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Chapter 1 : Health care reform - Wikipedia

Health sector reform deals with equity, efficiency, quality, financing, and sustainability in the provision of health care, and also in defining the priorities, refining the policies and reforming the institutions through which policies are implemented.

Advanced Search Abstract Background: This study investigates the impact of these reforms on the efficiency of public hospitals. Our study would contribute to the existing literature with a comprehensive analysis of the health system in a developing country. We employ the data envelopment approach and the Malmquist index to comparatively examine before and after the reform years. Our analyses compare the performances of public hospitals served in provincial markets. Inputs of number of beds, number of primary care physician, and number of specialists, and how they are used to produce outputs of inpatient discharges, outpatient visits and surgical operations are investigated. Indeed, as the performance indicators dead rate, hospital bed occupation rate and average length of stay are considered. The HTP was generally successful in boosting productivity due to advancements in technology and technical efficiency but in the socio-economically disadvantaged provinces productivity gains have not been achieved. The average technical efficiency gains took place because of the significantly improved scale efficiencies, as the average pure technical efficiency slightly improved. Lastly, the hospital performance indicators have not improved in the short run. It appears that the expected benefits from the health reforms in Turkey have been partially achieved in the short run. As a part of the major structural changes in the health care system, including the integration of security schemes under the Social Security Institution SSI and the implementation of Universal Health Insurance, the Ministry of Health MoH has implemented important reforms on the hospital sector; within the sector, there were three main public providers: First, in a performance-based supplementary payment system P4P has been initiated in the MoH health facilities. SSK health facilities have been transferred to the MoH. The family medicine has been established for an efficient referral system. The health information systems have been upgraded. Moreover, health personnel in the MoH hospitals accessed to improved medical technology and diagnostics through increased government investments and out sourcing these services to the private sector. This centralized way of operation restricted the use of RFs for hospital operating costs. The P4P is introduced because of health staff shortage and it has targeted to increase the volume of all type of services provided by the MoH hospitals. Thus, a salary of a physician became equal to the base salary plus the P4P bonus payment. Physicians are remunerated bonuses according to points they collect throughout the month from outpatient physical exams, inpatient procedures, tests and diagnoses. An aggregate amount of bonus payments is adjusted by the institutional performance multiplier that is assigned by the MoH according to institutional performance audit results. This global budget was decided depending on the past realizations of the MoH hospitals RFs expenditures. Furthermore, in , to coordinate health payments, SSI has developed the bundled prices for inpatient and outpatient health services that were set upon procedural and ICD 10 coding systems. The objective of our study is to investigate the impact of the HTP reforms on the efficiency and productivity of public hospitals in Turkey. We employ Data Envelopment Analysis DEA and the Malmquist index on the multiple inputs and outputs of the public hospitals in 81 provincial markets in years and pre- and post-reform years, respectively. We search that whether the reforms have an overall effect on productivity innovation in the Malmquist index or did they improve locally the productivity by aligning hospitals and combining resources the merger of MOH and the SSK hospitals may give this result. In the â€”13 Strategic Plan, the MoH states that the establishment of public hospital unions PHU will be completed until 6 and, according to the PHU law, all MoH hospitals in the same province will be united under one union and jointly carry out the planning, budgeting, and implementation. Therefore, to provide the necessary feedback to the policy-makers, we compare the public hospitals in terms of provinces serving as the data management units DMUs. In literature, there are three major studies considering the hospital sector efficiency in Turkey employing the DEA: None of these studies compare the impacts of the HTP reforms on the efficiency of the public hospitals: Thus, our study contributes literature by assessing the effects of the health sector reforms on public hospitals efficiency by comparing before and after the reform performances. Methodology The DEA allows dealing

with multiple outputs and inputs while looking for a production ratio that relate outputs and inputs. Due to different possible combinations of inputs as well as outputs there may be as many optimums as there are observed optimal combinations. The analysis can focus on optimizing outputs or inputs, in the analysis the output-driven approach has been chosen as the MoH hospitals managers have limited autonomy to hire or fire staff the most important input for the hospitals as all staffing decisions were made by the MoH 5. The frontier can be derived with two main methods: The main difference between the two is that CCR assumes a constant return to scale there is an optimal productivity ratio that can be reached whatever is the size of the DMU , while BCC assumes variable return to scales the optimum is a local one that depends on the size. Under imperfect competition and constraints on finance, DMUs cannot operate at the optimal scale. The variable return to scales VRS states the fact that production technology may display increasing, constant, or decreasing returns to scale. In our study, BCC method is employed since, in the Turkish hospital market, there are imperfect competition and financial constraints. In this study, DEA program version 2. According to output oriented DEA, for a given amount of inputs the units producing greater amounts of outputs will be the efficient. In order to illustrate it lets consider figure 1 , in which there are four DMUs A, B, C and D as each unit uses the same amount of a single resource but produces different amounts of outputs, y1 and y2. Employing the DEA to these units will classify A, B and C as efficient and they altogether construct the envelopment frontier and have an efficiency score of one. As D lies below this frontier, it is inefficient compared to its peers B and C. The inefficient DMUs has a technical efficiency score between one and zero 10 , 13â€" First, a technical productivity change that checks for the optimization of each DMU combination of inputs according to the benchmark for that combination, this is a local comparison to the best DMUs working with similar size. Secondly, a technical change productivity that looks for improvement by global innovation that shifts the frontier and the optimal size. These two factors can be measured by the Malmquist productivity change index that is defined as follows: If the Malmquist productivity change index is greater than 1, the improvement in productivity is gained relative to the previous year. However, if the index is less than 1 the productivity deteriorates, and if the index is equal to 1 then no productivity change occurred. The productivity of DMU rises if it uses its existing inputs more efficiently, and so it can produce more while consuming the same levels of inputs. In other words, productivity grows as technical efficiency grows. Also, the productivity can rise because of technological change such as adopting innovations like advanced IT technologies, improved designs and products. Consequently, the decomposition of Malmquist index becomes: Furthermore, we employ a non-parametric Wilcoxon signed-ranks test, which does not require any assumptions on the distribution, to compare before and after the reform performances of the MoH hospitals. In , there were hospitals operated by the MoH, 56 university and private hospitals. The university hospitals are operated according to totally different operational systems and regulations. Hence, main public health care providers, except university hospitals, in 81 provinces in Turkey that responded to the annually published MoH Statistical Year Book of Inpatient Health Care Organizations of Turkey, and , were included in this analysis. Table 1 Description of the variables of interest Variables.

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Chapter 2 : WHO | Sub-national and district management: Reforms

Mission The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient.

Published online Feb 1. This article has been cited by other articles in PMC. Abstract Background Despite the expanding literature on how reforms may affect health workers and which reactions they may provoke, little research has been conducted on the mechanisms of effect through which health sector reforms either promote or discourage health worker performance. Methods 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 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. Results The reforms in both countries affected the workforce through various mechanisms. In Bangladesh, the effects of the unification efforts resulted in a power struggle and general mistrust between the two former workforce tracts, family planning and health. However positive effects of the reforms were felt regarding the changes in payment schemes. Ugandan findings show how the workforce responded to a strong and rapidly implemented system of decentralisation where the power of new local authorities was influenced by resource constraints and nepotism in recruitment. On the other hand, closer ties to local authorities provided the opportunity to gain insight into the operational constraints originating from higher levels that health staff were dealing with. Conclusion Findings from the study suggest that a reform planners should use the proposed dynamic responses model to help design reform objectives that encourage positive responses among health workers b the role of context has been underestimated and it is necessary to address broader systemic problems before initiating reform processes, c reform programs need to incorporate active implementation research systems to learn the contextual dynamics and responses as well as have inbuilt program capacity for corrective measures d health workers are key stakeholders in any reform process and should participate at all stages and e some effects of reforms on the health workforce operate indirectly through levels of satisfaction voiced by communities utilising the services. Background In the last two decades, developing country governments have implemented a variety of reforms in the health sector on the understanding that these reforms would create the right individual and organisational incentives for improving health systems performance. However, reform initiatives have not always considered human resource issues that are relevant to their success and have often failed to include the participation or perspectives of the health workforce in reform planning processes and decision-making. A number of studies have considered the effects of reforms on the health workforce [[1 - 5] and [6]] and highlight the importance of human resources to the success of reform objectives [7] as well as the complexity of human resource management in the context of reforms [8 , 9]. These studies have pointed out that human resource issues need to be a primary consideration in reform design, suggesting that reforms can only be implemented successfully where there is consensual participation on the part of the workforce. Ngufor describes how health staff in Cameroon perceived reforms as a punishment inflicted on the nation by the International Monetary Fund IMF and the World Bank and as a result developed a laissez faire attitude to their work resulting in reduction of consultation times and absenteeism [4]. Similarly, workers in Zimbabwe were reported to perceive reforms as threatening their job security, salaries and training and expressed their demotivation in the form of unethical behaviour with their patients and neglect of work responsibilities [6]. In other parts of the world, health workers have resisted change on the grounds of conflicting values. In Latin America, for example, reforms were perceived as aiming to undermine the fundamental values that had inspired the design of the system, and sparked off a wave of resistance and strikes in El Salvador and Mexico. This led to the stalling and delay of the reform process [10 , 11]. Other studies have noted higher motivation levels among the health workforce through reforms. How do reforms affect the health workforce and create responses that are likely to encourage the success or failure of reform objectives? How does context influence

the routes through which reforms affect provider incentive environments and eventually motivation and performance? This approach takes account of the explanatory mechanisms and the context of health systems reforms. The research described above suggests that reform programmes cause a multitude of workforce responses which act as the lynchpin between formal arrangements at the outset of the reforms and the resulting changes in the system as experienced by people who use it.

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Chapter 3 : Healthcare in Tanzania - Wikipedia

The road to universal health coverage (UHC) needs not be driven by big reforms that include the initiation of health insurance, provider-funder separation, results-based financing, or other large health sector reforms advocated in many countries in sub-Saharan Africa and elsewhere.

Please update this article to reflect recent events or newly available information. January This section does not cite any sources. Please help improve this section by adding citations to reliable sources. Unsourced material may be challenged and removed. January Learn how and when to remove this template message Healthcare was reformed in after the Second World War, broadly along the lines of the Beveridge Report , with the creation of the National Health Service or NHS. It was originally established as part of a wider reform of social services and funded by a system of National Insurance , though receipt of healthcare was never contingent upon making contributions towards the National Insurance Fund. Private health care was not abolished but had to compete with the NHS. As part of a wider reform of social provision it was originally thought that the focus would be as much about the prevention of ill-health as it was about curing disease. The NHS for example would distribute baby formula milk fortified with vitamins and minerals in an effort to improve the health of children born in the post war years as well as other supplements such as cod liver oil and malt. Many of the common childhood diseases such as measles, mumps, and chicken pox were mostly eradicated with a national program of vaccinations. The NHS has been through many reforms since This necessitated the detailed costing of activities, something which the NHS had never had to do in such detail, and some felt was unnecessary. The Labour Party generally opposed these changes, although after the party became New Labour , the Blair government retained elements of competition and even extended it, allowing private health care providers to bid for NHS work. Some treatment and diagnostic centres are now run by private enterprise and funded under contract. However, the extent of this privatisation of NHS work is still small, though remains controversial. The administration committed more money to the NHS raising it to almost the same level of funding as the European average and as a result, there was large expansion and modernisation programme and waiting times improved. The government of Gordon Brown proposed new reforms for care in England. One is to take the NHS back more towards health prevention by tackling issues that are known to cause long term ill health. The biggest of these is obesity and related diseases such as diabetes and cardio-vascular disease. The second reform is to make the NHS a more personal service, and it is negotiating with doctors to provide more services at times more convenient to the patient, such as in the evenings and at weekends. This personal service idea would introduce regular health check-ups so that the population is screened more regularly. Doctors will give more advice on ill-health prevention for example encouraging and assisting patients to control their weight, diet, exercise more, cease smoking etc. Waiting times, which fell considerably under Blair median wait time is about 6 weeks for elective non-urgent surgery are also in focus. A target was set from December , to ensure that no person waits longer than 18 weeks from the date that a patient is referred to the hospital to the time of the operation or treatment. This week period thus includes the time to arrange a first appointment, the time for any investigations or tests to determine the cause of the problem and how it should be treated. An NHS Constitution was published which lays out the legal rights of patients as well as promises not legally enforceable the NHS strives to keep in England. Germany[edit] Numerous healthcare reforms in Germany were legislative interventions to stabilise the public health insurance since Health care in Germany , including its industry and all services, is one of the largest sectors of the German economy. The total expenditure in health economics of Germany was about Direct inpatient and outpatient care equal just about a quarter of the entire expenditure - depending on the perspective. Pharmaceutical drug expenditure grew by an annual average of 4. An actual example of and First time since the drug expenditure fell from That was caused by restructuring the Social Security Code: Health care in the Netherlands The Netherlands has introduced a new system of health care insurance based on risk equalization through a risk equalization pool. In this way, a compulsory insurance package is available to all citizens at affordable cost without the need for the insured to be assessed for risk by the insurance company.

Furthermore, health insurers are now willing to take on high risk individuals because they receive compensation for the higher risks. Healthcare in Russia Following the collapse of the Soviet Union, Russia embarked on a series of reforms intending to deliver better healthcare by compulsory medical insurance with privately owned providers in addition to the state run institutions. According to the OECD [31] none of reforms worked out as planned and the reforms had in many respects made the system worse. Russia has more physicians, hospitals, and healthcare workers than almost any other country in the world on a per capita basis, [32] [33] but since the collapse of the Soviet Union, the health of the Russian population has declined considerably as a result of social, economic, and lifestyle changes. However, after Putin became president in there was significant growth in spending for public healthcare and in it exceed the pre level in real terms. Polls in are reported to have shown that However, the NHI is a pay-as-you-go system. The aim is for the premium income to pay costs. The system is also subsidized by a tobacco tax surcharge and contributions from the national lottery. January Learn how and when to remove this template message As evidenced by the large variety of different healthcare systems seen across the world, there are several different pathways that a country could take when thinking about reform. In comparison to the UK, physicians in Germany have more bargaining power through professional organizations i. The Netherlands used a similar system but the financial threshold for opting out was lower Belien The Swiss, on the other hand use more of a privately based health insurance system where citizens are risk-rated by age and sex, among other factors Belien Healthcare is generally centered around regulated private insurance methods. One key component to healthcare reform is the reduction of healthcare fraud and abuse. Also interesting to notice is the oldest healthcare system in the world and its advantages and disadvantages, see Health in Germany. Chan School of Public Health aim to provide decision-makers with tools and frameworks for health care system reform. The authors selected these control knobs as representative of the most important factors upon which a policymaker can act to determine health system outcomes. The authors view health care systems as a means to an end. Accordingly, the authors advocate for three intrinsic performance goals of the health system that can be adjusted through the control knobs. This goal is concerned with the degree of satisfaction that the health care system produces among the target population. The authors also propose three intermediate performance measures, which are useful in determining the performance of system goals, but are not final objectives [42]. Alternative frameworks for health care reform Framework.

Chapter 4 : Health sector reforms and human resources for health in Uganda and Bangladesh: mechanism

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Recent statistics shows that there were about 7 private firms as indicated in the Tanzania Insurance Regulatory authority TIRA [19] which were providing health insurance per se, while a few of other general insurance firms combine health insurance benefit under life insurance. The scheme was initially intended to cover public servants but recently there have been provisions which allow private membership. This scheme covers the principal member, spouse and up to four below 18 years legal dependants. There has been a steady increase in coverage from 2. The scheme accredits both public and private providers. There is a counterpart called TIKA which mainly targets the informal sector individuals in urban areas. Members of Strategies insurance are corporate employees and become members through their company. AAR [25] is another private health insurance in Tanzania. The firm started as a health-maintenance organisation HMO in but in it was re-registered as a private health insurance company. Jubilee Insurance, Resolution Health and Metropolitan Insurance are other examples of private health insurance firms with more less similar features as strategies and AAR. Beneficiaries of NHIF includes the contributing members, spouse and up to four dependants. The CHF beneficiaries include head of household, spouse and all children below 18 years. CHF mainly focuses its coverage in rural population while private health insurance schemes target urban population. Low insurance coverage leads to overreliance on direct payment at the point of use of health care, which is among the fundamental problem that restrain the move towards universal health coverage in many developing countries. In young women ages 15 to 24, there is an HIV prevalence rate of 3. More than half of available hospital beds are occupied by HIV-infected persons. It is imperative to reduce diarrheal diseases if the country is to achieve the Sustainable Development Goals. In the UNICEF Pneumonia and Diarrhea Report , there are strategies outlined for the low income countries to adopt in the fight against these two leading killer diseases. However, the EPI has included the pentavalent vaccine which protects against Haemophilus influenzae , a common cause of pneumonia. These cases were in HIV negative people. Non communicable diseases[edit] Tanzania has seen an increase of non communicable diseases as some of the leading causes of death. The major ones by contribution include: Maternal and child healthcare[edit] The maternal mortality rate per , births for Tanzania is This is compared with in and The UN Child Mortality Report reports a decrease in under-five mortality from per 1, live births in to 76 per 1, live births in , and in neonatal mortality from 40 per 1, live births to 26 per 1, live births. In Tanzania there are only two midwives per 1, live births; and the lifetime risk of death during delivery for women is one in Every year, , women die due to complications in pregnancy and childbirth, and 6. Due to considerable proportion of mortality being attributed by maternal and child health, the United Nations together with other international agencies incorporated the two into Millennium Development Goals MDGs 4 and 5. In this regard, Tanzania through the Ministry of Health and Social Welfare MoHSW adopted different strategies and efforts to promote safe motherhood and improve child survival. Maternal health indicators[edit] Maternal mortality ratio[edit] Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. Statistically, maternal mortality contributes to only 2. Many low-income countries have no or very little data and modelling is used to obtain a national estimate. Reduction of maternal deaths is one of the main goals of the Tanzanian poverty reduction strategy [43] and the health sector reform program, but progress has been slow. The Tanzania Demographic and Health Survey showed that 98 percent made at least one ANC visit and 43 percent made four or more visits. Most maternal deaths result from haemorrhage, complications of unsafe abortion , pregnancy-induced hypertension , sepsis and obstructed labour. According to official estimates, more than 20 women die of pregnancy and childbirth-related complications every day in Tanzania. Potentially the current figure national-wide will be more than 51 per cent. Shortage of health providers, among others, are limiting factors to be delivered by skilled provider. The ratio of doctors to patients in Tanzania is 1: While the ratio in the United States is 1: The proportion of children vaccinated against measles increased from

80 per cent in to 85 per cent in