SUPPORT FOR HEALTH SECTOR REFORM

(TC-97-10-03-0-SU)

EXECUTIVE SUMMARY

REQUESTER:	Ministry of Finance	
EXECUTING AGENCY:	Ministry of Health (MOH)	
BENEFICIARIES:	Government of Suriname	
AMOUNT AND SOURCE:	IDB:	US$1,370,000 (net income FSO)
	Other donors:	US$ 750,000 (JSF)
	Local counterpart:	US$ 185,000
	Total:	US$2,305,000
FINANCIAL TERMS:	Execution period:	24 months
	Disbursement period:	30 months

ENVIRONMENTAL AND SOCIAL REVIEW: The operation did not require an environmental and social assessment.

OBJECTIVES: The objective of the proposed technical cooperation is to assist the Government of Suriname to develop and initiate policy reforms to improve the efficiency, equity and financial sustainability of health services.

DESCRIPTION: The project will finance a series of analytical studies, policy workshops and implementation activities, some on a pilot basis, which will generate needed information and initiate the process of reform in key aspects of the health system. The operation will consist of five interrelated components:

a) Strengthening the policy-making capacity of the Ministry of Health, by carrying out a household survey of health care demand, utilization and expenditures, an analysis of sources and uses of funds in the sector, and an evaluation of the role and performance of the different modalities of primary care provision.

b) Improving the financial sustainability of the State Health Insurance Fund (SZF), through the development of financial and actuarial models and the development of new contracting and medical auditing mechanisms.

c) Modifying provider reimbursement methods, in order to introduce greater incentives for efficiency, equity and cost containment. Recommended changes will be piloted and evaluated.

d) Improving the targeting of public subsidies, in order to rationalize the use of public resources and improve the equity of health expenditures. A modified means-testing procedure or alternative mechanisms to reach the poor will be piloted in the Nickerie area.

e) Developing quality assurance mechanisms, so that cost containment is not achieved at the expense of the quality of care. The component will finance an assessment of existing practices and provide training in quality assurance to health professionals.

The execution of the project will be the responsibility of the MOH, which will establish a Health Reform Committee to provide overall policy direction and contract a Project Coordinator to manage activities.

BENEFITS: The technical cooperation will enable the Government to formulate policies to improve the equity and efficiency of health services. Specifically, the project will provide the Ministry of Health with a sound analytical basis for policy-making, while supporting the development of key policy changes in social insurance, provider reimbursement mechanisms, targeting mechanisms, and quality assurance. In addition, the project's activities will contribute to the rationalization of public expenditures in a situation of severe fiscal constraints, by placing the SZF on a sound financial footing and improving mechanisms to target public subsidies.

RISKS: There are two main risks: (a) There is limited institutional capacity available within the MOH, primarily as a result of shortages of qualified personnel. This risk will be mitigated by providing resources to increase the staffing of the Planning Unit, which will be the principal technical counterpart for the technical cooperation; (b) Given the pluralistic nature of Suriname's health system and the MOH's limited direct control over service provision and financing, there is a risk that substantial effort will go into policy analysis, but decision-making regarding implementation of recommendations will not occur. The design of the project mitigates this risk by establishing a Health Reform Committee which includes high level representatives from all key stakeholder

institutions, and which has as a key function advising the Government on critical policy decisions regarding implementation of policies.

EXCEPTIONS TO BANK POLICY: None.

RELATIONSHIP OF PROJECT IN BANK'S COUNTRY STRATEGY: The operation is consistent with the Bank's country strategy in Suriname, described in the 1997 Programming Memorandum (CP-1212), whose underlying thrust is to support policy reforms that improve institutional capacity and incentive frameworks and thereby enable resources to be used more efficiently and effectively. The operation also addresses the key development challenges identified in the programming memorandum. Specifically, it will contribute to the rationalization of public expenditures within the health sector, and thus assist in the consolidation of macroeconomic stability. It will also contribute to the development of Suriname's human resource base, by improving health services.

SPECIAL CONTRACTUAL CONDITIONS: Prior to first disbursement the GOS/MOH shall present to the Bank: (a) evidence that the Project Coordinator has been selected (paragraph 3.10); (b) evidence of appointment of additional staff for the Planning Unit (paragraph 3.11); (c) evidence that the Health Reform Committee has been established (paragraph 3.9); and (d) evidence of agreement between the MOH and the Bureau of Statistics to cooperate in the household survey (paragraph 3.2).

I. BACKGROUND

A. The health sector in Suriname

1.1 Suriname has a mixed public-private health system, in which the provision of services is largely separate from financing. Primary care services in the coastal region, where almost 90% of the total population lives, is provided by independent General Practitioners (GPs) and a network of public clinics managed by the semi-autonomous Regional Health Service (RGD). In the sparsely populated interior, primary care is provided through a network of health posts managed by the Medical Mission, an umbrella group of Christian NGOs. Secondary care is provided by the country's five general hospitals, three public and two private, located in the coastal region, four of them in Paramaribo. For more complex services, Surinamese citizens are referred to Holland, covered under Dutch Treaty funds.

1.2 Health services are financed through various categories of payers, which cover practically the whole population, resulting in minimal financial barriers to access. Public financing plays a key role. Approximately 34% of the population, classified as poor or near-poor based on means-testing, is covered by the Ministry of Social Affairs (MSA) for a practically unlimited package of services. This group obtains primary care at RGD clinics, whose budget is financed by the MSA, and inpatient care at either public or private hospitals, which are reimbursed by the MSA on a per diem basis.

1.3 The MSA also finances hospitalization for the approximately 14% of the population which resides in the interior. This group is treated at the private Diakonessen Hospital, which has a special arrangement with the Medical Mission. The primary care services rendered by the Medical Mission to this population are financed by the Ministry of Health (MOH).

1.4 Approximately 35% of the population, including civil servants and their families as well as voluntary enrollees, are affiliated to the State Health Insurance Fund (SZF), which is financed through payroll taxes and also covers a practically unlimited package of services. Affiliates of the SZF must be registered with either an independent General Practitioner or one employed by the RGD, in either case paid by capitation. Payment for either public or private hospitals is covered by the SZF on a per diem basis. SZF affiliates also have access to specialist outpatient services under a fee for service system.

1.5 The majority of the remaining 17% of the population obtains health coverage through their employers. Although private firms can choose to contribute to the SZF or purchase coverage from a small number of private insurance companies, the majority choose to self-insure, and some of the largest also operate company-run clinics

for ambulatory care. Services to private patients at all levels of care are paid on a fee for service basis.

B. Health policy issues

1.6 Suriname's health system has several characteristics which are conducive to good sectoral performance. In fact, other countries in the region are undertaking reform efforts which seek to introduce many of the features already found in Suriname. These include: (i) the separation of financing and provision of services; (ii) a mixed public-private system, under which the public sector contracts with private providers; (iii) public institutions, including hospitals, which enjoy a high degree of managerial autonomy and are run by professional managers; (iv) a social security system (SZF) with reasonably high coverage and no service delivery responsibilities; (v) a formal means-testing system for subsidizing care to the poor, and (vi) use of different provider reimbursement systems in the public sector, including capitation and per diem, as opposed to reliance on historical budgets.

1.7 On the other hand, while health status indicators are reasonable for the country's level of development, they are not commensurate with the country's health expenditures, which exceed those of comparable countries.1/ Suriname's health system has major weaknesses which compromise equity, efficiency and financial sustainability. Among the key problems identified in the sector are the following:

a. The Ministry of Health lacks both the information and institutional capacity to formulate and implement adequate policies for the sector in a resource constrained environment. Basic information on utilization, expenditures, and the performance of providers contracted with public financing is not available to inform decision-making. The lack of information is compounded by shortages of technical staff.

b. The SZF's financial situation is precarious, with deficits reaching 50% of current expenditures. In part this situation reflects the fact that the SZF functions as a passive payer of services, rather than an insurance fund capable of pooling risks, purchasing cost-effective services and managing care appropriately.

c. The existing provider reimbursement systems and the almost complete absence of copayments do not promote efficiency and cost containment. The flat capitation fee paid to independent General Practitioners by the SZF encourages over-referrals to

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1/ Reliable data on expenditures is not available, but it is estimated that in 1996 health expenditures represented approximately 7-8% of GDP.

specialists. The use of a simple per diem payment to hospitals by both the MSA and the SZF has resulted in Suriname's having the longest average length of stay in the Caribbean, 9.1 days in 1995.

d. The means-testing process used by the MSA does not result in adequate targeting of public subsidies, leading to an inequitable allocation of resources. In the coastal region, access to MSA coverage is based on self-reported income; in the interior, the entire population is assumed to be poor, despite extensive economic activity in the mining and timber industries.

e. There are deficient incentives for quality and an absence of formal quality assurance mechanisms in place. In the case of ambulatory care, the SZF must contract with all practitioners offering services, independent of the quality of care. In the case of inpatient care, long lengths of stay are partly the result of the absence of adequate treatment protocols.

C. Bank experience in the health sector

1.8 In 1987 the Bank approved a loan to remodel and expand the district hospital in Nickerie (533/OC-SU and 809/SF-SU). Civil works have been completed and equipment installed, resulting in expanded capacity. However, the hospital continues to suffer from a shortage of trained medical specialists and its operation remains dependent on financial subsidies from the Government. A short-term solution to the lack of specialists is being implemented with the assistance of the UNDP. The proposed technical cooperation will address the problem of financial sustainability of the Nickerie Hospital through sector-wide changes in financing and payment mechanisms. Improved financing, in turn, will increase the hospital's ability to offer additional incentives to attract specialists to the area in the medium term.

D. Bank strategy

1.9 The operation is consistent with the Bank's country strategy in Suriname, described in the 1997 Programming Memorandum (CP-1212), whose underlying thrust is to support policy reforms that improve institutional capacity and incentive frameworks and thereby enable resources to be used more efficiently and effectively. The operation also addresses the key development challenges identified in the Programming Memorandum. Specifically, it will contribute to the rationalization of public expenditures within the health sector, and thus assist in the consolidation of macroeconomic stability. It will also contribute to the development of Suriname's human resource base, by improving health services.

II. OBJECTIVES

2.1 The objective of the proposed technical cooperation is to assist the Government of Suriname (GOS) to develop and initiate policy reforms to improve the efficiency, financial sustainability and equity of health services.

III. PROJECT DESCRIPTION

A. Project components and activities

3.1 The project will finance a series of analytical studies, the development of policy recommendations and action plans to implement them, policy workshops, and implementation activities, some on a pilot basis. As a result, the project will generate needed information and initiate the process of reform in key aspects of the health system. The operation will consist of five interrelated components, designed to address the problems identified above, while preserving the positive structural aspects of the health system: (a) strengthening the policy-making capacity of the Ministry of Health; (b) improving the financial sustainability of the SZF;)c) modifying provider reimbursement methods; (d) improving the targeting of public subsidies; and (e) developing quality assurance mechanisms.

1. Policy-making capacity of the Ministry of Health (US$590,000)

3.2 The objective of this component is to generate needed information to enable the Ministry of Health to formulate sound policies for the sector. The component will finance consulting services to carry out three studies which will constitute key inputs for the evaluation of current policies and provide the analytical basis for the development of new policies to address existing problems. The studies include:

a. Household survey of health care demand and utilization, expenditures and MSA card holding. This survey will be carried out as a module of the planned household income and expenditure survey included in the Bank-financed technical cooperation for institutional strengthening of the Bureau of Statistics (ATN/SF-5124-SU). It will provide the basis for assessing the overall performance of the health sector in terms of availability of services, expenditures, access, and perceived quality of care.

b. Analysis of sources and uses of funds in the sector. The proposed study will produce the first round of estimates of National Health Accounts for Suriname, and set the basis for routine generation of financial information in the future.

c. Evaluation of the role and performance of the different modalities of primary care provision, including the RGD, independent General Practitioners, and the Medical Mission. The study will be followed by a policy workshop to discuss recommendations to improve primary care practice and the allocation of public resources under the different modalities.

2. Financial sustainability of the SZF (US$460,000)

3.3 The objective of this component is to place the SZF on a sound financial footing in the medium run and initiate its transformation into an active purchaser of health services. Consulting services will be provided to carry out the following:

a. Develop a computerized spreadsheet actuarial model to assess and simulate SZF finances under different assumptions about benefit packages, utilization rates, reimbursement levels and copayments, and recommend specific strategies to gradually restore the institution's financial balance.

b. Analyze existing contracting, medical auditing, and data gathering processes employed by the SZF and develop an action plan to put in place new procedures to enable it to function as a modern purchaser of services.

c. Evaluate existing proposals for the development of a national health insurance scheme, beginning with an assessment of the technical and political feasibility of integrating SZF and MSA insurance and payment functions to take advantage of economies of scale in administration.

3. Provider reimbursement mechanisms (US$302,000)

3.4 The objective of this component is to introduce greater incentives for efficiency, equity and cost containment through the modification of existing provider payment mechanisms. Consulting services will be provided to undertake the following activities:

a. Assess existing provider reimbursement mechanisms in terms of their impact on equity, efficiency and cost containment, and develop proposals to modify such mechanisms in order to minimize perverse incentives such as excessive GP referrals, long lengths of hospital stay and overbilling of patients.

b. Pilot and evaluate modified reimbursement mechanisms for different groups of providers, including the RGD, the Medical Mission, independent GPs, medical specialists, and hospitals, as appropriate and feasible. The specific design of the pilot will be agreed upon with the Bank prior to implementation.

4. Targeting of public subsidies (US$232,000)

3.5 The objective of this component is to improve the targeting of public subsidies in order to rationalize the use of public resources and improve the equity of health expenditures. Consulting services will be provided to carry out the following activities:

a. Assess current procedures used by the MSA to grant health cards and their impact, including estimates of the number of non-poor beneficiaries awarded cards as well as the number of poor who lack cards, drawing on the household survey carried out under the first component.

b. Develop recommendations to improve the means testing procedure or alternative options to reach the poor, taking into account the possible trade-offs between the accuracy of targeting and the cost of the targeting effort.

c. Pilot and evaluate a modified system, based on a more stringent means-testing process, or new system for identifying the poor in the Nickerie area. This pilot will take advantage of the relative geographical isolation of the area as well as the availability of hospital utilization statistics by MSA beneficiaries generated under the previous loan. The specific design of the pilot will be agreed upon with the Bank prior to implementation.

5. Quality assurance (US$320,000)

3.6 The objective of this component is to provide technical assistance to health institutions and professional associations in the areas of quality assurance, accreditation, and licensing, so that cost containment is not achieved at the expense of the quality of care. Specific activities include the following:

a. Assess existing quality assurance, licensing, certification and accreditation practices and procedures, and recommend changes in existing procedures and training programs, as appropriate.

b. Provide training in quality assurance to RGD staff, and clinical staff and administrators of both public and private hospitals, as well as independent GPs.

3.7 Terms of reference for the activities outlined above are contained in Annex II, available in the technical files. The proposed sequence of activities is contained in Annex III.

B. Expected results

3.8 The products of the technical cooperation will include the generation of a sound analytical basis for policy-making,

recommendations for specific policy reforms to be undertaken in the short, medium and long-terms, action plans for implementation of reforms, and pilot testing and evaluation of selected policies. Specific results include the following:

a. Evaluation of current performance of health sector based on analysis of household demand and utilization of services.

b. First round estimates of National Health Accounts combined with methodology to update information on sources and uses of funds on a routine basis.

c. Evaluation of proposal to merge MSA and SZF payment functions.

d. Financial and actuarial model for SZF developed and in use.

e. Action plan to implement new contracting and medical auditing procedures for SZF.

f. Modified provider payment mechanisms developed, piloted and evaluated.

g. Modified or alternative targeting mechanisms developed, piloted and evaluated.

h. Quality assurance procedures and indicators developed and health personnel trained in new procedures.

C. Project execution

3.9 The Ministry of Health will have primary responsibility for the execution of the operation. In order to ensure that key stakeholders are involved in the assessment of existing problems and the development of policy options to address them, and that decisions about implementation are taken, a Health Reform Committee will be established. The committee will be chaired by the Minister of Health and include high level representatives of the Ministry of Finance, Ministry of Social Affairs, SZF, RGD, the Hospital Association (NZR), the Medical Mission and the Medical Association will be established. This committee will be responsible for providing overall policy direction, discussing policy recommendations, building consensus and identifying Government decisions required to implement recommendations in both the short term, including pilot projects, and in the medium term. The input of the Health Reform Committee will thus be critical in advancing reforms from design to implementation.

3.10 The MOH will employ a Project Coordinator who will be responsible for managing the Technical Cooperation. The Project Coordinator will carry out administrative and technical duties, as described in the Terms of Reference contained in Annex IV, available in the technical files. The selection of the candidate for Project

Coordinator, which will be subject to the Bank's no-objection, is a condition prior to first disbursement.

3.11 The Project Coordinator's technical duties, including the identification of suitable counterparts for the different components, monitoring of the technical quality of outputs, and dissemination of results, will be carried out with the support of the MOH's Planning Unit. In order to carry out this role, the Planning Unit's staff will be strengthened by the addition of an economist/financial specialist and a health policy/management specialist. The appointment of these technical staff is a condition prior to first disbursement.

D. Reporting and monitoring

3.12 Due to its policy reform focus, the project will require close supervision by the Country Office and Headquarters. The Country Office will be directly responsible for daily supervision and will guide the Project Coordinator in the application of Bank policies for contracting of consulting services. Headquarters will provide technical inputs through monitoring of technical reports and periodic administration missions.

3.13 Reporting and monitoring will be the primary responsibility of the Project Coordinator, who will prepare semi-annual progress reports documenting activities undertaken during the previous six months and a workplan for the following period. These reports will be submitted to the IDB and to the Health Reform Committee within 30 days of completion of each six-month period.

3.14 The consultants contracted under the technical cooperation will submit copies of all technical reports prepared by consultants to the Health Reform Committee through the Project Coordinator. The Health Reform Committee will review these reports and present recommendations in writing. Copies of all technical reports will also be submitted to the Bank by the Project Coordinator.

3.15 The Project Coordinator will also present annual financial statements to the IDB, including one final statement, documenting the uses of Bank and counterpart contributions. These statements will be certified by independent auditors selected by mutual agreement between the GOS and the Bank in accordance with procedures acceptable to the latter. The annual financial statements shall be presented within 90 days of the close of each fiscal year and the final statement within 90 days of the date of the final disbursement.

3.16 During execution, periodic administration missions will take place as indicated in Annex III. These missions will evaluate progress achieved to date and determine if any adjustments are required, including possible changes in the project design. Decisions required for implementation of budgeted activities, including pilots, will also be discussed and agreed upon. In addition,

resource requirements for further implementation activities will be identified, so that preparation of a potential Bank operation can be initiated. A final assessment will take place once the project is completed, and will be designed to evaluate achievements and agree on areas for future IDB support. The Project Coordinator will produce a draft final report summarizing the results of the technical cooperation, which will be submitted to the IDB for approval within 30 days of completion of activities.

E. Cost and financing

3.17 The cost of the program is estimated at US$2,305,000, of which the Bank will provide US$1,370,000 and the Japanese Special Fund US$750,000, both on a non-reimbursable basis. The Government will provide US$185,000 in counterpart funds. The Bank and the Japanese Special Fund (JSF) will finance consulting services and policy workshops. The Bank will also provide support for project execution, including limited computing equipment, a vehicle and the salary of the Project Coordinator. Counterpart funds will cover the additional staff of the Planning Unit as well as general support for execution.

3.18 The consolidated budget by component is presented in the table below. A detailed budget, including assumptions, is available in Annex V, available in the technical files.

BUDGET OVERVIEW (in US$)				
Project Components	**JSF**	**IDB**	**GOS**	**TOTAL**
1. MOH policy-making capacity		**590,000**		**590,000**
Consulting services firm		512,000		512,000
Individual consultants		15,000		15,000
Survey materials		61,000		61,000
Workshop		2,000		2,000
2. SZF Financial Sustainability	**430,000**	**30,000**		**460,000**
Consulting services firm	426,000	30,000		456,000
Workshops	4,000			4,000
3. Provider Reimbursement mechanisms		**302,000**		**302,000**
Consulting services firm		300,000		300,000
Workshop		2,000		2,000
4. Targeting of subsidies		**232,000**		**232,000**
Consulting services firm		230,000		230,000
Workshop		2,000		2,000
5. Quality assurance	**320,000**			**320,000**
Consulting services firm	300,000			300,000
Training sessions	20,000			20,000
Project execution:		**114,400**	**185,000**	**299,400**
Project coordinator		72,000		72,000
Staffing of planning unit			144,000	144,000
General support		42,400	41,000	83,400
Contingencies		**101,600**		**101,600**
TOTAL	**750,000**	**1,370,000**	**185,000**	**2,305,000**

3.19 The disbursements of the Bank's and the JSF's contributions, with the exception of the amount set aside for contingencies, will be administered by the MOH through the Project Coordinator. Upon written request of the GOS, the Bank may establish a revolving fund up to the equivalent of 10% of the Bank's contributions.

3.20 Prior to the request for first disbursement of Bank and JSF resources, the GOS should present to the satisfaction of the Bank the following: (a) a written communication indicating the person(s) who will represent the GOS in all communications with the Bank related to project implementation; (b) a written request for disbursement of the revolving fund; (c) the selected Project Coordinator; (d) evidence of appointment of two additional staff to the Planning Unit of the MOH; (e) evidence of establishment of the Health Reform Committee; and (f) evidence of agreement between the MOH and the Bureau of Statistics to cooperate in the household survey.

F. Procurement of consulting services

3.21 All consultancy services will be provided by firms, selected according to Bank procedures, which require international competitive bidding for contracts in excess of US$200,000. The three studies under the second component, designed to improve the financial sustainability of the SZF, will be carried out by one firm in order to ensure consistency in the analysis and recommendations, and thus be the subject of a single ICB package. Goods, including one vehicle and computing equipment, will be acquired, according to Bank standard procedures.

IV. BENEFITS AND RISKS

A. Benefits

4.1 The technical cooperation will enable the Government to formulate policies to improve the equity and efficiency of health services. Specifically, the project will provide the Ministry of Health with a sound analytical basis for policy-making, while supporting the development of key policy changes in social insurance, provider reimbursement mechanisms, targeting mechanisms, and quality assurance. In addition, the project's activities will contribute to the rationalization of public expenditures in a situation of severe fiscal constraints, by placing the SZF on a sound financial footing and improving mechanisms to target public subsidies in the medium term.

B. Risks

4.2 There are two main risks. The first concerns the limited institutional capacity available within the MOH, primarily as a result of shortages of qualified personnel. The design of the project mitigates this risk by providing resources to increase the staffing of the Planning Unit, which will be the principal technical counterpart for the technical cooperation. Additional counterparts will be drawn from other sectoral institutions, especially the SZF.

4.3 Given the pluralistic nature of Suriname's health system and the MOH's limited control over service provision and financing, there is a risk that substantial effort will go into policy analysis, but decision-making and implementation of recommendations will not occur. The design of the project mitigates this risk by establishing a Health Reform Committee which includes high level representatives from all key stakeholder institutions and which has as a key function advising the GOS on critical policy decisions required to implement new policies.

SURINAME - SUPPORT FOR HEALTH SECTOR REFORM
LOGICAL FRAMEWORK
TC-97-100-30-SU

Description	Verifiable Indicators	Means of Verification	Assumptions
ove the health status of the population of e	Improvement of basic health indicators	Vital and health statistics	Improvements in the efficien financial sustainability of ser in improvements in health st
: t the Ministry of Health to identify problems, and e and initiate policy reforms to improve the y, equity and financial sustainability in the ector	Studies and policy documents containing analysis of existing problems and specific proposals to address them	GOS Policy Documents Consultant reports	Problems identified represen constraints to improving hea
: -making capacity of MOH increased	Analytical studies completed and discussed: 1) household survey of demand, utilization and expenditures; 2) Sources and uses of funds; 3) Evaluation of role and performance of primary care providers	Consultant reports Health Reform Committee minutes Policy workshops MOH policy documents	Collaboration of Bureau of S undertaking health survey
financial balance improved and its nation into an active purchaser of services	Financial and actuarial model developed and in use Information requirements to maintain up-to-date financial, medical and actuarial information established New procedures to contract providers and conduct medical auditing developed	Consultant reports Health Reform Committee minutes SZF financial statements and reports	GOS willing and able to mee commitments to the SZF and increase cost recovery efforts benefit package to civil serva
ler payment mechanisms modified to improve y and cost containment	Modified payment systems developed, piloted and evaluated	Consultant reports Health Reform Committee minutes	Provider acceptance of new p mechanisms

Description	Verifiable Indicators	Means of Verification	Assumptions
vement in the targeting of public subsidies	Alternative methods to improve accuracy of targeting developed Pilot project in Nickerie area undertaken and evaluated	Consultant reports Health Reform Committee minutes MSA policy documents	MSA collaboration in health GOS willing to increase cost efforts by applying more stri requirements for subsidies
y assurance program implemented	Quality assurance procedures and indicators developed Health personnel trained in quality assurance	Consultant reports MoH Policy Documents	Provider acceptance of new
inputs:		Project reports	
coordination	US$72,000 (24 person-months)		
of MOH Planning Unit	US$144,000 (48 person-months)		
services	US$1,300,000 (113 person-months)		
orkshops	US$10,000 (5 workshops)		
workshops	US$20,000 (10 workshops)		

SURINAME
SUPPORT TO HEALTH SECTOR REFORM
TC-97-100-30-SU

SEQUENCE OF ACTIVITIES

COMPONENTS AND ACTIVITIES	OO	YEAR 1				YEAR 2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Staffing of Planning Unit									
Appointment of Project Coordinator									
Establishment of Health Reform Committee									
Bidding and Selection of Firms									
Component 1									
Household Survey									
National Health Accounts									
PHC Evaluation									
Component 2									
SZF Model									
Purchasing Medical Auditing									
MSA-SZF Integration Feasibility Study									
Component 3									
Analysis of Payment Systems									
Pilots and Evaluation									
Component 4									
Targeting Study									
Pilot and Evaluation									
Component 5									
QA Policy									
Training									
IDB Administration and Review Missions									

TC-97-100-30-SU
LEGIII/SU-10004

PROPOSED RESOLUTION

SURINAME. NON-REIMBURSABLE TECHNICAL COOPERATION
FOR SUPPORT TO THE HEALTH SECTOR REFORM

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such agreements as may be necessary and to adopt such other measures as may be pertinent for the execution of the plan of operations referred to in Document AT-_____, with respect to a nonreimbursable technical cooperation to support the health sector reform in Suriname.

2. That up to the sum of US$1,370,000 or its equivalent in other convertible currencies is authorized for the purposes of this resolution, chargeable to the net income of the Fund for Special Operations.

3. That the above-mentioned sum is to be provided on a nonreimbursable basis.

TC-97-100-30-SU
LEGIII/SU-10005

PROPOSED RESOLUTION

SURINAME. NON-REIMBURSABLE TECHNICAL COOPERATION
FOR SUPPORT TO THE HEALTH SECTOR REFORM

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as Administrator of the Japan Special Fund established pursuant to the letter agreement dated April 26, 1988 between the Government of Japan and the Bank, to enter into such agreements as may be necessary and to adopt such other measures as may be pertinent for the execution of the plan of operations referred to in Document AT-_____, with respect to a nonreimbursable technical cooperation to support the health sector reform in Suriname.

2. That up to the sum of US$750,000 is authorized for the purposes of this resolution, chargeable to the resources of the Japan Special Fund.

3. That the above-mentioned sum is to be provided on a nonreimbursable basis.