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THE WORLD BANK

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The World Bank

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Speaking Engagement:
Innovations in Health Care Financing
Conference

Monday, March 10, 1997
8:45 - 9:45 a.m.
Ritz-Carlton Hotel, Pentagon City

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President Wolfensohn - Briefings Books for Presidents Meetings - Meeting Materials
Speaking Engagement - Innovations in Health Care Financing Conference - March

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A. CLASSIFICATION

☐ Meeting Material
☐ Trips
☐ Speeches

☐ Annual Meetings
☐ Corporate Management
☐ Communications with Staff

☐ Phone Logs
☐ Calendar
☐ Press Clippings/Photos

☐ JDW Transcripts
☐ Social Events
☐ Other

B. SUBJECT: SPEAKING ENGAGEMENT: INNOVATIONS IN HEALTH CARE FINANCING CONFERENCE // JDW TO DELIVER KEYNOTE SPEECH // (B) (N)
VENUE: RITZ-CARLTON HOTEL IN PENTAGON CITY (03/10/97)
CONTACT (HDD): GEORGE SCHIEBER (DE FERRANTI) @ 87319
PROGRAM:

INTRODUCTION OF JDW: BY DE FERRANTI

20 MINUTE SPEECH: JDW

FOLLOWED BY OVERVIEW OF CONFERENCE: R. FEACHAM
DEPARTURE OF JDW

ATTENDEES: 300-350 CONF. PARTICIPANTS: 30 MINISTERS, BANK STAFF, STAFF FROM COUNTRY MINISTERS, WB STAFF, STAFF FROM OTHER INTERNATIONAL ORGANIZATIONS & BILATERAL DONORS, AND PEOPLE FROM THE PRIVATE SECTOR

NOTES:

(10/11/96) ITEM REQUESTED AND PLACED ON CALENDAR
AT G. BERGEN'S REQUEST -- JDW ADVISED THAT HE WOULD LIKE TO DO THIS

1/30 - COPIED TO CAROLINE FOR FOLLOW-UP

(10/17) COPIED TO STEVAN FOR TRAVEL CALENDAR

(B) HDDDR // DUE: FEB. 24

SPEAKING POINTS: CAROLINE ANSTEY

EXC: ANSTEY // ALI (2/13)

Brief Includes:

---Cover note from Caroline

---Talking Points

---Briefing Note

---Program

---Partnerships in Ghana & Zambia

DATE: 03/10/97

C. VPU

Corporate

☐ CTR
☐ EXT
☐ LEG
☐ MPS
☐ OED
☐ SEC/Board
☐ TRE

Regional

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☐ LAC
☐ MNA
☐ SAS

Central

☐ CFS
☐ DEC
☐ ESD
☐ FPD
☐ FPR
☐ HRO

Affiliates

☐ GEF
☐ ICSID
☐ IFC
☐ Inspection Panel
☐ Kennedy Center
☐ MIGA

D. EXTERNAL PARTNER

☐	IMF
☒	UN
☐	MDB/Other IO
☐	NGO
☐	Private Sector

☐	Part I
☐	Part II
☐	Other

E. COMMENTS:

File Location <table><tr><td>☒ EXC</td><td>☐ IISC</td><td>☒ Archives</td></tr></table>	☒ EXC	☐ IISC	☒ Archives	Cleared By Caroline Anstey	Date: 03/10/97
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Innovations in Health Care Financing

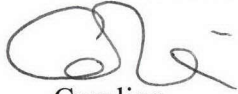
Mr. Wolfensohn:

You are making the keynote at the above. They would like you to speak for 20 minutes. David de Ferranti will introduce you. You will be followed by Richard Feachem.

The Conference is sponsored by the World Bank and co-sponsored by ~~ADB~~ WHO, USAID, US Agency for Health Care Policy and Research, US Health Care Financing Administration, the Commonwealth Fund and EDI. - Julie Boraman

The audience will include over 30 Ministers and Secretaries of Health and Finance. (See Briefing Note).

I attach a briefing note on the Conference, talking points and the program.



Caroline
2/26/97

97% GDP worldwide

James D. Wolfensohn
Opening Remarks to Innovations in Health Care Financing
Monday March 10th, Ritz Carlton Hotel

4.57.
Introduction

Daily Committee

Baba 7
International
Conference

- Delighted to be here today at the World Bank's largest conference on health care financing.
- Extremely pleased to see the large number of colleagues from our member countries including over 30 Ministers and Secretaries of Health and Finance as well as partners from other international organizations, NGOs, and the private sector.

Importance of health and health reform

- No country has ever achieved sustainable economic growth without parallel improvements in human development.
- effective investments in health and education are a sine qua non for economic development and poverty alleviation.
- And these are in turn a sine qua non for global stability.

But global disparities in health are enormous.....

148
2 Bill New
cumulative

Developing countries:

- account for 84 percent of the world's population and 93 percent of the global disease burden.
- account for only 18 percent of the world's income and 11 percent of global health spending.
- have one-third the number of physicians and one-six as many inpatient beds per capita as developed countries.
- Today globally there are 16 million cases of HIV positivity - a country like India may see 7 million cases by the end of the century.

malaria

malaria - 2 mill deaths - Diarrhea - Pneumonia

What about
malaria
4 mill

And the current imbalances between health expenditures and illness will worsen.....

- By 2020 expenses to treat non-communicable diseases and injuries will account for almost 80 percent of the disease burden compared to just over 50 percent now.
- Moreover, while real per capita income for developing countries over the next 10 years is projected to grow at an annual rate of 3.7 percent, growth in Sub-Saharan Africa, one of the poorest regions, and the Middle East and North Africa is projected to be less than one percent.

What does
this mean

Rapidly dying 1 like developed world

VIABILITY

SUSTAINABILITY

working on about

Health

VIABILITY, sustainability

of Health Care

Public

Private

MOBILIZE
CAPITAL

how know - monitor

monitoring

to prevent works me

CONTAIN HEALTH
CASES

not work
Jordan,
West
Agencia

9/10

HNP

2 Bill

new budget

11 Bill

86 countries

Core guide is Health Equity

Urgent need for cost-effective interventions that can target the poor and can use scarce resources fairly and efficiently.

- Also need to recognize that good health doesn't exist in a vacuum - important roles of sanitation, clean water, nutrition, and education, particularly girls education, in improving health.

DEB

NOT
EXIST IN
A VACUUM

Population - environment

What is the Bank's role in all this?

- Bank lending in human development areas (education, HNP, and social protection) has increased significantly over the last 10 years, from \$1 billion in 1986 to \$5 billion in 1996.
- Human development loans now account for 24 percent of new lending, compared to 8 percent in 1986.
- In terms of actual projects, the number of HNP projects has increased from 29 operations in 1986 to 69 in 1996. (And Bank lending in other related areas such as education, environment, and urban/rural development have important effects on health and health sector performance.)
- And the Bank's macroeconomic and financial sector work, makes it well-suited to work with other partner organizations and client governments in tackling the full range of problems relating to health sector reform.

TO Reps
a mar

Macro. sector work is key

But need to do things differently

A Local Approach.....

LOCAL OWNERSHIP
COORDINATING

- We can't be in the business of imposing programs devised in Washington, London or Paris which have no resonance to local conditions or don't involve local people.
- This is particularly true in the case of the health sector where there is no single right answer.
- Importance of training - We are developing training on the state of the art issues in health care financing through EDI's Flagship Program on Sustainable Health Financing (-5-6 week course on the most important areas of health care financing); ultimately, the course will be offered in different regions and in several languages; on the Wednesday following this conference, EDI will be soliciting participants views on the design of this course.

EDI
Programs

launch the course

.....Partnerships

- Both between the public and private sector - almost half of all health financing in the developing world now comes from the private sector;

- And among donors, governments, private sector, UN agencies, NGOs.
- (e.g. Ghana - EU, ODA, USAID, UNFPS, UNICEF, WHO and the Bank working with Ghana Government in a sector wide approach to health development - for the first time explicit health policies linked to resource allocation with all public sector financing being put on the table). Donor consortium changed its usual way of doing business - from separate projects often with conflicting objectives, multiple missions etc to reaching consensus on both policy and operational matters. This is also happening in Zambia. (See attached notes).

Importance of Best Practice and the Networks

- New network initiative will improve the Bank's effectiveness and provide the backbone for the Knowledge Bank - for example one of the first acts of the new HD Network has been to embark upon a major effort to develop comparative epidemiological and health expenditure information for all the countries of the world.
- Network Staff currently developing a Bankwide Sector Assistance Strategy (SAS) for the HNP sector.
- The SAS will provide the Bank with a broad sector strategy built up from the different regional perspectives.

Conclusion

- Conference comes at a very opportune time
- With health sectors now accounting for nine percent of total worldwide production, health reform has become a critical economic as well as social issue in all countries.
- Your experience and advice can make this Conference and the resulting published conference proceedings of real value.
- I thank you for coming and look forward to our continued collaboration in the future.

C.Anstey
2/26/97

Briefing Note

Prepared for Mr. James D. Wolfensohn's Keynote Speech at
The Innovations in Health Care Financing Conference

Others who will be joining Mr. Wolfensohn during the Introductory Session are:

David de Ferranti, Director, Human Development Network
Richard Feachem, Director, Health, Nutrition and Population

Date of Speech: March 10
Time: 8:45 a.m. to 9:45 a.m.
Location: Grand Ballroom A, the Ritz-Carlton, Pentagon City

Background

The purpose of the Conference is to help Bank staff, policy makers in our client countries, and other interested individuals understand the equity, microeconomic, macroeconomic, and administrative implications of alternative health financing mechanisms. The main focus of the Conference is on health care financing-- the issues surrounding raising revenues to pool collectively health risks through various compulsory and voluntary public and private revenue raising mechanisms. Background materials have been developed which for the first time bring together all the various methods in one set of policy-relevant documents. The Conference will serve as both a forum for discussing the various approaches as well as a training session for Bank staff and high level technocrats from the Bank's client countries.

The Conference has been developed by the Human Development Department and a Steering Committee composed of representatives from the regions. Financial support for the Conference has been given by the Bureau for Europe and Independent States, USAID, the Agency for Health Care Policy and the Health Care Financing Administration and Research (Department of HHS), the Commonwealth Fund, and the Economic Development Institute of the World Bank.

Done? any more

The Content of the Meeting

Eighteen international experts from both developed and developing countries will provide their views on how to improve equity and efficiency in the financing of health care systems. More specifically, the Conference will focus on the appropriate roles for government and the private sector in relation to health care financing; alternative public and private sources of revenues; and effective mechanisms for managing health expenditures to assure equity and efficiency. Applied policy applications and prescriptions will be emphasized through case studies based on low-and middle-income countries.

The 13 Conference papers include seven main thematic papers covering: (1) a global overview; (2) private insurance; (3) government financing of health systems; (4) user charges; (5) rural risk-sharing schemes; (6) medical savings accounts; and (7) managed competition. The six case studies will cover: Africa, Egypt, Latin America, Russia, Singapore, and Thailand.

Description of Audience of the Conference

The audience at this Conference will total about 300 participants:

- Approximately 110 World Bank staff from the regions and Headquarters, financed through their divisions.
- 10 Ministers of Health financed by the Economic Development Institute from: Argentina, Bangladesh, Cote d'Ivoire, Hungary, India, Iran, Palestine National Authority, Uruguay, Uzbekistan, and Zambia.
- About 70 high level staff including Ministers of Health, Deputy Ministers of Health and Permanent Secretaries paid for by project funds from: Argentina, Brasil, Bulgaria, Chad, China, Columbia, Costa Rica, Dominican Republic, Ecuador, Egypt, Georgia, Ghana, Kenya, Lebanon, Malawi, Mexico, Mongolia, Morocco, Nepal, Nicaragua, Palestine National Authority, Panama, Peru, Rwanda, Tanzania, Tunisia, Uganda, Zambia and Zimbabwe.
- The ECA region, through the Dutch trust fund, has financed the participation of about 20 Ministers of Health, Deputy Secretaries and other high level political staff from their region.
- About 50 participants are from multilateral and bilateral agencies such as the: ADB, AUSAID, CIDA, ODA, SIDA, UNICEF, USAID, and WHO.
- About 50 interested individuals from the private sector.

Conference Presenters

Description of the 18 international experts who will be presenting at the Conference:

Deborah Chollet Alpha Center	Bengt Jonsson University of Stockholm	Len Nichols The Urban Institute
Andrew Creese World Health Organization	Sirilaksana Khoman Thammasat University Thailand	Nicholas Prescott The World Bank
Alain Enthoven Stanford University	Maureen Lewis The World Bank	Nadwa Rafeh Economist, Egypt
Paul Gertler University of California at Berkeley	Andre Medici The Inter-American Development Bank	Helen Saxenian The World Bank
Jeffrey Hammer The World Bank	Joseph Wang'ombe University of Nairobi	George Schieber The World Bank
Phua Kai Hong National University of Singapore	Philip Musgrove The World Bank	Igor Sheiman Economist The Russian Federation

Agenda

Please refer to attached pages which details the agenda.

AN INTERNATIONAL CONFERENCE

Innovations in Health Care Financing

SPONSORED BY THE WORLD BANK

March 10 - 11, 1997

**The Ritz-Carlton, Pentagon City
Minutes from Washington, DC in
Arlington, VA
USA**



Co-sponsored by:

- Inter-American Development Bank ■ World Health Organization
- U.S. Agency for Health Care Policy and Research
- U.S. Health Care Financing Administration ■ U.S. Agency for International Development - Bureau for Europe and New Independent States
- The Commonwealth Fund ■ World Bank Economic Development Institute

Alpha Center is the coordinator of this conference for the World Bank. Registration and hotel information is enclosed. Should you have questions related to your participation in this conference, please contact us by email at "worldbank@ac.org@internet" or by fax at (001)(202)296.1825. Please address mail correspondence to Alpha Center, P.O. Box 33226, Washington, DC 20033-2336, U.S.A.





Financing health care is a critical concern for rich and poor countries alike as health care systems account for more than eight percent of total world production. The funds raised through public and private means determine the resources available for a country to improve population health status, promote access to care, enhance the quality and efficiency of service delivery systems, and promote socio-economic development. The ways that different countries finance their systems reflect political decision-making at the highest levels and involve difficult tradeoffs among fiscal, political, and social objectives.



This World Bank conference will bring together internationally recognized experts, reform leaders, World Bank staff, and country representatives to consider the broad range of issues that relate to financing health care systems in middle- and low-income countries. Participants will learn about traditional public and private health care financing options, as well as state-of-the-art approaches to health care financing such as medical savings accounts and managed competition.



The conference will explore both the conceptual and operational policy contexts for introducing changes in health care financing. These include: how to regulate private health insurance; using broad-based consumption and income taxes to raise revenues versus taxing specific commodities; the design and administration of user charges; and the conditions needed for successful informal risk pooling in poor rural and urban communities. Case studies and examples will highlight the advantages and problems of different financing methods.



The specific knowledge objectives of the conference include:

- 
- Learning about the different public and private methods for financing health care systems;
 - Understanding the strengths and weaknesses of different approaches from the perspectives of insurance principles, equity, efficiency, tax burden, administrative feasibility, employment, economic growth, inflation, and international competitiveness;
 - Learning how different health care financing methods have worked in low-, middle- and upper- income countries; and
 - Understanding how to apply these approaches in both developed and developing countries.

The conference will be conducted in English. No interpretation services will be provided.

CONFERENCE FACULTY



Deborah Chollet
Alpha Center

Andrew Creese
*The World Health
Organization*



Alain Enthoven
Stanford University

Paul Gertler
*University of California
at Berkeley*



Charles Griffin
The World Bank

Jeffrey Hammer
The World Bank

Phua Kai Hong
*National University of
Singapore*

Bengt Jonsson
University of Stockholm

Sirilaksana Khoman
Thammasat University

Maureen Lewis
The World Bank

Andre Medeci
*The Inter-American
Development Bank*

Joseph Wang'ombe
University of Nairobi

Philip Musgrove
The World Bank

Len Nichols
The Urban Institute

Nicholas Prescott
The World Bank

Nadwa Rafeh
Economist, Egypt

Helen Saxenian
The World Bank

George Schieber
The World Bank

Igor Sheiman
*Economist,
Russian Federation*

AGENDA

Saturday & Sunday, March 8 & 9, 1997

3:00 pm – 6:00 pm **Early Registration**

Monday, March 10, 1997

7:00 am – 5:00 pm **Conference Registration**

7:00 am – 9:00 am **Continental Breakfast**

9:00 am – 9:45 am **Opening Remarks**
James Wolfensohn, President, The World Bank

9:45 am – 10:45 am

Plenary Session

**The Social, Economic, and Institutional Context of
Health Care Financing Reforms**

The session will describe health care financing in the broader context of macroeconomic stability and growth, taxation, institutional structures and overall health system reform. It will describe the underlying epidemiological, economic, service delivery, and institutional issues in different regions of the world. Criteria for evaluating alternative financing methods will be presented, including equity, efficiency, tax incidence, administrative feasibility, and macroeconomic stability. Implementation will be considered in the context of the political, institutional and economic realities that developing countries face.

11:15 am – 12:30 pm

Plenary Session

Government Financing and Social Insurance

The session will introduce alternative governmental methods of health care financing and their rationales. It will describe how alternative public means for generating revenues can finance health care systems. The issues that arise when labor taxes are used to finance health care systems will be explored, such as the effects on public and private employment. The presenter will use the experience of social insurance systems in Europe, Latin America and Russia to illustrate the development, experience, successes and failures of these systems.

12:30 pm – 2:00 pm

Lunch

2:00 pm – 3:15 pm

Plenary Session

Private Insurance

The session will introduce the basic concepts of insurance and the insurability of health care. The presenter will review different types of private insurance (such as comprehensive plans, catastrophic plans, supplemental plans and integrated managed care plans) and alternative ways to pool risk (group plans versus non-group plans). Consumer and insurer incentives in a private health insurance system will be described, as will equity and efficiency issues related to private health insurance and linkages between private health insurance and other financial markets. Systems of regulating private insurance will be highlighted. The presenter will provide examples of successful and unsuccessful private insurance arrangements from North America, the Middle East and North Africa.

3:45 pm – 5:00 pm

Concurrent Session I

Discussion Panel: Government Financing and Social Insurance

3:45 pm – 5:00 pm

Concurrent Session II

Discussion Panel: Private Insurance

6:30 pm – 9:00 pm

Reception and Informal Dinner





Tuesday, March 11, 1997

7:45 am – 9:00 am

Continental Breakfast

9:00 am – 10:30 am

Plenary Session

Rural Risk Sharing and User Charge Strategies

The session first will introduce the concept of risk pooling arrangements to finance health care in rural areas and explore the potential for risk pooling arrangements in urban areas. This segment will consider the conditions of economic development and health services delivery, the institutional structures in the community that favor the use of informal risk pooling arrangements, and the role of government. Finally, the presenter will describe the use of prepayment, revolving funds and user fees, with particular attention to how informal risk pooling arrangements might interact with more formal or larger systems of health care financing. Examples will be provided, including experience with the Thai health card.

The second half of the session will focus on the development and use of user charges to finance health care. The presenter will discuss basic policy issues related to user charges, including effects on revenue generation, the demand for health care, and health status. The necessary administrative systems will be described, as well as economic incentives for providers and patients, and the equity and efficiency effects of user charges. Evidence of the impacts of various user-charge schemes in developed and developing countries will be presented with special emphasis on the experiences of Africa and Asia.

11:00 am – 12:30 pm

Concurrent Session I

Discussion Panel: User Charges

11:00 am – 12:30 pm

Concurrent Session II

Discussion Panel: Rural Risk Sharing

12:30 pm – 2:00 pm

Lunch

2:00 pm – 3:30 pm

Plenary Session

Managed Competition and Medical Savings Accounts (MSAs)

The session will begin with a presentation of the concept of managed competition. The presenter will describe how markets that are making greater use of private insurance might apply managed care concepts, and explore the underlying conditions necessary to implement managed competition in developed and developing countries. This segment also will consider the usefulness of managed competition as a model for organizing conventional insurance markets versus managed competition to organize systems of care that integrate financing and delivery (i.e., managed care), and the feasibility of managed competition in rural areas. The presenter will discuss the implementation and impact of managed competition on health systems in Latin America and the United States.

The session then will turn to the concept and potential role of MSAs in different health care financing and delivery systems, both in developed and developing countries. The presenter will discuss the place of MSAs in public versus private systems of insurance, the necessary institutional conditions for implementing MSAs, and their likely effects in developed and developing countries. The experiences of MSAs in Singapore and the United States will be used to illustrate the potential strengths and weaknesses of this method of financing health services.

4:00 pm – 5:30 pm

Concurrent Session I

Discussion Panel: Managed Competition

4:00 pm – 5:30 pm

Concurrent Session II

Discussion Panel: Medical Savings Accounts

5:30 pm – 6:00 pm

Wrap-up

6:00 pm

Adjourn



Ghana

New Styles of Donor Collaboration

In the Ghana health sector, a consortium of donors (including DANIDA, EU, ODA, USAID, UNFPS, UNICEF, WHO, and the Bank) and other agencies has worked with the Ghana government in a sector-wide approach to health development. This collaboration has helped government to develop a policy and operation framework for the sector. For the first time, there are explicit health policies linked to resource allocation in Ghana, with the intention of providing more effective and equitable health services. All public sector financing (from government, donors, and fees) has been put on the table for open discussion about how to most effectively use the resources. This has become the basis for all public sector action, and includes new arrangements for regulating, financing, and promoting the private modern and traditional medicine sectors. Controversial projects have been identified, and healthy negotiations processes are ongoing, and based on objective information of what appropriate capital and incremental recurrent costs should be, and based on a joint commitment to establish transparent and fair processes. Joint and common planning and review has been used among donors following governments lead in an effort to reinforce their budget and policy processes. New implementation arrangements are also being established. Unified financial management arrangements have been set up; decentralized management units are in the process of being certified to handle pooled donor funds. Sector wide indicators have been agreed for the next year, and processes have been put in place to strengthen the Ministry of Health systems to be used for common accounting, reporting, and auditing. These processes support a series of health reforms that is increasingly getting more funds for service delivery to district health management teams from headquarters. These policies are starting to result in greater utilization of health services, including more outreach clinics to inaccessible areas, improved physical environments, and improved staff morale.

The donor consortium has specifically responded to a vision of the Ministry of Health to develop their own health systems in a more coherent manner. It has thus put the Ministry in the lead of pursuing the broader development and reform agenda of the Government. The consortium has changed its usual way of doing business (from the old situation of separate projects with conflicting objectives, multiple missions and onerous reporting requirements, little consensus on operations), into a more coherent and joint approach, reaching widespread consensus on both policy and operational matters. A very collegial relationship has developed among the donors, with leadership coming from a variety of agencies, including the Bank.

Rather than following traditional project preparation, new processes have been needed. For example, a team from the Ministry of Health came to Washington early on in the preparation period to meet with several donor agencies to plan the change processes; joint government and multi-donor preparation and appraisal missions have been done with different donors taking the lead among donors (e.g. DANIDA for financial management; ODA for public health and social assessments; World Bank for economic analysis and procurement; WHO and UNICEF on information systems); regular health partner meetings are held in Ghana with government as chair, and involving NGOs and other agencies; and several ad hoc meetings have been held in European donor headquarters. Joint aide memoires have been written with government. Wherever possible, studies and objective information have been used to inform evidence-based policy. The economic analysis was a living process used in the negotiation of program

options across the sector, not a simple justification for financing by the donors. In summary, the donor consortium has helped to clearly recognize and practically put the government in the lead in health sector development.

CC: Alexander Preker
CC: Selvi Chellamuthu

(ALEXANDER PREKER@A1@WBWASH)
(SELVI CHELLAMUTHU@A1@WBWASH)

The World Bank/IFC/MIGA
O F F I C E M E M O R A N D U M

DATE: February 27, 1997 11:56am

TO: CAROLINE ANSTEY

(CAROLINE ANSTEY@A1@WBWASH)

FROM: Julie McLaughlin, AFTH1

(JULIE MCLAUGHLIN@A1@WBHQB)

EXT.: 84679

SUBJECT: Notes for Wolfensohn for HCF Conference - Zambia

Okay a few comments on the Zambia Health Reforms:

+ Everything that David Peter's wrote on Ghana could be almost direct quote describing the process in Zambia. We have been implementing what has become known as a Sector Investment Program (or SIP) in the health sector in Zambia since Feb. 1995 (i.e., that is when the Bank's project became effective).

+ It is a very integrated program where we coordinate all donor inputs towards the government described reform program. The process is semiannual joint reviews of the evolution of the plans for implementation and the progress made so far. Donor missions are discouraged from coming outside of these two missions in order to ensure coordination and reduce the burden on the Ministry for hosting its many donors. We have made progress towards realizing joint procurement, disbursement, reporting, auditing systems. At district level, donor moneys are commingled in single accounts and reported upon collectively. No donor has distinct geographic or programmatic claims, although most still have specific areas which they prefer to support within the MOH plan. We have significantly reduced parallel operations and the practice of separate donor implementation units.

+ We recognize that Donors (including the Bank) have developed the practice of distinct procurement, disbursement, accounting, reporting and planning procedures because we have never trusted the government systems. Unfortunately, this have undermined the development of government systems and they remain weak today. In the Zambia Health project, we have committed to developing the government systems and capacity so that they will be able to sustain programs. In the context of sector reform, the emphasis on systems development has been appropriate. Also, we have recognized that a) unless we are willing to let some money flow through the systems we will never be able to build accountability; and b) that we ALL have to be willing to compromise our own rules, focusing more on the spirit rather than the letter of the law as regards issues such as procurement. A significant improvement has been made in the levels of transparency on both sides.

+ In the context of reform, the emphasis has been on establishing a health care system which will be cost-effective and financially sustainable. The coordination of donor's support has been critical, but so have numerous other initiatives. Sida, WHO, USAID and the Bank have

worked together with the Ministry of Health to develop a health care financing strategy which is comprehensive, considering public and private sectors and the costs as well as the financing of health services. Most health care financing efforts in the Africa Region have emphasized revenue generating through user fees and insurance. In Zambia, we have looked at equally at how to reduce costs and to increase allocative and technical efficiency. For example:

- The government bases its investment decisions on, and sets public sector standards based upon, the defined minimum package of cost-effective services. What medical school education will be financed, what equipment will be procured, what infrastructure will be developed, what supervision will be financed, what drugs will be procured, etc. are assessed against the criteria of what is required to deliver the defined package.
- The role of the private sector (today, very limited) is being encouraged though subsidized investment to provide services for individuals who desire care outside of the essential package and/or who want the same services with more amenities.
- User fees are employed less for generating resources (in a country where the Bank's poverty assessment identifies 70% of the population as poor) than for regulating use, discouraging by-passing, and promoting a sense of participation. The level of fees are locally determined, retained at the point of collection and used to finance community-identified health activities.
- Prepayment schemes exist at community level which allow families and individuals to pay in advance for primary care coverage.
- The central hospital (University Teaching Hospital) has closed its out-patient department recognizing that it was not cost-effective to provide primary services at a tertiary care facility. All patients must be referred or pay full cost recovery. If a primary care facility refers indiscriminately, it is forced to reimburse UTH for the cost of the primary care services provided.
- Over the past three years, the proportion of the public sector budget allocated for district-based services (i.e., primary, essential services) have been increased to 30% and that of UTH reduced from 40% to 17%.
- All referral-level hospitals (Central and Provincial hospital) have been made "autonomous" and are given an annual fixed amount from the MOH with which they are to complement with fees and fully finance their costs. The aim is for districts to receive the same level of autonomy, but as of today their grants cover only non-salary, non-drug costs.

- District Boards and Hospital Boards are given grants as part of a "commissioning" process. They submit proposals annually and sign contracts to deliver specific services in a particular way to a defined population with the center. They report quarterly on both financial and programmatic indicators.

- As a further effort to separate the role of provision from financing of basic health services, a Central Board of Health has been established and charged with standard setting, quality control and commissioning out the delivery of all publicly-financed health services. The Central Board of Health forms the contracts with District and Hospital Boards, but as well contract out the services for the Essential Drugs Store and National Public Health Laboratory. The MOH has subsequently been reduced to a skeleton staff required to address health policy, the coordination of donors and budgeting.

- The Essential Drugs and Medical Supplies Store is being formed as a renewal of the previous Central Medical Stores (a parastatel which did not provide good value for money). The existing infrastructure will continue to be owned by the MOH, but the management will be contracted out and charged with efficient procurement, storage, sale and distribution of essential drugs. To ensure better value through procurement, IDA capitalized a revolving fund which will be replenished through the purchase made by District and Hospital Boards. Previously, the Zambian MOH had not procured in bulk, nor employed ICB to acquire drugs.

- In an effort to increase the role of the private sector while maintaining quality, a feasibility study has recently been completed on franchising private health services. The idea is that the capital investment required by new providers would be subsidized in exchange for their agreeing to provide an explicitly described package of services at a defined price in a specified manner, and to meet requirements for in-service training. Each franchisee will carry the same identifying name/label and acquire free publicity.

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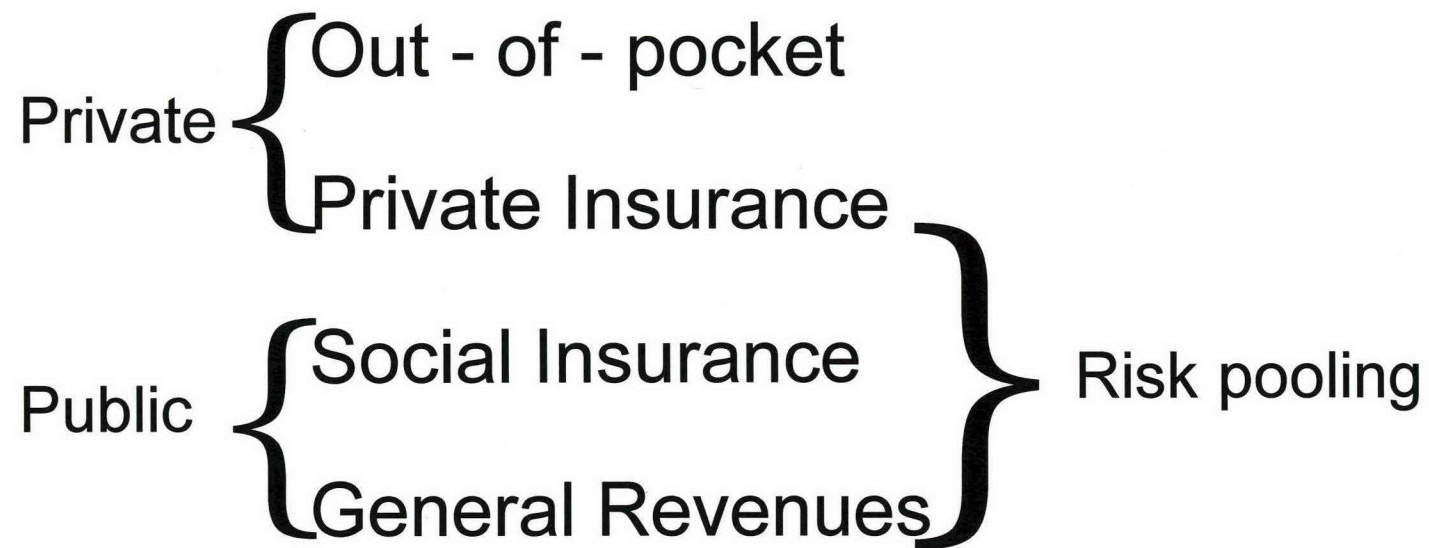
HEALTH SECTOR EXPENDITURE
PUBLIC + PRIVATE
 (% of GDP)

>9%	<2%
1. USA	1. Sudan
2. Argentina	2. Cameroon } Nigeria }
3. Croatia	4. Indonesia
4. Canada	5. Senegal
5. Austria } France }	6. Sri Lanka
7. Czech Republic } Switzerland }	
8. Germany	
← <u>\$ per capita per year</u> One thousand-fold difference →	

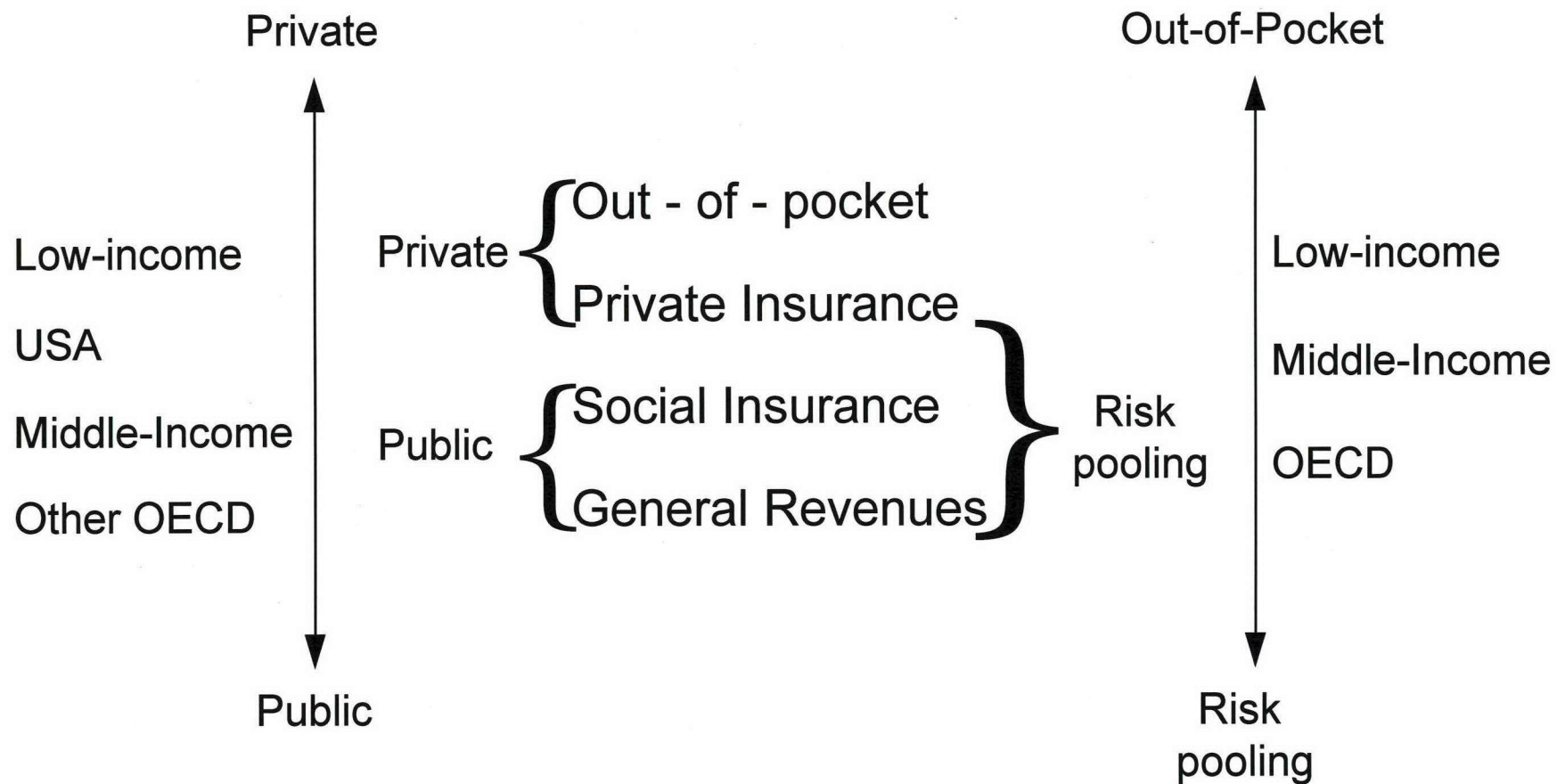
The Three Questions

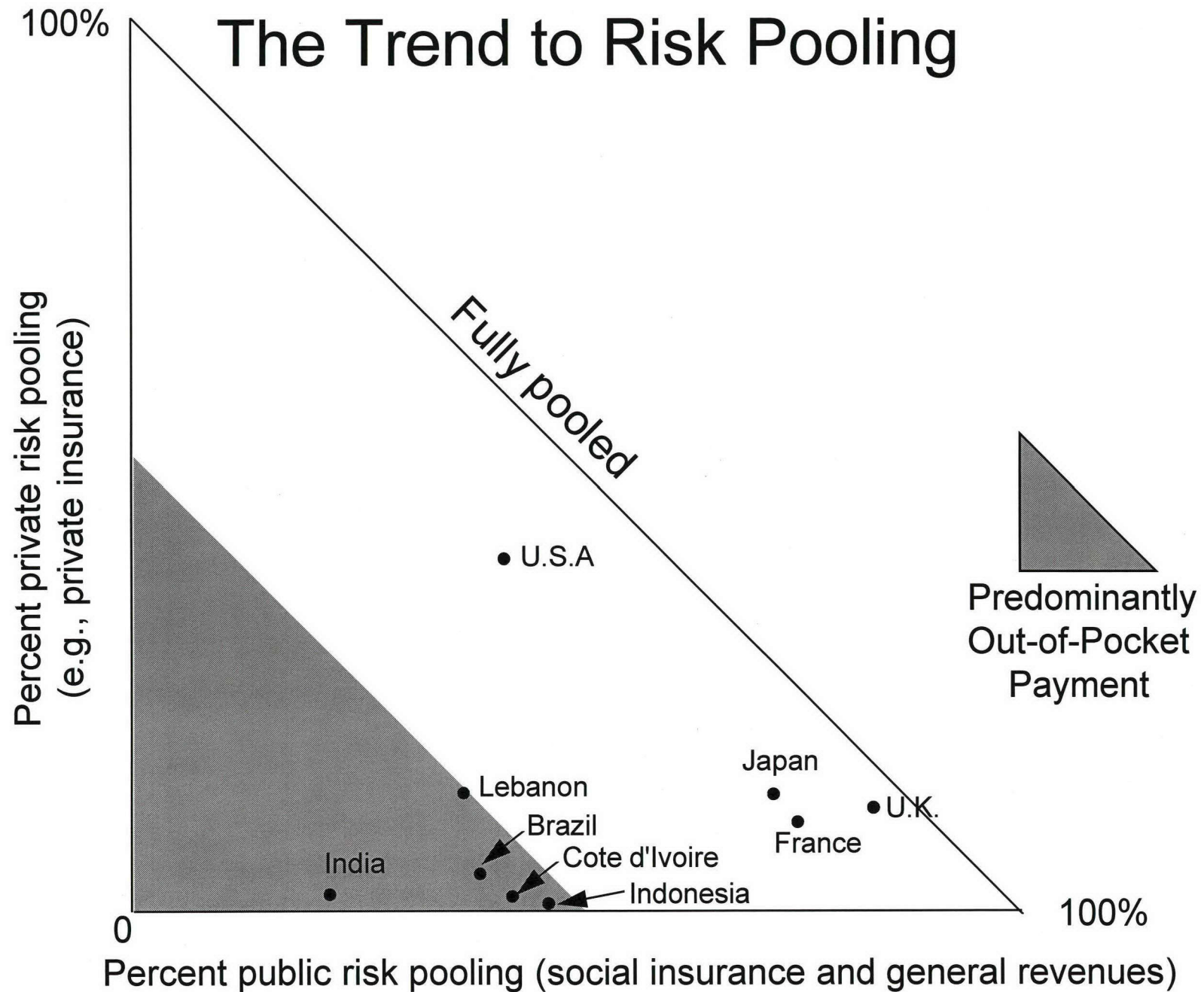
- How do we raise finance?
- What do we finance?
- How do we pay providers?

How Do We Raise Finance?



How Do We Raise Finance?



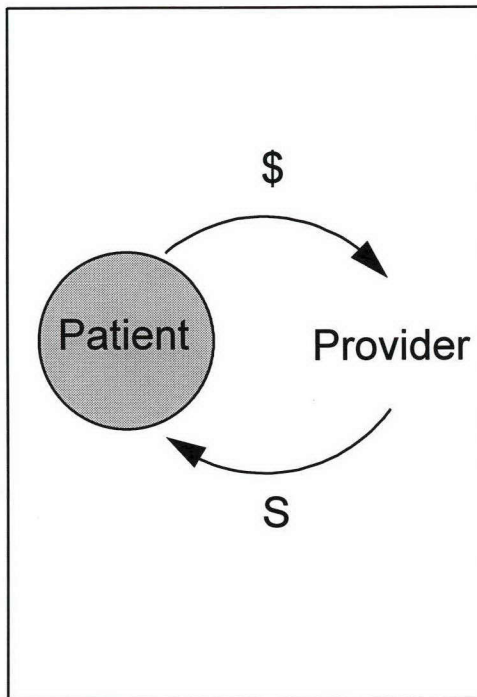


What Do We Finance?

- Personal clinical services
- Public health
- R & D
- Training

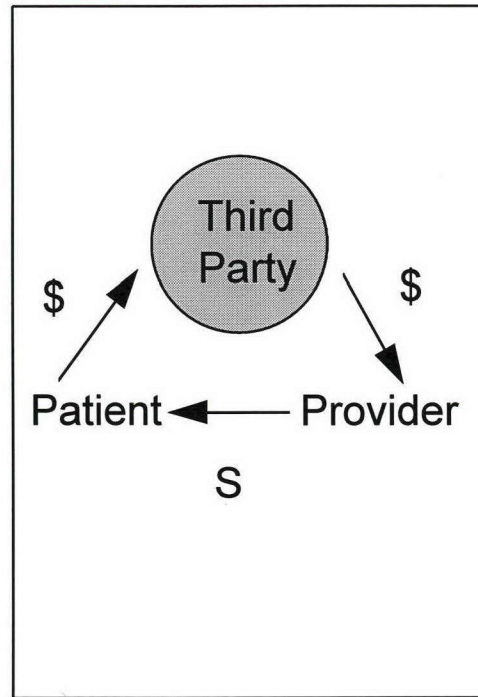
How Do We Pay Providers?

Traditional



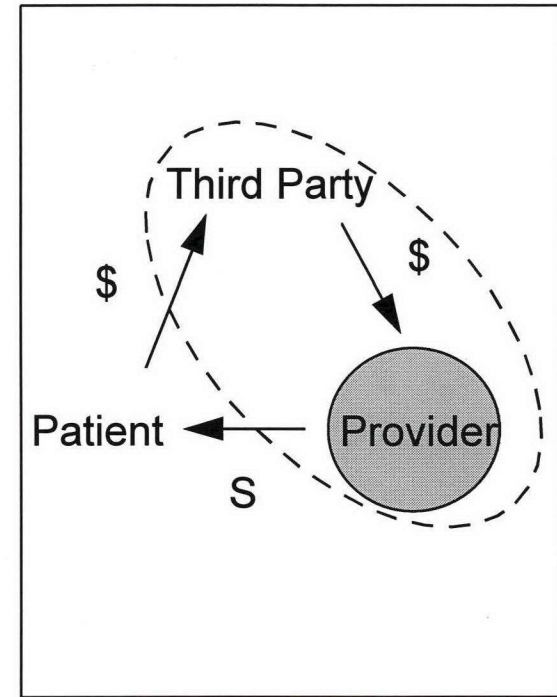
\$ = Money

Modern



S = Services

Post-modern



● = locus of risk

Is an MoH
an HMO
spelt wrong?