KNOWLEDGE PROGRAMME FINAL REPORT

PROJECT NUMBER : KP11 **STARTING DATE:** 1 April 2001
COMPLETION DATE: 31 March 2006

TITLE: **Health Systems Development: The role of health systems in protecting the health of the poor**

PRINCIPAL INVESTIGATOR: Barbara McPake

LEAD ORGANISATION: London School of Hygiene and Tropical Medicine

1. ACHIEVEMENT OF THE RESEARCH PROJECT OBJECTIVES

The triennial review report revised the wording of the purpose of the Health Systems Development Knowledge Programme: *'To inform policy and practice and influence the climate of opinion about how health systems can be more accessible to poor people and deliver better health services'*. Our work to inform policy and practice and influence the climate of opinion continues both internationally and within countries. In particular, we are working with the group Development Initiatives, experts in alerting policy makers' attention to research findings, to achieve wider publicity for the content of the Programme's work. Development Initiatives are working with us to produce accessible summaries of our key findings in attractive dissemination materials, to lobby relevant health systems stakeholders to the insights we have produced and to organise an international meeting planned for September 2006. We are finalising a series of 5 synthesis papers cutting across the work of the Programme. At national level we have developed relationships that have enabled us to communicate our 'health systems approach' to research and policy making which is becoming better understood and influential. This approach is explained in detail later in this report.

We do believe that we have significantly increased knowledge and understanding to inform policy and practice about how health systems can be more accessible to poor people, and most of this report expands on the nature of that knowledge and understanding and why we believe the Programme has succeeded in making a significant contribution. We will use a no-cost extension until the end of October 2006 to continue with the dissemination activities that contribute to achieving the HSD Programme's purpose.

The following table identifies the knowledge outputs from our original logical framework and our achievements against each one.

Outputs	1.1 OVIs	1.2 Meeting OVIs
1. policy-relevant new knowledge – revised headings	High quality policy relevant research judged by peer groups	Human resources: 10 research projects Health system structure: 9 research projects Processes: policy: 6 research projects Processes: operation: 9 research projects Global and regional initiatives: 4 research projects Use: 5 research projects Civil society: 4 research projects Methodology: 6 research projects Probes: 9 research projects

	Publications	109 publications in peer reviewed journals and edited books published or forthcoming by end March 2006
	Recognition	Senior members of the programme have been multiply recognised by international bodies in appointment to senior posts, advisory boards, review panels, and steering committees and have received international awards. Full details in annual reports.
		The South African maternal health situation analysis was extensively cited in the South African confidential enquiry on maternal health.
		The technical advice of programme members is extensively commissioned by international agencies and national governments, and has been provided to World Bank, WHO, DFID and governments of South Africa, Uganda, Mozambique, Bangladesh and Russia.
2. Dissemination	Projects linked to government	Of the 46 projects listed in the 04/05 annual report 35 have direct links to national or local government in the form of involvement in the research process (including participation in development workshops) or commissioning of the study. Others either have indirect involvement (consultation and dissemination) or are desk-based or more theoretically oriented.
	Briefing papers / notes	18 id21 highlights
	Meetings attended, local, country, international	Face to face meetings in all countries on regular basis with DFID, national government and in some cases local government officials. International agency consultations – see meetings attended in annual reports.
	Conferences	8 meetings organised 63 papers presented in meetings Full details of meetings attended in annual reports
	TA and consultancy	Full details provided in annual reports.
	Academic articles	158 peer reviewed journal articles, books or book chapters, published or forthcoming 39 reports and working papers
	Training	See next section
3. Strengthen research capacity	Research activities	35 proposals developed jointly North-South/East-West Uncounted, but at least in these 35 there has been in-programme review and support for proposal development and where the projects have reached the relevant stage for report and publication production. On an even wider range of projects (also uncounted), there has been pairing of senior-junior researchers, sometimes within Northern or Southern institutions. 37/96 published papers, books and book chapters are jointly North/South or East/West authored. In Uganda a book was published containing seven chapters focussing on health systems in Uganda in a collaboration between IPH, the Ministry of Health and LSHTM
	Researcher development	7 Programme PhDs complete 1 Capacity building workshop held across Programme Skills development through practice and theoretical discussion – especially in 5 annual programme workshops

	Research training	12 PhDs in progress Masters training in 5 programme institution benefits from engagement with programme research
	Institutional	All programme institutions have ethical review procedures or engage with national processes. Stable funding had impacts on staffing in each institute, enabling increasing no. or researchers to specialise in health systems research rather than follow funding opportunities. All institutions benefited from the multiplier effect made possible by programme funding.
	National	CHP has been commissioned to develop capacity of the NDoH policy analysis unit including support for policy reviews, and quarterly briefing documents. HSD support is well integrated with the Health Economics Unit in the MoHFW in Bangladesh. In Uganda, HSD and stakeholders across government have shared insights across the research programme and the activities of range of agencies in the development of 7 papers for a special issue of Health Policy and Planning

2. SUMMARY OF THE RESEARCH WORK

The work of the Health Systems Development Programme suggests that the key to improving health outcomes is to better understand and address the *dynamic responses* of health care users and providers to the many aspects of a health system and its environment.

By dynamic responses, we mean that the behaviour of users and providers constantly changes in reaction to the behaviour of others and to changing policies and health system organisation, producing in turn changes to policy and organisation.

Existing approaches to policy design and research tend to search for predictable pathways between health interventions and their outcomes. The *health systems approach* recognises the unavailability of one-size-fits-all solutions. It starts with a review of evidence of the impact of an intervention in different contexts, and seeks to identify patterns in the evidence available. Credible candidate interventions can then be proposed, introduced and continuously evaluated. Continuous, responsive interventions recognise that the setting is continuously responsive.

The research work of the programme concludes that where dynamic responses are given inadequate attention, the poorest groups are least likely to benefit from programmes and policies that are designed to extend access or improve quality of care.

For example, in Cameroon, revenue sharing schemes were designed to improve worker commitment, but the scheme resulted in health workers across the system seeking to locate in hospitals that generated the greatest revenues to the detriment of preventive and primary care. Similarly, rural practice allowances in South Africa seemed to have more (demoralising) effect on those excluded from the allowances than they did motivating effect on those receiving. In Russia, resources are linked to used capacity, leading to incentives to keep beds filled by keeping patients in hospital for long periods. As a result, people avoided using the service at all for tuberculosis care.

In Uganda, the informal systems by which job security and opportunities within the system are obtained were disrupted by reforms in ways reformers had not foreseen. For example, decentralisation shifted some personnel management functions from the (national) public service commission, to district local government. Health workers had less faith in the fairness of the local systems, were concerned about the intrusion of the politics of ethnicity, and could not perceive satisfactory career structures in the restructured job market.

The dynamic responses of users are equally important in determining the outcomes of health systems. In Bangladesh, a national programme was initiated to create a network of community clinics that would be easily accessible to those living in rural areas. Yet when seeking maternal care, women were found to travel further to attend sub-district health centres. Women would only seek care when they perceived their pregnancy to be at risk of complication. The community level facilities could only provide for routine delivery and so were not considered useful.

It is often most difficult to protect the poorest groups from the results of these responses because they have the least ability to manipulate systems in their interests either because they lack the resources, or the social connections.

3. RESULTS/FINDINGS OF THE RESEARCH PROJECT

The structure of the programme has three dimensions – topics, probes and countries.

After the second year of the project, the topic categories under which we conducted work were re-structured (with the agreement of DFID), into the following list: Human resources, Health system structure, Processes: policy, Processes: operation, Global and regional initiatives, Use, Civil society, Methodology.

We used the idea of 'probes' of health system functioning: specific conditions and services through which we would examine detailed questions likely to have system wide relevance. The main probes used were maternal health, tuberculosis, HIV and STIs, and diabetes (type 1). We originally intended also to use under-5 mortality but we had under-estimated the extent to which working in these specific areas required development of specialist knowledge, and a fifth probe proved over-ambitious – although we have written a research proposal in this area towards the end of the programme.

The main countries in which work was conducted are Bangladesh, Russia, South Africa and Uganda, but we have also worked in Armenia, Brazil, Bulgaria, Cameroon, Ethiopia, Georgia, Kazakhstan, Malawi, Mozambique, Tanzania, Turkmenistan, Yemen, Zambia and Zimbabwe. It was always intended that our partnership with Russia would provide the basis for work in a number of central and eastern European, and former Soviet Union countries.

The table below summarises the *main* projects that HSD has undertaken over its life. It uses the topic headings and an additional list of projects that have used the probe approach under which it was common to address multiple topics – although there is duplication where probe projects focused mainly in one topic area.

1. Human resources
Impact of health sector reform on human resources in Bangladesh and Uganda
Managing people in the health sector in Cameroon

Labour markets and disease control
Assessment of health worker incentives in Tula
Ethnography of provider practice in labour wards in South Africa
Nursing staff dynamics in maternal health care in South Africa

2. Health system structure
Essential service package evaluation in Bangladesh
Procurement and drug supply evaluation in Bangladesh
Management training evaluation in Bangladesh
Intergovernmental relations and HIV/AIDS service delivery in South Africa
Decentralisation in Brazil
Health sector reform in Russia
Community health financing in Armenia and Yemen
Informal payment in Bulgaria and Hungary
Constraints to achieving MDGs
Transactions costs and disease control

3. Processes: policy
Government and PNFP relationships in Uganda
District health boards and referral hospitals in Zambia
Relationships in development partnerships in Uganda

4. Processes: operation
Hospital autonomy and markets in Uganda
Maputo central hospital: costs and special clinic (Mozambique)
Hospital reform in Bulgaria

5. Global and regional initiatives
GFATM tracking study in four countries (Mozambique, Tanzania, Uganda, Zambia)
Impact of public private partnerships in Uganda

6. Use
Peer review and consumer rights in Tanzania and Zimbabwe
Health seeking behaviour review
Maternal health seeking behaviour in Bangladesh and Uganda (also in maternal group)
Perceptions of illness and care: TB in Samara (Russia)
Access to insurance in Russia
Health seeking behaviour in 8 former Soviet Union c
Health seeking behaviour of the tribal populations of Bangladesh

7. Civil society
Participation
Health and human rights

8. Methodology.
Probes
Pattern recognition

9. Probes
Comparative maternal health study
Access and quality in maternal health in Russia
Ethnography of provider practice in labour wards in South Africa
Nursing staff dynamics in maternal health care in South Africa
National evaluation of maternal health care in South Africa
Barriers to access to maternal care in Uganda and Bangladesh

Diabetes in Kyrgyzstan

Diabetes and hypertension in Dubna: pathways to treatment and care (Russia)
Perceptions of illness and care: tuberculosis in Samara
Comparative HIV policy environments: Uganda and South Africa
Intergovernmental relations and HIV/AIDS service delivery in South Africa

The following synthesises some of the main lessons that have emerged from this research.

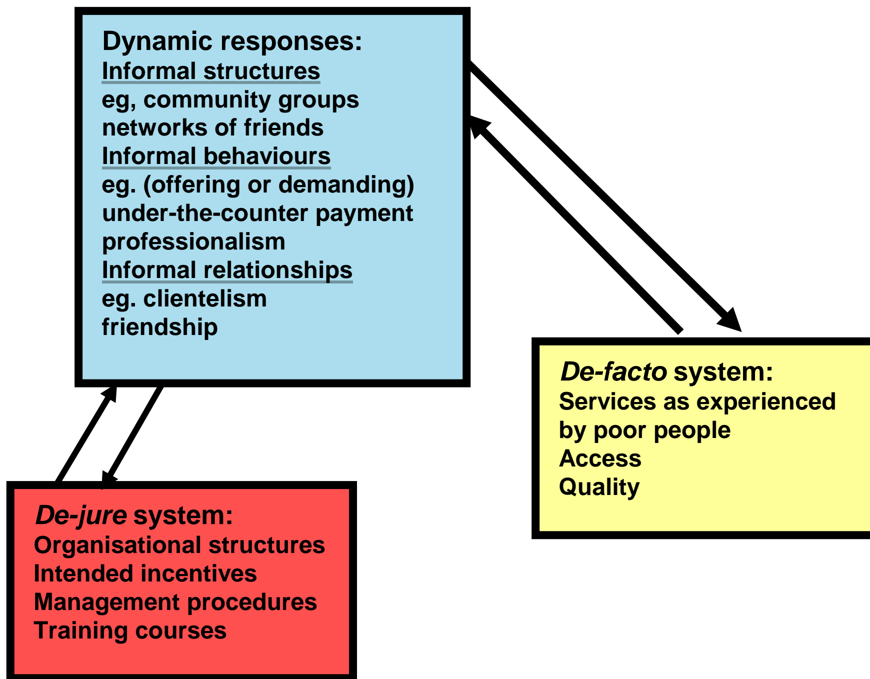
Our methodological work has focused on the environment of complexity that characterises any attempt to bring about the social change that is fundamental to improving health systems. Complexity implies that the effect of an intervention – for example a new policy or a change to health system structure – cannot be predicted with certainty but will be drawn from a set of alternative possibilities. What health systems research can do in this context is clarify that set of alternatives, and suggest the critical mechanisms that have to be triggered to produce better outcomes.

We have developed the 'dynamic responses' model to express this. Dynamic responses are the lynchpin between formal arrangements (the *de-jure* system) and the *de-facto* system as experienced by poor people. The interplay of these components is then the focus of enquiry. Whilst formal arrangements offer the entry point for intervention, the ability of poor people to access services responsive to their needs, crucially depends on how those implementing the *de-jure* system respond. The development of programmes and policy that improve outcomes for poor users requires direct engagement with context and with how formal organizational structures, intended incentives and management procedures interact with informal structures, behaviours and relationships. These dynamic responses may have positive or negative effects through circumventing anti-poor formal arrangements or subverting pro-poor intentions of formal arrangements. However, our research suggests that the poor are often the losers from the processes of dynamic response because they have the least ability to manipulate the system in their own interests, using either financial resources or social and political connections[1].

The programme's topics can be located in relation to the model. The topics 'health system structure', and 'global and regional initiatives', are the components of the *de-jure* system: we have used those topics to see the processes of health system change from the perspective of the intervention. Under the topics 'human resources', 'use' and 'civil society' we have been able to focus on three types of responders: health workers (in the broad sense: everybody employed in the health system including managers and governors of the system), users and the wider community in which health systems are located. The topics 'processes (policy)', and 'processes (operation)' have allowed us to look more closely at the nature of the responses. What is clear from spelling out that location, is that the topics are really starting points for enquiry. Whichever topic we have started with, it has been necessary to consider all the elements of the model to understand how health system outcomes can be made better – hence individual projects have sometimes defied categorisation and moved from one topic area to another as they have developed.

[1] McPake, B., Blaauw, D., and Sheaff, R. Recognising patterns: health systems research beyond controlled trials, in draft.

Figure 1



Under the topic 'human resources' we have concluded that technocratic approaches to public health see human resources as a set of capacities that can be brought to bear on a health problem if they are recruited to its resolution. The health sector reform movement of the 1990s, while often recognising the importance of incentive environments persisted in viewing human resources as passive tools of reform. Three HSD projects in Uganda, Bangladesh, South Africa and Russia have clarified the implications of ignoring the reality of the dynamic responses of those expected to manage and implement change.

Both Uganda and Bangladesh are countries with low levels of human development and high levels of implementation of health sector reform during the 1990s. The draft paper *'The impact of health sector reforms on human resources in health in Uganda and Bangladesh'*[2] highlights that reform design has not ensured that the workforce can benefit from constructive engagement in reform processes to the detriment of both staff performance and reform implementation. For example, performance management initiatives failed to tackle the environments of patronage in both countries. In Uganda, decentralisation and resource shortage served to concurrently reinforce patronage in the first case because nepotism was perceived by health workers as a greater problem at district than at national level, and in the second because without the inputs required to perform, promotion could only be based on non-performance based criteria. Systems of payment for promotion were uncovered. In contrast, in Bangladesh, unification at sub-district level of the health and family planning structures destabilised the pre-existing network of patronage. This served to increase insecurity among health workers without compensating benefits.

In a similar vein, a project in South Africa used an ethnographic approach to focus more tightly on the effects of financial reforms on a specific group of health workers: midwives working in 2 district hospitals. The Public Financing Management Act introduced new procedures for accountability for resources. Those responsible for implementing the new measures in the two hospitals were strongly influenced by an interpretation that they were at risk of criminal prosecution for failure to account even for small items. Consequently, over-stringent, petty measures were put in place that undermined staff morale and were seen to underpin rude treatment of patients by midwives who felt harshly treated themselves[3].

And in Russia, a study assessing stakeholder views of the implementation of general practice to replace the model of primary care based on policlinics found similar obstacles in the dynamic responses of health workers to the reform implementation. The concept of general practice was seen to conflict with the dominant paradigm of vertically organised and hospital-dominated specialist services making it difficult for example for general practitioners to carry out new roles such as health promotion or the development of partnership with social services to care for elderly or disabled people. Boundary disputes with specialist policlinic doctors and hospital physicians hampered general practitioners' work. As a result, many newly trained general practitioners are returning to work in traditional roles lacking the infrastructure and procedures supportive of new models of care[4],[5]. Municipalities were seen as key actors, but have been relatively disengaged with the reform process led by the regional government.

---

[2] Rahman SA, McPake B, Normand C and Kielmann T. . Health seeking behaviour of the hill tribal population in Bangladesh, in draft

[3] Penn-Kekana L, Blaauw D and Schneider H. 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy and Planning* 19(1): 171-177, 2004.

[4] Rese A, Balabanova D, Danishevski K, McKee M, Sheaff R. Implementing general practice in Russia: getting beyond the first steps. *BMJ* 331: 204 – 207, 2005.

[5] Balabanova D, Hongoro C, McPake B and Normand C. Informal practices in health care systems: what are the issues? In preparation for submission to *Health Policy*

In all three projects, it can be seen that health sector reform has tended to take a rather deterministic view of the relationship between health sector structures and outputs, and it is recommended that reformers pay more attention to what can be realistically expected from health workers given an understanding of the formal and informal incentives and constraints they face.

The research therefore points out the need to gain a broad understanding of the context in which health workers respond to interventions, in the design of those interventions. As a result, in Cameroon, our research has sought to provide an understanding of the context in which it was proposed to implement incentive based performance contracts, and the implications of that context for the design of those. The project was born of the interest of the Ministry of Public Health and donors in finding a way to address the crisis of adherence and motivation among health sector personnel. Having experienced salary cuts in 1993 and a currency devaluation in 1994, health workers are conducting a range of secondary jobs from agriculture to commerce, as well as private consultations. In such a climate, in which the working culture has been transformed into one where each worker seeks to maximise his or her external income, simply raising salaries is unlikely to result in greater adherence to primary health work. We set out to understand, in the Cameroon context, what could be learned from existing performance assessment processes and previous contracting experiences about how best to design a district performance contract. Our findings indicate that the more successful bonus sharing and performance-assessment processes among these examples in Cameroon have the following key characteristics: 1) Transparency in accounting, finances and bonus-sharing, 2) Marking of individuals for their work in a process that is transparent and involves persons beyond the individual health unit, 3) Clear objectives for an individual's work, known to him or her, 4) Trust is not assumed and mechanisms for evaluating work and results are cross-checked and verifiable by others, 5) Those affected by the scheme are part of running it, 6) Sanctions against those who do not play by the rules are enforced, 7) There is a team leader who has the responsibility and authority to manage any performance system[6].

Our work in the area of health system structure has led to the development of our argument that informal structures can be more influential than formal structures, and that the effects of change in formal structures operate through mechanisms of dynamic response. One project examined inter-governmental relations in HIV/AIDS services in South Africa. The research identified the strengths and weaknesses in relation to what HIV/AIDS services are provided, how HIV roles and responsibilities functions are allocated, and how they are coordinated. It highlighted the complex array of actors involved in HIV service provision and the difficulties this presents for the allocation of role and responsibilities as well as coordination. The study described the formal mechanisms, such as structures and meetings, that have been developed to coordinate HIV activities but also demonstrated the importance of informal organisational relationships in governmental coordination[7]. Similarly, in Brazil, local political culture and informal management was shown to be critical in determining health system performance. Factors implicated in an improving situation after a 4 year interval between ethnographic studies included growing professionalisation of health system staff and growing expectations and empowerment of the electorate. More conceptual work has tried to disentangle the related concepts of culture, leadership, communication, conflict, power, trust and social capital within organisations, so that such 'informal' dimensions of structures can be more clearly articulated and examined[8].

---

[6] Ambegaokar M, Ongolo-Zogo P, Aly T, Betsi E, Fouda J, Mubudu L and McPake B. Incitations et Sanctions: Resultats de recherche pour la conception de contrats de district, MSPDROS/PASS-UE/LSHTM-HPU, Yaoundé, 2005

[7] Blaauw D. Organisational relationships and health sector reform, in preparation.

[8] Medeiros R and Atkinson S. Breaking vicious and virtuous circles of local health system performance, informal management and political culture in Northeast Brazil, in preparation.

Analysis of health sector reform in Russia, highlights the importance of the role of financial incentive mechanisms in driving dynamic responses among critical actors. According to the *de-jure* system, decentralisation has vested authority at the regional level but in practice, it is the municipal level that exercises most authority. Municipalities own facilities in which much routine health care is delivered and finance the insurance of the unemployed, constituting a significant share of health financing. These roles prove more significant than regulations in determining the ability to exercise authority[9]. Another study in Russia has shown how the insurance reforms have resulted in 'gridlock' associated with conflicting incentives in the central resource allocation process (to prolong length of stay) and in the insurance financing rules (to curtail length of stay)[10].

Our work under the two process headings has enabled us to look in more detail at the roots of dynamic responses in relationships between individuals and the organisations in which they are grouped. The key factor underpinning the implementation of the SWAp approach in Uganda is that of trust between development and national government partners. Over a long period, trust was able to grow as the transparency of government processes and prioritisation improved through mechanisms such as joint review meetings and as development partners were able to tie up fewer resources in conditionalities. More recently, this virtuous circle has been undermined by important new funding streams such as GFATM that are highly controlled and circumscribed, and a general decline in the political environment in Uganda[11].

Work in Zambia that looked at the relationships between district and hospital boards used a transactions cost framework through which to understand dynamic responses. Although the contracts specified that funding would be withdrawn from providers who faltered in meeting their mandate, the respondents observed that this had never happened. On the contrary, block contracts encouraged cost-shifting between districts and hospitals. Districts referred inappropriately to hospitals and hospitals failed to provide adequate care to referred cases[12].

Finally, work in the area of 'use' has highlighted the importance of an emphasis on dynamic responses here too. Access is often seen as a one-stop contact with the health system that is obstructed by a range of obstacles at a given point in time. Our research suggests that illness is better understood as involving a continuum of care seeking, requiring access to prolonged, often lifelong treatment at different levels of the health system. A dynamic interaction between provider and patient behaviour, usually at the level of the frontline service determines what care is accessible[13]. This was illustrated by a study of health seeking behaviour by people with tuberculosis in Samara, Russia. While initial entry to the system was relatively uncomplicated, subsequent access to reliable diagnostic services, and patient retention during treatment were problematic. The different barriers that manifested themselves at each stage, prior to and during treatment, could be shown to relate to differing perceptions of risks and benefits and to patient expectations. These were socially patterned; although most users faced few costs as clinical encounters were formally free and pharmaceuticals were highly subsidised, some marginalised groups experienced considerable costs. They included those who were not registered with the authorities, migrants, and former prisoners. Furthermore, while the immediate, direct costs faced

[9] Danichevski K. Implementing decentralisation in Russia. In, *Decentralisation in Health Care*, in preparation.
[10] Sheaff R. Governance in gridlock in the Russian health system; the case of Sverdlovsk oblast. *Social Science and Medicine* 60(10): 2359-2369, 2005.
[11] Oliveira Cruz V, Cooper R, McPake B, Yates R, Ssengooba F, Omaswa F, Tashobya CK and Murindwa G. Is the sector-wide approach (SWAp) improving health sector performance in Uganda. In, Tashobya CK, Ssengooba F and Oliveira Cruz V (eds) *Health systems reformed in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, 2006.
[12] Kamwanga J. District health boards and referral hospitals: an economic analysis of contracting in the Zambian health sector, PhD thesis (submitted for award), 2006.
[13] Balabanova D, Parkhurst J, McKee M and McPake B. Access to health care: taking into account health systems complexity, draft

by those outside marginalised groups (including travel, absence from work, hospital food and supplementary medication) were relatively low and physical availability of service was adequate, over the longer term affected households experienced a significant decline in their financial resources because of inadequate social support, reduced employment opportunities, and even workplace discrimination. These factors combined to reduce the probability that the patient would complete treatment, illustrating how the decision to access care can vary over time with patients moving in and out of treatment, and be influenced by different factors at different stages of treatment [14].

Many of the dynamic response patterns identified, across the programme's research, are found to disadvantage the poorest patients. Where health workers job security or incomes are threatened by changes in their environments, they may as was shown in South Africa, react by mistreating patients, or as in Uganda[15], withholding elements of treatment. Informal charges[4,14] and social status[14] may protect better off patients from this abuse. The Samara case just cited, demonstrates how dynamic responses in use may disadvantage particular marginalised groups. Mechanisms that seek to improve motivation by allowing facilities to retain revenue collected for staff bonuses make those facilities that the poor are more likely to use the least attractive, for example in Cameroon[16].

The research process and its dissemination also have to take place within the health system, and be understood as a component of the dynamic responses that it seeks to investigate and influence. In our dissemination strategy, we have focused on the informal structures, behaviours and relationships that influence how research results are translated into policy and implementation and we have emphasised the development and maintenance of long-term formal and informal relationships. Long-term relationship development enables definition of priority needs for new knowledge, incorporates users into research, involves policy-makers and other actors at all stages of our work, ensures the research agenda remains responsive to change and demand, and involves users in the communication of interim and final research results. We have capitalised on friendship networks of consortium members and established new ones, identified common purpose with individuals to work together on particular projects, kept in regular contact even without particular business to conduct and consulted in interpreting our research findings for feasible policy and implementation. Policy-makers and stakeholders have met in some countries under an HSD umbrella to discuss health system developments and emerging evidence, commission research, have invited HSD members to sit on expert and steering committees and in some cases have attended the annual HSD knowledge programme workshops.

In Bangladesh, we have strong relationships with senior political decision-makers and government executives that have enabled some results from our previous research to be transformed into policy with relative ease. For example, we have regularly briefed successive Secretaries of Health with the result that identification of cultural barriers between Bengali providers and tribal users contributed to a policy of posting staff in their own communities, and a DFID-funded experiment responded to our recommendation that community clinics are better managed by NGOs.

In Uganda, whilst we have had good links at all levels of government, in-country offices of bi- and multi-laterals and with NGOs, the middle-level executives, country offices and NGOs have been

---

[14] Dimitrova B, Balabanova D, Atun R, Drobniewski F, Levicheva V, Coker R. Barriers to tuberculosis care in Russia: health service providers' perceptions. *Health Policy and Planning*, in press.
[15] Ssengooba, F., McPake, B., Hanson, K., Hongoro, C., Kasasa, S., Rutebemberwa, E. Tiered services, user charges and quality in Ugandan hospitals, submitted to *Health Economics*
[16] Ambegaokar M, Ongolo-Zogo P, Aly T, Betsi E, Fouda J and McPake B. Travail en Equipe ou Travail Individuel : Facteurs de Motivation du Personnel de la Santé Primaire au Niveau du District, MSP-DROS/PASS-UE/LSHTM-HPU, Yaoundé, 2004.

most receptive. Jointly with the Ministry of Health, we have produced a book of papers that reflect on the reform processes in Uganda[17]. Successive Director Generals of Health Services in Uganda contributed to the book. There are multiple ways in which specific policy recommendations have been put into practice on the basis of the relationships developed. For example, Ssengooba was appointed to the committee developing regulation of private patient initiatives in Mulago hospital and used research on hospital autonomy on which to base his inputs. We believe that our advice against the introduction of the social insurance programme has been understood by important stakeholders in the Ugandan system which is weighing against the political momentum for this policy. However, our most noticeable impact – and we consider the more important process by which a health systems approach to policy making can be nurtured - has been in enabling these groups to reflect on their role in implementation, and inputs to policy processes and to understand their actions within the dynamic response framework.

In South Africa and Russia, national-level political and executive officers are less accessible and thus we have focused on local government as well as indirect routes through the media and academic groups including specialist medical groups to influence policy and practice. In South Africa, our work on maternal health is prominently cited in the most recent report on Confidential Enquiries into Maternal Deaths, a particular success in influencing the specialist obstetrics and gynaecology community initially resistant to health systems perspectives. In addition, the Department of Health has commissioned further projects on maternal health policy based on our results. In Russia, work commissioned by the local governments of Tula and Dubna oblasts highlighting links between local epidemiological trends and dimensions of health system performance have provoked discussions on the need for prioritisation of preventive and promotive activities and co-ordination across sectors.

We are concluding the life of the Programme with a series of national and international dissemination workshops. These have so far been held in Kampala (31 October 2005) and Dhaka (17 November 2005), and will be held in Moscow (27 & 28 April 2006) and London (September 2006). Participation in the national workshops held to date testifies to our success in building up strong effective relationships and a reputation for useful insights. This is the second set of dissemination meetings we have held in Uganda, Bangladesh and Russia in addition to making contributions to other relevant meetings – for example there has been an annual health economics and systems meeting in Bangladesh where we have had a strong presence on each occasion. In South Africa, we have taken the view that dissemination to specific targeted audiences is more effective. Conference presentations have been made at maternal health, midwifery, human resources and public health meetings, and dissemination meetings with senior managers at local and national levels concerned with maternal health, HIV, and human resources have been held.

The communications strategy of the programme has been judged successful in establishing such policy dialogue at national-level and embedding our research in national health systems[18] through the development of long-term relationships with a range of stakeholders in each country of the consortium.

4. POLICY RELEVANCE

All our work concerns policy and is directly policy relevant. We hope that the text provided under section 3. is sufficiently self-explanatory on this point.

---

[17] Kirunga-Tashobya C, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: Processes and outputs, IPH*, HSD and MoH, Uganda, 2006.

[18] Waddington, C., and Grace, C. (2005) Triennial review, DFID Knowledge Programme, Health Systems Development, DFID Health Resource Centre, London.

Our critical contribution beyond the research content that has been outlined above, is to propose a 'health systems approach' to policy making. The health systems approach recognises the unavailability of one-size-fits-all solutions, due to the interactions of elements within the system. It starts with a review of evidence of the impact of an intervention – expansion of the health infrastructure for example – in different contexts, and seeks to identify patterns in the evidence available. For example, the 'realistic evaluation'[19] approach aims to provide evidence of context-mechanism-outcome configurations in specific settings and can be used in an accumulating manner to generate the basis for recognition of patterns. Credible candidate interventions can then be proposed, introduced and continuously evaluated in a realistic manner – identifying how they work, for whom, and in relation to which key contextual elements. Continuous, responsive interventions recognise that the setting is continuously responsive. This set of methods produces a health systems approach to policy making. To support this approach clearly requires long term relationship building with policy makers and continuous input into policy dilemmas on the basis of a growing volume of research results – the approach we have described above.

5. RESEARCH CAPACITY STRENGTHENING

We have outlined the countable activities, such as numbers of PhD students supervised, in section 1. These are important, and given the limited capacity in health systems research in both Northern and Southern countries, make a significant contribution to the trained research capacity that exists. From the start we took and explained the view that the resources for capacity building within the programme would not allow an institutional strengthening approach and have focused our specific capacity strengthening activities on programme members and close collaborators.

We consider that there have been two capacity strengthening elements of the programme that have been particularly important: methodology development and in-country communication of the 'health systems approach'.

Health systems research is an undeveloped field whose definition is implicitly contested even if explicit debate has not been engendered. There has been a growing movement to 'epidemiologise' the research area. For example the Cochrane Collaboration has called for the increasing use of randomised and controlled methods in evaluation of health systems change. We believe this misunderstands the fundamentally social nature of the field and the need for engagement with complexity that implies – as we have explained in earlier sections. Globally, but perhaps particularly in low income countries, there is a lack of capacity to resist the epidemiological paradigm, which attracts substantial funding from medically staffed research bodies. Working together, the partners to the programme have developed a distinct, social science based approach, and we hope that the publications in the pipeline will attract wide attention so that the missing explicit debate may take place. We are working with the Development Initiatives group to support the attraction of attention to this work. In the process, all of us, both Northern and Southern based, have developed a clearer vision of the purpose, approach and appropriate methods of health systems research which will carry forward into our future work. At best, the thinking developed will lead to more useful and appropriate health systems research by larger numbers of health systems researchers.

The dynamic responses model is an approach to both research, and to policy development. Within countries, we have been able to communicate this approach to policy making to some degree, and

---

[19] Pawson, R and Tilley (1997) Realistic evaluation, Sage Publications (NOT AN HSD OUTPUT).

have started a series of dialogues with policy makers of different types that reflect the insights of the model. However, while implicit in much of the work of the early part of the programme, we have only explicated the model in the last two years. The sustainability of the in-country processes has to be questioned given the limited time we have had to embed the more explicit ideas in our relationships with national level stakeholders. However, many of us will continue to work using this framework in the same countries and we hope to be able to maintain our dialogues to a sufficient degree to allow an embedding of the core ideas over a longer time period.

6. WORK OUTSTANDING

We are still completing the writing up of the full range of results of the Programme, and have further outstanding dissemination activities including two planned meetings, and the use of the Development Initiatives group to further publicise the outcomes from the programme. We will use a no-cost extension to the end of October 2006 to complete this work.

7. INTELLECTUAL PROPERTY RIGHTS

We don't believe there are IPR issues of any significance arising from the work of this programme.

8. FINANCIAL SUMMARY

The financial summary will be forwarded once the School's books have been closed for the financial year 2005-2006.

9. LINKS WITH DFID

We have linked frequently with DFID advisors in partner countries and in the UK, most recently (and in the case of the London meeting, imminently) by inviting their participation in the series of dissemination workshops that mark the end of the Programme. We've had particularly consistent interest from both health advisers in Uganda, more sporadic interest in the other three countries. The engagement of in-country health advisers is particularly important to support our attempts to strengthen the research-policy interface.

We have appreciated the annual review meetings with DFID advisors, and the helpful advice input through the triennial review process, after which we concentrated our activities over the last 18 months of the Programme on synthesising and disseminating the outputs of the Programme.

Nevertheless, we recognise that members of DFID staff face constraints in providing as close a relationship with research programmes as they and we would like. Frequent staff movements within DFID both in low and middle income countries, and in the UK has meant that there has been little consistency in feedback, or sense that anyone in particular in DFID perceives much stake in the success of the research programmes' mission. In general it is clear that a reducing civil service establishment combined with an increasing budget and mission imply less engagement with any particular part of that mission, and increasing use of consultants without long term stake in programmes, or consistency in advice.

If DFID were to arrange a seminar series about its funded research programmes we would welcome being asked to present on (1) The health systems approach to research and policy making; (2) Rethinking health care access in a complexity framework; (3) Maternal health and the

inter-generational transmission of poverty.

Annex 1: Important and significant findings

Health Systems Factors Influencing Maternal Health Services: A Four-Country Comparison

Access to health care: taking into account health systems complexity.

Hospitals' response to increasing autonomy and market forces: evidence from 4 countries

Prevention and promotion in decentralised rural health systems: a comparative study from Northeast Brazil

The Global Fund: managing great expectations

Recognising patterns: health systems research beyond controlled trials, in preparation

Implementing general practice in Russia: getting beyond the first steps

The human perspective on health care reform: coping with diabetes in Kyrgyzstan.

Health service utilisation in the Former Soviet Union: evidence from eight countries.

'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective.

Health Systems Factors Influencing Maternal Health Services: A Four-Country Comparison

J Parkhurst, L Penn-Kekana, D Blaauw, D Balabanova, K Danishevski, SA Rahman, V Onama, F Ssengooba

While the availability and use of trained midwives can shape the quality of care received in pregnancy and childbirth, a number of other underlying health systems structures and processes are important. The management of health workforces, the mix of public and private provision and the impact of reforms affect quality of care across countries.

During a comparative study, conducted in 2001-2002, researchers at the London School of Hygiene and Tropical Medicine, UK examined how the structure and operation of a health system influences maternal health care provision and outcomes in Bangladesh, Russia, South Africa and Uganda.

Significant conclusions from the study include:

- Health outcomes in pregnancy and childbirth are not rigidly linked to quantifiable inputs, such as number of staff or proportion of women delivering with a skilled attendant. Instead, there is a range of possible health outcomes from any given set of these variables. Much of this range will be dictated by the larger systems structures in which these factors operate.
- The connection between the numbers of mothers dying during pregnancy and childbirth and use of skilled attendants will be mediated by elements such as health centre workplace dynamics, national reforms shaping practice, or formal and informal private practice by health workers.
- The impact of private providers on maternal health depends on the services they offer, the populations they serve, and their interactions and relationships with other health providers.
- Private sector providers can be difficult to regulate. In urban areas they compete with the public sector, but in rural areas they can fill a gap where the public sector does not operate.
- Health sector reform can put a strain on health workers. However, a lack of reform can slow improvements in maternal health services, as is the case in Russia.
- User fees can increase staff motivation but may reduce demand for services. Removing fees may not necessarily increase demand.
- Informal fee charging and medical staff working in both private and public sectors take place in various forms. Public sector doctors may also operate private clinics to which they may refer their patients, while ward staff may re-sell drugs or charge for services.

The four country comparison reveals some common elements where the structure of health care systems can affect maternal health care. Implications for policy include:

- It is essential to look beyond the simple measurable inputs into a health system, such as numbers of staff or use of services, in order to understand how to improve quality and outcomes.
- The effectiveness of birth attendants depends on the system in which they work. The mix of staff, human resource allocations and the accessibility of emergency care can affect health outcomes.
- Income disparities allow the private sector to attract public sector staff. But where public services are not available, the private sector can play an essential role in maternal care.
- Informal health care providers may be poorly linked to the rest of the health system, bringing increased risks for women.
- Informal practices can undermine state policies on free care, but may operate to support public sector workers in positions that would be otherwise unfilled.
- The impact of any reform will depend on the structure of the system and how the reform is implemented. There is no simple cause-and-effect link between a reform and its impact.

Source(s): Parkhurst JO, Penn-Kekana L, Blaauw D, Balabanova D, Danichevski K, Rahman SA, Onama V and Ssengooba F. Health systems factors influencing maternal health services: a four-country comparison. *Health Policy* 73(2): 127-138, 2005.

Access to health care: taking into account health systems complexity.

D Balabanova, J Parkhurst, M McKee and B McPake

Established theoretical frameworks on access to care and utilisation as a proxy for access, including the demand and supply model; the 'health belief' and 'behavioural' models, sought to conceptualise decision-making processes and barriers to care. These approaches provide a useful starting point in understanding individual care seeking, but they do not address the inherent complexity involved in accessing appropriate health services, or account for non-linear behaviour and the dynamic interaction between health systems and communities.

Drawing on recent multi-country research, this paper seeks to contribute to the understanding of access in low and middle-income settings, while focusing on patterns that cut across settings, employing a conceptual framework which looks at the 'dynamic responses' that sit between the *de jure* health services in place, and the *de facto* outcomes seen.

The paper examines several areas of complexity in relation to access. These involve identifying time and skills continuums required for achieving successful access to care, the role of communities in mediating access of individual members, and the dynamic interaction of patient and provider behaviour. It suggests an approach to conceptualising access while taking uncertainty and complexity into account.

Access is often seen as a one-stop contact with the health system that is obstructed by a range of obstacles at a given point in time. Our research suggests that illness is better understood as involving a continuum of care seeking, requiring access to prolonged, often lifelong treatment at different levels of the health system. A dynamic interaction between provider and patient behaviour, usually at the level of the frontline service determines what care is accessible.

While the current debate focuses on identifying and addressing barriers to seeking good quality care, or counting staff and facilities, we argue that studies of access should incorporate complexity (theoretically and methodologically), particularly the continuous nature of treatment and the diversity of barriers at each stage, the dynamic provider-patient interaction in each context, and the need to draw on community resources in bridging access gaps. Availability of financing is only part of the problem, and the interacting individual and systemic incentives need to be addressed.

Hospitals’ response to increasing autonomy and market forces: evidence from 4 countries

B McPake and K Hanson

The policy of hospital autonomy is contingent on the idea that market forces can discipline hospitals and so improve their performance. That idea is contested from two perspectives. First, under most forms of autonomy implemented, hospitals are not the residual claimant to surpluses generated by their activity and may pursue other objectives with unclear implications for their behaviour. Second, hospital contracts are inevitably incomplete, perverse incentives may arise and hospitals may seek to increase surplus by excluding or under treating particular patient groups.

Evidence to assess the validity of the market forces model, or alternatively of either conflicting model is scarce. The operation of health sector reform is multi-faceted, time lagged and beset by inter-relationships between multiple variables. Research funding is usually small scale and haphazard. This paper seeks to draw together evidence across four countries (the UK, Zambia, Indonesia and Colombia) where evidence of hospital performance in the wake of reform is relatively robust, in an attempt to identify patterns of response to reform.

Across these four countries, the evidence suggests that hospital reform may be associated with productivity improvement, although in all cases it is difficult to link robustly the reforms with the measured improvements. In three of the four countries: the UK, Zambia and Indonesia, it is easier to link reform with the development or further development of two-tier or multi-tier service provision strategies, raising questions regarding the equity impact of the policy. In Colombia, there is no similar evidence and certain features of the Colombian programme seem to protect against negative equity effects. These are an absence of out-of-pocket payments, and measures which mandate cross-subsidies among different groups. Such measures have been difficult to implement in Colombia, a middle income country, and may not be feasible in lower income countries.

Prevention and promotion in decentralised rural health systems: a comparative study from Northeast Brazil

S Atkinson, L Fernandes, A Caprara and J Gideon

Policies to reform health care provision often combine the organizational restructuring of decentralization with ideological restructuring through a new model of health care that gives greater weight to prevention and promotion. Decentralization provides a discretionary space to the local health system to define and develop its own activities. The central policy aim to shift the model of health care therefore must rely on incentives rather than directives and is likely to result in variation at local levels in the extent and mode of its implementation. The local processes affecting variation in local implementation of policies for prevention and promotion have not been studied in a developing country. This study does so by comparing two rural health systems with different levels of prevention and promotion activities in one of the poorest regions of Brazil, Ceará State in the northeast. The health system with greater activities of prevention and promotion also has a more advanced stage of decentralization, but this is in combination with many other, interacting influences that differentiate the two health systems' ability to adopt and implement new approaches. While beyond the scope of this paper to detail options for regional and national managers to encourage the adoption of a greater focus on prevention and promotion, it is clear that strategies needs to target not only the vision and actions of local health system staff, but critically also the expectations of the local population and the attitudes of local government.

Source: Atkinson S, Fernandes L, Caprara A and Gideon J. Prevention and promotion in decentralised rural health systems: a comparative study from Northeast Brazil. *Health Policy and Planning* 20(2): 69-79, 2005.

The Global Fund: managing great expectations

R Brugha, M Donohue, M Starling, F Ssengooba, G Fernandes and G Walt

The Global Fund was set up in 2002 to provide funds for the fight against AIDS, tuberculosis and malaria. How successful has it been so far at attracting, managing and distributing additional resources? Initial delays in the paying out of grants and the provision of guidelines heightened the difficulties faced by potential recipients who were often unable to effectively participate in the proposal submitting process.

Groups in recipient countries, known as country coordinating mechanisms (CCMs), apply for money from the Fund. CCMs were formed at very short notice, with less than six weeks until the Round One deadline for grant applications. CCMs include a broad representation from governments, non-government organisations (NGOs), civil society, multilateral and bilateral agencies, and the private sector. In many countries, already existing national AIDS councils were used as a basis for CCMs.
The London School of Hygiene and Tropical Medicine, working with local collaborators, carried out research in 2003-04 to find out how well the Global Fund and the CCMs were operating. Senior figures involved in the fight against AIDS, tuberculosis and malaria from Mozambique, Tanzania, Uganda and Zambia, were interviewed.

The study found that, in order to be effective, the Global Fund needed to address the following issues:

- The CCM partnerships did not represent their constituents effectively, due to lack of time, capacity and poor communications infrastructure.
- In Tanzania, Uganda, and Zambia, CCM meetings were dominated by government officials.
- The Global Fund's delay of more than a year in explaining the roles of these new partnerships caused confusion amongst CCM members.
- Governments were concerned they would not be able to meet the Global Fund's requirements for feedback, for example, many NGOs could not provide quarterly financial reports.
- The delays in providing grants have held up health projects. A year after a £12 million malaria grant was awarded to Tanzania only 4 percent of the money had been handed over.

Countries, which have long been starved of resources for tackling major health problems, cannot overnight provide the necessary infrastructure to spend the money effectively. It takes time to staff and implement new programmes.

The Global Fund is one of several new global initiatives, including the World Bank Multi-Country AIDS Programme and the US President's Emergency Plan for AIDS Relief, each set up to provide funding in the fight against AIDS. These initiatives need to work closer together, as well with existing national programmes, to prevent overlap and duplication. The Global Fund's aim of providing funding for major diseases will be jeopardised unless:

- 'umbrella' bodies or other networks to involve civil society are supported. For example, in Mozambique an umbrella body for international NGOs provided feedback from the CCM to its constituents through e-mail discussions
- representatives on CCMs are willing to speak for the interests of their communities
- tensions between existing bodies such as national AIDS councils and Ministries of Health can be resolved.

Source(s): Brugha R, Donoghue M, Starling M, Ssengooba F, Fernandes G and Walt G. The Global Fund: managing great expectations. *The Lancet* 364(9428): 95-100, 2004.

Recognising patterns: health systems research beyond controlled trials, in preparation

B McPake, D Blaauw and R Sheaff

If it were not for controlled trials, polio sufferers would still be lying in iron lungs. Nevertheless, experimental approaches have severe limitations in studying systems such as health systems that change from within as a result of human agency, and in which context, rather than something to be controlled or neutralised is the key issue to be understood in order to explain when, where and why interventions do or do not work.

In order to answer such questions, it is necessary to attend to the 'black-box' between the intervention and its effects, or the mechanisms of effect. In health systems, a series of policy initiatives with multiple intentions on the part of their designers are launched, often concurrently. These determine changes to the de-jure health system, which can be described in terms of its legislation, regulations and organisational structures. The implications of the de-jure system for the de-facto system that is
experienced by its users are mediated through a series of 'dynamic responses' on the part of the human agents that form the chain linking the two. These determine how accessible health systems are to whom, the quality of the services delivered by the system and the outcomes of the system, for example in terms of health improvement or poverty alleviation. Research focusing on the mechanisms of effect in social systems has been termed 'realistic evaluation'.

New language for conceptualising such systems is available in the discourse on complexity which has rapidly traversed the breadth of science. Mathematical and statistical techniques which when grouped together have been labelled 'pattern recognition' have been developed to deal with situations of complexity in which mechanisms that result in outcomes are less than fully deterministic, or of a cause and effect nature. There is considerable scope for greater use of such methods in health systems research, both in their quantitative manifestations which are increasingly
in use in other fields, and in qualitative manifestations which are currently only partially articulated. New techniques of both types are required to more fully develop health systems research methodology and there are germs of promising methods in those that are being developed in other areas. Such an approach emphasises that health systems research is indeed a multi-disciplinary field as has long been widely assumed. Further, identifying contrasting theoretical and methodological approaches to pattern recognition more clearly identifies how specific disciplines can make both discrete and complementary contributions to a potentially cumulative understanding of the key issues in securing health system development.

Implementing general practice in Russia: getting beyond the first steps

A Rese, D Balabanova, K Danichevski, M McKee and R Sheaff

Implementation of primary care reform in Russia has proved difficult and slow. The scale of the task has been underestimated, given the estimated need for 90 000 GPs in Russia (based on one per 1500 population). Only about 2500 have so far been trained; even when added to the 29 789 district physicians, trained under the old system, they will cover only 35% of the population. Russia is not, however, unique in failing to understand the scale of the task.

Earlier reform efforts have also been problematic, such as the Leningrad experiment and related activities, in which regional and local governments were briefly given the right to set up contracts with provider associations, subsequently deemed inconsistent with the new compulsory insurance system.

The study findings highlight the importance of a system-wide approach. While some new elements of primary care have been put in place, many others are missing. Many trainees return to work in facilities lacking the infrastructure and procedures needed for new models of care. The broad, federal legislative framework provides no detailed guidance on the roles and responsibilities of general practitioners and their relationship with specialists. GPs have little opportunity to use new skills. Little evidence exists of meaningful integration into the healthcare system, with the persisting hierarchical and hospital dominated system leading to demoralisation. Yet the new model seems popular with patients, as has also been noted in other former communist countries.

Change is needed at several levels. Firstly, there is a need for supportive legal and regulatory frameworks to exist at federal level, allowing regional authorities to develop locally applicable policies. An explicit human resource strategy should tackle staff motivation and retention. Incentives must be aligned with the goals of reform and be system-wide, taking account of those working in primary and secondary care.

Secondly, resources are needed to support change. The Russian healthcare system is moving from a model based on cheap, poor quality labour to one with fewer, skilled people supported by modern technology. This is bound to be painful, eliciting opposition from those with most to lose. The process of change will inevitably require targeted investment and technical support.

The directors identified municipalities as important stakeholders, contrary to widely held assumptions about the importance of regional health authorities. Garnering support from local stakeholders who can facilitate change, but who often obstruct it, is essential.

This study suggests serious weaknesses in general practice in Russia, a similar situation to that in some other eastern European countries, yet many stakeholders support change. The prevailing paradigm will have to change if the reforms are to succeed.

Source: Rese A, Balabanova D, Danichevski K, McKee M and Sheaff R. Implementing general practice in Russia: getting beyond the first steps. *British Medical Journal* 331: 204-207, 2005.

The human perspective on health care reform: coping with diabetes in Kyrgyzstan.

B Hopkinson, D Balabanova, M McKee and J Kutzin

Health systems world wide are confronted by the challenge of rising levels of chronic diseases. Yet existing approaches to health system analysis often fail to capture the complexity of the responses required to address this challenge. In this paper we describe the results of a pilot study using a rapid appraisal technique to assess the performance of the health care system in Kyrgyzstan, a former Soviet central Asian republic. The study focuses on diabetes, a condition whose effective management required a co-ordinated response involving many components of the health care system. The study sets out a conceptual framework in which the system is seen from the perspectives of users, health professionals and policy-makers. It sees the effective delivery of health care as dependent on appropriate investment in human, physical, intellectual and social resources. The study reveals important weaknesses in all of these areas, although it also notes that current policies, while constrained by the legacy of the past and by limited resources, are beginning to tackle them. This pilot study indicates that rapid appraisal, using a condition such as diabetes, where those affected can be easily identified, offers a means of gaining important insights into a health care system.

Source: Hopkinson B, Balabanova D, McKee M and Kutzin J. The human perspective on health care reform: coping with diabetes in Kyrgyzstan. *International Journal of Health Planning and Management* 19: 43-61, 2004.

Health service utilisation in the Former Soviet Union: evidence from eight countries.

D Balabanova, M McKee, J Pomerleau, R Rose and C Haerpfer

Background: In the past decade, the countries that emerged from the Soviet Union have experienced major changes in the inherited Soviet model of health care that was centrally planned and provided universal, free access to basic care. The underlying principle of universality remains but coexists with new funding and delivery systems and there are growing out-of-pocket payments.

Objective: To examine patterns and determinants of health care utilisation, the extent of payment for health care, and the settings in which care is obtained, in Armenia, Georgia, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukraine.

Methods: Data were derived from cross-sectional surveys, representative of adults aged 18 and over in each country, conducted in 2001. Multi-stage random sample of 18,428 individuals, stratified by region and area was obtained. Instrument contained extensive data on demographic, economic and social characteristics, administered face-to-face. The analysis explored the health seeking behaviour of users and non-users (those reporting an episode of illness but not consulting).

Results: In the preceding year, over half of all respondents visited a medical professional, ranging from 65.7% in Belarus to 24.4% in Georgia, mostly at local primary care facilities. Of those reporting an illness, 20.7% of all did not consult although they felt they should have done so, varying from 9.4% in Belarus to 42.4% in Armenia and 49% in Georgia. The main reason for not seeking care was lack of money to pay for treatment (45.2%), self-treatment with home-produced remedies (32.9%), and purchase of non-prescribed medicine (21.8%). There are marked differences between countries; unaffordability was a particularly common factor in Armenia, Georgia and Moldova (78%, 70%, 54%), and much lower in Belarus and Russia. In Georgia and Armenia, 65% and 56% of those who had consulted paid out-of-pocket, in the form of money, gifts or both; these figures were 8% and 19% in Belarus and Russia respectively and 31.2% overall. The probability of not consulting a health professional when seriously ill was significantly higher among those over 65, and with lower education. Use of health care was markedly lower among those with fewer household assets or shortage of money, and dissatisfied with their material resources, factors that explained some of the effect of age. A lack of social support (formal and informal) decreases further the probability of not consulting, adding to the consequences of poor financial status. The probability of seeking care for common conditions varies widely among countries (persistent fever: 56% in Belarus; 16% in Armenia) and home remedies, alcohol and direct purchase of pharmaceuticals are commonly used. Informal coping strategies, such as use of connections (36.7%) or offering money to health professionals (28.5%) are seen as acceptable.

Conclusions: This paper provides the first comparative assessment of inequalities in access to health care in multiple countries of the former Soviet Union, using rigorous methodology. The emerging model across the region is extremely diverse. Some countries (Belarus, Russia) have managed to maintain access for most people, while in others the situation is near to collapse (Armenia, Georgia). Access is most problematic in health systems characterised by high levels of payment for care and a breakdown of gate-keeping, although these are seen in countries facing major problems such as economic collapse and, in some, a legacy of civil war. There are substantial inequalities within each country and even where access remains adequate there are concerns about its sustainability.

Source: Balabanova D, McKee M, Pomerleau J, Rose R and Haerpfer C. Health service utilisation in the Former Soviet Union: evidence from eight countries. *Health Services Research* 39(6) Part II: 1927-1949, 2004.

'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective.

L Penn-Kekana, D Blaauw and H Schneider

Poor practice by health care workers has been identified as contributing to high levels of maternal mortality in South Africa. The country is undergoing substantial structural and financial reforms, yet the impact of these on health care workers performance and practice has not been studied. This study, which consisted of an ethnography of two labour wards (one rural and one urban), aimed to look at the factors that shaped everyday practice of midwives working in district hospitals in South Africa during the implementation of a public sector reform to improve financial management. The study found that the Public Financing Management Act, that aimed to improve the efficiency and accountability of public finance management, had the unintended consequence of causing the quality of maternal health services to deteriorate in the hospital wards studied. The article supports the need for increased dialogue between those working in the sexual and reproductive health and health systems policy arenas, and the importance of giving a voice to front-line health workers who implement systems changes. However, it cautions that there are no simple answers to how health systems should be organized in order to better provide sexual and reproductive health services, and suggests instead that more attention in the debate needs to be paid to the challenges of policy implementation and the socio-political context and process issues which affect the success or failure of the implementation.

Source: Penn-Kekana L, Blaauw D and Schneider H. 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy and Planning* 19(1): 171-177, 2004.

Funding: Health Systems Development Programme, DFID

Annex 2: Communication of new knowledge

Publications

1.1 Human resources

Ambegaokar M, Ongolo-Zogo P, Aly T, Betsi E, Fouda J, Mubudu L and McPake B. *Incitations et Sanctions: Resultats de recherche pour la conception de contrats de district*. MSPDROS, PASS-EU, LSHTM-HPU, Yaounde, 2005.

Ambegaokar M, Ongolo-Zogo P, Aly T, Betsi E, Fouda J and McPake B. *Travail en Equipe ou Travail Individuel: Facteurs de Motivation du Personnel de la Santé Primaire au Niveau du District*. MSP-DROS, PASS-EU, LSHTM-HPU, Yaounde, 2004.

Ambegaokar M. Managing people in the health sector: personnel motivation, team-working and contracting in public and nonprofit organisations in Cameroon. PASS-EU, LSHTM-HPU, 2003.

Chabikuli N, Blaauw D, Gilson L and Schneider H. Human resource policies: health sector reform and the management of PHC services in South Africa. In Ijumba P and Barron P (eds) *South African Health Review 2005*. Durban: Health Systems Trust, chp 8, pp 104-114, 2005.

Danichevski K. Reduction of child and maternal mortality and MDGs for health in Russia. In, *UNDP Report on Human Development in Russia*, 2005.

Dejong JL and Tell T. A review of Martha Nussbaum's "Women and Human Development". *Third World Planning Review* 23(3), 2001.

Filippi V, Brugha R, Ronsmans C, Browne E, Gohou V, Bacci A, De Brouwere V, Sahel A, Goufodji S, Alihonou A and Ronsmans C. Obstetric audit in resource poor settings: lessons from a multi-country project auditing 'near miss' obstetrical emergencies. *Health Policy and Planning* 19(1): 57-66, 2004.

Gruen R, Anwar R, Begum T, Killingsworth JR and Normand C. Dual job-holding practitioners in Bangladesh: an exploration. *Social Science and Medicine* 54(2): 267-279, 2002.

Hongoro C, Oliveira Cruz V, McPake B and Ssengooba F. *Human resource studies in health for poor and transitional countries*. HSD working paper HSD/WP/06/04, 2004.
Online copy available at: http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/06-04_human_resource_studies.pdf

Hongoro C and McPake B. Human resources in health: putting the agenda back to the front [Editorial]. *Tropical Medicine and International Health* 8(11): 965-966, 2003.

Penn-Kekana L. The case of the HIV baby with HIV Negative parents. How nurses in maternity wards deal with HIV/AIDS [in French]. In, Fassin D (ed) *Afflictions. L'Afrique du sud, de l'apartheid au sida* Paris: Karthala, chp 5, pp 139-159, 2004.

1.2 Health system structure

Al Serouri AW, Balabanova D and Al Hibshi S. *Cost sharing for primary health care: Lessons from Yemen*. Oxfam Working Papers series. Oxford: Oxfam, pp 84, 2002.

Ambegaokar M and Lush L. Family planning and sexual health organizations: management lessons for health system reform. *Health Policy and Planning* 19(Suppl 1): i22-i30, 2004.

Atkinson S, Cohn A, Fernandes L, Ducci ME and Caprara A. *Changing health systems in Latin America: promotion, protection and prevention within the decentralised system*. Final Report to the European Commission, project no. IC18 - CT98 - 0344. [pp216] University of Manchester, 2001.

Atkinson S, Fernandes L, Caprara A and Gideon J. Prevention and promotion in decentralised rural health systems: a comparative study from Northeast Brazil. *Health Policy and Planning* 20(2): 69-79, 2005.

Atkinson S and Haran D. Back to basics: does decentralisation improve health system performance? Evidence from Ceará in north east Brazil. *Bulletin of the World Health Organization* 82(11): 811-890, 2004.
Online copy available at: http://www.who.int/bulletin/volumes/82/11/en/822.pdf

Atkinson S. Political cultures, health systems and health policy. *Social Science and Medicine* 55(1): 113-124, 2002.

Balabanova DC, Falkingham J and McKee M. Winners and losers: Expansion of insurance coverage in Russia in the 1990s. *American Journal of Public Health* 93(12): 2124-2130, 2003.

Balabanova D and McKee M. Reforming health care financing in Bulgaria: the population perspective. *Social Science and Medicine* 58(4): 753-65, 2004.

Balabanova D and McKee M. Access to health care in a system transition: the case of Bulgaria. *International Journal of Health Planning and Management* 17(4): 377-395, 2002.

Balabanova D and McKee M. Understanding informal payments for health care: the example of Bulgaria. *Health Policy* 62(3): 243-273, 2002.

Blaauw D. State transformation, health sector reform and HIV/AIDS policy implementation in post-apartheid South Africa: The tensions of public sector decentralisation [in French]. In, Fassin D (ed) *Afflictions. L'Afrique du sud, de l'apartheid au sida.* Paris: Karthala, chp 4, pp 111-138, 2004.

Blaauw D, Gilson L, Penn-Kekana L and Schneider H. *Organisational relationships and the 'software' of health sector reform*. DCPP background paper. Disease Control Priorities Project, 2003.
Online copy available at: http://www.fic.nih.gov/dcpp/wps/wp23.pdf

Blaauw D and Schneider H. Improving the management of sexually transmitted diseases in the private sector in South Africa. In, Soderlund N, Mendoza-Arana P and Goudge J (eds). *The new public/private mix in health: exploring the changing landscape* Geneva: Alliance for Health Policy and Systems Research chp 5, pp 74-91, 2003, 2003.

Brugha R and Pritze-Aliassime S. Promoting safe motherhood through the private sector in low and middle income countries. *Bulletin of the World Health Organization* 81(8): 616-623, 2003.

Chabikuli N, Schneider H, Blaauw D, Brugha R and Zwi A. Quality and equity of privately provided sexually transmitted diseases care in South Africa. *Health Policy and Planning* 17(Suppl 1): 40-46, 2002.

Danishevski K and McKee M. Reforming the Russian health-care system. *The Lancet* 365(9464): 1012-1014, 2005.

Edwards N and McKee M. The future role of the hospital. *J Health Serv Res Policy* 7: 1-2, 2002.
Online copy available at:
http://dandini.catchword.com/vl=4307891/cl=16/nw=1/fm=docpdf/rpsv/catchword/rsm/13558196/v7n1/s1/p1

Few R, Harpham T and Atkinson S. Urban primary health care in Africa: a comparative analysis of city-wide public sector projects in Lusaka and Dar es Salaam. *Health and Place* 9: 45-53, 2003.

Figueras J, McKee M, Cain J and Lessof S (eds). Health systems in transition: learning from experience. Copenhagen: European Observatory on Health Care Systems, 2004.
Online copy available at: http://www.euro.who.int/document/E83108.pdf

Gaal P and McKee M. Informal payment for health care and the theory of 'INXIT'. *International Journal of Health Planning and Management* 19(2): 163-78, 2004.

Gaal P and McKee M. Fee-For-Service or Donation? Hungarian perspectives on informal payment for health care. *Social Science and Medicine* 60(7): 1445-1457, 2005.

Hanson K, Atuyambe L, Kamwanga J, McPake B, Mungule O and Ssengooba F. Towards improving hospital performance in Uganda and Zambia: reflections and opportunities for autonomy. *Health Policy* 61(1): 73-94, 2002.

Hanson K, McPake B and Archard L. Creating markets in hospital care: the adoption of developed country health sector reforms by developing countries. Is it appropriate? [Editorial]. *Tropical Medicine and International Health* 6(10):747-748, 2001.

Healy J and McKee M. Hospitals in transition in central and eastern Europe and central Asia. *Eurohealth* 7(3) Special Issue: 1, 2001.
Online copy available at: http://www.who.dk/document/OBS/Eurohealthspecialissue2001.pdf

Janson S and McKee M. The implications of terrorism for public health. *European Journal of Public Health* 12: 1-2, 2002.

Lochoro P, Bataringaya J, Tashobya CK and Kyabaggu JH. Public-private partnership in health: working together to improve health sector performance in Uganda. In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 5, pp 83-96, 2006.

Lock K, Andreev EM, Shkolnikov VM and McKee M. What targets for international development policies are appropriate for improving health in Russia? *Health Policy and Planning* 17(3): 257-263, 2002.
Maclehose L, Brand H, Camaroni I, Fulop N, Gill N, Reintjes R, Schaefer O, McKee M and Weinberg J. Communicable disease outbreaks involving more than one country: systems approach to evaluating the response. *British Medical Journal* 323: 861-863, 2001. *Online copy available at:* http://bmj.com/cgi/content/full/323/7317/861?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=10329

McKee M. *The World Health Report 2000: advancing the debate*. European Regional Consultation on the World Health Report 2000, Copenhagen, Denmark, 2001.
Online copy available at: http://www.who.int/health-systems-performance/regional_consultations/euro_mckee_background.pdf

McKee M. Measuring the efficiency of health systems: The World Health Report sets the agenda but there's still a long way to go. *British Medical Journal* 323: 295-296, 2001. *Online copy available at:* http://bmj.com/cgi/content/full/323/7308/295?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=10329

McKee M. *What are the lessons learnt by countries that have had dramatic reductions of their hospital bed capacity?*. Copenhagen: WHO Health Evidence Network, 2003.

McKee M and Healy J. The changing role of the hospital in Europe: causes and consequences. *Clinical Medicine* 1: 299-304, 2001.

McKee M, Healy J and Falkingham J. *Health care in Central Asia*. Buckingham: Open University Press. pp238, 2002. *Online copy available at:* http://www.who.dk/document/e74484.pdf

McKee M and Healy J. Réorganisation des systèmes hospitaliers: leçons triées de l'europe de l'Ouest. *Revue Médicale de l'Assurance Maladie* 33: 31-36, 2002.

McKee M and Healy J. *Hospitals in a changing Europe*. Buckingham: Open University Press. pp 288, 2002.

McKee M and McPake B. The devil is in the detail. *British Medical Journal* 329(7475):1175-6, 2004.
Online copy available at: http://bmj.bmjjournals.com/cgi/content/full/329/7475/1175

McPake B. The globalisation of health sector reform policies: is 'lesson drawing' part of the process? In, Lee K, Buse K, Fustukian S (eds). *Health Policy in a Globalising World* Cambridge University Press chp 7, pp 120-139, 2002, 2002.

McPake B and Hanson K. *What do we know about relaxing the service delivery constraints to achieving the Millennium Development goals?*. Report to the World Bank, April, 2003.

McPake B, Yepes F, Lake S and Sanchez LH. Is the Colombian health system reform improving the performance of public hospitals? *Health Policy and Planning* 18(2): 182-194, 2003.

McPake B, Yepes F J, Lake S and Sanchez L H. Cautious optimism? Hospital performance following health sector reform in Columbia. *id21 Newsletter*, 2003.
Online copy available at: http://www.id21.org/health/h1bm3g1.html

Mills A, Brugha R, Hanson K and McPake B. What can be done about the private health sector in low income countries? *Bulletin of the World Health Organization* 80(4): 325-330, 2002.
Online copy available at: http://www.who.int/bulletin/pdf/2002/bul-4-E-2002/80(4)325-330.pdf

Murindwa G, Tashobya CK, Kyabaggu JH, Rutebemberwa E and Nabyonga J. Meeting the challenges of decentralised health service delivery in Uganda as a component of broader health sector reforms. In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 6, pp 97-108, 2006.

Nakamba P, Hanson K and McPake B. Competing for business? Improving hospital services in Zambia with market forces. *id21 Newsletter*, 2003. *Online copy available at:* http://www.id21.org/health/h1pn1g1.html

Nakamba P, Hongoro C, McPake B, Hanson K, Chirwa BU and Sund BB. Zambia - case study. In: Eriksson P, Diwan V and Karlberg I (eds). *Health sector reforms: What about hospitals?* Goteborg: The Nordic School of Public Health chp 5.1, pp 41-63, 2002.

Nandraj S, Khot A, Menon S and Brugha R. A stakeholder approach towards hospital accreditation in India. *Health Policy and Planning* 16(Suppl 2): 70-79, 2001.

Nazerali H, Oteba MO, Mwonga J and Zaramba S. Medicines – driving demand for health services in Uganda? In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 4, pp 61-82, 2006.

Oliveira Cruz V, Cooper R, McPake B, Yates R, Ssengooba F, Omaswa F, Tashobya CK and Murindwa G. Is the sector-wide approach (SWAp) improving health sector performance in Uganda? In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 2, pp 29-44, 2006.

Preker AS, McKee M, Mitchell A and Wilbulpolprasert S. Strategic management of clinical services. In, Alleyne G, Breman J, Claeson M, Evans D, Jamison D, Jha P, Measham A, Mills A and Musgrove P (eds) *Disease control priorities in developing countries*, second edition. World Bank and OUP, chp 73, pp 1339-1352, 2006.

Rechel B, Schwalbe N and McKee M. Health in South Eastern Europe: a troubled past, an uncertain future. *Bulletin of the World Health Organisation* 82(7): 539-46, 2004.
Online copy available at: http://www.who.int/bulletin/volumes/82/7/en/539.pdf

Rese A, Balabanova D, Danichevski K, McKee M and Sheaff R. Implementing general practice in Russia: getting beyond the first steps. *British Medical Journal* 331: 204-207, 2005.

Schneider H, Chabikuli N, Blaauw D, Funani I and Brugha R. Improving the quality of STI care by private general practitioners: A South African case study. *Sexually Transmitted Infections*. 81(5): 419-420, 2005

Schneider H, Chabikuli N, Blaauw D, Funani I, Brugha R. Factors Associated with quality of care for sexually transmitted infections amongst private general practitioners in Gauteng Province. S Afr Med J, 95(10): 782-785, 2005

Sheaff R. Governance in gridlock in the Russian health system; the case of Sverdlovsk oblast. *Social Science and Medicine* 60(10): 2359-2369, 2005.

Ssengooba F, Atuyambe L, McPake B, Hanson K and Okuonzi S. What could be achieved with greater public hospital autonomy? Comparisons of Public and PNFP hospitals in Uganda. *Public Administration and Development* 22: 415-428, 2002. *Online copy available at:* http://www3.interscience.wiley.com/cgi-bin/fulltext?ID=101521744&PLACEBO=IE.pdf

Ssengooba F, McPake B, Hongoro C, Hanson K and Okuonzi S. Uganda - case study. In: Eriksson P, Diwan V and Karlberg I (eds). *Health sector reforms: What about hospitals?* Goteborg: The Nordic School of Public Health, chp 5.2, pp 64-82, 2002.

Ssengooba F, Oliveira Cruz V and Pariyo G. *Capacity of ministries of health and opportunities to scale up health interventions in low income countries: a case study of Uganda*. Paper commissioned by the United Nations Millennium Development Project, April, 2004.

Ssengooba F, Yates R, Oliveira Cruz V and Tashobya CK. Have systems reforms resulted in a more efficient and equitable allocation of resources in the Ugandan health sector? In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 7, pp 109-119, 2006.

Tashobya CK, McPake B, Nabyonga J and Yates R. Health sector reforms and increasing access to health services by the poor: what role has the abolition of user fees played in Uganda? In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 3, pp 45-60, 2006.

Thompson CR and McKee M. Financing and planning of public hospitals in the European Union. *Health Policy* 67(3): 281-291, 2004.

Walt G, Brugha R and Haines A. Working with the private sector: the need for institutional guidelines. *British Medical Journal* 325: 432- 435, 2002. *Online copy available at:* http://bmj.com/cgi/content/full/325/7361/432?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=10322

Yates R, Tashobya CK, Oliveira Cruz V, McPake B, Ssengooba F, Murindwa G, Lochoro P, Bataringaya J, Nazerali H and Omaswa F. The Ugandan health systems reforms: miracle or mirage? In Tashobya CK, Ssengooba F and Oliveira-Cruz V (eds) *Health systems reforms in Uganda: processes and outputs*. London: Health Systems Development Programme, LSHTM, chp 1, pp 15-28, 2006.

Zwi A, Brugha R and Smith E. Private health care in developing countries. *British Medical Journal* 323: 463-464, 2001. *Online copy available at:* http://bmj.com/cgi/reprint/323/7311/463.pdf

1.3 Processes: policy

Atkinson S, Cohn A and Ducci ME. Implementation of promotion and prevention activities in decentralised health systems: case studies from Chile and Brazil. *Health Promotion International* 20(2): 167-175, 2005.

Balabanova D and McKee M. How would you like to pay? Health care financing reforms and popular values in Bulgaria. *id21 Newsletter*, 2004. *Online copy available at:* http://www.id21.org/health/h1db1g2.html

Balabanova D and McKee M. The cost of free healthcare: under-the-counter payments in Bulgaria. *id21 Newsletter*, 2001. *Online copy available at:* http://www.id21.org/health/h1mm1g2.html

Balabanova D and McKee M. Coping, just - access to care in the new Bulgarian health system. *id21 Newsletter*, 2003. *Online copy available at:* http://www.id21.org/health/h1db1g1.html

Blaauw D and Gilson L. *Health and poverty reduction policies in South Africa*. Report submitted to WHO, 2001. *Online copy available at:* http://www.hsd.lshtm.ac.uk/Downloads/who_report.pdf

Danichevski K and McKee M. Campaigners fear that Russia's new tobacco law won't work. *British Medical Journal* 342: 382, 2002. *Online copy available at:* http://bmj.com/cgi/content/full/324/7334/382/a?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=103

Delcheva E and Balabanova D. Hospital sector reform in Bulgaria: first steps. *Eurohealth* 7(3) Special Issue: 42-46, 2001. *Online copy available at:* http://www.who.dk/document/OBS/Eurohealthspecialissue2001.pdf

Hongoro C and McPake B. Trace amounts? Assessing hospital costs in Zimbabwe. *id21 Newsletter*, 2003. *Online copy available at:* http://www.id21.org/health/h1ch2g1.html

Hongoro C and Normand C. Health care providers: The role of compensation and incentives in disease control priorities in developing countries. In, Alleyne G, Breman J, Claeson M, Evans D, Jamison D, Jha P, Measham A, Mills A and Musgrove P (eds) *Disease control priorities in developing countries*, second edition. World Bank and OUP, chp 71, pp 1309-1322, 2006.

Hutchings A, Allen P, Fulop N, King A, Protopsaltis G, Normand C and Walters R. The process and impact of trust mergers in the National Health Service: a financial perspective. *Public Money & Management* 23(2): 103-112, 2003.

Lush L. Service integration: an overview of policy developments. *International Family Planning Perspectives* 28(2): 71-76, 2002.

Lush L, Walt G and Ogden J. Global guidelines and the rise and fall of syndromic management for STIs. *id21 Newsletter*, 2004. *Online copy available at:* http://www.id21.org/health/h6ll1g1.html

McKee M. Health and the challenges of enlargement. *European Public Health Update* 59: 2-6, 2001.

McKee M. What can health services contribute to the reduction of inequalities in health? *Scandinavian Journal of Public Health* 30(3) Suppl 59: 54-58, 2002. *Online copy available at:* http://ramiro.catchword.com/vl=10464934/cl=14/nw=1/fm=docpdf/rpsv/catchword/tandf/14034948/v30n3x59/

Normand C. Making the trade-off between efficiency and equity. In Kernick D (ed) *Getting health economics into practice* Abingdon: Radcliffe Medical Press, chp 22, pp 237-246, 2002.
Online copy available at: http://www.radcliffe-oxford.com/books/bookdetail.asp?ISBN=1+85775+575+8

Ogden J, Walt G and Lush L. Pass or fail - ensuring successful transfer of health policy between countries. *id21 Newsletter*, 2004. *Online copy available at:* http://www.id21.org/health/h4jo1g1.html

Wadee H, Gilson L, Blaauw D, Khumalo G and Mills A. *Public-private interactions in the South African health sector: Experiences and perspectives from national, provincial and local levels*. Centre for Health Policy, Johannesburg, 2003.

Wadee H, Gilson L, Blaauw D, Erasmus E, Thiede M, Okorafor O and McIntyre D. *Health care inequality in South Africa: Public/private interactions and policy responses*. Paper prepared for conference: Commercialisation of Healthcare: Global and Local Dynamics and Policy Responses, United Nations Research Institute for Social Development, Geneva, March, 2003.

1.4 Processes: operation

Balabanova D, McKee M, Pomerleau J, Rose R and Haerpfer C. Health service utilisation in the Former Soviet Union: evidence from eight countries. *Health Services Research* 39(6) Part II: 1927-1949, 2004. *Online copy available at:* http://www.hsd.lshtm.ac.uk/publications/journals/cross-country_comparisons.pdf

Blaauw D, Gilson L, Modiba P, Erasmus E, Khumalo G and Schneider H. Governmental relations and HIV service delivery. In, *Decentralising health services in South Africa: Constraints and opportunities.* Durban: Health Systems Trust chp 3, 2004.
Online copy available at: http://www.hst.org.za/uploads/files/govservicedel.pdf

Chabikuli N, Schneider H and Brugha R. *Syndromic case management of STI in the private for profit sector. A guide for conducting reflective seminars with general practitioners*. Centre for Health Policy, South Africa, 2004.

Dejong JL. Population and development: from population control to reproductive health. In: Kirkpatrick C, Clarke R and Polidano C (eds). *Handbook of Development Policy and Management.* Edward Elgar, chp 22, pp, 2002.

Enarson D, Olarte RL, Kibuga D, Cirillo D and Oliveira Cruz V. *External review of the National Tuberculosis and Leprosy Programme, Republic of Mozambique*. Report submitted to the World Health Organization, 2006.

Grosskurth H, Brugha R, Foster S and Laing R. Managing a health service. In, Parry E and Mabey D (eds) *Health and Disease in Modern Africa.* Cambridge: Cambridge University Press, chp 5, pp 87-110, 2004.

Hanson K, Ranson K, Oliveira-Cruz V and Mills A. Expanding access to priority health interventions: a framework for understanding the constraints to scaling-up. *Journal of International Development*, special issue 15(1): 1-14, 2003.
Online copy available at: http://www3.interscience.wiley.com/cgi-bin/fulltext/102522935/PDFSTART

Hanson K, Ranson K, Oliveira Cruz V and Mills A. *Constraints to scaling up health interventions: a conceptual framework and empirical analysis*. CMH Working Group paper 13, 2001.
Online copy available at: http://www3.who.int/whosis/cmh/cmh_papers/e/pdf/wg5_paper13.pdf

Hanson K, Ranson K, Oliveira Cruz V and Mills A. Obstacle course – constraints to scaling up health interventions for the poor. Id21 newsletter, 2003. *Online copy available at*: http://www.id21.org/health/h1kh1g2.html

Healy J and McKee M. Reforming hospital systems in turbulent times. *Eurohealth* 7(3) Special Issue: 2-7, 2001.
Online copy available at: http://www.who.dk/document/OBS/Eurohealthspecialissue2001.pdf

Healy J and McKee M. Implementing hospital reform in central and eastern Europe. *Health Policy* 61(1): 1-19, 2002.

McKee M and Healy J. Health promoting hospitals: meeting the needs of the people. *Journal of Health Gain* 5(2): 3-7, 2001.

McKee M and Janson S. The challenge of stewardship. *European Journal of Public Health* 11(2): 122-123, 2001.
Online copy available at: http://www3.oup.co.uk/eurpub/hdb/Volume_11/Issue_02/pdf/110122.pdf

McPake B, Nakamba P, Hanson K and McLoughlin B. *Private wards in public hospitals: two tier charging and the allocation of resources in tertiary hospitals in Zambia*. HEFP working paper 05/04, LSHTM, 2004. *Online copy available at:* http://www.hefp.lshtm.ac.uk/publications/downloads/working_papers/05_04.pdf

Nolte E and McKee M. Does healthcare save lives? Avoidable mortality revisited. London: Nuffield Trust, pp139, 2004.

Oliff M, Mayaud P, Brugha R and Semakafu AM. Integrating reproductive health services in a reforming health sector: the case of Tanzania. *Reproductive Health Matters* 11(21): 37-48, 2003.

Oliveira-Cruz V, Hanson K and Mills A. Approaches to overcoming constraints to effective health service delivery: a review of the evidence. *Journal for International Development*, special issue 15(1): 41-66, 2003.
Online copy available at: http://www3.interscience.wiley.com/cgi-bin/fulltext/102522937/PDFSTART

Oliveira Cruz V, Hanson K and Mills A. *Approaches to overcoming health systems constraints at the peripheral level: a review of the evidence*. CMH Working Group 5, paper 14, 2001.
Online copy available at: http://www3.who.int/whosis/cmh/cmh_papers/e/pdf/wg5_paper14.pdf

Oliveira-Cruz V, Kurowski C and Mills A. Delivery of priority health services: searching for synergies within the vertical versus horizontal debate. *Journal for International Development*, special issue 15(1): 67-86, 2003.
Online copy available at: http://www3.interscience.wiley.com/cgi-bin/fulltext/102522934/PDFSTART

Ranson K, Hanson K, Oliveira-Cruz V and Mills A. Constraints to expanding access to health interventions: an empirical analysis and country typology. *Journal for International Development*, special issue 15(1): 15-39, 2003. *Online copy available at:* http://www3.interscience.wiley.com/cgi-bin/fulltext/102522933/PDFSTART

Rechel B and McKee M. *Learning lessons from the experience of the Task Force on Communicable Disease Control in the Baltic Sea Region. Programme evaluation*. European Centre on Health of Societies in Transition, London School of Hygiene & Tropical Medicine, pp72, 2004.

Suwandono A, Gani A, Purwani S, Blas E and Brugha R. Cost recovery beds in public hospitals in Indonesia. *Health Policy and Planning* 16(Suppl 2): 10-18, 2001.
Wadee H, Gilson L, Blaauw D, Khumalo G and Mills A. Public-private interactions in the South African health sector. In, *Decentralising health services in South Africa: Constraints and opportunities.* Durban: Health Systems Trust, chp 6, 2004. *Online copy available at:* http://www.hst.org.za/uploads/files/lghcc_report.pdf

1.5 Global and regional initiatives

Brugha R, Donoghue M, Starling M, Ssengooba F, Fernandes G and Walt G. The Global Fund: managing great expectations. *The Lancet* 364(9428): 95-100, 2004.

Brugha R, Starling M, Donoghue M, Walt G, Cliff J, Fernandes B, Nhatave I, Ssengooba F, Konde-Lule J, Ndubani P and Mwale S. Tracking the Global Fund in four countries: an interim report. Report submitted to country CCMs, study funders and the Global Fund Secretariat, 2003.

Brugha R, Starling M and Walt G. GAVI, the first steps: lessons for the Global Fund. *The Lancet* 359(9304): 435-438, 2002.

Brugha R and Walt G. Education and debate. A Global health fund: a leap of faith. *British Medical Journal* 323: 152-154, 2001. *Online copy available at:* http://bmj.com/cgi/content/full/323/7305/152?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&searchid=10331

Brugha R and Zwi A. Global solutions to local health problems: where is the evidence? In Lee K, Buse K and Fustukian S (eds) *Health Policy in a Globalising World*. Cambridge University Press, chp 4, pp 63-77, 2002.

Coker RJ, Atun RA and McKee M. Health care system frailties and public health control of communicable disease on the European Union's new eastern border. *The Lancet* 363(9418): 1389-1392, 2004.

Dejong JL. *The challenge of increasing the scale of Non-Governmental Organisations' HIV/AIDS programmes in developing countries*. Peer-reviewed publication for HORIZONS and the International HIV/AIDS Alliance, September, 2001.

Dejong JL, Kothari U and Minogue M. The political economy of globalisation. In: Kothari U and Minogue M (eds) *Development theory and practice.* Basingstoke: Palgrave Publishers. pp240, 2001.

Jha P, Mills A, Hanson K, Kumaranayake L, Conteh L, Kurowski C, Nguyen SN, Oliveira-Cruz V, Ranson K, Vaz LME, Shengchao Yu, Morton O and Sachs JD. Improving the health of the global poor. *Science* 295: 2036-2039, 2002.

Lush L. *Impact of public-private partnerships addressing access to pharmaceuticals in low income countries: Uganda pilot study*. Geneva, Report prepared for the Initiative on Public-Private Partnerships for Health and the UK Department for International Development, 2003.

Lush L, Walt G and Ogden J. Transferring policies for treating sexually transmitted infections: what's wrong with global guidelines? *Health Policy and Planning* 18(1): 18-30, 2003.

Mayhew S, Walt G, Lush L and Cleland J. Donor involvement in reproductive health: saying one thing and doing another? *International Journal of Health Services* 35(3): 579-601, 2005.

McKee M, Garner P and Stott R. *International Co-operation and Health*. Oxford: Oxford University Press. pp 228, 2001. *Online copy available at:* http://www.oup.co.uk/pdf/0-19-263198-5.pdf

Rechel B and McKee M. *Healing the crisis. A prescription for public health action in South-Eastern Europe*. New York: Open Society Institute, pp36, 2003.
Online copy available at: http://www.lshtm.ac.uk/ecohost/see/Inf%20review.pdf

Ssengooba F. Uganda's minimum health package for health care: rationing within the minimum? *Health Policy and Development Journal* 2(1), 2003.

Starling M, Brugha R, Walt G, Heaton A and Keith R. *New products into old Systems. The initial impact of the Global Alliance for Vaccines and Immunization (GAVI) at country level*. Save the Children Fund briefing report, 2002. *Online copy available at:* http://www.savethechildren.org.uk/scuk_cache/scuk/cache/cmsattach/627_gavireport.pdf

Walt G and Lush L. Getting drugs to the ground: global public private partnerships for neglected diseases. *Biotechnology and Development Monitor* 46: 9-12, 2001.

Walt G, Lush L and Ogden J. International organisations in transfer of infectious diseases policy: iterative loops of adoption, adaptation and marketing. *Governance* 17(2): 189-210, 2004.

1.6 Use

Balabanova DC and McKee M. Self-reported health in Bulgaria: levels and determinants. *Scandinavian Journal of Public Health* 30(4): 306-312, 2002.

Borghi J, Hanson K, Acquah CA, Ekanmien G, Filippi V, Ronsmans C, Brugha R, Browne ENL and Alihonou E. Costs of near-miss obstetric complications for women and their families in Benin and Ghana. *Health Policy and Planning* 18(4): 383-390, 2003.

Danichevski K. Variation in medical practices in Tula oblast (in Russian). *Head Physician* Central Public Health Research Institute, Moscow, pp 23-29, 2003.

Hanson K, McPake B, Nakamba P and Archard L. Preferences for hospital quality in Zambia: results from a discrete choice experiment. *Health Economics* 14(7): 687-701, 2005.

MacKian S. *A review of health seeking behaviour: problems and prospects*. UOM/HSD Working paper HSD/WP/05/03, 2003.
Online copy available at: http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/05-03_health_seeking_behaviour.pdf

MacKian S, Bedri N and Lovel H. Up the garden path, and over the edge: where might health-seeking behaviour take us? *Health Policy and Planning* 19(3): 137-146, 2004.

McKee M, Balabanova D, Akingbade K, Pomerleau J, Stickley A, Rose R and Haerpfer C. Access to water in the countries of the former Soviet Union. *Public Health* 120: 364-372, 2006.

Nakamba P, Hanson K and McPake B. Markets for hospital services in Zambia. *International Journal of Health Planning and Management* 17(3): 229-47, 2002.

Shkolnikov VM, McKee M, Chervyakov VV and Kyrianov NA. Is the link between alcohol and cardiovascular death among young Russian men attributable to misclassification of acute alcohol intoxication? Evidence from the city of Izhevsk. *J Epidemiol Community Health* 56: 171-174, 2002.

1.7 Civil society

Atkinson S and Haran D. Individual and district scale determinants of users' satisfaction with primary health care in developing countries. *Social Science and Medicine* 60(3): 501-513, 2005.

Chervyakov VV, Shkolnikov VM, Pridemore WA and McKee M. The changing nature of murder in Russia. *Social Science and Medicine* 55(10): 1713-1724, 2002.

Gilmore A and Balabanova D. Russia: the lobbyist's art is alive and well. *Tobacco Control* 11(4): 293, 2002.

1.8 Methodology

Andreev EM, McKee M and Shkolnikov VM. Health expectancy in the Russian Federation: a new perspective on the health divide in Europe. *Bulletin of the World Health Organization* 81(11): 778-788, 2003. *Online copy available at:* http://www.who.int/bulletin/volumes/81/11/en/Andreevarabic1103.pdf

Andreev EM, Nolte E, Shkolnikov VM, Varavikova E and McKee M. The evolving pattern of avoidable mortality in Russia. *International Journal of Epidemiology* 32: 437-446, 2003.

Bamford L and Chopra M. *Developing a strategy for monitoring IMCI implementation in South Africa*. Report submitted to UNICEF October, 2001.

Danichevski K and Bobrik A. The future health trends in Russia: what can we expect? [in Russian]. *Issues of Public Health and Health Management* 3: 1-5, 2003.

Dolea C, Nolte E and McKee M. Changing life expectancy in Romania after the transition. *Journal of Epidemiology and Community Health* 56(6): 444-449, 2002.

Eroshina K, Danishevski K, Wilkinson P and McKee M. Environmental and social factors as determinants of respiratory dysfunction in junior schoolchildren in Moscow. *Journal of Public Health* 26(2): 197-204, 2004.

Grieve R, Nixon R, Thompson S and Normand C. Using multilevel models for assessing the variability of multinational resource use and cost data. *Health Economics* 14(2): 185-196, 2005.

Logminiene Z, Nolte E, McKee M, Valius L and Gaizauskiene A. Avoidable mortality in Lithuania: 1991-1999 compared with 1970-1990. *Public Health* 118(3): 201-210, 2004.

McPake B. *Methodological issues in comparing international drug prices*. Drug Pricing Project Advisory Board, 2001.

McPake B, Kumaranayake L and Normand C. *Health Economics: an international perspective*. Routledge. 280pp, 2002.

Nolte E, Scholz R and McKee M. Progress in health care, progress in health? Patterns of amenable mortality in central and eastern Europe before and after political transition. *Demographic Research* Special Collection 2-6: 139-162, 2004.

Normand C, Meyer J and Bentley J. Research ethics and complex studies. *NT Research* 8(1): 17-26, 2003.

Rechel B, Laidon S and McKee M. Are the health Millennium Development Goals appropriate for Eastern Europe and Central Asia? *Health Policy* 73(3): 339-351, 2005.

Shkolnikov VM, McKee M and Leon DA. Changes in life expectancy in Russia in the 1990s. *Lancet* 357: 917-921, 2001.

Stevens W and Normand C. Optimisation versus Certainty: Understanding the issue of heterogeneity in economic evaluation. *Social Science and Medicine* 58(2): 315-320, 2004.

1.9 Probes

Barnett T and Parkhurst JO. HIV/AIDS: Sex, abstinence and behaviour change. *Lancet Infectious Disease* 5(9): 590-593, 2005.

Bobrik A, Danishevski K, Eroshina K and McKee M. Prison health in Russia: the larger picture. *Journal of Public Health Policy* 26(1):30-59, 2005.

Brugha R. Antiretroviral treatment in developing countries: the peril of neglecting private providers. *British Medical Journal* 326: 1382-1384, 2003.

Danichevski K. Preliminary assessment of determinants of birth outcomes in Tula oblast [in Russian]. *Journal of Health Economics* I M Sechenov Moscow Medical Academy (MMA) 12: 31-37, 2003.

Danichevski K, Balabanova D, Parkhurst J and McKee M. *What do we know about the state of maternal health in Russia? Report on the situation analysis*. MMA/HSD working paper HSD/WP/03/03, 2003.
Online copy available at: http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/03-03_russia.pdf

Danishevski K, Balabanova D, McKee M, Nolte E, Schwalbe N and Vasilieva N. Inequalities in birth outcomes in Russia: evidence from Tula oblast. *Paediatric & Perinatal Epidemiology* 19(5): 352-359, 2005.

Danichevski K, Kobrinski B and Kucherenko V. Pregnancy and birth outcomes and social factors in Tula oblast (Moscow) [in Russian]. *Issues of Public Health and Health Management* 4: 23-27, 2003.

Dejong JL. *Making impact on HIV and AIDS: NGO experiences of scaling up*. Intermediate Technology Development Group. pp 160, 2003.

Hongoro C and McPake B. Hospital costs of high burden diseases: malaria and pulmonary tuberculosis in a high HIV prevalence context. *Tropical Medicine and International Health* 8(3): 1-9, 2003.

Hongoro C, McPake B and Vickerman P. Measuring the quality of hospital tuberculosis services: A prospective study in four Zimbabwe hospitals. *International Journal for Quality in Health Care* 17(4): 287-292, 2005.

Hopkinson B, Balabanova D, McKee M and Kutzin J. The human perspective on health care reform: coping with diabetes in Kyrgyzstan [shortened reprint]. *Diabetes Voice* 49(3): 10-13, 2004.
Online copy available at: http://www.diabetesvoice.org/issues/2004-09/The_human_perspective_on_health-care_reform_coping_with_diabetes_in_Kyrgyzstan.pdf

Hopkinson B, Balabanova D, McKee M and Kutzin J. The human perspective on health care reform: coping with diabetes in Kyrgyzstan. *International Journal of Health Planning and Management* 19: 43-61, 2004.

Horwood C, Liebeschuetz S, Blaauw D, Cassol S and Qazi S. Diagnosis of paediatric HIV infection in a primary health care setting with a clinical algorithm. *Bulletin of the World Health Organisation* 81(12): 858-866, 2003

Lush L. International effort for anti-retrovirals: a storm in a teacup? *Tropical Medicine and International Health* 6(7): 491-495, 2001.

Lush L. International effort for anti-retrovirals: politics or public health? In: Granville B (ed) *Proceedings of conference on the Economics of Essential Medicines*. London: Royal Institute of International Affairs, 2002.

McPake B. Saving the lives of vulnerable children. *Lancet* 365(9478):2154-6, 2005.

Ogden J, Walt G and Lush L. The politics of 'branding' in policy transfer: the case of DOTS for tuberculosis control. *Social Science and Medicine* 57(1): 179-188, 2003.

Oliff M and Brugha R. *Report on country policies, regulations and policy arena governing collaboration between the traditional and public health sectors relevant to HIV/AIDS/STI control in Uganda and Zambia*. Report to EC, INCO International Scientific Cooperation Projects, 2003.

Oliveira-Cruz V, Kowalski J and McPake B. The Brazilian HIV/AIDS 'success story' - can others do it? *Tropical Medicine and International Health* 9(2): 292-297, 2004.

Parkhurst J. The Ugandan success story? Evidence and claims of HIV prevention. *The Lancet* 360: 78-80, 2002.

Parkhurst J. National responses to HIV/AIDS: the importance of understanding context. [Editorial] *Journal of Health Services and Research Policy* 8(3): 131-133, 2003.

Parkhurst J. The response to HIV/AIDS and the construction of national legitimacy: lessons from Uganda. *Development and Change* 36(3): 571-590, 2005.

Parkhurst J, Balabanova D and Danichevski K. International maternal health indicators and middle-income countries: Russia. *British Medical Journal* 331(7515): 510-513, 2005.

Parkhurst J and Lush L. The political environment of HIV: lessons from a comparison of Uganda and South Africa. *Social Science and Medicine* 59(9): 1913-1924, 2004.

Parkhurst JO, Penn-Kekana L, Blaauw D, Balabanova D, Danichevski K, Rahman SA, Onama V and Ssengooba F. Health systems factors influencing maternal health services: a four-country comparison. *Health Policy* 73(2): 127-138, 2005.

Parkhurst JO and Rahman SA. *Access to and utilisation of professional child delivery services in Uganda and Bangladesh - Bangladesh Country Report*. HSD working paper HSD/WP/07/05, 2005.
Online copy available at: http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/07-05_access_study_report_bangladesh.pdf

Parkhurst JO and Ssengooba F. *Access to and utilisation of professional child delivery services in Uganda and Bangladesh: Uganda Country Report*. HSD working paper HSD/WP/08/05, 2005.
Online copy available at: http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/08-05_access_study_report - uganda.pdf

Penn-Kekana L and Blaauw D. *A rapid appraisal of maternal health services in South Africa: A Health Systems Approach*. CHP/HSD Working paper HSD/WP/01/02, also published as Briefing document 37, Centre for Health Policy, Johannesburg, 2002. *Online copy available at:*
http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/01-02_south_africa.pdf

Penn-Kekana L, Blaauw D and Schneider H. 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy and Planning* 19(1): 171-177, 2004.

Penn-Kekana L, Blaauw D, Tint KS, Monareng D and Chege J. *Nursing staff dynamics and implications for maternal health provision in public health facilities in the context of HIV/AIDS*. FRONTIERS final report, Johannesburg, 2005

Rahman SA, Parkhurst JO and Normand C. *Maternal health review, Bangladesh*. PRU/HSD Working paper HSD/WP/02/03, 2003. *Online copy available at:*
http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/02-03_bangladesh.pdf

Schneider H, Blaauw D, Gilson L, Chabikuli N and Goudge J. *Health systems strengthening and ART scaling up: Challenges and opportunities*. Monograph prepared for the Global Policy Research Network, 2004

Schneider H, Gilson L and Blaauw D. Systems and software: principles and implementation strategies for the scaling up of anti-retroviral therapy. *Aids Analysis Africa* 14(4): 1-2, 2004.

Schneider H, Ogden J and Lush L. *Policy transfer in South Africa: DOTS for the treatment of tuberculosis [&] Syndromic management of sexually transmitted infections*. Working paper of Johannesburg, Centre for Health Policy, University of Witwatersrand and London, Health Policy Unit, London School of Hygiene and Tropical Medicine, 2003.

Shapo L, Coker R and McKee M. Tracking diabetes in Albania: a natural experiment on the impact of modernisation on health. *Diabetic Medicine* 19(2): 87-88, 2002.

Smit J, Beksinska M, Ramikissoon A, Kunene B and Penn-Kekana L. Reproductive Health. In, *South African Health Review 2003/4.* Durban: Health Systems Trust, chp 5, 2004.
Online copy available at: http://www.hst.org.za/uploads/files/chap5_03.pdf

Ssengooba F, Neema S, Mbonye A, Sentubwe O and Onama V. *Maternal health review, Uganda*. IPH/HSD Working paper HSD/WP/04/03, 2003. *Online copy available at:* http://www.hsd.lshtm.ac.uk/publications/hsd_working_papers/04-03_uganda.pdf

Telishevka M, Chenett L and McKee M. Towards an understanding of the high death rate among young people with diabetes in Ukraine. *Diabetic Medicine* 18: 3-9, 2001.

In press

1.1 Human resources

Danichevski K. Human resources in Russia. In, McKee M and Dubois C-A (eds) *Human resources in Europe*. Open University Press, in press.

Rapid transition to market economy and years of reform influencing most sectors, and even introduction of health insurance left Semashko system almost unchanged. There is an excess of hospital facilities and other resources, including physicians, compared to western countries. Given relatively low health care funding it leads to informal charges and high turn-over where alternative sources of income are unavailable. However this issue is not peculiar to medical sector but characterises all state sectors including education, military and social. Primary health care and nursing jobs are understaffed and unattractive for young graduates. Lack of public health education and domination of clinicians in health management as well as loss of implementation tool and unclear division of responsibilities between authorities leaves little hope for quick and effective reform. Signing of Bologna declaration, initiatives to introduce general practice and public health profession, recent attention to health and demographic issues at the highest level of policy making leaves some hope for change some day.

1.2 Health system structure

Atkinson S. Approaches to studying decentralisation. In, Saltman R, Bankauskaite V and Vrangbaek K (eds) *Decentralization in health care: strategies and outcomes* European Observatory on Health Care Systems. OUP: Milton Keynes, chp 1, in press.

Danichevski K, Balabanova D, McKee M and Atkinson S. The fragmentary federation: experiences with the decentralised health system in Russia. *Health Policy and Planning*, in press.

The Russian Federation has undergone a process of major constitutional change in the post-communist period, as a strong central government has ceded extensive powers to the regions. This has important implications for the organisation of the health care system which, as with other elements of the Soviet system, had previously been highly centralised. Although it is now well-recognised that the powers of the Federal Health Ministry have been weakened considerably, the precise scale and nature of the process of decentralisation remains imperfectly understood. This paper for the first time, provides evidence on the decentralisation trends since the breakdown of the USSR, reporting the results of case studies undertaken in six regions of Russia (Samara, Tver, Tula, Chelyabinsk, Sverdlovsk and Moscow oblasts) to describe the organisation of health care financing, regulation and delivery. It shows that while there is a common model of health system (with the exception of Samara, where an innovative model has been achieved), there are many minor variations. The study confirms the limited scope for action by Federal authorities, but also shows that the power vested in the regional governments is more limited than was previously thought. Instead, the municipalities (rayons) emerge as important bodies, as they own the facilities in which much of the routine health care is delivered and, both directly and indirectly, by virtue of their contributions of insurance premiums for the non-working, provide a substantial amount of health care financing. The study demonstrates the complexity of the Russian health care system and identifies the widespread absence of mechanisms that might be used to bring about much needed change.

Gaal P, Evetovits T and McKee M. Informal payments for health care: evidence from Hungary. *Health Policy*, in press.

While there is a growing body of evidence that informal payments for health care are widespread and enduring in the former communist countries of Central and Eastern Europe and Central Asia, evidence on the scale of the phenomenon is not only limited, but what is available is often conflicting. Hungary exemplifies this controversy, as the available literature provides conflicting figures, differing by an order of magnitude among various surveys, with a similarly large difference between survey findings and expert estimates. This study advances understanding of the methodological issues involved in researching informal payments by providing a systematic analysis of the methodology of available empirical research and official statistics on the scale of informal payments in Hungary. The paper explores the potential sources of differences, to assess the scope to reduce the differences between various estimates and to define the upper and lower boundaries within which the true magnitude of informal payments can be expected to lie. Our analysis suggests that in 2001 the overall magnitude of informal payments lay between 16.2 and 50.9 billion HUF (€ 64.8–€ 203.6 million, US$ 77.1–242.4 million), which amounted to 1.5–4.6% of total health expenditures in Hungary. Looked at this way, informal payments do not seem to be an important source of health care financing. However, as informal payments are unequally distributed among health workers, with the bulk of the money going to physicians, with some not taking any informal payments, family doctors and some specialists may have earned between 60 and 236% of their net official income from this source in 2001. This suggests that it is not the overall amount of informal payment that makes it a policy concern, but the consequences of its unequal distribution among health workers. What is remarkable about informal payments in Hungary is that a relatively small amount of money can keep the system running, which gives rise to the hypothesis that, in certain cases, it is the hope of substantial informal payments in the future that motivates physicians to remain in the system. This is a difficult challenge for policy-makers as it would require a much larger amount of money to achieve equilibrium under any formal alternative.

Parkhurst J and Rahman SA. Life saving or money wasting? Bangladeshi women's perception of caesarean sections. *Health Policy*, in press.

Bangladesh has a high level of maternal mortality, corresponding to one of the world's lowest rates of use of skilled birth attendance (12.1%), and a similarly low rate of caesarean births (2.4%). While increasing the proportion of women who deliver with professional medical care is essential to prevent maternal deaths, past work has identified distrust of caesarean procedures in Bangladesh. The reasons behind this distrust can manifest itself in health seeking behaviour around maternal care. This paper presents findings from a qualitative study of 30 women in a rural district of Bangladesh who recently delivered in a health facility. It finds that the distrust in doctor's recommendations for surgery stemmed from high costs incurred and a

belief that it was used when not medically justified. This could lead to women avoiding or leaving medical facilities in extreme cases. Some women's experiences further illustrated disagreement among medical staff as to whether or not a caesarean procedure should be done, with conflicting financial incentives for doctors to perform caesarean deliveries, and for nurses and midwives to conduct normal deliveries. Policy makers must recognise that the fears women hold of caesarean deliveries may not simply be rooted in ignorance and may, in fact, reflect legitimate concerns with medical practice. Ultimately, it will be essential to address problems in the health systems environment which may promote improper service provision.

1.3 Processes: policy

Lush L. Why do the poor not have access to essential medicines? In, Attaran A and B Granville (eds) *Delivering Essential Medicines: the Way Forward.* London: Royal Institute of International Affairs, in press.

Pond B and McPake B. The health migration crisis: the role of four Organisation for Economic Cooperation and Development countries. *The Lancet*, in press.

The crisis of human resources for health that is affecting low-income countries and especially sub-Saharan Africa has been attributed, at least in part, to increasing rates of migration of qualified health staff to high-income countries. We describe the conditions in four Organisation for Economic Cooperation and Development (OECD) health labour markets that have led to increasing rates of immigration. Popular explanations of these trends include ageing populations, growing incomes, and feminisation of the health workforce. Although these explanations form part of the larger picture, analysis of the forces operating in the four countries suggests that specific policy measures largely unrelated to these factors have driven growing demand for health staff. On this basis we argue that specific policy measures are equally capable of reversing these trends and avoiding the exploitation of low-income countries' scarce resources. These policies should seek to ensure local stability in health labour markets so that shortages of staff are not solved via the international brain drain.

1.4 Processes: operation

Danichevski K. Implementing decentralisation in Russia. In, Saltman R, Bankauskaite V and Vrangbaek K (eds) *Decentralisation in Health Care*. Open University Press, in press.

As a result the powers of the Federal Health Ministry have been weakened considerably, health care financing, regulation and delivery were decentralized significantly. Ministry of health and regional health administration failed to change working style and continue attempts to manage health system top down, although the tools for such management are lost. Still there is a common model of health system across Russia, with very little variation from region to region, demonstrating that greater independence expected to promote adaptation to local consequences and improved efficiency did not facilitate much changes. Structurally and in terms of incentives it is still very similar to Semashko system of the USSR. The scope for action by Federal authorities is limited, but also the power vested in the regions is very limited. Instead, the localities or municipalities, emerge as important bodies, as they own the facilities in which much of the routine health care is delivered and, both directly and indirectly, by virtue of their contributions of insurance premiums for the non-working, provide a substantial amount of health care financing. They however are tied up with the obsolete decrees of the ministry of health of USSR (produced 1979-1980s) which are embedded in the system and can hardly be removed as well as by common legislation, e.g. on taxation, labour and most importantly by budget law. In addition they are poorly designed to facilitate change as the majority of localities in Russia lack separate health administrations, hence all health care within locality managed by the head of the biggest hospital. Central local hospital obviously faces all sorts of counterproductive incentives related to budgetary funding which is tied to numbers of beds and staff and to insurance funding which is tied to number of bed days and visits or number of patients treated, hence bigger facility enables to produce more treatment. The failed health reforms in Russia are often viewed as

result of inertia and lack of local capacity. However there is also a catch 22 situation: the ministry of health set up the norms interlinked to budgetary, taxation, labour and other legislations still enforced by respective supervisory agencies, but lost its power to head physicians of the localities, which learned to benefit from perverse incentives system and prevent any attempts to change it, fearing loss of power and funding. It is also important to mention that positive effects of decentralisation in health care are mocked by slow speed and inefficiency of non health care specific legislation reform, which is not aligned to needs of health sector and sustain Soviet system patterns in all governmental sectors.

1.6 Use

Dimitrova B, Balabanova D, Atun R, Drobniewski F, Levicheva V and Coker R. Barriers to tuberculosis in care in Russia: health service providers' perceptions. *Health Policy and Planning*, in press.

The Russian Federation has witnessed a marked rise in rates of tuberculosis (TB) over the past decade. Public health TB control institutions remain broadly modelled along pre-1990 lines despite substantial programmes of investment and advocacy in implementing the World Health Organization's 'Directly Observed Treatment – short course' (DOTS) strategy. In 2002, we undertook a qualitative study to explore health care providers' perceptions of existing barriers to access to TB services in Samara Oblast in Russia. Six focus group discussions were conducted with physicians and nurses from facilities in urban and rural areas. Data were analyzed using a framework approach for applied policy research. Barriers to access to care were identified in interconnected areas: barriers associated with the health care system, care process barriers, barriers related to wider contextual issues, and barriers associated with patients personal characteristics and behaviour. In the health care system, insufficient funding was identified as an underlying problem resulting in a decrease in screening coverage, low salaries, staff shortages, irregularities in drug supplies and outdated infrastructure. Suboptimal collaboration with general health services and social services limit opportunities for care and social support to patients. Worsening socio-economic conditions were seen both as cause of TB and a major obstacle to access to care. Behavioural characteristics were identified as an important barrier to effective care and treatment and health staff favoured compulsory treatment for 'noncompliant' patients and involvement of the police in defaulter tracing. TB was profoundly associated with stigma and this resulted in delays in accessing care and barriers to ensuring treatment success.

Todorova I, Baban A, Balabanova D, Panavotova Y and Bradley J. Providers' constructions of the role of women in cervical cancer screening in Bulgaria and Romania. *Social Science and Medicine*, in press.

The social and institutional context of health-care reform in Eastern Europe has important implications for cervical cancer screening and prevention. The incidence and mortality from cervical cancer in Bulgaria and Romania have risen, which is in sharp contrast to the steady decline in most other countries in Europe during the last 2 decades. To analyze these dynamics we conducted a multi-component study of health systems and psychosocial aspects of cervical cancer screening in Bulgaria and Romania. Following the disappearance of organized preventive programs, the initiative for cervical cancer screening has shifted to providers and clients and depends on the way they perceive their responsibility and interpret their own and each other's roles in prevention. We focus on how providers construct women and their role in prevention of cervical cancer through their accounts. The analysis identified several discourses and themes in provider's constructions of women's responsibility for prevention of disease. These include responsible women as 'intelligent' and 'cultured'; non-attenders as 'irresponsible' and 'negligent'; women as needing monitoring and sanctioning; and women as 'victims' of health-care reform. We discuss the implications for health-care reform and health promotion.

1.9 Probes

Danichevski K, Balabanova D, McKee M and Parkhurst J. Delivering babies in a time of transition: the changing pattern of maternal care in Tula, Russia. *Health Policy and Planning*, in press.

Objective: To investigate the provision of maternal services in Russia, with an emphasis on variations in practice. Method: The study was set in Tula Oblast. Data sources included an obstetric information database detailing all Tula deliveries in 2000 (n=11,123) and structured interviews with the heads of maternity facilities and hospital maternity departments. Results: Caesarean-section rates varied from 3.3% - 37%; episiotomy from 9% - 80%; and amniocentesis from 0% - 51%. As fertility rates fell since the 1980s, increasing numbers of women were hospitalised for 'pathological pregnancy' in attempt to preserve infrastructure. Conclusion: Over-medicalisation arises in a system typified by excess capacity and large numbers of specialists. Some practice variations were correlated with characteristics of mothers, but others derive from systems structures such as equipment availability. Improvements in practice will require addressing these structural elements and steering the clinical culture towards evidence based medicine, rather than simply writing new decrees.

Lush L. HIV and the health system in Botswana. . In, Beck EJ, Mays N, Whiteside AW, Zuniga JM (eds) *The HIV Pandemic: Local and global implications*. Oxford: Oxford University Press, in press.

Parkhurst J, Ssengooba F and Serwada D. HIV and the health system in Uganda. In, Beck EJ, Mays N, Whiteside AW, Zuniga JM (eds) *The HIV Pandemic: Local and global implications*. Oxford: Oxford University Press, in press.

Submitted

1.2 Health system structure

Alonso A and Brugha R. Rehabilitating the health system after conflict: a policy analysis of East Timor. Submitted to *Health Policy and Planning*.

Efforts to rehabilitate health systems after periods of prolonged conflict have often been characterised by poor co-ordination of external actors – multilateral agencies, donors and non governmental organisations (NGOs). This health systems and policy analysis describes the emergency relief and rapid establishment of a government-led district health system in East Timor, between 1999 and 2002, after decades of chronic conflict and Indonesian occupation. Future East Timorese policy makers and health professionals began to mobilise in May 1999, in preparation for independence. During the emergency phase, from September 1999 when violence erupted to March 2000, NGOs played a major role in the provision of relief to the population, co-ordinated by United Nations agencies. An Interim Health Authority, including local Timorese, was established in March and the major donors began to shift funding from NGOs to the newly established Ministry of Health. A rapid phasing-out of NGOs, accompanied by a sequence of steps to build the capacity of Timorese to manage the new district health system, was implemented. Early evidence shows that health service coverage continued to grow during implementation. The East Timorese and external actors (agencies and NGOs) can take credit for the remarkably seamless and successful post-conflict health systems rehabilitation.

Atkinson S, Cohn A, Ducci ME, Fernandes L, Caprara A and Smyth F. Changing health systems in Latin America: promotion and prevention within the decentralised system. Submitted to *International Journal of Health Planning and Management*.

The study aims to define factors that, within a context of decentralised health systems, enable or hinder change towards a health care model of promotion and disease prevention as advocated in current Latin American public health discourse. The project made in-depth case studies of the provision of health care, the space for activities for prevention and promotion within this and the factors influencing these in local health systems in rural and urban Brazil and Chile. The research was designed to enable three different scales of comparison: variation at the local scale (urban-urban, rural-rural in each country); variation at the regional scale (urban-rural in each country); variation at the national scale (Brazil and Chile). This design allows the

identification of influences on the model of health care from the three scales in the health system. The results raise issues for policy-makers at the three scales to consider in orienting a change in the model of health care provision given different local and national contexts. Four management implications from the study are: • Vertically and horizontally structured health systems both afford advantages and disadvantages in initiating a shift in the health model and each could seek ways to incorporate the benefits of the other • Rural systems under decentralised management require regional level support in developing project proposals and establishing new partnerships for action • A problem-solving approach to planning and priority setting is more likely to lead to local definition of the need for prevention and promotion • A flexible matrix structure of management within health centres with team work interacting with specialist skills facilitates staff commitment, innovation and the provision of a family health model.

Poletti T, Balabanova D, Kocharyan H, Arakelyan K, Hakobyan M and Normand C. The desirability and feasibility of scaling up community health insurance in low-income settings - lessons from Armenia. Submitted to *Social Science and Medicine*.

There is growing consensus that community financing mechanisms can raise revenue, increase equitable access to primary care, and improve social protection. More recently there has been interest in scaling up community financing as a step towards universal coverage either via tax-based systems or social health insurance. Using key informant interviews and focus group discussions in Armenia, this study sought to identify the desirability and feasibility of scaling-up community health insurance. The results suggest that there is broad-based political support for scaling up the schemes and this process is synergistic with major health sector reform directions. High levels of social capital within the rural communities should facilitate scaling up. Existing schemes have increased access and quality of care, but expansion of coverage is constrained by affordability and poor infrastructure and linkages with the broader health system. Long-term subsidies and system-building are essential if the expanded schemes are to be financially viable and pro-poor. Overall, successful scaling up community financing in Armenia would depend on addressing a range of obstacles related to legislation, institutional capacity, human resources and resistance to change among certain stakeholders.

1.4 Processes: operation

Kondo M and McPake B. Making choices between prepayment and user charges in Zambia. What are the results for equity? Submitted to *Health Economics*.

In many low income countries, user charges were introduced in the early 1990s in response to the failures ascribed to the free and universal service ideal that had previously prevailed. As predictable problems emerged of equity of access to care under user charge systems, interest grew in developing prepayment mechanisms that would raise additional resources for health services, but protect users from the risk of out of pocket payments at the time of need for care. In Zambia, user fees were introduced after 1991, and a prepayment scheme involving monthly subscription, from 1993 onwards. The prepayment scheme was subject to abuses of its terms that resulted in it failing to generate sufficient revenue. An alternative scheme using discount cards (consisting of a number of coupons to cover episodes of care at discounted rates) was devised as a means to avoid these problems. This research aimed to understand the equity implications of prepayment and discount cards relative to the user charges system they sought to improve. The paper proposes simple models predicting the roles of income, perceived health status, perceived quality of care and time preference in choice of payment mechanism and subsequent use of health services. It then tests these models using three data sets that could be accessed or collected: the Living Conditions Monitoring Survey conducted in 1998 in Zambia, routine health centre records and an outpatient survey designed for the purpose of this research. It is concluded that relative to user charges, prepayment facilitates access to care without incurring income related equity losses. Evidence concerning discount cards was weaker. We concluded that they also facilitate access, but to a lesser extent. Income related equity losses could not be ruled out in the case of discount cards, and this mechanism seemed to favour those who already had greater ease of access. Discount cards offer a credible intermediate solution between user charges and prepayment that avoid some of the problems that were associated with prepayment. However, since prepayment seems to be associated with the most positive outcomes, finding other solutions to their problems would be

preferred. Some health centres managed the prepayment scheme more successfully and their experience might be studied further for some alternative solutions.

McPake B, Hanson K and Adam C. 'Two-tier' charging strategies in public hospitals: implications for intra-hospital resource allocation and equity of access to hospital services. Submitted to *Journal of Health Economics*.

'Two-tier' charging, the practice of offering separate qualities of service at different prices, is a growing practice in public health facilities in many international contexts. The issue of 'pay-beds' provoked a heated debate in the UK NHS in the 1970s, and the issue of private patients continues to provoke debate there now. Similar strategies have been applied in countries as diverse as Indonesia and Israel and many low-income countries are now looking to this practice as a way of bridging the gap between available and needed finance, especially at hospital level. Advocates of the policy argue that it can be used to secure cross-subsidies from high-fee paying patients to the rest. Despite the extensive and long-running controversy, there has been no analytical model seeking to understand the implications of the strategy for cross-subsidy available. This paper models the incentives inherent in the policy under alternative assumptions about hospitals' objective functions (profit or public surplus, and revenue maximisation). It finds that whether or not two-tier charging will secure cross-subsidy from high-fee to ordinary patients depends on the own and cross-quality effects (the effects of both levels of quality on the demands for the two services) and other components of the demand functions for the two services, as well as on the assumed hospital objective functions. Under a range of assumptions, the policy will evoke cross-subsidy from ordinary to high-fee patients in place of the intended effects.

Ssengooba F, McPake B, Hanson K, Hongoro C, Kasasa S and Rutebemberwa E. Tiered services, user charges and quality in Ugandan hospitals. Submitted to *Health Economics*.

This paper explores the impact of tiered pricing arrangements, in which differing levels of quality are offered at different prices, in Ugandan public hospitals. We examine patterns of utilisation of such wards, and the relationship between choice of ward and clinical quality of care for 8 tracer conditions. Patient-level data on 6 different aspects of clinical quality and overall quality were collected for 876 patients in 5 hospitals, together with information about patient expenditure and socioeconomic and demographic characteristics. Determinants of quality were assessed by modelling the factors associated with mean quality scores. Different aspects of quality are found to be influenced by different variables. However, levels of patient expenditure are consistently and positively associated with quality of care, as is admission to a private ward. Other forms of discrimination are also identified. The implications of these findings for understanding provider responses to formal and informal fee structures are discussed.

1.6 Use

Brugha R, Browne ENL, Ohemeng-Dapaah V, Yevoo LL, Ronsmans C and Filippi V. Audit to improve the management of obstetric emergencies in Ghana: lessons from research in a practice setting. Submitted to *Studies in Family Planning*.

Systems for auditing the in-hospital management of life-threatening obstetric complications, terms near miss events, were introduced and evaluated in Ghana in 2000-2001, in two district level and one tertiary teaching hospitals. Hospital teams were trained and supported in conducting multi-professional audits, which involved doctors, nurse-midwives, support staff and administrators. Sixty-two cases were audited. Problems of poor recording in patients' case-notes by doctors and nurses were an obstacle to case auditing in all three hospitals, but improved during the course of the research in the small hospitals. Process evaluation demonstrated more successful implementation on the latter settings, where multi-disciplinary discussions involved many staff who had cared for the cases being audited. Positive changes were incremental and in some cases too place after the end of the study. The smaller hospitals, where senior staff were committed to the process and staff who had participated in patient care, were more conducive to the audit approach. The

near-miss study was just one of a number of quality of care initiatives introduced into the busy setting during this period.

Parkhurst J, Ssengooba F and Rahman SA. Overcoming access barriers for facility based delivery in low-income settings: insights from Bangladesh and Uganda. Submitted to *Journal of Health, Population and Nutrition* Special issue.

In both Bangladesh and Uganda a majority of women deliver their children at home, often without a skilled attendant present. A number of barriers to accessing health centres for delivery have been identified in the past, including costs, transportation, low perceived quality and socio-cultural norms to deliver at home. Yet in both countries some women manage to overcome these barriers. This paper reports on a comparative study investigating how some women were able to overcome known access barriers. 30 in-depth qualitative interviews were conducted in a rural district in each country with women who recently delivered in a health facility. The case studies provide insight into decision making processes behind seeking care and the roles of key individuals and social networks in facilitating use. The role of the husband was particularly important in Uganda, while in Bangladesh, a number of different key individuals could influence the decision to seek professional care, including unqualified local healers. In both settings having some personal links to a health centre helped facilitate use, and cost and transport barriers were often overcome through social networks. Finally, the study found that social prohibitions on use of health centres may be diminishing, with several Ugandan women explaining that their friends also used facilities, while in Bangladesh, perceived complications during delivery apparently justified use of professional medical care. These findings can help to guide policy makers in many low-income settings working to increase the use of skilled birth attendance.

1.7 Civil society

MacKian S. Archipelagos, geographers and participation: developing theory from local knowledges. Submitted to *Area*.

Participation in health has been a central component of world health care strategies since the Alma Ata conference in 1978, and it continues to capture the attention of international health policy makers and academics. However there remain stark differences in definitions and practice, and little critical engagement with theoretical frameworks for informing the practice of participation. This paper explores recent developments in discourses of citizenship and offers one way in which to theoretically contextualise the practice of participation. Concentrating on health systems, currently undergoing considerable transformation globally, with growing responsibilities for the individual user, the paper throws light upon a number of wider issues related to definitions and practices of participation more generally.

1.8 Methodology

Hongoro C and McPake B. Analysis and interpretation of hospital activity statistics in data constrained environments: what can we learn? Submitted to *Central African Medical Journal*.

The paper explores conceptual issues surrounding the definition of hospital output and its measurement, and measure performance of provincial hospitals in Zimbabwe. A combination of methods was used: literature review for the conceptual discussion on hospital product definition debate; the Pabon Lasso method for measuring hospital performance; and cost accounting methods to establish selected hospital unit costs. We argue that the definition of hospital output is determined as much by the objective for its measurement as by the ability of the system to generate requisite data for its measurement. It suggests that in developing country contexts where information technology is still developing, simple but effective methods of measuring hospital performance are recommended. The paper shows that it is feasible to screen hospitals by performance using basic hospital indicators such as: bed occupancy rate, bed turnover rate and average length of stay and comparing the results to those produced using cost analysis. The study also

shows that the Pabon Lasso method is sensitive to levels of hospital performance as measured by other indicators. Health system managers in low- and middle- income countries need to use simple and cost-effective methods for systematic analysis of hospital performance. The Pabon Lasso method seems to be a good starting point.

In preparation

1.1 Human resources

Blaauw D, Ambegaokar M, Penn-Kekana L, Hongoro C and McPake B. *Neither robots, nor angels: the 'dynamic responses' of health workers and the unintended effects on health systems functioning*. Health Systems Development Programme synthesis paper, in preparation.

Blaauw D, Penn-Kekana L and Hongoro C. Job characteristics affecting where South African public sector nurses choose to work: a discrete choice analysis, in preparation.

Conjoint analysis is increasingly being used to evaluate patient preferences for health care services because it provides an assessment of the relative importance of different aspects of care to patients. Conjoint analysis could also provide more complex insights into the preferences and choices of health care workers but only a handful of studies have adopted this approach to date. The aim of this study was to use conjoint analysis, in the form of a discrete choice experiment, to evaluate the relative importance of different financial and non-financial factors on nurses' choices about where to work. The research was conducted with a sample of 147 professional nurses working in maternal health services at public sector clinics and hospitals from three provinces of South Africa. Focus group discussions helped to select five key facility characteristics to include in the discrete choice experiment, namely; salary, staffing levels, the availability of equipment, the quality of facility management, and the availability of social amenities in the area. SPSS Orthoplan was used to generate 16 scenarios aimed at producing an orthogonal fractional factorial design. The data was analysed using a random effects ordered probit model in Stata. All five factors were statistically significant ($p < 0.001$) in influencing nurses' choices about where to work. The results confirmed that both financial and non-financial job characteristics are important and need to be considered in developing policy interventions to retain nurses at public sector health facilities in South Africa.

Ssengooba F, Rahman SA, Hongoro C, Rutebemberwa E, Mustafa A, McPake B and Kielmann T. The impact of health sector reforms on human resources in health in Uganda and Bangladesh, in preparation.

In the last two decades, developing country governments have implemented a variety of reforms in the health sector on the understanding that those reforms will create the right individual and organisational incentives for improving health systems performance. Little research has been conducted on the mechanisms through which health sector reforms effect and either promote or discourage health worker performance. This paper highlights some of the impacts that health sector reforms have had on human resources in Bangladesh and Uganda and traces the "losses and benefits" to provider incentives generated by reforms. The study findings were generated by triangulating both qualitative and quantitative methods of data collection and analysis among policy technocrats, health managers and groups of health providers. Quantitative surveys were conducted with over 700 individual health workers in both Bangladesh and Uganda and supplemented with qualitative data obtained from focus group discussions and key interviews with professional cadres, health managers and key institutions involved in the design, implementation and evaluation of the reforms of interest. Findings from the study suggest that a) reform planners have underestimated the role of context and thus failed to address broader systemic problems before initiating reform processes, b) a careful analysis of 'hospitable' or 'inhospitable' elements within contexts may predict the success or failure of reform objectives and c) reforms have varying effects on the health workforce which are perceived directly through e.g. changes in salaries, opportunities for promotion, job security and workload or indirectly through levels of satisfaction voiced by communities utilising the services.

1.2 Health system structure

Balabanova D, Hongoro C, McPake B and Normand C. Informal practices in health care systems: what are the issues? *Health Policy*, in preparation.

Informal practices occurring in the health systems of low and middle-income countries are increasingly reported. This paper focuses on informal ("under-the-counter") payments and informal dual practice, representing an unofficial exchange of a health service or provider skills for patient-supplied cash, goods or service. Criteria for distinguishing formal and informal practice include type of beneficiary (individual or institution), purpose, whether solicited by providers or for a publicly funded service; and whether illegal. Informal practices tend to be more common in particular parts of the system (urban tertiary facilities in CEE, in rural outpatient facilities in Uganda) but there is scarce evidence on their impact on access to and clinical quality of care. Informal practices could negatively affect users through a two-tier service. Such inequities threaten access to public health care and enhance cost escalation. They could also hamper health system operation and its reform, increasing supplier-induced demand, distorting resource allocation and continuity of care, and leading to loss of formal revenue and accountability. Informal practices could have positive effects such as improving staff retention, filling resource gaps in severely under-funded public health care systems, and preventing a collapse of basic care. This paper suggests a conceptual framework for analysis of the causes and impacts of informal practice. The main factors are access and quality of care in the public sector, provider characteristics (age, experience, circumstances and expectations), context (socio-economic, political and health system characteristics, culture and governance), and health policies (coverage, public-private mix, financing methods, regulation). The rationale for tackling (or not) informal practices and the possible interventions to address these practices, based on the framework, are discussed. Given the complexity of informal practice, only an integrated strategy involving a range of policy responses may be effective and sustainable. It should involve explicit and enforceable policy, creating formal payment options, prioritising access to basic care, improved human resource management, public and professional empowerment, and promoting accountability in the wider society.

Balabanova D, Poletti T and Normand C. Towards universal coverage in low-income countries: what role for community financing? *Social Science and Medicine* or *Health Policy and Planning*, in preparation.

Blaauw D. Organisational relationships and health sector reform. *Social Science and Medicine*, in preparation.

Discussions of health sector reform have tended to focus on formal structural change. The objective of this paper is to focus on the nature of organisational relationships, both within the organisation and between organisations, in the public health sector and to discuss the relevance of these issues to health sector reform. The first part of the paper looks at models of organisations and organisational change in the public sector. It explores common categorisations of health system and the nature of formal relationships in the health sector. The second part focuses on the informal aspects of organisations. It explores what is meant by these informal components and tries to disentangle the related concepts of culture, leadership, communication, conflict, power, trust and social capital within organisations. The last section discusses health sector reform from a relational perspective. It looks at the changes in formal relationships that underlie current reform initiatives as well as summarising available evidence on the impact of these reforms on the informal aspects of the organisation.

James C, Hanson K, McPake B, Balabanova D, Gwatkin D, Hopwood I, Kirunga C, Knippenberg R, Meesen B, Morris S, Preker A, Soucat A, Souteyrand Y, Tibouti A, Villeneuve P and Xu K. To retain or remove user fees: Reflections on the current debate, in preparation.

MacKian S. Snakes and ladders? Climbing the ladder of participation in Uganda's health system, in preparation.

McPake B and Hanson K. Hospitals' response to increasing autonomy and market forces: evidence from four countries, in preparation.

The policy of hospital autonomy is contingent on the idea that market forces can discipline hospitals and so improve their performance. That idea is contested from two perspectives. First, under most forms of autonomy implemented, hospitals are not the residual claimant to surpluses generated by their activity and may pursue other objectives with unclear implications for their behaviour. Second, hospital contracts are inevitably incomplete, perverse incentives may arise and hospitals may seek to increase surplus by excluding or under treating particular patient groups. Evidence to assess the validity of the market forces model, or alternatively of either conflicting model is scarce. The operation of health sector reform is multi-faceted, time lagged and beset by inter-relationships between multiple variables. Research funding is usually small scale and haphazard. This paper seeks to draw together evidence across four countries (the UK, Zambia, Indonesia and Colombia) where evidence of hospital performance in the wake of reform is relatively robust, in an attempt to identify patterns of response to reform. Across these four countries, the evidence suggests that hospital reform may be associated with productivity improvement, although in all cases it is difficult to link robustly the reforms with the measured improvements. In three of the four countries: the UK, Zambia and Indonesia, it is easier to link reform with the development or further development of two-tier or multi-tier service provision strategies, raising questions regarding the equity impact of the policy. In Colombia, there is no similar evidence and certain features of the Colombian programme seem to protect against negative equity effects. These are an absence of out-of-pocket payments, and measures which mandate cross-subsidies among different groups. Such measures have been difficult to implement in Colombia, a middle income country, and may not be feasible in lower income countries.

Polonsky J, Balabanova D, McPake B, Poletti T and Vyas S. Community health insurance schemes in Armenia: are they reaching the poor? *Bulletin of the World Health Organization*, in preparation.

Rahman SA, Iftekar MHM and Normand C. Health sector reform in Bangladesh: how does it work, in preparation.

Smith B and Atkinson S. *Health systems, maternal health and the millennium development goals*, in preparation.

The United Nations Millennium Development Goals are underpinned by a meta goal to eradicate extreme poverty and hunger by 2015. Health is central to this project, and this paper will outline how health systems are vital in ensuring the provision of effective health care for the poorest. Using the lens of maternal health and reviewing recent studies, evidence will be presented which demonstrates that reaching the maternal mortality goal is fundamental for reducing intergenerational transmissions of poverty, and that key systems issues underpin necessary changes in order to achieve such a target.

Tashobya CK, McPake B, Nabyonga J and Yates R. Health sector reforms and increasing access to health services by the poor: what role has the abolition of user fees played in Uganda, in preparation.

User fees were introduced in Uganda in the late 1980s against a background of poorly funded health systems and strong international support for the role of user fees in encouraging community participation and ownership and for their value in generating revenue. By the late 1990s, there were conflicting opinions about the effect of user fees on access to health services particularly by the poor and other vulnerable groups, in Uganda and other developing countries. In March, 2001, user fees were abolished in all public health units in Uganda except for private wings in hospitals. Abolition of user fees is only one of a number of reforms introduced in the health sector in Uganda since the turn of the century. To assess the impact that this policy change has had on the health sector, this paper draws on evidence from a number of different sources including data from the Ministry of Health, the World Health Organisation, Participatory Poverty Assessment Reports and the Uganda National Household Surveys. The data points to a significant and immediate increase in utilisation of health services following the abolition of user fees, in particular by the poor. The paper concludes that user fees may be a bigger barrier to health service access for the poor than was previously envisaged in developing countries. Furthermore, in order for sustained improvements in health service utilisation, the policy of abolition of fees should be implemented simultaneously with supply side reforms.

1.4 Processes: operation

Brugha R, Chandramohan D, Carneiro I, Zwi A, Sharma VP, Jones C, Verma A, Kantharia SL, Bradley D and Desai VK. Managing malaria in urban India: quality of care offered by public and private providers, in preparation.

A cross-sectional survey of reported malaria treatment practices of 217 public and private providers in an Indian city revealed major quality deficiencies. Qualified allopathic medical practitioners, working in public or private sector facilities, were significantly more likely to report treatment practices in keeping with national or internationally recommended guidelines than were qualified private non-allopaths and unqualified providers. Over or under dosages of chloroquine and under dosages of quinine were commonly offered as first line treatments, especially by private providers. Some respondents, mainly private medical practitioners, reported using mefloquine and artemisinins, which are not recommended by the national malaria control programme, usually in evidence-based dosages. Private providers, mainly unqualified providers and qualified non-allopaths, were the principal sources of primary care in the urban slums; these provider categories had the poorest knowledge of correct malaria treatment practices. The results highlight two of the challenges facing policy makers: how to promote evidence-based treatment practices among providers outside of government control; and how to ensure that disadvantaged populations have access to an acceptable quality of care.

1.5 Global and regional initiatives

Oliveira Cruz V, Cooper R, McPake B, Yates R, Ssengooba F, Kirunga Tashobya C, and Murindwa G. Is the sector-wide approach (SWAp) improving health sector performance in Uganda? In preparation for submission to *International Journal of Planning and Management*.

International donors provide the major source of development assistance to Uganda. Until recent years, for historical reasons and because of weakness of national policies and structures, development assistance had been largely organized through stand-alone projects. This modality of aid delivery was seen as an essential approach to allow flexibility to manoeuvre, quick response, and demonstrable results associated with priority concerns in health. However, project-based support has been criticised for causing fragmentation of the health system into several subsystems with differing capacities, delivering different health interventions to different beneficiaries. Concerns for equity, efficiency, and government leadership have since led to the introduction of the sector-wide approach (SWAp) in Uganda. The main objective of the SWAp is to improve the overall performance of the health system and consequently the health status of Uganda's population. To this end, it aims to coordinate development assistance to the sector and to reduce the administrative burden for government. This paper analyses the evolution of the SWAp, as one of the key reforms undertaken in Uganda since 2000, describing the structures and processes involved. Benefits of this reform include the establishment of a platform for coalition building and policy learning among stakeholders and improved donor coordination. However, the SWAp faces important challenges including the burden of persistent under-funding to the health sector and the renewed interest in vertical approaches to health sector funding arising from the introduction of new global health initiatives. These may adversely affect the SWAp objectives and risk destabilising the significant progress made in the health system in Uganda since 2000.

Oliveira Cruz V and McPake B. Shift in the approach to monitoring and evaluation in international development assistance for health. In preparation for submission to *Health Policy*.

The international community has in recent years introduced new modes of aid delivery which offer new ways of structuring the relationship and the aid contract. These newer modes of aid delivery are chiefly Sector Wide approaches (SWAp) and General Budgetary Support (GBS). The main difference between a SWAp and GBS is that the former is specific to a sector, such as health or education and in the latter, aid resources are not earmarked to any sectoral activity; they can be used to fund any type of government expenditure.

The changes taking place in the aid contract reflect donors increasing concern with the effectiveness of aid (Adam and Gunning, 2002; Lavergne, 2002). This growing concern was perhaps underpinned by changes regarding the functioning of government and the introduction of ideas from the New Public Management (NPM) debate. NPM advocates the use of performance related agreements among other changes which demand evidence of achievement of outcomes rather than legitimate use of inputs (Kaul, 1997). The instruments and measures of monitoring in the public sector have shifted their focus from inputs (mainly financial and human resources) to outcomes (for instance maternal mortality rates) (Paul, 1992). This shift is mirrored in changes in international development assistance. Commitment to results based management and a focus on international targets are to a large extent based on outcomes. Alternative delivery mechanisms closer to budget support than the project approach give recipients greater flexibility to focus on achievement of outcomes as opposed to accountability for inputs (Maxwell, 2003). The Millennium Development Goals (MDGs) are a clear example of this shift.
The aim of this paper is to provide an analysis of recent changes in relation to greater use of outcome based approaches to monitoring and evaluation in international development assistance for health, in particular by assessing advantages and disadvantages based on experience to date. For instance, the new monitoring model (outcomes-based) presents advantages such as allowing policy makers to focus on long term goals and ultimate objectives as for example the reduction of maternal mortality rates. The outcome-based model also has deficiencies, in particular measurement and verification is costly and current capacity is limited which allows the scope for opportunistic behaviour to arise.
We also give consideration to the choice of monitoring indicators by examining the balance of those that change faster, and are easier to detect with those more closely related to outcomes of interest as this seems to be key to managing international development assistance for health.
It is thus crucial that the international aid community pays careful attention to the problems related to the new model and seeks ways to reduce perverse incentives in the system. A balanced mixed-mode approach which continues to track inputs and processes while developing trust and monitoring focused on the measurement and validation of output and outcome measures is recommended. This may require additional investment in the short term to yield long term gains of greater transparency and accountability.

Oliveira Cruz V and McPake B. Agency theory as a conceptual framework for the analysis of relationships in international development assistance for health. In preparation for submission to *Social Science and Medicine*.

The use of agency theory as a conceptual framework to analyse relationships in the health sector is now well established since Arrow's contribution (1963). The application of agency theory in the sector has grown since. Recent contributions include for instance a study of hospital-based doctors in China (Liu, 1999), the design of physician payment incentives in the USA by Robinson (2001), the role of performance measurement in health care in the UK (Mannion and Goddard, 2002; Goddard *et al*., 2000) and the application of the principal-agent model to key elements of health care systems (Smith *et al*., 1997).
More recently, agency theory has been used to further the analysis of the relationships of Recipient Governments (RGs) and International Development Partners (IDPs), in more general terms (Zinnes and Bolaky, 2002; Martens *et al*., 2002; Svensson, 1997) and more specifically in relation to the use of performance indicators in the design of aid contracts, though only implicitly using an agency theory framework (Adam and Gunning, 2002) and to conditionality contracts (Killick, 1997), which as argued by Martens *et al*. (2002) is inherently about principal-agent relationships. Yet, there is a lack of empirical evidence relating the micro-institutional relationships in international aid organisations (Martens *et al*., 2002) and the discernment of the multiple stages of the aid delivery process and the many involved actors (principals and agents) with various (and often conflicting) objectives and constraints (Zinnes and Bolaky, 2002). In addition, agency theory has not been applied to the sector of International Development Assistance for Health (IDAH) specifically. The application of agency theory to this sector (health) is of particular relevance as health outcomes are determined within a complex scenario of uncertainties and various contributing factors. These complexities enhance the difficulties in monitoring and measurement, which instigate the use of principal agency theory to understand the explicit and implicit incentive structure of the aid contract.
The aim of this paper is to better understand principal-agent relationships between Recipient Governments and International Development Partners in the Health Sector. In this paper we explore the different types of principal-agent relationships in IDAH; discuss conflicting objective functions among the contractual parties (RGs and IDPs); apply elements of the dynamic model (multi-principals and multi-tasks) to IDAH; provide

an analysis of issues related to the compensation scheme in the aid contract; and discuss different options for dealing with agency problems.
The kinds of conflicts of interests between the various actors involved in the IDA - the multiple layers of delegations between actors and organisations, the broken feedback loop between the populations in 'donor' and recipient countries, the consequent weak accountability link across these institutions, and the difficulties related to monitoring (observing) the actions and or outputs yielded by agents - give rise to an array of incentive problems and highlight the need for devising sophisticated incentive structures (or at least being alert to the perverse incentives that may arise, and designing coping mechanisms).

1.6 Use

Balabanova D, Parkhurst J, McKee M and McPake B. Access to health care: taking into account health systems complexity. *Social Science and Medicine*, in preparation.

Established theoretical frameworks on access to care and utilisation as a proxy for access, including the demand and supply model; the 'health belief' and 'behavioural' models, sought to conceptualise decision-making processes and barriers to care. These approaches provide a useful starting point in understanding individual care seeking, but they do not address the inherent complexity involved in accessing appropriate health services, or account for non-linear behaviour and the dynamic interaction between health systems and communities. Drawing on recent multi-country research, this paper seeks to contribute to the understanding of access in low and middle-income settings, while focusing on patterns that cut across settings, employing a conceptual framework which looks at the 'dynamic responses' that sit between the de jure health services in place, and the de facto outcomes seen. The paper examines several areas of complexity in relation to access. These involve identifying time and skills continuums required for achieving successful access to care, the role of communities in mediating access of individual members, and the dynamic interaction of patient and provider behaviour. It suggests an approach to conceptualising access while taking uncertainty and complexity into account. Access is often seen as a one-stop contact with the health system that is obstructed by a range of obstacles at a given point in time. Our research suggests that illness is better understood as involving a continuum of care seeking, requiring access to prolonged, often lifelong treatment at different levels of the health system. A dynamic interaction between provider and patient behaviour, usually at the level of the frontline service determines what care is accessible. While the current debate focuses on identifying and addressing barriers to seeking good quality care, or counting staff and facilities, we argue that studies of access should incorporate complexity (theoretically and methodologically), particularly the continuous nature of treatment and the diversity of barriers at each stage, the dynamic provider-patient interaction in each context, and the need to draw on community resources in bridging access gaps. Availability of financing is only part of the problem, and the interacting individual and systemic incentives need to be addressed.

Rahman SA, McPake B, Normand C and Kielmann T. Health seeking behaviour of the hill tribal population of Bangladesh, in preparation.

This paper discusses the various elements underlying health-seeking behaviour among several ethnic groups in Bangladesh. By tracing responses concerning different treatment sources available in the tribal areas, reasons behind provider choice and highlighting issues concerning adolescent and maternal health and their health behaviour and knowledge, the authors attempt to provide a comprehensive portrait of obstacles and challenges faced in accessing and using health care provision in the tribal areas. Data for this study was collected using participatory tools and techniques including focus group discussions and interviews involving 162 men, women, adolescent boys and girls belonging to nine different tribal communities from six districts. Four main findings emerged from the study suggesting that tribal communities may differ from the predominant Bengali population in their health needs and priorities and thus challenge the present service delivery system that has largely been based on needs and priorities formulated by the plain land population. 1) Traditional healers are still very popular among ethnic groups in Bangladesh 2) Perceptions of quality and manner of treatment and communication override costs when it comes to provider preference 3) Gender and age play a role in household decisions concerning health matter

and treatment-seeking 4) There are distinct differences among the tribes concerning their health knowledge, awareness and treatment-seeking behaviour.

1.7 Civil society

MacKian S. *Neighbourhood Health Committees and their influence in health care management*, in preparation.

MacKian S. Reflections on participation, development and health, in preparation.

Smith B and Atkinson S. Locating poverty: intergenerational transmission and the irreversibilities associated with health and nutrition, in preparation.

Since the adoption of the Millennium Development Goals (MDGs), vast resources and imagination has been captured by the 'poverty project'. Locating poverty in order to design effective interventions is vital if this project is to succeed. Conceptual understandings and measurements of poverty have become increasingly sophisticated in recent decades. The debates and contestations in academic, practitioner and policy circles attest to the difficulties associated with such a task, and indeed 'poverty' still remains a somewhat amorphous label. One particularly interesting body of work which has begun to emerge is that on intergenerational transmissions of poverty. This paper will outline key studies in IGTP in order to demonstrate its importance in developing more nuanced understandings of where poverty resides and at which points interventions to tackle poverty may be most effective. The focus for this discussion will be the irreversibilities associated with health and nutrition, as child and maternal nutrition and health status are often cited alongside the timing of shocks and interventions as the critical factors in determining the irreversibility of poverty transfers, signified by the centrality of health in three of the MDGs.

1.8 Methodology

Bamford L and Brugha R. Process and content of IMCI supervisory visits in three South African districts, in preparation.

Bamford L and Brugha R. PHC supervision: challenges and opportunities, in preparation.

McPake B, Blaauw D and Sheaff R. Recognising patterns: health systems research beyond controlled trials, in preparation.

If it were not for controlled trials, tuberculosis sufferers would still be lying in iron lungs. Nevertheless, experimental approaches have severe limitations in studying systems such as health systems that change from within as a result of human agency, and in which context, rather than something to be controlled or neutralised is the key issue to be understood in order to explain when, where and why interventions do or do not work. In order to answer such questions, it is necessary to attend to the 'black-box' between the intervention and its effects, or the mechanisms of effect. In health systems, a series of policy initiatives with multiple intentions on the part of their designers are launched, often concurrently. These determine changes to the de-jure health system, which can be described in terms of its legislation, regulations and organisational structures. The implications of the de-jure system for the de-facto system that is experienced by its users are mediated through a series of 'dynamic responses' on the part of the human agents that form the chain linking the two. These determine how accessible health systems are to whom, the quality of the services delivered by the system and the outcomes of the system, for example in terms of health improvement or poverty alleviation. Research focusing on the mechanisms of effect in social systems has been termed 'realistic evaluation'. New language for conceptualising such systems is available in the discourse on complexity which has rapidly traversed the breadth of science. Mathematical and statistical techniques which when grouped together have been labelled 'pattern recognition' have been developed to deal with situations of complexity in which mechanisms that result in outcomes are less than fully

deterministic, or of a cause and effect nature. There is considerable scope for greater use of such methods in health systems research, both in their quantitative manifestations which are increasingly in use in other fields, and in qualitative manifestations which are currently only partially articulated. New techniques of both types are required to more fully develop health systems research methodology and there are germs of promising methods in those that are being developed in other areas. Such an approach emphasises that health systems research is indeed a multi-disciplinary field as has long been widely assumed. Further, identifying contrasting theoretical and methodological approaches to pattern recognition more clearly identifies how specific disciplines can make both discrete and complementary contributions to a potentially cumulative understanding of the key issues in securing health system development.

Sheaff R, Blaauw D and McPake B. The logic of organisational tracer studies. A method for health systems analysis, in preparation.

Worrall E and Hongoro C. Costing a malaria epidemic in Zimbabwe: a novel methodology, in preparation.

Malaria is a serious public health problem in Zimbabwe and many areas of the country are prone to seasonal epidemics causing death and illness on a large scale. One such epidemic occurred in the North East of Zimbabwe in 1995/96. We costed the control of this epidemic in Hwange district in Matabeleland North and the control of malaria in the following year in the same district. We used the results in combination with epidemiological data from the National Health Information Unit to estimate the cost of malaria control for all districts in Zimbabwe for 1995/96 and 1996/97. We then used the estimates of the provincial cost of malaria control to estimate the additional cost of malaria control in epidemic years compared to non-epidemic years.

1.9 Probes

Parkhurst J and Rahman SA. Non professional health practitioners and referrals to facilities: maternal care lessons from Bangladesh, in preparation.

Conferences

The new philanthropy and its significance for international institutions, Cambridge, July 2001

Title: Global Health Fund [1.5]
Speaker: R Brugha

International Health Economics Association, York, 22-25 July 2001

Organised session: Hospital reform in developing countries - understanding governance arrangements and the effects of change (BM) [1.2]

Abstract Title: Contracting with referral hospitals in Zambia
Authors: K Hanson and B McPake

Abstract Title: Predicting hospital behaviour under health sector reform: the case of Zimbabwe
Authors: C Hongoro

Abstract Title: Hospital reform in Colombia - effects on efficiency, equity and quality of care
Authors: S Lake, B McPake and F Yepes

Accepted Abstracts

Title: Low cost medical insurance in Zimbabwe: is it really low cost? (Oral presentation)
Authors: L Kumaranayake, C Hongoro and L Nherera

Annual conference of the European Public Health Association, Dresden, November 2002

Title: Reforming health care financing in Bulgaria: the population perspective [1.3]
Authors: Balabanova D and McKee M

Annual Conference for the Global Forum for Health Research, Geneva, 2001

Title: Public-private partnerships and guaranteeing drug delivery through health systems: issues needing further research [1.2]
Author: L Lush

XIVth International AIDS Conference, Barcelona, July 2002

Title: Capacity issues in the Brazilian health system in providing HIV/AIDS prevention and care [1.9]
Author: V Oliveira-Cruz

Title: Bridging gaps between public and traditional health care sectors - testing a model to improve quality of STI/HIV/AIDS care in sub-Saharan Africa [1.2]
Author: R Ungem, R Brugha, E Faxelid, D Kabatesi, P Mayaud, P Ndubani, F Ssengooba and R Vongo
Title: Improving the quality of STI care in the private sector, South Africa: a district based multipronged approach[1.2]
Author: N Chabikuli, H Schneider, A Zwi and R Brugha

Japanese International Health Association, workshop, Tokyo, August 2002

Title: The role of economic research in international health policy [1.8]
Author: B McPake

10th Annual conference of the European Public Health Association, Dresden, Germany, 28-30 November 2002

Title: Reforming health care financing in Bulgaria: the population perspective [1.2]
Authors: D Balabanova and M McKee

22nd Conference on Priorities in Perinatal Care in Southern Africa, Free State, 11-14 March 2003

Title: Maternal health services in South Africa, Uganda, Russia and Bangladesh. Lessons of a comparative study for South Africa. Keynote address [1.9]
Authors: L Penn-Kekana, D Blaauw and J Parkhurst

Title: The use of analgesia in labour wards in two district hospitals - a qualitative study [1.9]
Authors: L Penn-Kekana, D Blaauw and H Schneider

Title: Socio-economic inequalities and maternal health in South Africa [1.9]
Authors: D Blaauw and L Penn-Kekana

Public Health 2003, Cape Town, South Africa, 24-26 March 2003

Title: Intergovernmental relationships and health service delivery [1.3]
Authors: D Blaauw, L Gilson, P Modiba, G Khumalo, E Erasmus and H Schneider

Title: Public-private interactions in the South African Health System [1.2]
Authors: H Wadee, L Gilson, D Blaauw, E Erasmus and A Mills

Memoire, histoire et sida en Afrique du Sud. EHESS-CNRS. Paris, May 2003

Title: The political economy of AIDS policy implementation in South Africa [1.9]
Authors: H Schneider and D Blaauw

4th International Health Economics Association, San Francisco, USA, 15-18 June 2003

Title: Two tier charging in public health facilities - an economic model predicting implications for equity [1.2]
Authors: B McPake, K Hanson and C Adam

Title: Agency theory and the relationships between recipient governments and international development partners - case study of Uganda [1.5]
Authors: V Oliveira Cruz and B McPake

Title: Community clinics in Bangladesh: why have they failed to provide local health services [1.4]
Authors: C Normand and SA Rahman

Celebrating Alma Ata 1978-1993 Conference, Johannesburg, August 2003

Title: Considering Public-Private Interactions (PPIs) in the South African Health Sector – Implications for Primary Health Care [1.2]
Author: H Wadee

Making the link, Sexual-Reproductive Health and Health Systems, John Snow International, Leeds, 9-11 September 2003

Title: Intergovernmental coordination and the delivery of HIV services [1.3]
Authors: D Blaauw, L Gilson, P Modiba, E Erasmus, G Khumlao and H Schneider

Title: The impact of financial accountability reforms on midwives working in two district hospitals in South Africa [1.9]
Authors: L Penn-Kekana and D Blaauw

Reproductive Health Priorities Conference, Johannesburg, October 2003

Title: The use of the national minimum data sets for hospitals and clinics in the evaluation of maternal health services in South Africa [1.4]
Authors: N Naicker, L Penn-Kekana and D Blaauw

Sixth International Conference on Healthcare Resource Allocation for HIV/AIDS: Healthcare Systems in Transition, Washington DC, USA, 13-14 October 2003

Title: Uganda: Health System and HIV/AIDS Response [1.9]
Authors: JO Parkhurst, F Ssengooba and D Serwadda

11th Annual Conference of the European Health Association, Rome, Italy, 20-22 November 2003

Title: Winners and losers: the expansion of insurance coverage in Russia in the 1990s [1.2]
Authors: D Balabanova, J Falkingham and M McKee

23rd Conference on Priorities in Perinatal Care in Southern Africa, Limpopo, South Africa, 9-12 March 2004

Title: Staffing issues in two maternity wards. Insights from an ethnographic study [1.1]
Authors: L Penn-Kekana, D Blaauw and H Schneider

On Health Conference, Greece, 3-5 June 2004

Title: Health sector reforms in Bangladesh: How does it work? [1.4]
Author: SA Rahman and MHM Iftekhar

12th Annual Conference of the European Public Health Association, Norway, 7-9 October 2004

Title: Urban-rural disparities in health and living conditions in the Former Soviet Union: towards a comprehensive regional analysis [1.6]
Authors: D Balabanova, M McKee and K Akingbade

Title: Variations in obstetric practices in Tula region of Russia [1.9]
Authors: K Danichevski, D Balabanova, J Parkhurst and M McKee

'Reproductive Health Issues in Eastern Europe and the Former Soviet Union' conference held by the International Union for the Scientific Study of Population and the East European Institute for Reproductive Health, Bucharest, 17 – 20 October 2004

Title: Implementing cervical cancer screening in Bulgaria: what are the health system-level constraints that should be addressed? [1.2]
Authors: D Balabanova, Y Panayotova, J Georgiev and J Bradley

Meeting of the International Society of Critical Health Psychology, Sheffield, UK, 29 March – 1 April 2005

Title: Providers' constructions of women's responsibility for prevention: The case of cervical cancer screening in Bulgaria [1.6]
Authors: I Todorova, Y Panaiotova, D Balabanova and J Bradley

XIth International Symposium in Medical Geography, Forth Worth, USA, 6-9 July 2005

Title: The academic imagination and policy practice: approaches to study decentralisation in health systems
Author: Sarah Atkinson

Critical theorists in geography analyzing health, health care and health system policies often locate themselves at a distance from those engaged in policy and these in turn reject the deliberations of the academics as of little practical relevance. This paper aims to build understanding across this divide between critical and policy-oriented geographies of health, demonstrating through the example of academic approaches to studying decentralization in health systems how the assumptions we hold, often implicitly, about the nature of decentralization and health systems strongly influence the aspects of implementation that we choose to evaluate and therefore the policy conclusions we then draw. The paper argues that any theoretical approach taken to studying the practice and outcomes of any health care policy will depend on the metaphors through which a researcher imagines the health system and the influences interacting with it. This relation between our imagining of an organization and how we privilege particular aspects of organizational life draws on three of Morgan's eight 'images of organization'. The majority of studies of decentralization in health systems fall into the organization as organism image some of which are expanded with descriptive elements more typical of the organization as political system image. Whilst there are few falling entirely into the organization as cultures, recent writers have promoted this as an interesting and important perspective to adopt. The paper spells out the implications these different academic imaginings of health systems have for the policy-relevant conclusions in applied research.

5th International Health Economics Association (iHEA) Congress, Barcelona, Spain, 10-13 July 2005

Title: Human resource implications for access to essential health services in Uganda [1.1]
Authors: C Hongoro, F Ssengooba and E Rutebemberwa

The role of human resources in health systems is unquestionable. Health systems of most developing countries are over burdened by diseases most notably malaria, tuberculosis and HIV/AIDS in the face of worsening human resource problems. Both internal and external labour migration and low uptake of health training are some of the reasons proffered for the human resource capacity problems. Uganda is no exception to this.

Problems exist in terms of both availability (versus need/demand) and distribution between urban and rural areas, and between rich and poor districts. The distribution pattern of health workers in the country proxies levels of availability and access o essential services. The paper explores the availability of various health professional categories in Uganda against set norms (establishes gaps) through an analysis of data from a national human resource in health inventory study carried out in 2003. It shows the geographical spread of health workers in the decentralised health system and maps that to health system performance indicators (primary and secondary services) such as DPT3 coverage, deliveries in facilities, outpatient attendances, approved posts filled, and HIV prevalence. The underlying hypothesis is that relatively well staffed areas are likely to have better access to essential services and hence perform better than poorly staffed areas. Equity of access to essential service issues are explored using Gini-style indices (see Brown 1994).
The evidence shows associations between availability and distribution of health workers (spatial practitioner distribution), and access to essential services and some of the performance indicators. The paper ends by drawing policy implications for human resource development in Uganda.

Title: In-service training: does this investment match onto health systems needs and roles [1.1]
Author: Freddie Ssengooba

Planning and setting priorities of training interventions for the workforce is an essential input in improving quality and performance of the health system. In-service training is a large industry with extensive investments in developing and developed countries alike. New services being integrated, new technologies being adopted into health systems employ in-service training as the vehicle to target the workforce. Recent attempt to scale up interventions for HIV/AIDS, malaria and TB in developing countries have in-service training claiming a huge proportion of health budgets. However, the systems of prioritizing such training is rarely systematic and planed to address the needs and responsibilities of the different levels of the health system and ultimately its beneficiaries – the clients.
We use the data collected from a sample of Ugandan health providers (individuals and institutions) to explore the incidence of in-service training. A set of trainings (courses) aimed at building/sustaining provider competence in providing the national minimum health care package is used to calculate the incidence benefits by level of the health system, cadre-type and across public and NGO sectors. Cost information is drawn from program and management records from a number of stakeholder institutions involved in financing and providing such training.
Preliminary results (full result by early 2005) indicate that the method and tools used in this work have potential impact on targeting investments for in-service training and also serve as a benchmark for prioritization for in-service training at national and sub-national levels. This method also indirectly assesses the readiness of the health system to deliver key services such as ARVs and other services and products by providing a quick mapping of provider capacity.

Title: Health Sector Reforms in Bangladesh: Effects on Human Resources [1.1]
Authors: SA Rahman, F Ssengooba, C Hongoro

Bangladesh Government undertook several reform initiatives under the Health and Population Sector Programme (HPSP, 1998-2003). The purposes of the reforms were to introduce cost-effective and sustainable health services; avoid duplications in service provision and management; reduce the burden of communicable diseases; improve quality of care; increase maternal and child care facilities; improve access for the poor to public health care facilities; remove rivalry between health and family planning personnel's and thus bringing harmony in the organisation.
The major reform initiatives were unification of health and family planning services; establishment of a new health care facility- Community Clinics to provide services close to clients; introduction of a comprehensive training programme for providers. Currently more than 133,000 health and family planning personnel are

engaged in delivering services to the people of Bangladesh. Success of reforms greatly depends on the way they respond to the initiatives.
Keeping that in mind, the reform initiatives were reviewed by a research team of the Makerere University of Uganda and the Health Economics Unit, Ministry of Health and Family Welfare, Bangladesh with the financial assistance from the WHO Geneva to investigate the impact of those reforms on human resources capacity development, staff performance and incentive environment. A mix of qualitative and quantitative methods was used to collect information from different sets of health care providers and facilities.
The study shows little evidence that implementation of reforms has brought the intended benefits. The new unified management system was not found functioning, it was perceived as a take over by the health interest and Family Planning personnel lost authority and felt degraded. This worsened morale among family planning personnel, created more rivalry than pre-unification. Reform did not bring better promotion scope, rather some lower level pests of the family planning department became blocked and virtually no incentive existed for deployment in remote underserved areas. Reform could not improve discriminatory salary payment between health and family planning personnel and thus created dissatisfaction among the family planning personnel. The community clinics are not functioning mainly for serious shortage of supplies and minimum community involvement. Huge financial resources are needed to maintain the large number (11000) of Community Clinics. Providers of community clinics were found not capable of handling the assigned job. The centrally planned and locally executed training programme brought some benefit but not up to the expectation. Intended skill development was found far below the expectations. Scope of utilization of training skills was found very limited making the investment in training fruitless.
Taken overall into consideration, it may be concluded that there has been very little effect in terms of creating fruitful incentive mechanism for health care personnel, reduction of service delivery cost, ensuring harmony among the health and family planning personnel, increasing availability and quality of health and family planning services, and improvement of the system as a whole

Title: Performance-based Contracting: a case study of non-profit hospitals in Uganda [1.2]
Authors: F Ssengooba, B McPake and N Palmer

Background: Agency theory provides that economic incentives if sufficiently powered, will appeal to the self-interest of the agents and result in a desired response to an incentive contract. By implication, performance bonuses are increasingly used as carrots in performance contracting in health care.
Organizational process theories on the other hand define a broad incentive environment embedded in organizational processes – eg communication, equitable benefits and leadership, trust and team dynamics – that could override the economic rewards in influencing organizational performance.
Hospitals are complex organizations with multiple stakeholders that espouse different and sometimes countervailing objectives and behaviors, have multiple services and dynamic financing and management contexts. This level of complexity probably explains why most work on performance-based contracting (PBC) in developing countries has focused on primary level care institutions despite the greater potential benefits the PBC policy could have at hospital levels.
Objectives: The study examines the nature of response to performance contractual processes (service targets, performance surveillance and feedback and Bonus payment) by hospital stakeholders. Agency theory and organizational process theories are being used as analytical templates to understand the hospital motivations and the response behaviors towards PBC. It also assesses the stakeholders (MOH, hospital boards, hospital Managers and clinical groups) objectives, their organizational and economic context, and strategies employed over time to respond to performance targets, monitoring and accompanying bonus. Changes in access to participating hospitals will also be assessed using benefit incidence across different social economic groups.
Methods: Triangulation of qualitative and quantitative techniques are being used in a case study methodology to understand this response. Eight non-profit hospitals in five Ugandan districts participating in a PBC pilot constitute the case study hospitals. The pilot includes mostly primary level health care

facilities and is using service targets – percentage increase in output volumes from previous year for: Immunization, family planning, out-patient attendance, institutional deliveries and malaria treatment. A maximum bonus of 11% of base grant for the year constitutes the incentive. In-depth interviews with hospital stakeholders are being conducted. Management records on revenue and expenditure profiles, utilization statistics, staff numbers and professional mix have been collected to understand the capacities of the hospitals. Stakeholder perceptions of organizational processes ie task relationships and support, leadership, performance feedback, and bonus benefits are being collected in prospective surveys (every 6 months- 3 rounds). Clients' information on hospital benefits and socioeconomic status were collected at baseline and will be collected after one year of implementing PBC. Results from two rounds of data collection will be ready for presentation by July 2005.
Potential implications: The study explores in-depth the mechanisms that enhance or constrain the response to performance contacts/targets in complex organizations - hospitals. This knowledge is critical in understanding the internal mechanisms for hospital performance and in the designing of potential organizational interventions that would compliment or even substitute financial incentives to enhance contracting as a management tool in public-private partnerships in health delivery.

Title: Agency Theory as a Conceptual Framework for the Analysis of Relationships in International Development Assistance for Health [1.5]
Authors: V Oliveira-Cruz and B McPake

The use of agency theory as a conceptual framework to analyse relationships in the health sector is now well established since Arrow's contribution (1963). The application of agency theory in the sector has grown since. Recent contributions include for instance a study of hospital-based doctors in China (Liu, 1999), the design of physician payment incentives in the USA by Robinson (2001), the role of performance measurement in health care in the UK (Mannion and Goddard, 2002; Goddard *et al*., 2000) and the application of the principal-agent model to key elements of health care systems (Smith *et al*., 1997).
More recently, agency theory has been used to further the analysis of the relationships of Recipient Governments (RGs) and International Development Partners (IDPs), in more general terms (Zinnes and Bolaky, 2002; Martens *et al*., 2002; Svensson, 1997) and more specifically in relation to the use of performance indicators in the design of aid contracts, though only implicitly using an agency theory framework (Adam and Gunning, 2002) and to conditionality contracts (Killick, 1997), which as argued by Martens *et al*. (2002) is inherently about principal-agent relationships. Yet, there is a lack of empirical evidence relating the micro-institutional relationships in international aid organisations (Martens *et al*., 2002) and the discernment of the multiple stages of the aid delivery process and the many involved actors (principals and agents) with various (and often conflicting) objectives and constraints (Zinnes and Bolaky, 2002). In addition, agency theory has not been applied to the sector of International Development Assistance for Health (IDAH) specifically. The application of agency theory to this sector (health) is of particular relevance as health outcomes are determined within a complex scenario of uncertainties and various contributing factors. These complexities enhance the difficulties in monitoring and measurement, which instigate the use of principal agency theory to understand the explicit and implicit incentive structure of the aid contract.
The aim of this paper is to better understand principal-agent relationships between Recipient Governments and International Development Partners in the Health Sector. In this paper we explore the different types of principal-agent relationships in IDAH; discuss conflicting objective functions among the contractual parties (RGs and IDPs); apply elements of the dynamic model (multi-principals and multi-tasks) to IDAH; provide an analysis of issues related to the compensation scheme in the aid contract; and discuss different options for dealing with agency problems.
The kinds of conflicts of interests between the various actors involved in the IDA - the multiple layers of delegations between actors and organisations, the broken feedback loop between the populations in 'donor' and recipient countries, the consequent weak accountability link across these institutions, and the difficulties related to monitoring (observing) the actions and or outputs yielded by agents - give rise to an array of

incentive problems and highlight the need for devising sophisticated incentive structures (or at least being alert to the perverse incentives that may arise, and designing coping mechanisms).

Title: Shift in the Approach to Monitoring and Evaluation in International Development Assistance for Health [1.5]
Authors: V Oliveira-Cruz and B McPake

The international community has in recent years introduced new modes of aid delivery which offer new ways of structuring the relationship and the aid contract. These newer modes of aid delivery are chiefly Sector Wide approaches (SWAp) and General Budgetary Support (GBS). The main difference between a SWAp and GBS is that the former is specific to a sector, such as health or education and in the latter, aid resources are not earmarked to any sectoral activity; they can be used to fund any type of government expenditure.
The changes taking place in the aid contract reflect donors increasing concern with the effectiveness of aid (Adam and Gunning, 2002; Lavergne, 2002). This growing concern was perhaps underpinned by changes regarding the functioning of government and the introduction of ideas from the New Public Management (NPM) debate. NPM advocates the use of performance related agreements among other changes which demand evidence of achievement of outcomes rather than legitimate use of inputs (Kaul, 1997). The instruments and measures of monitoring in the public sector have shifted their focus from inputs (mainly financial and human resources) to outcomes (for instance maternal mortality rates) (Paul, 1992). This shift is mirrored in changes in international development assistance. Commitment to results based management and a focus on international targets are to a large extent based on outcomes. Alternative delivery mechanisms closer to budget support than the project approach give recipients greater flexibility to focus on achievement of outcomes as opposed to accountability for inputs (Maxwell, 2003). The Millennium Development Goals (MDGs) are a clear example of this shift.
The aim of this paper is to provide an analysis of recent changes in relation to greater use of outcome based approaches to monitoring and evaluation in international development assistance for health, in particular by assessing advantages and disadvantages based on experience to date. For instance, the new monitoring model (outcomes-based) presents advantages such as allowing policy makers to focus on long term goals and ultimate objectives as for example the reduction of maternal mortality rates. The outcome-based model also has deficiencies, in particular measurement and verification is costly and current capacity is limited which allows the scope for opportunistic behaviour to arise.
We also give consideration to the choice of monitoring indicators by examining the balance of those that change faster, and are easier to detect with those more closely related to outcomes of interest as this seems to be key to managing international development assistance for health.
It is thus crucial that the international aid community pays careful attention to the problems related to the new model and seeks ways to reduce perverse incentives in the system. A balanced mixed-mode approach which continues to track inputs and processes while developing trust and monitoring focused on the measurement and validation of output and outcome measures is recommended. This may require additional investment in the short term to yield long term gains of greater transparency and accountability.

Title: The Ugandan Health Systems Reforms: Miracle or Mirage? [1.5]
Authors: R Yates, B Mcpake, V Oliveira Cruz and C Tashobya

Poor health indicators in the 1990s prompted the Government of Uganda and development partners to embark on an extensive programme of health systems reforms to improve sector performance. Five years into the Sector Wide Approach (SWAp) process, with only an 18% increase in total resources, these reforms have resulted in large rises in outputs for ambulatory services. Nationally, outpatient attendances have increased by 117% (from 9.3 million to 20.2 million). Immunisation rates (as measured by DPT3 uptake) have also more than doubled from 41% to 83%. Furthermore, external research has shown that the growth in

consumption of these services appears to be highest by the poorest socio-economic groups. However, statistics for key in-patient services, most noticeably maternity services, remain virtually unchanged.
This paper attempts to assess the significance of these changes. Is it a miracle of improved efficiency or a mirage unlikely to lead to improved health outcomes? The paper also identifies the key reforms within the health sector and across government, which may be responsible for the changes in output performance. It highlights a number of supply side reforms, which have increased the availability of essential inputs. These include: more efficient and equitable budget allocations, donors switching their financing mechanism from projects to direct budget support and improved management of vital inputs – most notably in pharmaceutical supplies. In addition, a major demand side policy (abolishing user fees) had an immediate and significant impact on the consumption of services. The paper concludes that increased utilisation of ambulatory services does signify improvements in consumer welfare and therefore health sector performance. It argues that in tackling price and quality constraints simultaneously, the Ugandan Government has successfully changed the population's perceptions about the value for money offered by Government and NGO health services. This has led to the large increases in consumption of ambulatory, primary health care services especially by the poorer members of Ugandan society.
However, stagnant maternity outputs indicate that key in-patient services are still not meeting the expectations of the population. Here it is likely that quality changes have been less pronounced and patient costs more persistent – resulting in relatively unchanged consumer perceptions of value for money. It is argued that significant additional investment will be required in maternity services if more Ugandan women are to give birth in health units.
Only reliable outcome data will resolve the debate about the significance of the changes in output indicators. However it is anticipated that a doubling in the consumption of effective primary health care services by the population will lead to improvements in health status. Further research will also be required to disentangle the relative impact of the different components of the reforms. In particular, how significant was the decision to scrap user fees in causing the subsequent surge in demand for services? Further analysis of these reforms could be immensely beneficial to other resource constrained sub-Saharan African countries trying to improve their health indicators.

Title: Sector Wide Approach as an aid contract modality in Uganda [1.5]
Authors: V Oliveira Cruz, B McPake, R Yates, F Seengooba, C Kirunga Tashobya and G Murindwa

Rationale: Concerns for equity, efficiency, and government leadership have led to the introduction of the sector-wide approach (SWAp) in Uganda. The main objective of the SWAp is to improve the overall performance of the health system and consequently the health status of Uganda's population.
Objectives: The relationship between the Government and development partners under this aid modality (SWAp) is interpreted as a contractual arrangement. This is a new approach to research in this field. The objective of this paper is to analyse the negotiation and monitoring environments of the SWAp contract in Uganda.
Methodology: We use a qualitative case study approach. Methods include key informant interviews, documentary analysis and direct and participant observation (4 of the authors have been part of the Ugandan SWAp).
Results: The framework governing the SWAp contract in Uganda is the Health Sector Strategic Plan – a five year plan developed by various stakeholders which aims to address the country's key health challenges. The specific contract instrument is the Memorandum of Understanding signed by the Government with various development partners. Policy advice, priority setting, decision-making, strategic management, monitoring and evaluation are carried out yearly, through Joint Review Missions and followed up on a monthly basis through the Health Policy Advisory Committee. Other structures exist and are entrusted with more specific functions such as budget priority reviews. Annually, actions or processes are agreed between the parties, called undertakings, for specific areas of high priority. Progress towards the achievement of undertakings is reviewed, and for a number of donors, successful achievement of the undertakings may determine the

release of funds to the Government's budget. Yearly tracking studies are agreed between the parties and allow an in-depth assessment of problems, formulate recommendations for action, and serve as opportunities to build consensus for these actions to be carried out, instead of functioning as internal types of audit.
Conclusions: The SWAp related structures, as the joint review missions, offer a very distinctive opportunity for the contractual parties to share their performance, experiences, views and knowledge, thereby contributing to a more in-depth and open understanding of the system and the reasons why certain elements are not working well. The functioning of these structures seems to be providing confidence to more development partners that their resources are channelled according to the plans and agreed priorities. While these development partners increasingly trust the efforts and commitment of the Government of Uganda, they also stress the need to improve accountability mechanisms. However, competition by other contract modes, i.e. vertical projects (e.g. new global health initiatives) may challenge the functioning of the SWAp arrangement. The project incentive structure particularly benefits actors at the national level, preferring project modes and associated control in procurement, high salaries, foreign travel, and limited transparency in decision making, e.g. who gets recruited and how. Conversely, the incentive structure of the SWAp mode lies at the operational level (districts) with a greater emphasis on flow of funds to district level and associated activities and more elements of transparency regarding how funds are used.

DSA Conference, Milton Keynes, UK, 7-9 September 2005

Title: Using agency theory to analyse relationships between recipient governments and development partners: a case study of Uganda [1.4]
Authors: V Oliveira Cruz and B McPake

Abstract: Previous studies of relationships between recipient governments (RGs) and international development partners (IDPs) in the health sector have tended to apply political economy frameworks to understand the key interchanges between these two sets of actors. Recently, agency theory has been used to further this analysis, but its use has not been applied to the health sector specifically. This study aims to contribute to a better understanding of the types of principal-agent relationships between RGs and IDPs and how these are affected by different aid modalities in the health sector in Uganda. Lack of accountability and transparency in practices and mechanisms of both sides have been persistent complaints in RG-IDP relationships. Hence, we analyse the circumstances under which IDPs act as principals and RGs as agents, and, in contrast to previous studies, when RGs act as principals and IDPs as agents. New ways of structuring aid modalities offer approaches to managing the relationships differently by altering the incentive and monitoring environment. In the Ugandan health sector, responsibility for meeting development targets is reviewed at a Joint Review Mission attended by all relevant state actors and IDPs. This new monitoring mechanism is argued to focus on results/outcomes rather than inputs to a greater extent than project modes of assistance, and can, therefore, change the nature of the relationship between RGs and IDPs. We have used qualitative methods (interviews, participant observation and documentary analysis) to understand the effects of this restructuring, specifically analysing alternative aid modalities in terms of incentive compatibility, rewards and penalties.

Medicine and Health in the Tropics Congress, Marseille, France, 11-15 September 2005

Title: Encouraging diversity in HIV prevention messages: Learning from Uganda [1.9]
Author: J Parkhurst

Abstract: The international community is continually looking to understand 'what works' for HIV/AIDS prevention, particularly what can bring about sexual behaviour change in diverse populations. Uganda remains one of the few countries to have shown decreasing HIV prevalence and incidence across the general population, and is commonly looked to for lessons of HIV success. Yet while recent efforts have attempted

to distil single messages from the Ugandan experience – most notably the so-called 'ABC' approach to prevention – in-depth investigation has revealed that a wide diversity of messages on the ground may have been particularly conducive to bringing about behaviour change. The government of Uganda worked to establish an enabling environment whereby many different groups – be they government, NGO, or religious organisations - each became involved in HIV prevention in unique ways. Research has shown that Ugandans are more likely to learn about HIV/AIDS from friends and close family networks than in other countries, and it appears that the best way to encourage communication through close social networks may be to have local groups designing custom tailored messages on the ground. Rather than promoting single messages of prevention, Uganda's experience shows the importance of establishing a political and social climate that enables multiple messages to be developed and applied.

Global Forum for Health Research Forum 9, Mumbai, India, 12-16 September 2005

Title: Human resources for health in decentralized Uganda: Implications for health systems research [1.1]
Authors: F Ssengooba, E Rutebemberwa, A Rahman and C Hongoro

Abstract: Decentralization is among the major reforms that have unfolded across the globe and in health-care delivery systems. Hypothesized benefits include responsiveness and efficiency in decision-making, accountability and a means of building democracy among health service users. The international community that is trying to scale up essential interventions is grappling with human resource problems, some aggravated by the decentralized governance systems. A study in six Ugandan districts has explored changes in the job environment of the health workforce under the decentralization policy. The study findings were generated by both qualitative and quantitative methods of inquiry targeting technocrats, health managers and health providers at different levels of the provision system. The survey covered 589 health workers and 101 health facilities. Unlike the previous centralized system of direct posting upon graduation, decentralization (1993) created a demand- driven recruitment of health workers. However, countervailing budget constraints imposed a cap on recruitment soon thereafter. The District Service Commissions – decentralized structures with human resource responsibilities was poorly resourced for the mandate. Workers described a "cage syndrome" a feeling of being trapped in a district system with no institutional arrangements to grow beyond what the district can offer. Budget constraints imposed a de facto policy against promoting workers into higher positions, a view held by 40% of respondents. Workers in under-served areas felt particularly underprivileged due to stringent controls against them taking annual leave and further training. Performance accountability of health workers to local authorities bred a widely shared (74%) sense of insecurity in job tenure. Performance judgements were divorced from institutional failures, e.g. poor drug budgets, higher workloads and salaries below minimum living wage. "Politicking" and "appeasement" towards local leaders were described as some of the major adaptive survival strategies, especially among workers with management responsibilities. These findings have implications in the design and strategies to motivate the workforce and the capacity to strengthen decentralized health systems to respond to national priorities and Millennium Development Goals. Findings point to a neglected function of human resource management. Research efforts to understand the incentive environment embedded in the decentralized systems of financing, institutional rules and patronage systems are needed as a prerequisite to designing human resource interventions that are critical to strengthening health system capacities.

12th Priorities in Reproductive Health and HIV Conference, October 2005.

Title: Job characteristics affecting where the maternal health nurses choose to work: A discrete choice experiment.
Authors: D Blaauw, L Penn-Kekana and C Hongoro

The international health human resource crisis has become an important concern for policymakers and health systems researchers. The shortage, skill imbalances, maldistribution, migration, and demotivation of health workers undermines health system performance in many developing countries including South Africa, and are a significant constraint on the achievement of global health priorities such as the

improvement of maternal health. There is a growing literature on the range of factors, such as remuneration, working conditions, and career opportunities, that influence the migration of nurses, but existing studies and methodologies have not evaluated the relative importance of these different factors in different contexts.
Conjoint analysis is a quantitative methodology for evaluating the relative importance of the different product attributes that influence consumer choice behaviour. Conjoint analysis is increasingly being used to assess patient preferences for health care service delivery but only a few studies, all from developed countries, have utilised this approach to analyse the preferences and choices of health care workers. The purpose of this study was to use conjoint analysis, in the form of a discrete choice experiment, to evaluate the relative importance of different financial and non-financial factors on maternal health nurses' choices about where to work.
Focus group discussions with maternal health nurses were used to select five key facility characteristics to include in the discrete choice experiment, namely; salary, staffing levels, the availability of equipment, the quality of facility management, and the availability of social amenities in the area. SPSS Orthoplan was used to generate 16 scenarios aimed at producing an orthogonal fractional factorial design. The scenarios were organised into 15 choice pairs and incorporated into a self-administered questionnaire that was administered to a sample of 147 professional nurses working in maternal health services at public sector clinics and hospitals in three provinces in South Africa. The collected data was analysed by multiple regression using a random effects ordered probit model in Stata 7.0.
All five factors were statistically significant ($p<0.001$) in influencing maternal nurses' choices about where to work. Higher salaries, good facility management, and the availability of equipment were the most important determinants of nurses' decisions. Salary levels were more important to younger nurses and nurses working in hospitals, while rural nurses were relatively more concerned about facility management.
The results confirmed that both financial and non-financial job characteristics affect maternal health nurses' choices about where to work and need to be considered in the development of policy interventions to retain nurses at public sector health facilities in South Africa.

Title: Nursing staff dynamics in maternal health services [1.1] [poster presentation)
Author: L Penn-Kekana and D Blaauw

5th Annual Congress of Midwives of South Africa, Mpumalanga, South Africa, 29 November – 2 December 2005

Title: "I'm just forcing myself to come to work: I'm not happy at all". Motivation levels among midwives in the public sector [1.1]
Authors: L Penn-Kekana and D Blaauw

Introduction: South Africa has relatively high levels of maternal mortality for a middle-income country. Poor health care workers practice has been identified as a contributory factor. Much of the explanation for poor practice has focused on availability (numbers and norms) and distribution of health care workers. It is increasingly being argued in the international literature that issues of motivation also need to be considered. This research project explored levels of motivation and causes of de-motivation amongst midwives.
Methods: The study was carried out in Limpopo, KwaZulu-Natal and Mpumalanga provinces in South Africa. 15 hospitals and 27 clinics were randomly sampled using multi-stage cluster sampling. In these facilities all midwives on duty in the maternity ward were asked to complete self-administered questionnaires. The questionnaire included 52 different questions on various aspects of motivational. Data were analysed in SPSS, with multiple regression models developed to evaluate factors associated with nurses intention to leave and organizational commitment.
Findings: Midwives working in maternity services were extremely demotivated and many indicated that they were considering going overseas. Factors associated with intention to leave included working at an urban area and a hospital rather than a clinic. Having children, dissatisfaction with pay & promotion, and poor co-worker relationships were also important. Factors associated with organisational commitment included facility management, supervisor relationships, nurse-doctor relationships, as well as workload and ability to cope with change.

Conclusion: Attempts to improve the quality of care in maternity services are not going to be succeed until both financial and non-financial factors that are causing midwives low levels of organisational commitment and going overseas are tackled. These problems need to be tackled at a health system wide level.

Title: Health system factors impacting on the quality of care provided by midwives. Insights from an ethnographic study [1.1]
Author: L Penn-Kekana

Introduction: Poor practice by midwives is contributing to high levels of perinatal and maternal deaths in South Africa. Although numbers of midwives is an important issue, little attention has been paid to the unique and complex circumstances under which midwives operate and the pressures that they face.
Methods: An ethnographic study in two maternity wards in two district hospitals. One urban & one rural. The main body of the work was carried out in 2002 and 2003 but follow up work has been carried out in 2004 & 2005. The focus of the research project was to understand factors that impacted on the everyday practice, including clinical practice, of midwives.
Results: A heavy non-clinical workload; poor staff development; poor relationships among staff and between staff and hospital management; staff and hospital management struggling to implement policies imposed from higher up in the system; new financial management systems: midwives uncertainty about career paths; junior staff not receiving rural allowances; tensions with community representatives, and new performance management systems all directly impacted on the quality of care provided by midwives.
Conclusions: A number of policy reforms, some public sector wide, designed to improve the way that the public service is run; and the quality of care that is provided for the general public; are because of they way that they are designed implemented and prioritised, causing real problems for midwives. Midwives need to engage in wider health system policy debates and not stick to a narrow maternal health focus. National policy makers need to be made aware of the impact of their policies on the quality of care for women and their babies.

2nd International Conference Health Financing in Developing Countries (CERDI), Clermont-Ferrand, France, 1-2 December 2005

Title: Management is context specific: Cameroon's process for considering the design of district performance contracts [1.1]
Authors: M Ambegaokar, P Ongolo-Zogo, T Aly, E Betsi, J. Fouda and B. McPake

Like many other developing countries, Cameroon is faced with trying to achieve public health objectives, such as those enshrined in the Millennium Development Goals, in the context of a health sector facing serious challenges. Among other constraints, the opportunistic behaviour of health sector personnel earning low public salaries has resulted in a reallocation of some of their time to outside income generating activities. Consideration is being given by the Ministry of Public Health to the use of performance-based district contracting in order to engage personnel better in the achievement of particular primary health care objectives by using financial incentives. The notion of using performance-based remuneration and contracts is not, of course, an entirely domestically generated idea. It is a global policy vogue and, increasingly, the use of performance rewards is being tried in the health sectors of both developed and developing countries. Contracts that use performance-based remuneration are theoretically argued to motivate health sector personnel to work towards achieving public health goals by putting in place an appropriate incentive structure. However, the design and implementation of such a system is more complex than it at first sounds, with implications for health sector personnel management, provincial and district management and financial authority. The appropriate design of such a system is unlikely to be generic, but will need to be developed in response to a particular local context. It is possible that some, perhaps many, health sector settings are not conducive to the use of contracts and financial performance incentives. The research presented in this paper was commissioned by the Ministry of Public Health of Cameroon to inform

discussions about whether and how to develop performance contracting for primary health care delivery at the district level in Cameroon.
We looked for lessons from existing and earlier experiences in the Cameroonian health sector with performance measurement and bonus payments and found that, although there have been many failed attempts, meaningful examples of reward allocation based on verified performance at the individual level exist in the Cameroon health sector. The most successful of these have been entirely locally generated and developed and have the follow characteristics:

- Transparency in financial management
- Performance criteria at individual level
- Clear work expectations known to each worker
- Real mechanisms for verifying and evaluating the work done
- Real sanctions applied against those who do not respect the rules of the game
- Identification and involvement of all parties in managing the system
- Good "leadership"

These are not hypothetical or theoretical findings, but observations from real Cameroonian contexts and, as such, are appropriate to inform the design of any future performance remuneration in the Cameroon health sector. Many of the contexts in which we found these characteristics of successful performance measurement and remuneration developed in isolation from global debates about contracting. As such they can be seen as "genuine experiments to discern the most appropriate local solutions to local problems" and may therefore serve as a way forward in the face of Pritchett and Woolcock's (2004) observation that global policy makers' attempts to identify the solution for every time and place must be untenable. Certainly they offer hope to the Cameroon Ministry of Public Health's attempts to address severe difficulties in the management of the sector.

Title: Aid Effectiveness and Changes in the Approach to Monitoring and Evaluation in International Development Assistance for Health [1.5]
Authors: V Oliveira Cruz and B McPake

Background: The international community has in recent years introduced new modes of aid delivery which offer new ways of structuring the relationship and the aid contract. These newer modes of aid delivery are chiefly Sector Wide approaches (SWAp) and General Budgetary Support (GBS). The main difference between a SWAp and GBS is that the former is specific to a sector, such as health or education and in the latter, aid resources are not earmarked to any sectoral activity; they can be used to fund any type of government expenditure. The changes taking place in the aid contract reflect donors increasing concern with the effectiveness of aid (Adam and Gunning, 2002; Lavergne, 2002) and greater focus on outcomes as a measure of performance.
Objective: The aim of this paper is to provide an analysis of recent changes in relation to aid effectiveness, in particular to the greater use of outcome based approaches to monitoring and evaluation in international development assistance for health. In addition, we provide an overview of advantages and disadvantages of the new model based on experience to date.
Methods: The methodology is a historical review and analysis of the developments of new approaches of monitoring and evaluation in international development assistance for health. Data comes from an examination of official reports and review of the literature.
Results: The growing concern with aid effectiveness seems to be underpinned by changes regarding the functioning of government and the introduction of ideas from the New Public Management (NPM) debate. NPM advocates the use of performance related agreements among other changes which demand evidence of achievement of outcomes rather than legitimate use of inputs (Kaul, 1997). The instruments and measures of monitoring in the public sector have shifted their focus from inputs (mainly financial and human resources) to outcomes (for instance maternal mortality rates) (Paul, 1992). This shift is mirrored in changes in international development assistance. Commitment to results based management and a focus on

international targets are to a large extent based on outcomes. Alternative delivery mechanisms closer to budget support than the project approach give recipients greater flexibility to focus on achievement of outcomes as opposed to accountability for inputs (Maxwell, 2003). The Millennium Development Goals (MDGs) are a clear example of this shift.
The new monitoring model (outcomes-based) presents advantages such as allowing policy makers to focus on long term goals and ultimate objectives as for example the reduction of maternal mortality rates. The outcome-based model also has deficiencies, in particular measurement and verification is costly and current capacity is limited which allows the scope for opportunistic behaviour to arise.
We also give consideration to the choice of monitoring indicators by examining the balance of those that change faster, and are easier to detect with those more closely related to outcomes of interest as this seems to be key to managing international development assistance for health.
It is thus crucial that the international aid community pays careful attention to the problems related to the new model and seeks ways to reduce perverse incentives in the system. A balanced mixed-mode approach which continues to track inputs and processes while developing trust and monitoring focused on the measurement and validation of output and outcome measures is recommended. This may require additional investment in the short term to yield long term gains of greater transparency and accountability.

Title: Sector, Wide Approach as an aid contract modality in Uganda [1.5]
Authors: V Oliveira-Cruz**,** R Cooper, B McPake and R Yates

Rationale: Concerns for equity, efficiency, and government leadership have led to the introduction of the sector-wide approach (SWAp) in Uganda. The main objective of the SWAp is to improve the overall performance of the health system and consequently the health status of Uganda's population.
Objectives: The relationship between the Government and development partners under this aid modality (SWAp) is interpreted as a contractual arrangement. This is a new approach to research in this field. The objective of this paper is to analyse the negotiation and monitoring environments of the SWAp contract in Uganda.
Methodology: We use a qualitative case study approach. Methods include key informant interviews, documentary analysis and direct and participant observation (2 of the authors have been part of the Ugandan SWAp).
Results: The framework governing the SWAp contract in Uganda is the Health Sector Strategic Plan – a five year plan developed by various stakeholders which aims to address the country's key health challenges. The specific contract instrument is the Memorandum of Understanding signed by the Government with various development partners. Policy advice, priority setting, decision-making, strategic management, monitoring and evaluation are carried out yearly, through Joint Review Missions and followed up on a monthly basis through the Health Policy Advisory Committee. Other structures exist and are entrusted with more specific functions such as budget priority reviews. Annually, actions or processes are agreed between the parties, called undertakings, for specific areas of high priority. Progress towards the achievement of undertakings is reviewed, and for a number of donors, successful achievement of the undertakings may determine the release of funds to the Government's budget. Yearly tracking studies are agreed between the parties and allow an in-depth assessment of problems, formulate recommendations for action, and serve as opportunities to build consensus for these actions to be carried out, instead of functioning as internal types of audit.
Conclusions: The SWAp related structures, as the joint review missions, offer a very distinctive opportunity for the contractual parties to share their performance, experiences, views and knowledge, thereby contributing to a more in-depth and open understanding of the system and the reasons why certain elements are not working well. The functioning of these structures seems to be providing confidence to more development partners that their resources are channelled according to the plans and agreed priorities. While these development partners increasingly trust the efforts and commitment of the Government of Uganda, they also stress the need to improve accountability mechanisms. However, competition by other contract

modes, i.e. vertical projects (e.g. new global health initiatives) may challenge the functioning of the SWAp arrangement. The project incentive structure particularly benefits actors at the national level, preferring project modes and associated control in procurement, high salaries, foreign travel, and limited transparency in decision making, e.g. who gets recruited and how. Conversely, the incentive structure of the SWAp mode lies at the operational level (districts) with a greater emphasis on flow of funds to district level and associated activities and more elements of transparency regarding how funds are used.

Title: Health Sector Resource Allocation in the Era of Budget-Support by Development Partners in Uganda
Authors: F Ssengooba, R Yates, V Oliveira-Cruz and C Kiringa Tashobya

Background: One of the claims of the sector-wide approach (SWAp) in the health sector is that improved coordination mechanisms should lead to a better allocation of resources within the sector. In particular, it is argued that the pooling of financial resources, in order to fund a coherent sector-wide plan, should lead to improved efficiency in contrast to project-based aid which earned itself a “fragmentalistic” label.

This paper explores the evidence to support this assertion in the case of the Ugandan health budget reforms since 2000. It also asks if the reforms are addressing another vital performance measure, that of improving the equitable allocation of health care resources. Paper is based on secondary analysis of the national household survey and national health accounts for the period 2000 – 2003.

Findings: An assessment of the largest financing mechanisms, the government budget and donor projects, seems to indicate that overall, allocative and operational efficiency has improved. This has largely been driven by the performance of the government budget since 2000, which has increased allocations to district primary health care services from 23 percent to 43 percent over a four-year period, thereby increasing the provision of services available for the rural population and addressing the major causes of ill health (e.g. malaria). Fifty percent of the non-wage funds were earmarked for drugs a policy that responded (albeit low drug funding per capita) to the client concerns voiced in participatory poverty assessment reports.

Donor projects appear to be less efficient at allocating resources to services that directly affect the poor. It is estimated that 34 percent of project-based funding is attributable to elements of the health sector plan in Uganda. The rest of the fund appear trapped in items such as technical assistance and project administration – all of which have little trickle-down effect. It would appear beneficial in welfare terms that the project-mode has been overtaken by the public budget as the largest conduit for sector funding ie 33.6 percent and 54.1 percent respectively in fiscal year 2002-03. user fees, local government and charitable donations accounted for the rest. However, the this analysis is likely to change in the context of international resort to project modes of assistance typified by the disease approach implicit in the Global Fund and other global initiatives to provide treatments for HIV/AIDS.

Recommendation: Relatively Increased funding for rural services demonstrated in the district primary care grants also indicates a more broadly equitable allocation of resources towards the rural poor as the high need groups. New financing modalities such as the Global Fund should learn from the Uganda experience and channel resources in a manner that maximizes the trickle-down of benefits to the target populations.

Title: Health care outputs have doubled in Uganda: What has been the role of health financing reforms? [1.5]
Authors: R Yates, C Kirunga Tashobya, V Oliveira-Cruz, B McPake and H Nazerali

Objectives: Poor health indicators in the 1990s prompted the Government of Uganda (GoU) and development partners to embark on an extensive programme of health systems reforms. A Sector Wide Approach (SWAp) was launched in 2000, which initiated a wide range of supply side and demand side reforms. Many of these initiatives relate to health financing, where there has been a significant trend to replace donor project funding and patient fees with GoU budget financing.
A large volume of literature has been written about how Government led SWAPs *should* improve sector efficiency but to date, actual results of these reforms have been rare. The question remains: Do SWAPs work? The primary objective of this paper is to provide output evidence from Uganda to suggest that they can. Specifically, the paper attempts to highlight which aspects of the reforms are driving changes in the consumption of services. Given the universal need to improve health sector efficiency in the developing world, these results and this analysis could have great significance for other countries embarking on health financing reforms.
Method and Data: Using MoH publications and interviews with key stakeholders, the paper identifies the major reforms within the health sector and across government, which may be responsible for the changes in output performance. It highlights a number of supply side reforms, which appear to have increased the availability of essential inputs. These include: more efficient and equitable budget allocations, donors switching their financing mechanism from projects to direct budget support and improved management of vital inputs – most notably in pharmaceutical supplies. In addition, a major demand side policy (abolishing user fees) is identified as having had a profound impact on the consumption of services.
Output and health expenditure data on GoU and NGO health services were derived primarily from GoU management systems. This data was triangulated with recent independent research from WHO and the World Bank, which also provided insights on the socio-economic breakdown of beneficiaries.
Results: Five years into the SWAp process, the Ugandan health sector has recorded large rises in outputs for ambulatory services. Nationally, outpatient attendances have increased by 141% (from 9.3 million to 22.4 million). Immunisation rates (as measured by DPT3 uptake) have also more than doubled from 41% to 92%. Monthly out-patient statistics show that a rapid increase in outputs occurred in the month following the abolition of patient charges. Furthermore, external research has shown that the growth in the consumption of these services appears to be highest by the poorest socio-economic groups.
However, statistics for key in-patient services, most noticeably maternity services, have shown smaller increases. An analysis of health expenditure trends over this period indicate that rises in outputs have been achieved with only a modest (18%) increase in the level of health sector financing.
Analysis: The paper attempts to assess the significance of these changes. Do these output changes signify improved sector performance which will lead to better health outcomes? The paper concludes that increased utilisation of ambulatory services does signify improvements in consumer welfare and therefore health sector performance. It argues that in tackling price and quality constraints simultaneously, the Ugandan Government has successfully changed the population's perceptions about the value for money offered by Government and NGO health services. This has led to the large increases in consumption of ambulatory, primary health care services especially by the poorer members of Ugandan society.
However, stagnant maternity outputs indicate that key in-patient services are still not meeting the expectations of the population. Here it is likely that quality changes have been less pronounced and patient costs more persistent – resulting in relatively unchanged consumer perceptions of value for money. It is argued that significant additional investment will be required in maternity services if more Ugandan women are to give birth in health units.

Only reliable outcome data will resolve the debate about the significance of the changes in output indicators. However it is anticipated that a doubling in the consumption of primary health care services by the population will lead to improvements in health status. Further research will also be required to disentangle the relative impact of the different components of the reforms. In particular, how significant was the decision to scrap user fees in causing the subsequent surge in demand for services? Further analysis of these reforms will be beneficial to other resource constrained sub-Saharan African countries trying to improve their health indicators.

Title: Agency Theory as an Analytical Framework for the Understanding of Relationships between Development Partners and Recipient Governments [1.5]
Authors: V Oliveira-Cruz and B McPake

Background: The use of agency theory as a conceptual framework to analyse relationships in the health sector is now well established since Arrow's contribution (1963). The application of agency theory in the sector has grown since. Recent contributions include for instance a study of hospital-based doctors in China (Liu, 1999), the design of physician payment incentives in the USA by Robinson (2001), the role of performance measurement in health care in the UK (Mannion and Goddard, 2002; Goddard *et al*., 2000) and the application of the principal-agent model to key elements of health care systems (Smith *et al*., 1997).
Objective: The aim of this paper is to better understand principal-agent relationships between recipient governments and international development partners in the health sector. In this paper we explore the different types of principal-agent relationships in international development assistance for health; discuss conflicting objective functions among the contractual parties (recipient governments and international development partners); apply elements of the dynamic model (multi-principals and multi-tasks) to international development assistance for health; provide an analysis of issues related to the compensation scheme in the aid contract; and discuss different options for dealing with agency problems.
Methods: The methodology is a historical review and analysis of the application of agency theory to analyse the relationship between development partners and recipient governments in the health sector. Data comes from an examination of official reports and review of the literature.
Results: Agency theory has more recently been used to further the analysis of the relationships of recipient governments and international development partners, in more general terms (Zinnes and Bolaky, 2002; Martens *et al*., 2002; Svensson, 1997) and more specifically in relation to the use of performance indicators in the design of aid contracts, though only implicitly using an agency theory framework (Adam and Gunning, 2002) and to conditionality contracts (Killick, 1997), which as argued by Martens *et al*. (2002) is inherently about principal-agent relationships. Yet, there is a lack of empirical evidence relating the micro-institutional relationships in international aid organisations (Martens *et al*., 2002) and the discernment of the multiple stages of the aid delivery process and the many involved actors (principals and agents) with various (and often conflicting) objectives and constraints (Zinnes and Bolaky, 2002). In addition, agency theory has not been applied to the sector of international development assistance for health specifically. The application of agency theory to this sector (health) is of particular relevance as health outcomes are determined within a complex scenario of uncertainties and various contributing factors. These complexities enhance the difficulties in monitoring and measurement, which instigate the use of principal agency theory to understand the explicit and implicit incentive structure of the aid contract.
The kinds of conflicts of interests between the various actors involved in international development assistance - the multiple layers of delegations between actors and organisations, the broken feedback loop between the populations in 'donor' and recipient countries, the consequent weak accountability link across these institutions, and the difficulties related to monitoring (observing) the actions and or outputs yielded by agents - give rise to an array of incentive problems and highlight the need for devising sophisticated incentive structures (or at least being alert to the perverse incentives that may arise, and designing coping mechanisms).

Participatory workshop, University of Manchester, 16 February 2006

Title: Patients' rights: meaning and action in different contexts
Authors: B Smith and S MacKian