p. 28).⁷⁴
- 4.39 In summary, these results indicate that the attainment of efficiency and quality gains cannot rely on solely on competition, either because a competitive environment might be difficult to realize, or because its presence is no assurance of efficiency and quality improvements.
- 4.40 **Quality of private sector providers.** The commonly accepted perception that the quality of private providers is better than that of the public sector is contradicted by the increasingly accumulating evidence available (Iunes (1994), Brugha and Zwi (1998), Kamat (2001), Das (2006)). "*Poor treatment practices [of private providers] have been reported for diseases such as tuberculosis and sexually transmitted infections with implications not only for the individuals treated but also for disease transmission and the development of drug resistance*" (Mills et al. (2002), p. 326). That such a mismatch occurs is not surprising, given the asymmetry of information that characterizes the health field. The inability of consumers to appropriately assess the technical quality of care tend to result in a perceived quality that is not necessarily related to the technical quality of the service, but to such factors such as the interpersonal skills of providers and the comfort and physical characteristics of the setting.
- 4.41 There is limited evidence about the extent in which the quality of the private providers accessed by the poor is lower than the non-poor. However, Das and Hammer (2005) find in their study of Delhi, India, that the quality of providers (public and private) is significantly lower in the poorer neighborhoods. Das (2006) find in all the cases studied (Delhi, Indonesia, Mexico, Paraguay, and Tanzania) that households in poor areas have access to, and receive, lower quality care from private doctors than households in rich areas.
- 4.42 The great majority of Bank projects have also explicitly identified the existence of quality problems in the private sector. However, few operations included any type of assessment mechanism with which to measure the quality and performance of private providers during project preparation.
- 4.43 **Cost reductions and sustainability.** There is almost no reliable empirical evidence to confirm the conceptual expectations, in this case that the contracting of private providers would unquestionably lead to efficiency gains and lower costs per unit of service provided. The Cambodia experience reports efficiency improvements, but the services contracted-out from the private sector in

- Zimbabwe were more expensive than those provided by the government. See also the results below for Guatemala, Honduras and El Salvador.
- 4.44 In addition, contracting also generates non-trivial transaction costs related to the design and maintenance of contracts, as well as additional costs related to the loss of purchasing power. The evidence from developed countries indicates that administrative costs can be high: while as much as 25% in the U.S. (Reinhardt (2005)). A 1997 report of the UK's Audit Commission, cited by Donaldson, Gerard, and Mitton (2005), indicated that administrative costs were higher than the costs savings generated through the contracting mechanisms implemented by the Britain's National Health System (NHS). The generalization and financial sustainability of contracting experiences are, therefore, not ensured.
- 4.45 **Regulatory capacity.** *“Unfortunately, there is little documentation of the effectiveness of quality regulation of healthcare facilities in the Region. Although the policies are in place, their enforcement is not well documented, nor are the consequences for facilities that fail or cease to meet requirements”* (Zeribi and Marquez (2005), p. 14). The evidence for the generalized assertions regarding the weak institutional capacity of the countries of the Region comes from the observed presence of a large number of informal providers, the limited scope of information systems, the limited personnel and resources allocated for supervisory and enforcement activities, etc.
- 4.46 Even though Bank projects point out to the weak institutional/regulatory capacity of the countries (see Box 4.7 in Annex 2), in the majority of cases, the actions needed to improve regulatory capacity were implemented *simultaneously* with contracting mechanisms, not prior to them. The second Guatemala loan (GU-0125, 1221/OC-GU), for example, recognizes and attempts to address the problems generated by contracting providers without an adequate regulatory capacity in place.⁷⁵
- 4.47 **Results from Bank experiences with contracting.** There is very little reliable evidence on performance and results of contracting experiences. Studies from developing countries, mostly from Asia and Africa, indicate that contracted providers perform better than traditional public sector services (Loevinsohn and Harding (2005)), but the results available, including the commonly cited success case of Cambodia, must be viewed with caution due to methodological problems (e.g. small sample size, no baseline, no control groups, etc.). See Box 4.8 in Annex 2.
- 4.48 Below we present the results from three Bank experiences with contracting mechanisms: Guatemala, Honduras, and El Salvador.⁷⁶ Unfortunately, as with other contracting evaluations, the data provided by the studies that evaluate these experiences must also be viewed with caution (see Box 4.9 in Annex 2 for a more detailed description of these studies).⁷⁷ The first two studies date from 2005, while the El Salvador case is from 2004 and was conducted only a few months after implementation began.⁷⁸ We also summarize the results from the Nicaraguan experience (not Bank financed). Notwithstanding their limitations, these studies, particularly Guatemala and Honduras, represent the most

- comprehensive, well-thought, and rigorous efforts to evaluate contracting experiences in LAC.
- 4.49 Interestingly, despite the continuous Bank involvement in this area in Guatemala and other countries for more than a decade, the study that analyzes the Guatemala experience was produced by the World Bank.
- 4.50 **Guatemala and Honduras.** If, on the one hand, the contracted-out delivery model for both Guatemala and Honduras are very similar – a basic package of primary care is delivered by contracted-out NGOs (paid on a capitated basis) to poor rural populations through outreach (itinerant) services – the Guatemala model also involved contracted-in services, i.e. NGOs hired only as health services administrators/financial managers for services delivered by the Ministry of Health (MOH) (see Box 4.9 in Annex 2).
- 4.51 Table 4.2 summarizes the findings from the Guatemala and Honduras studies regarding the fulfillment of the main pre-requisites and assumptions of the contracting process. As it can be seen, many of the pre-requisites for successful contracting have not been adequately satisfied. These limitations may compromise the likelihood of achieving the objectives of improving efficiency and quality.
- 4.52 Both studies indicate significant levels of coverage under contracting. However, the Guatemala data indicate that, in general, the contracted-in services tended to perform better than the contracted-out and public providers in all categories surveyed: immunization rates, provision of prenatal care, growth monitoring, and control of respiratory illnesses. Differences in performance between contracted-out and public services were generally not significant. The Honduras results show no significant differences in access and the data on perceived quality are not conclusive.
- 4.53 In both cases, the services provided by the contracted-out entities involved the delivery of a very limited basic package of services through periodic (outreach or itinerant) visits of medical teams to the communities. While this approach might be adequate for dealing with some health problems and does represent an increase in coverage for isolated populations, it cannot respond appropriately to acute events with significant incidence rates (such as diarrheal and respiratory illnesses), or to chronic diseases that are highly prevalent in LAC such as hypertension and diabetes. In this sense, the long-term technical sustainability of these outreach contract models financed by Bank projects might be questioned: they are not permanent solutions nor actual substitutes for traditional “permanent” services. They may in fact run the risk of reproducing the pattern of “poor services for the poor” so criticized in the public sector.
- 4.54 Furthermore, the better results observed in Guatemala from the contracted-in services, i.e. those that use the private sector to manage the resources of the public sector, suggest that the existing delivery model had a potential that could have been better explored and tested. In contrast to most African and Asian developing countries where contracting has been implemented, LAC has a relatively well-developed health care delivery system.⁷⁹ This difference and the epidemiological profile of the Region may limit the validity a delivery model based on contracted-out

- private providers supplying a limited package of PHC services (particularly episodically).
- 4.55 USAID (2006) provides a very critical assessment of the Guatemalan experience: “*There is little evidence on whether the overall goal of the contracting-out initiative - to maximize impact on health while keeping cost at a sustainable level – was achieved [in Guatemala]. . . . Insufficient capacity of providers and lack of dependable providers in rural areas, where availability of services on a particular day depended on whether volunteers came to work, adversely impacted both the quality of care and equity of access to care. . . . Guatemala’s mandate to expand health service coverage resulted in policies that sacrificed both quality and equity in favor of achieving widespread coverage. One of the major reasons for this failure was that the program did not develop a key set of performance indicators according to which providers would be monitored and reimbursed. This resulted in provider behavior that was not aligned with the policy goals outlined in the program; in particular, the contracting initiative failed to ensure service of acceptable quality to improve maternal and child health*” (pp. 8-9). These points are particularly relevant given USAID’s large experience with NGO contracting in Guatemala and Central America.
- 4.56 **El Salvador.** As noted above, in the El Salvador case the surveys were conducted only a few months after program implementation, and in this sense its conclusions are necessarily limited. The preliminary results presented, however, go in the same general direction of the two other experiences discussed above: (i) in general, there are no major differences in performance between the contracted out and the publicly provided services;⁸⁰ and (ii) the unit costs of the contracted out model is four times greater than the public service arrangement.
- 4.57 **Nicaragua.** Despite the limitations of the data, and the relatively short period of implementation,⁸¹ the results obtained by Bitrán and Maceira (2004) for the contracting experience of Nicaragua are striking: “*Nicaraguan communities in the early stages of NGO support are less well off than those without NGO support*” (p. 27. Emphasis added). In fact, the data show that NGO support had a negative impact in six of the eight categories evaluated (curative care for children with acute diarrhea, curative care for children with upper respiratory infection, immunizations, family planning, prenatal care, and institutional birth delivery), when compared to the control group that did not receive NGO support (i.e. relied on publicly provided services).⁸²

3. Summary

- 4.58 The conceptual and empirical discussion of this section indicates that there is no clear evidence to affirm that the implementation of contracting mechanisms to provide basic primary care have been able to achieve the objectives of improving efficiency and quality. It may have been able to provide coverage for certain types of services, but the appropriateness of the delivery model used might be questionable for the reality of LAC. Furthermore, these delivery models have shown to be relatively expensive – in 1999 the contracting of NGOs consumed

over 40% of Guatemala's resources allocated for the sector⁸³ – and the long-term technical sustainability of outreach contract models financed by Bank projects should be questioned: they are not permanent solutions nor actual substitutes for traditional “permanent” services.

- 4.59 It is, therefore, clear that if contracting experiences are to be continued and/or expanded in the Region, they need to be adapted and carefully evaluated. In fact, in the case of Guatemala, the fact that evaluation information is only now becoming available implies that: (i) resources were released during execution of a PBL loan, and (ii) the program was used as a model for other Bank experiences in Central America (e.g. Honduras, Dominican Republic, Nicaragua, El Salvador and Panama) without appropriate evidence on performance or results. Claims of population coverage disseminated through the program, for example, were based on reports and information generated by the contracted NGOs themselves, entities that had their payments determined by the coverage rates achieved. This problem has been recognized by the Bank, and the second Guatemala project (GU-0125, 1221/OC-GU), incorporated in its design a contractual clause for disbursement that required an “auditoría concurrente” to be carried out by an external firm to confirm the actual delivery of services.^{84, 85}

D. Performance-based incentives

1. Conceptual issues

- 4.60 As indicated in Table 3.3, two-thirds of Bank projects approved between 1995 and 2005 supported the implementation of supply-side performance-based incentives or “*contratos/convenios de gestión*.”⁸⁶ These measures were expected to improve the efficiency and quality of service delivery.
- 4.61 It is important to distinguish between ex ante and ex post financial incentives.⁸⁷ The former relates to financing mechanisms – prospective payments, for instance – that define, ex ante, a reimbursement schedule expected to induce a certain change in performance (prospective payments, for instance, are expected to increase output production and reduce average costs). By definition, payments are made independently of the results achieved. Ex post incentives, on the other hand, relates resources to performance results. Examples include the transfer of resources from one level of government to another, or the payment of private providers, on the basis of agreed performance goals or targets achieved. This is the concept behind the so called “*contratos/convenios de gestión*.”⁸⁸
- 4.62 The introduction of these more sophisticated reimbursement schemes (particularly ex post instruments) adds other dimensions of complexity to the regulatory process that require even further from the limited institutional capacity of the countries and more sophisticated monitoring and information systems, thus increasing the gap between necessary and actual regulatory capacity.
- 4.63 This fact has been clearly recognized in the Paraguay project (PR-0028, 1006/OC-PR): “*dada la importancia en utilización que tiene el sector privado, en ausencia total de regulación, el introducir sistemas de pago como la capacitación en las*

condiciones actuales podría introducir aún mayor inequidad en la prestación; las personas más pobres y las más enfermas podrían recibir menor nivel o volumen de atención sin ningún sistema de control. Es por ello que también es fundamental comenzar con el proceso de regulación del sector privado para lo cual es necesario fortalecer la capacidad normativa del [Ministerio de Salud Pública y Bienestar Social] MSPBS, diseñar el marco regulatorio apropiado y congruente a las características del sector privado y crear la Superintendencia de Salud” (PR-2194, p. 13). Despite this alert, and the recognized regulatory capacity of LAC countries, most projects with contracting mechanisms approved since 1998 have incorporated performance-based incentives.

- 4.64 This is particularly important, since incentive schemes that reward/penalize institutional performance, such as those supported by the majority of Bank projects, can potentially have a negative impact on the population that depends on the service. The “penalties” that might result from poor performance – e.g. smaller transfers or budgets – are likely to affect mostly the local population that depends on services that can become underfunded.
- 4.65 Finally, it must be remembered that civil service laws and regulations may impede the implementation of incentive-based payment systems.

2. Empirical evidence

- 4.66 There is very little evidence demonstrating the success of performance-based payment mechanisms in both developed and developing countries: “*we are not a stage where there is anything resembling reliable conventional wisdom or set of evidence-based generalizations that can inform policy*” (Culyer (2006, p. 38)). Kane et al. (2004), conduct a comprehensive review of the literature on economic incentive for providers and find that there is little evidence available to support the assumed effectiveness of provider financial incentives in the U.S. private sector as means for inducing preventive care. They also call attention to the fact that bonuses are not easily implemented. The Canadian journal *Healthcare Papers* dedicates an entire issue to the discussion of pay-for-performance mechanisms (Rochon (2006)), with the review paper by Pink et al. (2006, p. 24) drawing three main conclusions: (i) pay-for-performance programs differ substantially, “*suggesting that different environments and goals may require different pay-for-performance programs. At minimum, it shows that there is no consensus about the design of government-sponsored pay-for-performance programs;*” (ii) “*remarkably little is known about the effects of pay-for-performance*”; and (iii) “*despite a lack of substantial evidence, pay-for-performance of publicly financed healthcare is being implemented by governments in the United States, the United Kingdom and Australia.*” The discussion presented indicates that pay-for-performance mechanisms have generated few positive net outcomes for the health system and evidences the difficulties involved in the measurement, monitoring, and evaluation of results.⁸⁹ Consistent with the results reviewed by Kane et al. (op. cit.), they also point out to their high design and administration costs. England’s Audit Commission found little evidence of efficiency and output improvements

during these first years of implementation of the Payment by Results system.⁹⁰ It also found that the costs of implementing the program have been higher than expected (Boyle (2005)).

- 4.67 The majority (65%) of Bank projects support the implementation of performance-based incentives as instruments for improving quality. However, the Canadian synthesis shows that there is little reliable evidence regarding the effects of incentive systems on the health of patients and on the quality of care.
- 4.68 In developing countries, the evidence available is even more limited. As with contracting, several performance-based programs have been implemented in a context that is less relevant for the LAC context, post-conflict poor countries of Africa and Asia, where the public sector's capacity to provide service is almost non-existent. Even though several recent programs have collected baseline data, most do not have control groups. The Haitian USAID pilot experiment with pay-for-performance (Eichler, Auxila and Pollock (2001)), is such a case; it is a before-after study without control groups. Their data show significant improvements in immunization coverage after the introduction of performance-based payments, but mixed results in other targeted interventions. The results obtained from a sample of Chinese hospitals caution that care should be used when designing a bonus scheme since the incentive system may lead to less socially desirable results such as the increase in unnecessary procedures and increases in hospital admission (Liu and Mills (2005)).

E. User fees

1. Conceptual issues

- 4.69 The rationale for the implementation of user fees was disseminated by a seminal 1987 World Bank study "Financing Health Services in Developing Countries: An Agenda For Reform" (Akin, Birdsall and De Ferranti (1987)) and reinforced in the 1993 WDR.⁹¹ User fees were expected to expand the provision of basic services, improve the access of the poor to care, and improve efficiency (see Box 4.10 in Annex 2). It is important to point out that user fees were first proposed mainly for the reality of the poor countries of Africa.
- 4.70 The implementation of user fees was the reform measure supported by the least number of Bank projects: 7 out of 30. Six of these were in countries of Central America and non-English speaking Caribbean and one was in Paraguay.
- 4.71 However, even such a small number of projects is a (negatively) remarkable finding for several reasons:
- a. first, because evidence of the negative impact of user fees on the poor were being reported since the eighties, as illustrated by this quote from Gertler, Locay and Sanderson (1987) referring to Peru: "*An increase in user fees with reinvestment would result in a substantial decrease in demand by the poor and a slight increase in demand by the rich. In addition, there would be a relatively large welfare reduction for the poor and a slight rise in welfare for the rich*" (p. 85);

- b. second, while these projects supporting user fees were approved between 1995 and 2001, the World Bank was distancing itself from the measure by the mid-nineties (Abbasi (1999c)). Furthermore, many of the better known empirical studies were reported before 1995;
- c. third, the countries for which user fees were being implemented or supported had some of the lowest tax revenue efforts in the Region. While it may not have been “unethical” it was certainly regressive to propose the implementation of a cost recovery mechanism – that almost by definition will mostly be paid by the poor (who are the ones that have no option but to use public services) – in such countries; and
- d. fourth, it is conceptually known that, in the health sector, supply-side measures are much more effective than demand-side interventions in minimizing the problems of improper utilization of services.⁹²

2. Empirical evidence

- 4.72 The overwhelming evidence accumulated shows that, in practice, user fees have negative impacts on equity, access, efficiency and revenue collection (see Box 4.11 in Annex 2). Furthermore, mechanisms to protect the poor (fee waivers and/or fee-scale arrangements), are generally ineffective; first because they cannot fully prevent patients from deterring care; and second because such systems are costly and difficult to implement and administer. It is therefore fortunate that legal restrictions in the countries have impeded the implementation of new user fee systems such as those supported by the Bank.
- 4.73 *“The experience of user fee schemes, which proliferated in the 1990s, suggests that such schemes have negative impacts on equity, especially at the primary care level, and should be applied with great caution in poor communities”* (Tollman, Doherty, and Mulligan (op. cit.), p. 1200). Gilson and McIntyre (2005) summarize well the negative impact of user fees on equity: *“user fees are the most regressive form of healthcare financing available; they contribute to the unaffordable cost burdens imposed on poor households; and they represent one facet of the social exclusion experienced by these households”* (p. 762).
- 4.74 In Lima, user fees decreased public hospital utilization by the poor (and even by the not so poor) and increased that of the rich (Arroyo (1999), Flores (2006)). Flores (op. cit.) summarizes well the Honduran results reported by Fiedler and Suazo (2002): *“In Honduras, user fees were introduced throughout the whole network of health care facilities with a highly regressive structure of payments for services. . . . The exemption of payment, which is meant to be a measure of protection for the poor population, is ineffective in providing that protection. . . . Most users who pay for services at health facilities belong to the poorest strata (Fiedler & Suazo 2002). The data from Honduras demonstrates that user fees, in addition to being counterproductive for equity, are also inefficient. The resources generated from user fees do not surpass 2% of the Ministry of Health’s budget. More than two thirds of the funds collected are used for the administration of the user fee system”* (p. 18).

F. Decentralization

1. Conceptual issues

4.75 Despite the 1996 Social Development Strategy call to “*approach decentralization with caution*,” this has been the measure most commonly supported by Bank projects. It has been present in almost three-quarters of the projects approved between 1995 and 2005 and in 90% of the projects approved between 1995 and 2001 (Table 3.3). These numbers are not surprising, decentralization – the transfer of authority and responsibility of public functions from the central government to subnational levels of government or autonomous institutions (Hutchinson and LaFond (2004)) – became one of the most common health reform measures of the nineties. In fact, the decentralization of the health sector in most countries was part of a broader public sector decentralization process. Decentralization in general was seen as a measure that would improve the efficiency, equity and access, while the decentralization of service delivery through increased autonomy of health institutions, primarily hospitals, would promote greater efficiency and quality of inpatient care in the system. The Bank supported, through 10 projects, measures to increase hospital autonomy.

4.76 However, decentralization, *per se*, does not guarantee improved health sector efficiency or access. Decentralization processes depend on the successful implementation of a series of measures (e.g. accountability systems and transparent legal frameworks and transfer mechanisms), on the presence of adequate managerial and technical capacity at the local level, and on the existence of sufficient funding. Without these elements, decentralization may lead to increasing costs and the multiplication of administrative and bureaucratic structures, and therefore greater inefficiency. Thus, “*while none of these conditions are sufficient for successful decentralization, country experiences demonstrate that all of them are necessary*” (Hutchinson and LaFond (2004), p. xiii). It should also be noted that decentralization could generate substantial transactions costs, particularly in federative countries.⁹³ Finally, if appropriate mechanisms for community control and oversight do not exist or are ineffective, there is an increased likelihood that resources will be misallocated or used for political purposes. For all these reasons, it is clear that the decentralization process is not applicable or recommended for all countries.⁹⁴

2. Empirical evidence

4.77 While rigorous empirical evaluations of decentralization efforts are difficult to conduct, the evidence available suggests mixed but somewhat encouraging results. Data from the Philippines, Uganda, Brazil, Chile, and Colombia show that decentralization has tended to increase the allocation of local resources for the sector, furthermore, in the cases of Chile and Colombia the data suggest a reduction in the difference in per capita health expenditure between richer and poorer communities, thus indicating some (regional) equity improvement (Bossert (2000)).⁹⁵ The weak institutional capacity of Bolivia, however, generates an

- increase in inequalities in favor of municipalities with somewhat better political and/or technical conditions (Bossert (op. cit.)).
- 4.78 In the case of Brazil (Medici (2002)), there has been a significant increase in state and municipal financing; with these sub-national levels becoming the main sources of public financing for the health sector. However, the Brazilian data available until 1996 do not present evidence that the transfers of resources from the federal level to the states are equitable.⁹⁶
- 4.79 A study of the Nicaraguan decentralization process (Bossert, Bowser, and Corea (2001)) does not find very conclusive results, but the evidence suggests that “*local choice at the [Sistemas Locales de Atención Integral en Salud] SILAIS level has at least not exaggerated inequalities and inefficiency and may have contributed to improving equity and efficiency*” (p. 5). Canadian data indicate a positive and substantial impact of decentralization on the capacity of public policy in improving population health (Jimenez and Smith (2005)).
- 4.80 Data on the impact of decentralization on efficiency is limited, however, the international evidence suggests that despite increase in local health expenditures, data from the Philippines (Schwartz, Guilkey, and Racelis (2002)) and Uganda (Akin, Hutchinson, and Strumpf (2001)) show a worsening in allocative efficiency, due to a decline in the provision of resources to public goods activities and an increase towards private health goods.
- 4.81 The Bellagio Study Group on Child Survival (2003) found that the difficulties in implementing the decentralization process have compromised the performance of PHC-oriented systems.
- 4.82 **Hospital autonomy.** As noted above, the Bank also supported, in 10 projects, country efforts to increase hospital managerial and financial autonomy as part of the decentralization process.⁹⁷ The (limited) data on hospital autonomy in developing countries suggest few (if any) gains in terms of efficiency and quality of care (Govindaraj and Chawla (1996)). The experience of the Brazilian state of Sao Paulo (Costa and Ribeiro (2004)), on the other hand, appears to show significant efficiency and possibly quality differentials in the autonomous hospitals that operate under the special arrangement of “Organizações Sociais” (Social Organizations), even though these differences in performance cannot be explained solely by the autonomy given to these institutions.⁹⁸
- 4.83 The experiences of developed countries such as New Zealand and the U.K. show that hospital autonomy does not automatically enhance hospital performance. Furthermore, some case studies from Govindaraj and Chawla (op. cit.) indicate that, without the proper regulatory mechanisms in place, hospital autonomy can lead to abuses of the system and can have important consequences for hospital performance. Indonesian data indicate a negative equity impact, in fact Bossert, Kosen, and Gani (1997) find that “*the only clear evidence of improvements that have occurred from hospital autonomy were that management systems improved in autonomous hospitals*” (p. 4).⁹⁹

4.84 Finally, many of the assumptions implicit in the conceptual model of hospital autonomy are not likely to be met in practice. Decentralized public hospitals are instruments for two potentially conflicting objectives: to improve the sector's overall "efficiency and productivity," and to contribute to social policy goals. This is particularly true in the many instances in which public hospitals are the only source of care for certain areas. These facts, and their ultimate dependence on public resources, imply that hospitals are not likely to ever be as autonomous as assumed by the conceptual models.

G. A note on social insurance and payroll taxes

4.85 As noted in the previous chapter (see paragraphs 3.20 and 3.23), the Bank has supported the implementation of social insurance mechanisms in Belize, Bolivia, Colombia, Dominican Republic, Ecuador and Peru, and studies to assess their appropriateness were financed in Jamaica and Trinidad and Tobago.

4.86 Social insurance mechanisms share the common characteristic of modifying the way in which health services providers are remunerated. Social insurance aims at achieving two major objectives: (i) the pursuit of universal coverage, which has an ethical and social merit of its own; and (ii) the introduction of an explicit mechanism of "solidarity" that has important implications in a context of social exclusion and inequality such as the one that characterizes the Region.

4.87 Social insurance models are also financed by payroll taxes rather than general revenue. In the case of the countries of the English-speaking Caribbean, the implementation of payroll-based social insurance systems were particularly attractive as a mean for rapidly increasing the amount of (ear-marked) resources available to finance the sector.

4.88 However, payroll-based systems contain major problems and risks that have often been overlooked by policy makers:¹⁰⁰

- a. they tend to even further stimulate the growth of an informal sector that is already large in many countries of the Region;
- b. they introduce a distortion in the price of labor relative to capital, and therefore, have a disproportionately negative effect on sectors that are labor intensive and generators of employment;
- c. payroll taxes are pro-cyclical and can be more volatile than general revenues. This implies that in periods of economic recession, when the demand for health services tends to increase, the sector's main source of financing tends to become severely compromised. This is an important issue in a Region with high levels of volatility such as LAC;
- d. the data from developed countries indicate that health sectors financed by social insurance contributions tend to be regressive (Van Doorslaer and Wagstaff (1993));
- e. the labor-intensive nature of the Region's exports, and the pressures to maintain international competitiveness, are likely to impose important limits

on the growth of payroll taxes. These restrictions are likely to collide with the needs of the health sector, not only because in the short run its costs tend to increase faster than general prices, but also because in the medium to long-term, these costs are likely to increase even faster due to the ageing of the Region's population; and

- f. finally, the use of payroll taxes to finance the sector does not remove the need to compete for scarce sources of revenues, but simply shifts this competition to other areas that are also dependent on revenues from earnings such as pensions. In this clash, the health sector is at a considerable disadvantage, first because pensions costs will also rise with the Region's ageing, second because, if needed, general budgetary cuts to the health sector are politically and even legally easier implement than not making pension payments. In this sense, in the medium to long-term, that sector might be better-off finding resources from the general revenue rather than from payroll taxes.
- 4.89 These issues need to be carefully examined by policy makers, particularly in the context of the English-speaking Caribbean where health systems have been relatively successful.
- 4.90 The Colombian model of social insurance based on the principles managed competition has served as reference for other reform proposals supported by Bank projects during the nineties, e.g. the Dominican Republic (DR-0078) and Peru (PE-0146) (see Box 4.12 in Appendix 2 for a brief discussion of the Colombian managed competition model).
- 4.91 It should be noted that notwithstanding their names, some of the so-called insurance schemes implemented in the Region, such as Peru's "Seguro Materno Infantil" subsequently renamed "Seguro Integral de Salud" (supported by PE-0146), as well as Bolivia, "Seguro Materno Infantil"; and Ecuador "Aseguramiento Universal de Salud"), lack some of the key elements of an insurance scheme: payers do not manage risks, and most of the covered services are not rare and costly events. Their main common feature was the introduction of fee-for-service reimbursements for providers to cover variable costs of the pre-defined set of interventions targeted to the poor. The benefits sought were twofold: (i) to remove the financial and economic barriers faced by the poor, as eligibility to these programs waived the payment of user fees; and (ii) to encourage (through fee-for-service reimbursements) the provision of the covered interventions.

H. The changes in the countries

- 4.92 Even though the data available would not allow for establishing a causal relationship between the measures implemented by the Bank and/or the countries of the Region and health outcomes, OVE has also looked at what has happened to some key health sector related indicators during the period in which these reform measures were being implemented.
- 4.93 The 2004 data show that the current situation is generally quite similar or somewhat better than the one observed in the early nineties and discussed in

Section A of this chapter and Box 4.1: (i) as in 1990, the 2004 data on life expectancy also show 5 countries below the regression (all of them not significantly different from the estimated values); (ii) in relation to infant mortality, the 2004 data show 10 Bank-member countries with rates that put them below the regression line, i.e. with lower than expected mortality rates, (there were 9 countries in 1990) and 14 above the line (16 in 1990), of which only one, Brazil, beyond the boundary defined by one standard deviation (3 in the early nineties); and (iii) the 2004 under-5 mortality data show half of the countries (12) below the estimated line (10 in 1990), and the other half with rates that put them above the regression line (15 in 1990), but none of these rates were significantly different from the expected value.

- 4.94 Graph 4.1 displays the percentage changes between 1995 and (*circa*) 2004 of a relative composite index of impact/outcome indicators (negative numbers indicate an improvement in the relative index).^{101, 102} As the graph shows, the countries in which the Bank supported most reform measures (Guatemala, Dominican Republic, Paraguay, El Salvador, Haiti, and Panama) do not perform particularly well. Mexico's significant relative improvement and Paraguay's worsening stand out in the graph. Mexico shows major improvements in all indicators, particularly those related with immunization coverage. Paraguay's worsening relative performance is largely explained by the relatively small decline in the country's mortality indicators. It is very important to note that a worsening of the index does not necessarily imply a deterioration of the indicator, but the result of a worsening of the index *relative to other countries*.
- 4.95 In fact, and consistent with the discussion of paragraph 4.95, Graphs 4.2-4.12 show that the outcome/impact indicators of the Region have generally improved since the mid-nineties. The "negative outliers" in the data are: the decline in the proportion of children immunized against polio in Jamaica (Graph 4.8), and particularly against measles in the Dominican Republic, which have fallen close to the 60% level (Graph 4.9); the decline in the percentage of women receiving prenatal care in El Salvador and Chile (Graph 4.11). On the positive side it is worth noting the improvement in coverage of prenatal care in Guatemala and Peru (Graph 4.11), an area that has been supported by Bank interventions; and the increase in the proportion of birth deliveries assisted by trained personnel have also improved significantly in Bolivia and Peru (Graph 4.12).

V. CONCLUSIONS AND RECOMMENDATIONS

- 5.1 The Bank's interventions in the health sector were part of a general framework of structural reforms anchored on fiscal deficit reduction and market-based policies that dominated the development thinking of the period and permeated those working with the health sector, whether in the countries themselves, whether in the IFIs, including the Bank. This reform framework was translated into a set of health reform measures designed to induce, or at least mimic, market-like behavior by public and private agents.
- 5.2 The conclusions and findings derived from each of the main reform measures supported by the Bank between 1995 and 2005 show the presence of important empirical and conceptual limitations. These limitations suggest that, as a whole, the approach followed by the Bank may not have been able to improve the efficiency, quality or equity of the health systems of the Region, as intended by the projects approved during the period.¹⁰³
- 5.3 There is no data available to assess efficiency and quality of care at the country level, and very little data from household surveys that allow for general before and after comparisons. Data from Chile, Colombia, El Salvador, Nicaragua, and Panama obtained from the living standards measurement surveys (LSMS) show that equity, on the other hand, was a problem in the early to mid nineties and still remains one. In all these countries and in both periods, access to care (measured as the proportion of individuals with a health problem that sought and received care) for those in the upper quintile of the income spectrum is statically significantly greater than for those in the lower quintile (see Table 5.1). It must be noted, that with the exception of Panama, assessment of changes over time are not possible due to differences in the questions used in the surveys. The Panamanian data show a significant increase in the differences between the two groups (upper and lower quintiles), from 21 percentage points in 1997 to 32 percentage points in 2003.
- 5.4 Trujillo, Portillo, and Vernon (2005) evaluate the impact of Colombia's subsidized health insurance regimen on health services utilization by the poor. The authors use propensity score matching and instrumental variable techniques and find a generally positive impact on health services utilization by low-income children, women and elderly. Their results suggest, therefore, that the implementation of cross-subsidies mechanisms can generate positive impacts in a Region marked by high levels of inequality. Unfortunately their study does not assess the impact of the program on the health conditions of the poor.
- 5.5 The analysis of health sector and health system's performance is marked by major technical divergences and, sometimes, conflicting empirical evidence. Those working in the sector do not agree, for example, on how to apply the measures used to estimate the burden faced by the countries due to morbidity and mortality to the decision-making process.¹⁰⁴ This disagreement is mentioned here because it implies divergence in how sector priorities should be set. The World Health

- Report of 2000 (World Health Organization (2000)) attempt to define, measure and rank health systems' performance generated a level of technical and political disagreement and controversy rarely seen.¹⁰⁵ The results from this evaluation reflect this scenario: it shows that there is no single or "right" model for the organization of health systems.
- 5.6 The evidence available indicates that market-based instruments are not *necessarily* superior alternatives. The health sector is in fact characterized by both market failure and government failure, and the context-specific characteristics of the countries are critical for proper policy recommendation and implementation. These results, in turn, imply that health sector interventions were and will be largely experimental and the Bank should analyze different alternatives. Uncertainty is indeed inherent to the sector's policy context. Developed countries like New Zealand that were strong adopters of New Public Management policies have been revising their strategies.
- 5.7 However, one of the main findings of this evaluation is that Bank reform actions were not evidence-based; they have, to a large extent, followed a set of consensual assumptions of the time that resulted from the belief that market-based mechanisms and incentives were the only solution to the problems and inefficiencies observed in the sector. Despite the lack of empirical and sometimes conceptual support, these assumptions were not seriously questioned: they were judged to be right because they were based on the "right premises."¹⁰⁶
- 5.8 As Rice (1997) concludes: "*In spite of the fact that most questions in health policy can be answered only through empirical research, getting the theory right is nevertheless extraordinarily important to the enactment of sound health care policies. If analysts misinterpret economic theory as applied to health – by assuming that market forces are necessarily superior to alternative policies, and that other tools of the trade neatly translates to health care – then they will blind themselves to policy options that might actually be best at enhancing social welfare, many of which simply do not fall out of the conventional, demand-driven competitive model. Market forces may indeed have a prominent place in health care organization and delivery, but, as I have tried to show, economic theory does not show them to be necessarily a superior approach to health care policy*" (pp. 422-423).
- 5.9 For all these reasons the evaluation efforts and the analytical and empirical work required to *support the Bank's operational activities* need to be strengthened.
- 5.10 With regard to the need to strengthen evaluation efforts, this report has shown that that PHC is an area of significant relevance and potential impact on the organization and functioning of health systems that displays a remarkable paucity of empirical evaluation. Specifically, the experiences with basic packages need to be evaluated and potential scaling up alternatives assessed.
- 5.11 As shown by the contracting experiences of Guatemala and Honduras discussed in the previous chapter, several of the pre-requisites and assumptions required for the contracting of private sector providers have not been fulfilled. Accordingly, the Bank needs to assess the conditions in other countries in which it has financed

- similar approaches, formulate measures necessary to correct or mitigate existing limitations (if any), and analyze the set of conditions that can increase the likelihood of success.
- 5.12 The regulatory capacity of a country has been pointed out as critical for the successful implementation of many of the measures supported by Bank projects. This issue raises an important question that needs to be explicitly tackled by the Bank: should (or can) policy makers wait for an optimal regulatory system to introduce certain interventions? However, since it appears that the regulatory limitations have not been adequately addressed, the Bank should prioritize evaluations of the existing regulatory capacity in those countries that have Bank-financed operations aimed at implementing contracting mechanisms, performance-based incentives, and hospital autonomy.¹⁰⁷
- 5.13 With regard to analytical and sector work, OVE compiled the sector work published by the Bank between 1995 and 2005 (Table 5.2), despite containing a significant number of items (71), the vast majority of the work is unrelated to the key measures discussed here or to the main objectives of Bank projects. In fact, there were four studies related to the five key reform measures, eight studies related to reform in general, and only two to the objectives of efficiency, quality and equity/coverage.
- 5.14 In that respect, the implementation of “knowledge resource links” – website pages presenting main conceptual definitions, thematic reviews, applied research papers developed in-house or financed by the Bank, and links and references to the academic and policy-related literature (see Box 5.1 in Annex 2 for an example) – could be a tool that would serve both as a source of information and a catalyst for further research and exchange of ideas.
- 5.15 It is also clear that more sector work and analysis is needed. OVE strongly recommends that the Bank’s applied research agenda should be driven by the needs of the Operations Departments. As noted in Chapter III, recently approved projects suggest that the countries of the Region are seeking a still unclear but different path; therefore, the relevance of the Bank’s assistance relies upon its capacity to identify the themes and areas that need further research.
- 5.16 It should be pointed out that the problems found by this evaluation do not invalidate the Bank’s focus on systemic issues. IDB’s comparative advantages rely on its ability to understand, prescribe and intervene upon system-related issues, which does not necessarily mean reform measures. It must also be remembered that the Region is unique in the sense that it has a United Nations technical agency, the Pan-American Health Organization, to support the countries on disease-specific and epidemiological issues.
- 5.17 Examples of (non-reform) systemic issues that present potential for future Bank involvement include: (i) interventions aimed at improving the (epidemiological and health) surveillance capacity of the countries, an area that is related to regulatory and institutional systems, which as discussed throughout this document, are still weak in the Region; (ii) the design and implementation of health systems

networks. The Bank supported interventions in this area (e.g. CO-0139) during the period analyzed, and continues to do so to this date¹⁰⁸ (see also Box 5.1 in Annex 2); and (iii) human resources: the health sector is essentially labor intensive. While in developed countries it employs up to 10% of the formal workforce, in developing economies it uses large proportions of voluntary and informal labor. Furthermore, human resources are, perhaps, the most important factors in determining the quality and efficiency of any health service, since they are the final actors and decision-makers in the health care delivery process. Despite these facts, the development of the sector's human resources has not received adequate attention from the Bank or other agencies.¹⁰⁹

- 5.18 Finally, as indicated by the comparison with the World Bank presented in Chapter II, the Bank is competitive in the sector. The Bank's very positive health sector program in Colombia is an example of its competitiveness and the lessons that can be drawn from this experience should serve as a basis for the Bank in the future.

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ENDNOTES

Chapter 2

- ¹ OVE reviewed the evaluability matrices and/or results framework of all projects approved between 1995 and 2005.
- ² I.e. operations that have been defined by the Bank as health sector loans.
- ³ The terms loan, project and operation are used interchangeably throughout the document.
- ⁴ As noted above, the project-related figures discussed throughout this report refer only to projects classified as health sector loans. They do not consider other projects approved by the Bank that have components financing interventions in this area (e.g. social investment funds, conditional cash transfers, and non-health policy-based loans), nor water and sanitation operations that knowingly have major health impacts. It also excludes non-reimbursable technical operations, MIF projects and financing through the Project Preparation and Execution Facility. The monetary values were inflated to 2005 using the U.S. Consumer Price Index.
- ⁵ The year 1990 not only establishes a mid-point for the 1973-2005 period in which the Bank has been involved with health operations, but also a convenient decade-reference that facilitates presentation.
- ⁶ As will be discussed the next chapter, 1995 also marks the approval of the first actual health sector reform loan and, in this sense, a new direction for Bank interventions.
- ⁷ These results are even more marked if only investment loans are considered. Health sector investment projects represented 3.1% of the total number of investment projects approved by the Bank between 1973 and 1989 and 1.9% of the original approved amount (measured in constant dollars of 2005). Between 1990 and 2005 these shares represent 4.1% and 3.8%, respectively. During the 1995-2005 period health sector investment projects represented 4.4% of the total number of investment projects approved by the Bank in these years, and 5.1% of the original approved amount.
- ⁸ Even though the average health project approved after 1995 was relatively larger than the average education project, education projects have increased faster if compared by median values.
- ⁹ We have tried to make the two data sets as compatible as possible, in this sense, the only World Bank operations considered were those that could be identified as “pure” health sector projects and only for Bank member countries. Given the fact that their project classification is different, some errors might remain, but if they exist we believe they are small.
- ¹⁰ The Bank also has had very few health specialists (no more than 5) in Country Offices.
- ¹¹ The WB approved 6 projects for Argentina, 6 for Brazil, and 4 for Mexico. The IDB approved four loans for the “A” countries (one for Argentina, two for Brazil, and one for Venezuela).
- ¹² The Bahamas is not eligible for direct lending from the World Bank.
- ¹³ During this period, the World Bank did not lend to Belize, Chile, Colombia, El Salvador, Guatemala, Haiti, Suriname, and Uruguay; and the IDB to Barbados, Chile and Mexico. The World Bank has, however, two regional projects, one for Central America and another for the Caribbean.
- ¹⁴ Between 1995 and 2005, the WB approved 5 AIDS loans for English-speaking Caribbean countries, 2 for Brazil, 2 for Central America and the Dominican Republic, and 1 for Argentina
- ¹⁵ AIDS-related interventions were present in projects financed by the Bank in Bolivia, the Dominican Republic, Honduras, Panama and Suriname.
- ¹⁶ See for instance, Inter-American Development Bank (1985) and Johnston and Stout (1999).
- ¹⁷ These problems are not exclusive to the Region or to the developing world. Health systems in developed countries also suffer from the same type of perception, and have also implemented health sector reforms.

Endnotes (continued)

- ¹⁸ “[T]his paper sets forth the theoretical reasons for predicting that the state will *often* finance a bundle of social services that is both inefficient and inequitable” (Birdsall and James (1990) p. 2. Emphasis added); “*in general*, government actions may be neither efficient nor equitable” (Birdsall and James (1992), p. 1. Emphasis added).
- ¹⁹ For the application of the agency theory in the health sector see for instance Dranove and White (1987), Culyer and Newhouse (2000), and Phelps (2003).
- ²⁰ As noted by Mills, Bennett and Russell (2001): “*While NPM has a clear conceptual framework, there is not yet a fully fledged body of theory*” (p. 5).
- ²¹ In the United States this movement is commonly referred to as “reinventing government.”
- ²² Life expectancy at birth, for example, increased from 65.4 to 69.8 years between the periods 1980/85 and 1990/95; age-adjusted mortality rates from communicable diseases were reduced by almost one-half (from about 181 to approximately 94 per 100,000 population), and proportionate mortality rates from diarrheal diseases, were reduced by almost two-thirds: from the almost 22% to about 8% during the same period (Pan-American Health Organization (1998).
- ²³ “*Although health services are only one factor in explaining past successes, the importance of their role in the developing world is not in doubt*” (World Bank (1993), p. 3).
- ²⁴ Health sector reforms have been implemented and/or proposed in affluent countries as well. Even though many of the approaches are different, common topics such as an increasing role for the market, the concern with expenditure levels, and inequality issues are very much in the essence of the reforms proposed in these countries as well. “*The international health policy virus of ‘reform’ is affecting EU countries to varying degrees*” (Maynard (2005a)) (see also Maynard (2005b); Oliver, Mossialos and Maynard (2005a); Oliver, Mossialos and Wilsford (2005); Judge et al. (2005); and Horev and Babad (2005)).
- ²⁵ The Region’s health systems were classified by the Bank (Inter-American Development Bank (1996b)) in 4 organizational categories: i. public subcontractor (Brazil); ii. contract intensive (Argentina, Chile and Uruguay); iii. integrated public (The Bahamas, Barbados, Costa Rica, Jamaica and Trinidad and Tobago); and iv. segmented (all others).
- ²⁶ “*Comparing the health expenditures in Latin America and the Caribbean with spending in other parts of the world highlights a very interesting, if disturbing, trend. Whether measured in per capita terms, or as a proportion of GDP, the health expenditures in Latin America are significantly greater than the spending in other developing regions of the world. In fact, the public/private mix of health expenditures, as well as the proportion of GDP spent on health, in Latin America are beginning to resemble the patterns observed in the OECD countries*” (Govindaraj, Chellaraj and Murray (1997), p. 169).
- ²⁷ Epidemiological transition is the term used to describe the changes in the health profile of populations where infectious diseases are substituted by chronic or non-communicable diseases.
- ²⁸ This operation was, to some extent, a large (US\$38 million) technical cooperation designed to finance a set of elements necessary to support a dynamic process such as the on-going sector reform. The Program financed, for example, a large set of studies, information systems, institutional and human resources strengthening, and the support for policy design.
- ²⁹ Despite the fact that all 4 health sector loans approved in 1992 and 1993 were defining themselves as instruments to support health sector reforms – CO-0033, 716/OC-CO: “*El Programa se diseña como un instrumento facilitador de la reforma de salud, a través del apoyo al proceso de descentralización técnica administrativa del sector*” (PR-1883, p. 14). CR-0120, 711/OC-CR, 712/OC-CR: “*El Programa tiene por objeto principal apoyar las reformas institucionales del sector salud que permitan mejorar la eficiencia y la eficacia en la prestación de servicios en el contexto de la reforma del sector público*” (PR-1885, p. 11). PE-0030, 741/OC-PE: “*Emprender los estudios y acciones concretas que*

Endnotes (continued)

permitan sentar las bases para llevar a cabo programas de reformas sectoriales tomando en cuenta el papel de la seguridad social y de los otros entes que presten servicios públicos y privados de salud (PR-1907, p.11). PN-0029, 803/OC-PN: “*El Programa que se propone tiene tres propósitos: (i) iniciar un proceso de reforma del sector*” (PR-1968, p.12) – with the exception of the Colombian loan, these projects of the early nineties were still essentially financing infrastructure and equipment and non-reform activities. CR-0120: of the approximately US\$34.5 million to be financed by the Bank (excluding financial costs and resources “sin asignación específica”), US\$32 million were to be allocated for infrastructure and equipment expenses. As stated in the project document (p. 12): “*se ha detectado la necesidad de rehabilitar, ampliar y/o sustituir centros y puestos de salud en las áreas marginadas del país. Se estima que las necesidades más urgentes de inversión comprenden 119 puestos y 11 centros.*” (...) “*Asimismo, para el funcionamiento de la red hospitalaria nacional, resulta indispensable la sustitución del Hospital de Alajuela dado su estado avanzado de deterioro.*” PE-0030: Of the US\$57.5 million to be financed by the Bank (again excluding financial costs and resources “sin asignación específica”), approximately US\$55.2 million were infrastructure-related costs. PN-0029: approximately US\$27 million of the US\$36.9 of Bank’s financing (excluding financial costs and resources “sin asignación específica”) is allocated for infrastructure and equipment and US\$9 million in consultancies for managerial support of services and local programming.

³⁰ The names of 18 of the 30 operations approved between 1995 and 2005 refer to sector goals, and 16 use the word “reform” or a synonym of it (refer to Table 2.3). At the World Bank, 9 of the 40 health projects approved between 1995 and 2005 contain the word “reform” in their titles.

³¹ Of the 27 non-policy-based loans approved between 1995 and 2005, only 9 do not finance infrastructure or equipment.

³² The “Health Sector Reform Project - REFORSUS” (BR-0199, 951/OC-BR, approved in 1996), for example, allocated almost 84% of its resources for infrastructure and equipment, but included as conditions for infrastructure financing the implementation of management and maintenance development plans; as well as measures and technical assistance with system-wide scope. This operation was co-financed with the World Bank.

³³ Here the analogy to the Washington Consensus basic principle of “getting prices right” is so obvious that it must have been purposeful.

³⁴ Even though market-based policies characterized *most* health reforms in Region, not all countries followed this trend. Brazil is perhaps the most important example. The basis for restructuring the health system and creation of the Brazilian Unified Health System (SUS) was set by the Constitution of 1988 and by the “Lei Orgânica da Saúde” approved in 1990 (Medici, 1997) and was not only public-sector oriented, but also defines the private sector as supplementary to the SUS. The Chilean reform, on the other hand, was different in the sense that it began in the late seventies (Cifuentes, 2000). The so-called “Chicago boys” of the Pinochet regime implemented market-based principles throughout the Chilean economy.

³⁵ In 1998, the Bank published the book, “La Organización Marca la Diferencia” (Inter-American Development Bank (1998)), that reinforced its views on the importance of organizational changes in social services (i.e. health and education).

³⁶ The Bank’s Public Health Policy (OP-742), originally prepared in 1972, is much more based on service provision rather than systemic measures, and calls for an emphasis on preventive health measures and the control of eradicable and reducible diseases. The Board of Governors’ Report on the Eighth Replenishment (AB-1704) also places an emphasis on preventive care, however, as a document of the nineties, it also incorporate sector reforms as one of the areas for Bank support: “*In the health sector, emphasis will be placed on preventive measures and on primary health care. Priority will be given to combating infectious and contagious diseases, as well as to reducing infant and child mortality. Within this context and working with specialized agencies, major objectives of the Bank will be to assist in bringing about full coverage in inoculation, to provide assistance for mass vaccination*

Endnotes (continued)

campaigns for infants and school-age children, and to support implementation of environmental health projects, particularly in the water supply and sanitation subsectors. Likewise, the Bank will continue to support programs geared to improving the provision of services in the health sector, and the reform and modernization of the sector, including hospitals” (AB-1704, pp. 21-22).

- ³⁷ Despite the many criticisms received, the WDR indicated the World Bank’s commitment to increase its involvement with health issues, and gave it greater exposure and legitimacy in the sector (Reich (1994, 2002); Abbasi (1999a, 1999b, 1999c, 1999d, 1999e, 1999f); and Ruger (2005)). As a result, and through its influence in both finance and health ministries, the World Bank displaced the World Health Organization (WHO) as the major player in international health, and assumed the role of lead agency in the health sector, with the WHO providing medical expertise or “technical support” (Abbasi (1999a)). Political and leadership problems inside WHO during the late 1980’s and early 1990’s also contributed to its decline (Irwin and Scali (2005), Abbasi (1999a), Cassels and Watson (2001)).
- ³⁸ “*In developing countries, the package of suggested health sector reforms has generally included . . . :*
- *organisational reform and restructuring (decentralisation, downsizing, introduction of performance related incentives, ‘corporatisation’);*
 - *broadening health financing options (introduction of user fees, community financing or social health insurance);*
 - *encouraging greater diversity and competition in health service provision (privatisation, establishment of public-private partnerships); and*
 - *increasing the role of health service consumers (prioritisation of user choice, mechanisms to increase community accountability and participation).”* (Blaauw et al. (2003).)
- ³⁹ The correspondence between these measures and the WDR can be clearly seen from Table 3.2.
- ⁴⁰ The 1993 WDR summarizes well these last few recommendations: “*The challenge for most governments is to concentrate resources on compensating for market failures and efficiently financing services that will particularly benefit the poor”* (World Bank (1993), p. 6).
- ⁴¹ See also Schieber (1997).
- ⁴² Clearly, the types of measures that can be implemented are a function of a country’s specific context, the characteristics of the health system (e.g. cost-recovery mechanisms cannot be implemented if local legislation forbids the public sector to charge for services provided) and how advanced the country is in relation to the reform process itself.
- ⁴³ Indicators were classified under the category “other” for two main reasons: a) because they were not clearly defined (e.g. average throughput meets defined standards); or b) because they were not related to any specific objective (for example, Medicine Revolving Funds that have sustained at least their initial amounts; proportion of federal, state, municipal, and private health expenditures in total health expenditures). Of the 164 indicators, only 14 (8.5%) were classified in this category.
- ⁴⁴ The objective of improving equity and increasing coverage could, obviously, be seen as incorporating two separate goals. However the indicators used by projects to define coverage increase were related to expanding access to services or health insurance schemes, particularly for the poor (e.g health coverage in the provinces, particularly among low-income groups; number of people insured through social security system, increase access of the poorest population to health establishments, etc.), and in this sense were seen as equity-related and, therefore, a single general objective.
- ⁴⁵ No project has “other” as its sole objective category, and only one project has most of its indicators related to this category of objective.
- ⁴⁶ The exceptions are, in general, projects that tie their objectives to systemic improvements expected from the sector’s reform (e.g. efficiency, sustainability, equity, etc.). The projects that did not explicitly define health-related objectives were: CO-0088 (910/OC-CO), VE-0091 (867/OC-VE), BR-0199 (910/OC-BR), HO-0032 (1005/SF-HO).

Endnotes (continued)

- ⁴⁷ No project has indicators covering all 5 categories of objectives.
- ⁴⁸ For example: 1) “*The project’s main objective is to expand and improve the delivery of care under the Unified Health System (SUS), ... parallel to the introduction of policy reforms which would improve the financial sustainability, equity, efficiency and management of the SUS*” (BR-0199 951/OC-BR. Document PR-2143, p. 20); 2) “[*to enhance*] *the quality, efficiency and equity of health services provided by public and private institutions in the national health system*” (HA-0045, 1009/SF-HA. Document PR-2308, p. 11); and 3) “*Las acciones de este programa de apoyo tienen los siguientes objetivos: a) desarrollar una estrategia para las regiones donde la competencia no es viable . . . ; b) fortalecer la competencia en áreas donde sea factible, y fortalecer los instrumentos de políticas existentes . . . con el objeto de contribuir a la sustentabilidad financiera del sector; c) mejorar la eficiencia y calidad de servicios . . . ; d) mejorar la equidad . . . ; e) asegurar una oferta adecuada de servicios y corregir las distorsiones en el subsidio a la oferta existente; y f) establecer sistemas básicos de datos y sistemas de información*” (CO-0088, 910/OC-CO. Document PR-2096, p. 15).
- ⁴⁹ The two reform measures widely present in Bank projects approved between 1995 and 2001 to have the sharpest declines during the second phase, contracting and decentralization (see Graphs 3.2 and 3.3), are closely related to the objective of improving efficiency.
- ⁵⁰ The decline in the proportion of projects with infrastructure components observed after 2001 (Table 3.1) is related to the smaller size of these projects.
- ⁵¹ For a discussion of the reform fatigue in the economy as a whole see for instance Ortiz (2003) and Lora, Panizza, and Quispe-Agnoli (2003).
- ⁵² For example (to cite one per Operational Department) TT-0024, 937/OC-TT; DR-0078, 1048/OC-DR; BR-0199, 951/OC-BR.
- ⁵³ Although the presence of a reform fatigue inside the Bank cannot be demonstrated empirically, health sector specialists have frequently reported frustrations with health reform processes.
- ⁵⁴ The fact that after 2001 there were no projects with indicators classified as “other” also suggests a more focused approach. It also appears that these changes have not altered the fact that primary care continued to be a central feature of Bank actions (Table 3.3). This is not surprising, since an emphasis on primary care interventions is consistent with simpler and smaller projects.
- ⁵⁵ Inter-American Development Bank (2003).
- ⁵⁶ The 2003 Social Development Strategy has an approach that emphasizes results related to health status and the Millennium Development Goals. A noteworthy recommendation of the strategy is the mentioning of human resources issues, even though these references are made in the context of reform (Inter-American Development Bank (2003), p. 16).

Chapter 4

- ⁵⁷ Lev Landau’s original phrase was “Cosmologists are often in error, but never in doubt.” Cited by Simon Singh in his Big Bang: The Origin of the Universe, Harper Perennial, 2004.
- ⁵⁸ It must be clear that his evaluation does not intend to present an exhaustive review of the literature, but to show that there is enough evidence to support a cautious approach when implementing reform measures.
- ⁵⁹ The “*average educational attainment and health conditions are inadequate when compared to other countries of the world with comparable levels of income*” (GN-1932-1, p. 1). Even the main author of this report has used the same line of reasoning: “*Despite these improvements, the Region’s health indicators generally tend to be worse than other parts of the world of similar (and sometimes even of lower) income levels*” (Iunes (2001), p. 204).

Endnotes (continued)

- ⁶⁰ The basic package as a “selective PHC” approach must be distinguished from the approach proposed for the poor countries of Africa and Asia where premature death and morbidity could be dramatically reduced by a few simple interventions. “*The most famous example of selective PHC was the strategy for reduction of child mortality known as “GOBI” -- short for growth monitoring, oral rehydration therapy, breastfeeding and immunization. By concentrating on wide implementation of these interventions in developing countries, proponents argued, rapid progress could be made in reducing child mortality, without waiting for the completion of necessarily lengthy processes of health systems strengthening (or a fortiori for structural social change)*” (Irwin and Scali (op. cit.), p.p. 16-17).
- ⁶¹ “*The [1993 WDR] report identified highly cost-effective interventions targeted at the major causes of the prevailing burden of disease in low- and middle-income settings. These interventions were grouped into a ‘minimum package of health services,’ which, it was argued, governments and donors should prioritize for funding*” (Tollman, Doherty, and Mulligan (2006), p. 1194).
- ⁶² Some loans have the package described in technical annexes. Others only provide a very vague description: “Family Health and Health Promotion Subprojects will provide emphasis on the delivery of a basic package of cost-effective clinical and public health interventions.” BR-0199, 951/OC-BR. Document PR-2143, p. 22).
- ⁶³ The packages adopted in Peru, Panama and Suriname appear to be among the most comprehensive.
- ⁶⁴ In relation to health, the proposal of “universalismo básico” does not present, yet, a framework that can be implemented. It could also be argued that it is more an organization of ideas that have been proposed for some time (at least since the 1993 WDR), rather than a new approach. The proposal’s main new feature is its initial focus on “*grupos poblacionales que se encuentran en etapas vulnerables del ciclo de vida*” (Filgueira et al. (2006), p. 19). However, the groups mentioned — “*niños, madres, adultos mayores, desempleados*” — reflect a mixture of risks that emerge from the life cycle as well as from the economic cycle. Furthermore, LAC’s epidemiological data, which are supposed to be its basis — “*soluciones costo-efectivas basadas en evidencias epidemiológicas*” (Filgueira, (op cit.), p. 20) — do not justify the inclusion of “mothers” as a vulnerable group. If the concern is with maternal mortality (which is unnecessarily and disproportionately high in many LAC countries), then the appropriate group would be women within the reproductive period, if a woman is a mother, by definition, she has survived birth delivery. However, even in this case, the epidemiological data for the Region as whole (e.g. quality-adjusted life years lost, or proportional mortality rates) do not put this as a particularly vulnerable group (while it could be the case in particular countries).
- ⁶⁵ Doherty and Govender (2004) list some of the reasons why the results obtained in field trials may not necessarily translate to the reality of health systems: a) most studies focus on single interventions, whereas actual services tend to combine interventions; b) impacts measured in field trials are not necessarily the same as those measured by routine programs; c) there is considerable inconsistency between different studies; d) many studies are located in small geographic areas in a limited number of settings where generalization is uncertain; e) the indicators examined in the field trial may not identify and measure the relevant causal variable; and f) the impact of a routine program may be different because of differences in the quality of care provided under field trial versus normal conditions.
- ⁶⁶ The authors seem to be referring to PHC approach as the delivery of a set of basic and preventive services.
- ⁶⁷ This project was never executed as designed. It almost entirely was reformulated during the Argentinean crisis to support the financing of essential medicines (“Programa Remediar”).
- ⁶⁸ See for instance, Birdsall and James (1990); Filmer, Hammer, and Pritchett (2000); and the 1993 WDR.

Endnotes (continued)

- ⁶⁹ “Whether PHC is a good means of redistribution needs to be evaluated country by country and against other such programs. . . . Any particular country arguing for PHC as a redistributive mechanism must be careful that it is indeed achieving that aim” (Filmer, Hammer, and Pritchett (2002), p. 59).
- ⁷⁰ Results cross-referenced by Shi et al. (2002).
- ⁷¹ World Bank (n.d.).
- ⁷² “Contracting-in” is the term used for the employment of a private agent to operate and/or manage a government service, while the purchasing of services from private providers that have complete responsibility over all aspects of their delivery, including hiring, firing, procurement, etc., is called “contracting-out.”
- ⁷³ The Herfindahl-Hirschman Index (HHI) of a market is calculated by summing the squares of the percentage market shares held by the respective firms. A market with a HHI below 1,000 is usually regarded as “unconcentrated,” between 1,000 and 1,800 as “moderately concentrated,” and above 1,800 as “highly concentrated.” The Colombian estimates for all regions outside the metropolitan areas were above 3,000, with the aggregate estimate at over 6,000.
- ⁷⁴ “The results from empirical research are not uniform. Most of the studies of Medicare patients show a positive impact of competition on quality. This is not surprising, since economic theory for markets with regulated prices predicts such a result. However, the results from studies of markets where prices are set by firms (e.g, privately insured patients) are much more variable. Some studies show increased competition leading to increased quality, and some show the opposite” (Gaynor (2006), pp. 27-28).
- ⁷⁵ “El MSPAS enfrenta el reto adicional e impostergable de fortalecer el marco institucional que asegure la calidad en los servicios prestados por proveedores públicos y privados” (PR-2439, p. 4).
- ⁷⁶ Guatemala (GU-0023, 890/OC-GU and GU-0125, 1221/OC-GU), Honduras (HO-0032, 1005/SF-HO), and El Salvador (ES-0053, 1092/OC-ES).
- ⁷⁷ PN-0076 (1350/OC-PN) has a mid-term evaluation with limited data available and no household survey. ES-0053 (1092/OC-ES) has a recent evaluation (2005) that reports serious limitations in the monitoring and information system: “El primer problema grave se refiere a las importantes deficiencias que existen en el sistema de información, de control y monitorización de los programas y actividades de los proveedores: Falta de sistema de registro para medir la cobertura real, debilidad del sistema económico presupuestario, deficiencias en la explotación y en la sistematización de la información, etc.” (GCI Salud y Desarrollo - “Valoración Global del Proyecto”).
- ⁷⁸ For Guatemala see Danel and La Forgia (op. cit.); for Honduras, Bitrán et al. (2005); and for El Salvador, Maceira (2004) and Bitrán and Maceira (2004).
- ⁷⁹ See also Danel and La Forgia (2005), p. 83.
- ⁸⁰ The performance of the contracted out approach exceeds that of the public sector if outreach providers contracted by the program are included as part of the former. The limitation here is that this assessment involves different delivery models that might not be strictly comparable.
- ⁸¹ Some of the methodological limitations of the Nicaragua evaluation include: the limited baseline information available; the selection of the control groups was difficult to perform; and the intervention had been implemented only 12 to 18 months before the study.
- ⁸² The other two interventions evaluated, vitamin supply for children and growth monitoring, presented differences between the NGO supported communities and the control group, that were not statistically significant.
- ⁸³ In Guatemala, government financing for contracted-out services increased from US\$1.7 million in 1997 to US\$8 million in 1999 and US\$12 million in 2000.

Endnotes (continued)

- ⁸⁴ There were problems in reaching an agreement on this clause, which was altered so the auditing and supervision of the NGOs would be conducted by the Ministry of Health and its agencies in the Departments rather than an outside private company. While this approach is essentially correct, since the monitoring and evaluation of contracted providers is a permanent undertaking and, fundamentally, the responsibility of the public sector, its implementation is very risky given the limited capacity of the Ministry of Health (particularly at the local and regional levels).
- ⁸⁵ Surprisingly, despite this recognition, these same coverage numbers (of approximately 3 million people) continued to be repeated by the Bank in the GU-0125 loan document, and by others (e.g. La Forgia, Mintz, and Cerezo (2005)).
- ⁸⁶ Performance-based incentives are mechanisms that use resources (monetary or “in kind”) to induce desired results (outputs or outcomes). Similarly, payment for performance instruments imply a transfer of resources based on achieved results (outputs or outcomes). Accordingly, payment for performance is a type of performance-based incentive. These instruments can be applied on the supply or demand side. Conditional cash transfer programs are examples of demand-side payment for performance.
- ⁸⁷ Because the type of reimbursement mechanism used to pay providers defines the economic incentives and disincentives that will drive the behavior of suppliers, it can be critical for the design of contracting mechanisms. For example, while a pure fee-for-service system may induce over-production and escalating costs, a pure capitation system (i.e. the system in which the provider receives a fixed rate per patient covered within his or her “catchment” area) may increase reported coverage rates and, at the same time induce, under-production of necessary services and increase referrals.
- ⁸⁸ In practice, however, the “contratos/convenios de gestión” are sometimes more related to activities that agencies were expected to execute anyway, and did not incorporate bonus mechanisms or other types of incentives. Accordingly, the “incentive” given was to fulfill the agreement in order to avoid penalties (usually withholding or lowering transfers).
- ⁸⁹ Pink et al. (2006) also point out some of the risks related to pay-for-performance: “*First, current performance measures may not have sufficiently high sensitivity and specificity to accurately identify safer care when used in report cards or reimbursement plans. Second, there may not be a sufficient number of validated measures to have a substantial and comprehensive enough impact on safety or on reimbursement itself. Third, it seems likely that pay-for-performance, like all other methods of reimbursement, will have its own unanticipated perverse incentives that might undermine its effectiveness*” (p. 11).
- ⁹⁰ For an excellent discussion of the logic, issues, and risks of the Payment By Results initiative see Miraldo, Goddard, and Smith (2006).
- ⁹¹ “*Community financing, in the form of user charges and prepaid insurance schemes, has become a necessity in a number of low-income countries. But community financing is also a virtuous necessity: it can help to improve the quality and reliability of services, in part by making health workers more accountable to their clientele*” (World Bank (1993), p. 159).
- ⁹² While the consumer may initiate the contact with the system, the final utilization pattern is almost entirely determined by the physicians.
- ⁹³ In the case of Brazil, for instance, the decentralized nature of the SUS has led to the creation of committees — in each state there is a two-party committee involving representatives of the state and the municipalities, and at the national level a tri-party committee with representatives of the three levels of government — for the approval of certain policies and other systemic issues. Topics are approved by consensual agreement. In Brazil these decisions are termed “pactuadas.”

Endnotes (continued)

- ⁹⁴ The proposal to decentralize the health sector in Belize for example, a small country with limited technical capacity and a largely geographically concentrated population, was received with strong opposition in the Bank.
- ⁹⁵ “We have found that increases in funding seem to be associated with increases in utilization, and that the gap in per capita health expenditures between richer and poorer municipalities seems to be narrowing, not widening over time in both Chile and Colombia” (Bossert (2000), p. 41).
- ⁹⁶ “*Não há correlação entre os gastos públicos per capita com saúde e PIB per capita no nível de cada estado. Também não se verifica correlação entre transferências federais e PIB per capita estadual. Portanto, não há nenhuma prova de equidade nas transferências associadas aos gastos com saúde do governo federal para os estados realizadas até 1996*” (Medici (2002), p. 118).
- ⁹⁷ Hospital autonomy can also be seen as a form of contracting. However, hospital autonomy efforts were supported by Bank projects as means of transferring power and decision-making capacity to these institutions.
- ⁹⁸ It is important to note that the “Organizações Sociais” differ from the typical public hospital in several ways in addition to their autonomy for hiring personnel, invest, and contract services: (i) these were newly-built public hospitals; (ii) administration has been given to public or private non-profit entities under a “contrato de gestão” (the legal arrangement between these entities and the public institution has been termed “Organização Social” (OS)); and (iii) reimbursement is based on a global budget determined by costs (while public hospitals rely on a prospective payment reimbursement mechanism and some budgetary transfers, both unrelated to actual costs). In this sense, the differences in performance cannot be explained solely by the autonomous nature of these institutions. It should be pointed out, however, that the OS still has to comply with the main principles of the Brazilian Unified Health System (SUS), including the provision of free care.
- ⁹⁹ The discussion of user fees in the last subsection has also shown the negative impact of these instruments on autonomous institutions (Fiedler and Suazo (op. cit.)).
- ¹⁰⁰ The Dominican Republic project (DR-0078, 1047/OC-DR) recognizes the limits of financing social insurance programs through payroll taxes when it states that “*increasing the payroll tax on the formal sector workers to cross subsidize the cost of the same comprehensive package of services for the rest of the (mostly low-income and non-salaried) population is not economically feasible*” (PR-2227 Rev., p. 36), thus creating a contributory (payroll financed) regime, and a subsidized (general revenue-financed) regime.

Chapter 5

- ¹⁰¹ The index is the average of country rankings for 11 impact/outcome indicators: life expectancy at birth; infant and under-five mortality rates; percentage of mortality of children less than five years old due to infectious intestinal diseases and acute respiratory infections; estimates mortality rates due to communicable diseases adjusted by age; proportion of children less than one year old immunized against poliomyelitis, measles and DPT; proportion of pregnant women attended by trained personnel during pregnancy; and proportion of birth deliveries attended by trained personnel. Source: Pan-American Health Organization.
- ¹⁰² Uruguay had the best composite index of all Bank-member countries in both periods. Bolivia was the lowest ranking country in 1995 and Haiti in 2004.
- ¹⁰³ It is obvious that empirically based studies and evaluations would be required to better determine the extent in which the three main objectives defined by Bank projects have been achieved.
- ¹⁰⁴ One of the most commonly used instrument to measure the burden of disease and mortality is the Disability-Adjusted Life Years (DALYs), which was used in the 1993 WDR. The literature debating this instrument and its usefulness for priority setting is extensive and it is not our intention to list it, but

Endnotes (continued)

Murray and Acharya (1997), Williams (1999), Murray and Lopez (2000) and Mooney and Wiseman (2000), serve as a good illustrative examples.

¹⁰⁵ For illustrative purposes see Almeida et al. (2001); Musgrove (2003); Brundtland, Frenk, and Murray (2003).

¹⁰⁶ In this sense, ideology played a role in Bank actions. In fact, it could be argued that this was unavoidable: policy recommendations cannot be value-free. As pointed out by Williams (2005, p.8), “*policy recommendations cannot emerge directly from a positive analysis — only from a normative analysis.*” Even the analysis of health systems may not be completely value-free — “*no matter how well a health care system is performing in some people’s eyes, it will always be failing in those of others*” (Oliver, Mossialos, and Maynard (2005b), p. S3). Furthermore, since health, as any other resource, is not equally allocated across individuals or groups, and since its determinants are affected by political actions, health-related measures are necessarily part of the political realm. See Bambra, C., Fox, D., and Scott-Samuel, A (2005).

¹⁰⁷ In fact, RE3/SO3, the Government of Colombia, and OVE are currently discussing a possible joint evaluation of Colombia’s monitoring and regulatory systems and instruments.

¹⁰⁸ For example the projects prepared during 2006 in Nicaragua and Guatemala.

¹⁰⁹ As noted in Chapter III, the Bank has approved only one stand-alone project in the area of human resources for the health sector (BR-0305).