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Improving Stewardship of Complex Mixed Health Systems: Learning from Health Care in the United States

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Improving Stewardship of Complex Mixed Health Systems:

Learning from Health Care in the United States

The basic goal of any health system, to ensure access to quality care, can be especially challenging to achieve when public and private actors are not coordinated. Although many low- and middle-income countries have a history of government focus on public provision of health care, often these countries have weak stewardship mechanisms for the health system at large. Mixed health systems, where public and private providers operate side by side to provide health services, can pose unique challenges for such smaller economies.

The World Health Organization defines health system stewardship as, "...the ability to formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide the necessary intelligence on health system performance in order to ensure accountability and transparency."¹ Governments of developing countries have chosen not to focus on the stewardship of private providers for a number of reasons, including a negative perception of the private sector² and the lack of a simple interface to engage the fragmented and disorganized landscape of informally- and formally-trained, and publicly- and privately-financed health care. This can also be explained by their limited resources, which tend to be prioritized toward public delivery of services rather than stewardship of non-state providers.

Key challenges to stewardship of developing countries' mixed health systems include:

- A weak infrastructure for gathering information about providers and other stakeholders in fragmented health systems
- Inadequate regulation of providers and care quality
- Limited opportunities for public-private collaboration and underdeveloped policy consultation and policy analysis mechanisms

This paper considers how the experiences of the U.S. health system can inform stewardship practices of mixed health systems in the developing world. While the U.S. health care system faces many significant challenges, it provides a number of promising mechanisms for system-wide stewardship, which could potentially help address these challenges if appropriately tailored. The United States has succeeded in bringing together private and public actors to collect health information, regulate and accredit providers, and contribute to the policy consultation and analysis process despite lacking a single governing body to oversee health care. For these reasons, the U.S. health system experience provides valuable insights into what mechanisms governments without strong central control of the health system can use to improve health outcomes and what mechanisms have a lesser impact. While not all U.S. strategies are appropriate for developing countries, the many processes that the United States uses to steward its own complex mix of public and private actors are relevant for countries hoping to build stewardship capabilities.

This paper offers an overview of the U.S. health system and some shared characteristics of mixed health systems in the developing world. It discusses which stewardship mechanisms in

the United States may be most relevant and potentially adaptable to developing countries – namely information collection, quality regulation, and policy analysis and consultation. The report concludes with concrete tools that donors such as philanthropies and non-governmental organizations, government officials, and other health system stakeholders can use to strengthen stewardship in developing countries with mixed health systems.

This paper describes three cross-cutting recommendations that can help developing countries develop stronger stewardship mechanisms and drive improvements in health care:

1. **Strengthen Professional and Consumer Associations:** Professional and consumer associations can help governments reduce the transaction costs of interacting with health system stakeholders. Associations can also be important vehicles for collecting and disseminating information, obtaining and providing policy input, generating policy analysis, and self-regulating and improving quality of care.
2. **Expand Mechanisms for Private Accreditation:** Accreditation provides an objective and efficient means for evaluating providers' compliance against an accepted set of quality benchmarks and performance and safety standards. It also offers a way to create goals for self-improvement and stimulate the raising of quality standards. Accreditation can serve as a powerful tool for providers to differentiate themselves from competitors based on care quality. Private accrediting organizations can relieve governments of the operational burden of managing their own accrediting agency; private organizations can also leverage economies of scale by establishing regional, rather than country-specific organizations.
3. **Bolster the Capacity of Independent Research and Policy Institutes:** A comprehensive network of think tanks, universities, and other non-profits and civil society organizations is critical for reviewing existing policies and programs and generating new dialogue. Fostering an environment where rigorous, unbiased policy analysis is conducted and disseminated is a key mechanism for instilling private stakeholders with trust in public policy and improving overall stewardship.

Developing Countries' Mixed Health Systems: Lack of Stewardship Leads to Poor Health Outcomes

Mixed health systems vary widely in developing countries and each faces unique challenges depending on their political and socioeconomic contexts. Each mixed system has a unique blend of public and private providers, and the lines between these sectors often blur.³ Despite these variations, developing countries with mixed health systems share a number of characteristics. For example, many are challenged by limited funding and financing mechanisms that can result in high out-of-pocket expenditure for patients, capacity constraints, and variable quality across providers.⁴ In addition, it is common for ministries of health in developing countries to narrowly focus on direct provision of care, rather than considering how to leverage the myriad private providers to deliver care, innovate, and achieve better health outcomes.

Enacting strategic policy directions in the midst of these challenges is not simple, but without stewardship initiatives, these characteristics can lead to numerous adverse outcomes within the health system. Countries striving to advance their health care systems can improve fragmented delivery infrastructure, enhance quality, and bolster regulatory and policy processes in the long term by focusing on strengthening the stewardship of their mixed health systems.

Publically Financed Services vs. Private Health Markets

The spectrum of publically-financed versus private health markets may overlap depending on how publically financed services are provided. In developing countries, governments typically provide health care directly through government-run hospitals and salaried physicians, while the private health markets operate independently. Conversely, in the United States, Medicare pays private providers directly for services.

Data on utilization of private providers and the degree of private spending suggest that many developing countries have large private markets for health care. However, despite these markets, governments traditionally provide publically-financed government services. A review of Demographic and Health Survey (DHS) data from 19 low-income Sub-Saharan African countries and six low-income Asian countries demonstrates that, while countries vary in the public-private mix of health care provision, the private sector plays a prevailing role in a number of them in maternal and child care for family planning, child diarrhea, and child fever/cough. For example, more than 50 percent of family planning services were provided through the private sector in eight of the Sub-Saharan African countries and two of the Asian countries.⁵ In addition, a recent survey in one large state in India found that 76 percent of all health providers worked in the private sector.⁶

Demand for private sector care is high in these countries for a number of reasons. Not only are private-sector providers frequently more geographically accessible, often they are more responsive to consumer preferences in terms of privacy and speed of service.⁷ For example, household surveys in Egypt show that people perceive the private sector as providing higher quality of care than the public sector, and 47 percent of the respondents surveyed visited private providers based on this assumption of quality.⁸ A review of mortality rates in 25 low-income

countries in Africa and Asia found that countries with a more dominant private sector had lower rates of mortality in those under the age of five.⁹

Despite the significant role that private markets play in delivering health services, most developing countries do not devote a significant share of public resources to regulating the private providers that operate in these markets either through positive or negative incentives. They have traditionally devoted their health resources to publicly-financed government delivery systems, channeled through one central ministry or office, despite the presence of parallel private providers and market systems. Specifically, the majority of these funds have gone to support health facility construction and health workforce salaries.¹⁰ In Ghana, for example, more than half of the Ministry of Health’s (MOH) budget went directly to salaries in 2006.¹¹

When governments devote the majority of their resources and attention to government delivery systems and neglect their role as stewards of the larger health system, patients are at greater risk for negative quality and financial outcomes. This silo mentality hampers governments’ abilities to evaluate their health care system as a whole and make the necessary corrections. Moreover, countries may miss opportunities to promote key health interventions and improve access for vulnerable groups by capitalizing on the care provided by private providers.

Lack of Stewardship Leads to Negative Outcomes

Although many factors are at play, targeted stewardship mechanisms, such as regulation, are critical to mitigating negative outcomes for patients. These range from poor health to financial burdens. Figure 1 describes a number of the negative delivery and financing outcomes that may be associated with unregulated health markets in mixed health systems.

Figure 1 – Negative Outcomes in Unregulated Health Markets

Category	Negative outcome	Example
Delivery	Uneven quality	<ul style="list-style-type: none"> • Unlicensed drug sellers • Untrained providers • Unhygienic conditions • Understaffed facilities
	Inappropriate diagnosis	<ul style="list-style-type: none"> • IV drip for common viruses • Diarrhea diagnosed as Malaria without blood test • Improper prescribing of antibiotics
Financing	Price-gouging	<ul style="list-style-type: none"> • Overcharging for services • Overcharging for drugs
	Catastrophic expenses	<ul style="list-style-type: none"> • Out-of-pocket payment for long-term hospitalization • Out-of-pocket payment for surgery • Out-of-pocket payment for chronic illness over time
	Inequitable expenditures	<ul style="list-style-type: none"> • Poor pay disproportionately more of their income for health care than the rich • Poor more likely to pay out-of-pocket
	Lack of financial access	<ul style="list-style-type: none"> • Financially prohibitive to seek care at perceived high quality outlets

Source: Lagomarsino, Nachuk, and Singh Kundra 2009

Negative Delivery Outcomes: Care quality can vary widely across providers

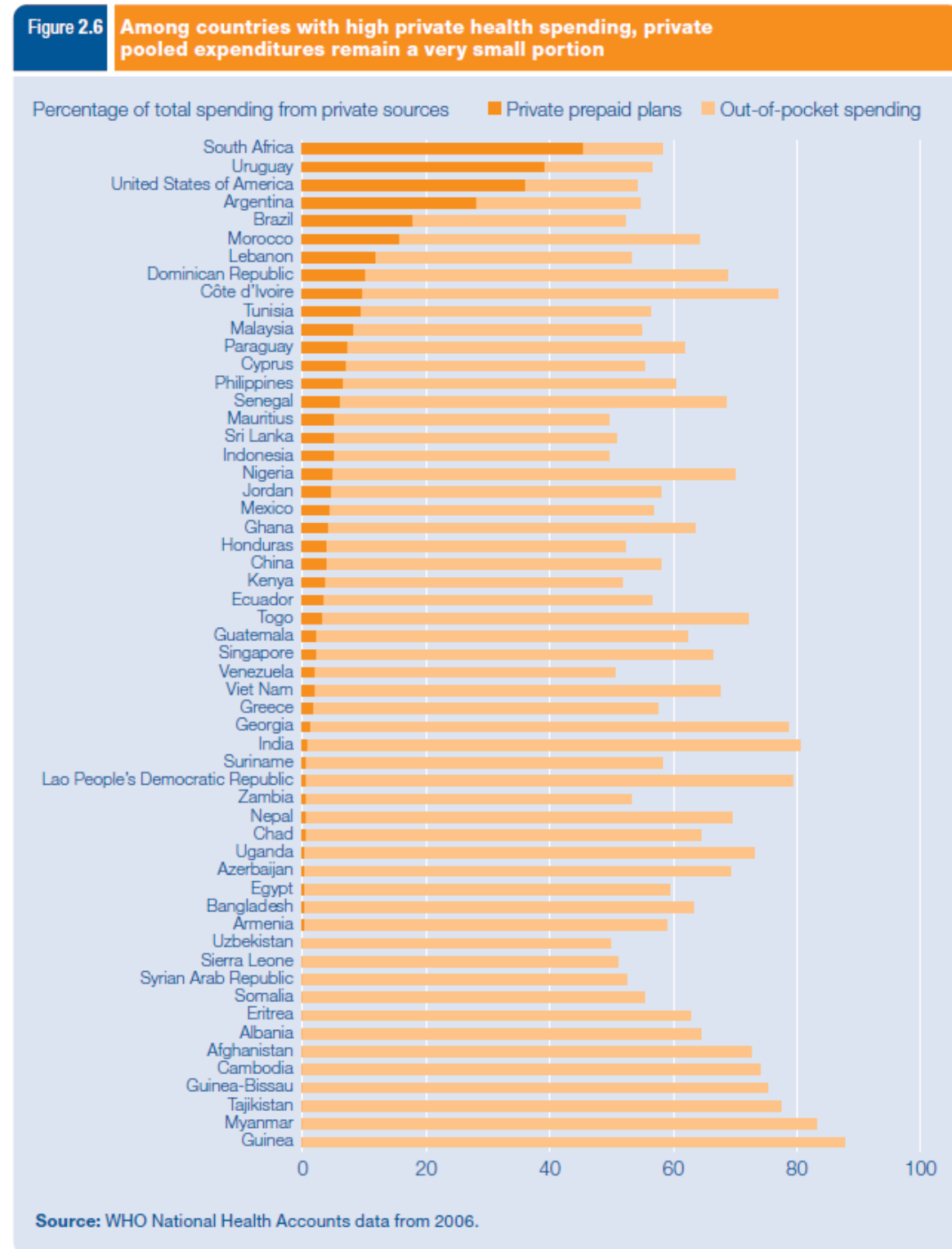
Variation in care quality across providers is one of the most challenging issues facing patients. Poor care quality can result in a number of harmful medical consequences. For example, there is evidence that providers across both Asia and Africa under-dose treatment medications, do not adhere to treatment guidelines, and unnecessarily prescribe antibiotics.¹² This type of improper prescribing and inadequate treatments has been shown to lead to the emergence of drug-resistant diseases.¹³

Unnecessary overuse and underuse of care are both additional risks for patients in systems relying heavily on out-of-pocket spending as a source of financing. Without adequate regulatory mechanisms and incentives for quality in mixed health systems, the burden falls on patients, who do not have the clinical expertise to adequately assess the care and treatment that they need and are receiving.¹⁴

Negative Financial Outcomes: High out-of-pocket spending and lack of financial access

Weak stewardship mechanisms can result in providers overcharging patients for care¹⁵ and poor households spending a disproportionate amount of their income on health care.¹⁶ Without mechanisms to control cost and user fees, patients may be forced to pay for catastrophic, long-term medical expenses out of pocket.¹⁷ Systems that rely more heavily on out-of-pocket spending face more challenges in ensuring access to health care, particularly for the poorest and most vulnerable.¹⁸ Health expenditure data indicate that, despite country variation in the mix of public and private delivery, more than half of total health spending in developing countries comes from out-of-pocket payments.¹⁹ Figure 2 shows the dominance of out-of-pocket spending relative to pre-paid health plans in countries with high private health care spending. While financial protection mechanisms are not a subject of this paper, mechanisms like risk-pooled prepaid plans are an important type of stewardship mechanism that countries can promote.

Figure 2. High Out-of-Pocket Spending in Countries with High Private Health Spending



Source: Lagomarsino, Nachuk, and Singh Kundra 2009

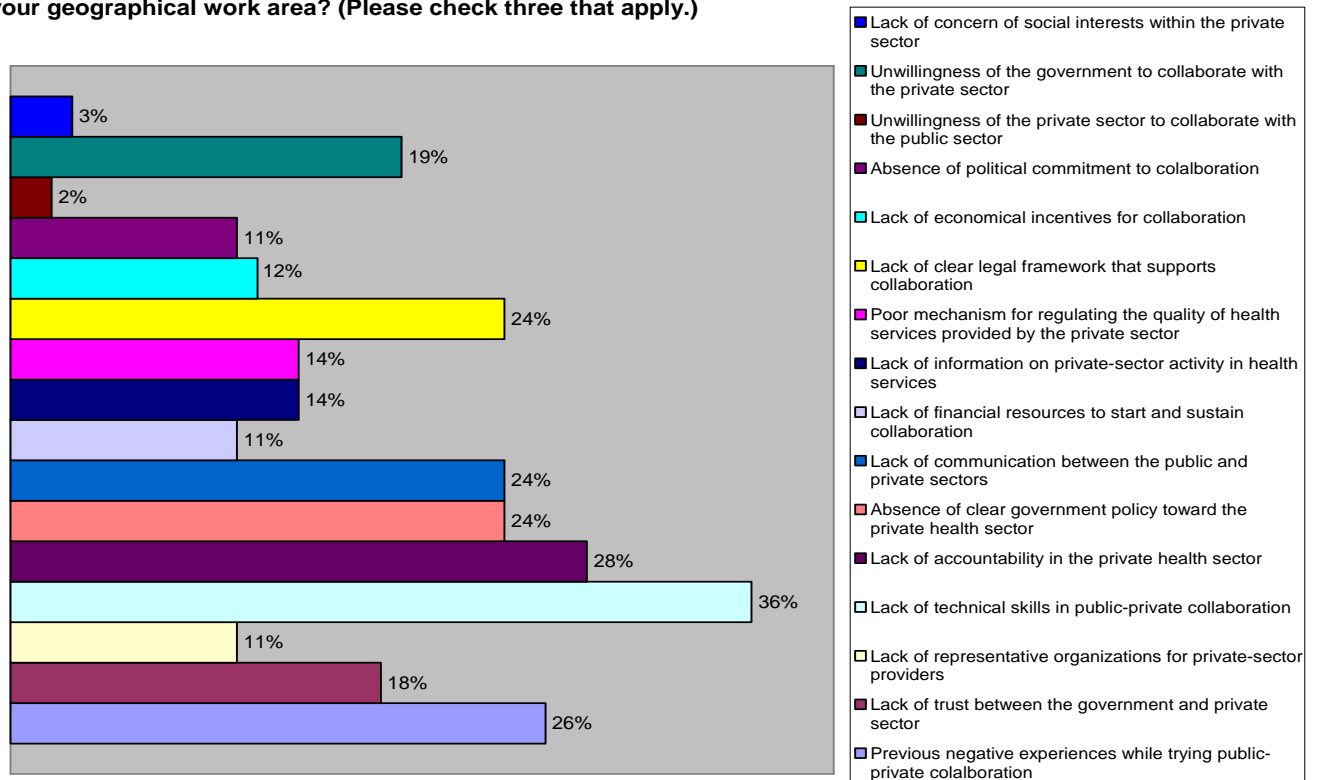
Why the Lack of Focus on Stewardship in Developing Countries?

If such large portions of many developing country health systems are private, why have those countries focused so little on the stewardship of their mixed health systems? Why have private sectors not reached out to public sectors to facilitate stewardship of the whole health system?

These are complex questions with many nuanced answers. Possible explanations include the challenges of fragmentation in such systems, as well as lack of resources and capacity for stewardship. In addition, many governments are also plagued by lack of transparency or – in extreme cases – corruption. Finally, evidence exists that some public servants have little desire or incentive to engage with the private sector and/or fear loss of control. Conversely, the private sector reports a lack of trust in the public sector and, at the national level, a fear of government interference.²⁰ Figure 3 shows some barriers to public-private collaboration.¹

Figure 3. Barriers to Public-Private Collaboration

Which of the following do you feel best describes barriers for public-private collaboration in your geographical work area? (Please check three that apply.)



Source: Hozumi, Frost, Suraratdecha, Pratt, Sezgin, Reichenbach, Reich, and PATH 2008

¹ An online survey was conducted by PATH and the Global Health Council from May 27 to July 2, 2008. The survey sought to gather perceptions from global health communities on private-sector participation in the financing and provision of health services for low- and middle-income countries. In total, 1,201 responses were received, of which 469 completed responses were included in the analysis.

Fragmented Systems

One distinct challenge of mixed health systems in developing countries is that provider mix varies widely; providers include relatively well-appointed government hospitals in large metropolitan areas, poorly-resourced government clinics in rural areas, high-end urban private hospitals, NGO or church clinics, informal unlicensed corner dispensaries, untrained “quacks,” and traditional healers. Patients choose between formal, informal, public, for-profit, and not-for-profit providers; however, these distinctions are not always clear-cut.²¹ Many doctors are on the government payroll, staffing public clinics for a portion of the day, but “moonlighting” in private clinics in the afternoons.²² When public salaries are low, providers may require additional informal payment from patients or may temporarily leave their day post for more lucrative private work, causing access problems in public clinics.²³

In general, private providers in developing countries’ mixed health care systems are poorly organized. Professional associations and self-regulating bodies are still generally in their infancy. Where they do exist (primarily at the national level, and most commonly in the more formal sector), they are often quite weak. While some “social franchises” or networks of private providers have been created recently in some countries, most private providers operate independently, with few integrated systems, group practices, or formalized networks to connect them.

There is also a great deal of fragmentation among the providers that patients rely on directly for maintaining their health. Households in developing countries with public-private systems may seek care from a number of different providers on different occasions or even for the same health episode. This array of private and public and formal and informal providers can lead to a great deal of fragmented, uncoordinated care, which in turn can result in unnecessary morbidity and mortality, particularly for patients with complex diseases, such as HIV/AIDS and tuberculosis.²⁴

Provider fragmentation also makes it extremely challenging and costly for governments to interact with providers in order to collect key information, seek provider input on policy decisions, and regulate entry and quality. These challenges are discussed in more detail in Chapter 4.

Lack of Resources and Capacity

Governments in developing countries are further hampered by a lack of resources, which can make it difficult to devote funds to activities such as data collection on private providers, quality regulation, or policy consultation with multiple stakeholders. Instead, a large proportion of state funds are used to build, staff, and supply government hospitals and clinics. Stewardship has not historically been a donor priority, as many donors choose to address disease-specific issues; however, recent trends indicate stewardship is a growing priority among donors.

Lack of funds poses a particular challenge for capacity development efforts because governments have not traditionally prioritized stewardship. They do not necessarily have people within government ministries with the right set of skills for tasks such as mapping providers, regulating provider entry, promoting quality measurement and improvement, and supporting public-private collaboration and policy consultation. Thus, even if political leaders or donors decide to prioritize these activities, they may face significant implementation challenges.

Lack of Priority Placed on Stewardship Activities

There is a significant need for political commitment and strong leadership to accelerate public-private partnerships and coordination of care in mixed health care systems. However, the evidence suggests that most ministries of health in developing countries do not prioritize stewardship with the private sector. A survey of global health stakeholders found that 19 percent of respondents believed the private sector unfairly took advantage of the public sector.²⁵ Likewise, private providers are often reluctant to collaborate with government since there is frequently no economic incentive for collaboration, little transparency, and no clear policy regarding interactions with the private sector.²⁶ Not surprisingly, such mutual mistrust and misunderstanding inhibits effective collaboration.

A survey of health care stakeholders in low- and middle-income countries found that across the globe, the most commonly cited barrier to effective collaboration between the public and private sectors is a lack of political commitment.²⁷ Donors, who have traditionally not focused their support on building up whole health systems, have not helped this cause.²⁸ In addition, ministries of health in developing countries may understandably focus their limited time and resources on cost-effective, disease-specific or population-specific (vertical) interventions, which do not necessarily preclude stewardship activities, but could draw staff availability and attention away from long-term health system stewardship goals.

Lack of Transparency

Transparency issues can also be a significant impediment to stewardship in low-income countries with mixed health systems. In extreme cases, lack of transparency can signal corruption, which complicates regulatory processes and undermines quality control mechanisms. For example, in many developing countries, government officials expect bribes from providers in order to receive accreditation, which in turn leads to poor quality health care.²⁹ Similarly, providers can often expect additional informal payments to supplement low government salaries, a practice that while common, is difficult to document and correct.

Why might U.S. stewardship strategies be applicable to developing countries with mixed health systems?

Like many health systems in the developing world, the U.S. health system includes a complex mix of public and private stakeholders who contribute to the financing, delivery, and regulation of health care. In addition, the U.S. system grapples with fragmentation of providers and a lack of a centralized governing body for the whole health system. Yet, while it faces a number of significant and well-documented challenges – including high costs, variable quality, and uneven access – health care in the United States also excels in several areas, including innovation, public-private sector collaboration, monitoring baseline quality, and extensive stakeholder engagement in the policy process.

As a result, the United States can serve as a valuable case study for developing countries with mixed health systems – especially those encountering some of the same challenges that the U.S. system faces now and has faced in the past. Private or public-private stewardship and regulatory mechanisms may be particularly appropriate for countries that lack government resources and capacity and/or are plagued by lack of transparency. The U.S. model for public-private collaboration and engagement could also be instructive for countries grappling with how to engender more cooperation across sectors.

This chapter provides a high-level overview of the U.S. health system and explores the various structures and processes that govern how health care is regulated, financed, and delivered in the United States. Specifically, this chapter discusses the key institutions, structures, and stakeholders — public and private — that oversee the U.S. system.

General Characteristics of the U.S. Health System

While the federal government's role in the U.S. health system is not as dominant as in many other industrialized nations, it plays a significant part in financing, organizing, overseeing, and, in some limited cases, delivering health care in America. Local, state, and federal government spending together were responsible for nearly half (46 percent) of the estimated \$2.4 trillion spent on health care in 2008. Of these funds, \$461 billion was spent on Medicare and \$361 billion was spent on Medicaid.³⁰

Although the United States has several publicly-financed health insurance programs, the federal government generally does not participate in direct delivery of care for the bulk of the population (with the exception of the Veterans Administration (VA), Indian Health Service, and some state- or locally-run public hospitals that cater to the poor and uninsured). Rather, the government acts as a payer for some populations, purchasing care from private providers on behalf of specific groups, and regulating quality using this purchasing power. With approximately 45 million Americans enrolled in Medicare, 59 million enrolled in Medicaid, and almost nine million enrolled in both programs, the federal government is one of the largest payers in the health care market.³¹ The federal government is also an employer, and thus helps to finance coverage for nearly 9 million federal workers and their dependents through the Federal Employees Health Benefits program.³²

Despite the significant and ever-growing government contribution to health care payment in the United States, many institutions responsible for the functioning and regulation of the health care system are predominantly private organizations. These organizations have been highly influenced by the stakeholders that created them; thus, regulatory influence ranges from a high degree of insular self-regulation, such as that seen in the medical profession, to strict federal oversight, such as the Food and Drug Administration's regulation of pharmaceuticals. Infrastructure has grown to meet the needs of this mixed health care system as it has evolved.

Infrastructure

The United States does not have a central governing agency that is in charge of health care. Rather, it relies on a number of executive bodies to regulate specific components of the health care system.

The U.S. Department of Health & Human Services (HHS), which includes several institutions responsible for particular core functions of the health care system, is the primary executive body tasked with overseeing health care (Figure 4). Programs managed by HHS include Medicare, Medicaid, and Children's Health Insurance Program (CHIP), which are health benefit programs for adults ages 65 and older, low-income individuals and families, and children, respectively. Other important institutions include the Centers for Disease Control and Prevention, responsible for disease surveillance; the National Institutes of Health, which funds scientific research; the Health Resources and Services Administration, responsible for improving access to health care; and the Agency for Healthcare Research and Quality, tasked with improving the quality, safety, efficiency, and effectiveness of health care.

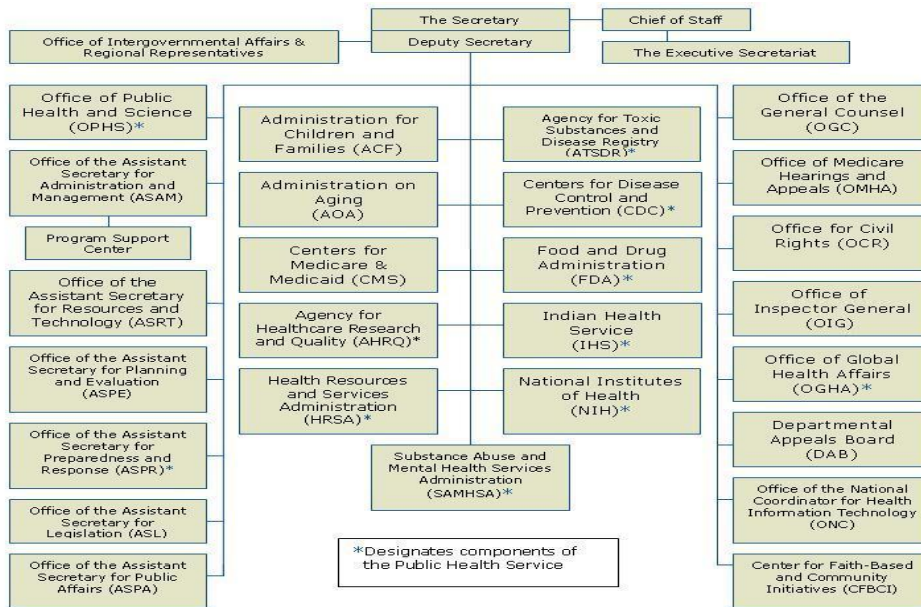
Outside of HHS, the VA is responsible for the actual provision of health care for veterans through government-owned facilities, while the Department of Defense manages the TRICARE system, a publicly-financed medical benefits program for active-duty and retired military personnel and their family members, which relies on contracted private providers.³³

In addition to the variety of federal regulatory bodies, state and local governments also play a role in the regulation – and in some cases, the provision – of health care. Medicaid and CHIP, for example, are coverage programs that are jointly funded by the state and federal governments and run largely by the states. State and local health departments are involved in outreach and enrollment for these programs, in addition to overseeing a multitude of public health and disease surveillance programs.

This decentralization of health functions presents an obvious organizational challenge for the U.S. health system. This is particularly true for population health challenges that require coordination among government agencies and other stakeholders and necessitate a comprehensive strategy. For example, the obesity epidemic has been so difficult to address because different factors that contribute to the epidemic are regulated by different departments within the government; for example, food guidelines are determined by the Department of Agriculture, while subsidized school breakfast and lunch programs are regulated by the Department of Education. These care coordination challenges extend to the patient level as well, in part because of the same decentralization that impacts funding and regulation of care. Because of the many funding and regulatory silos, it can be difficult to hold providers

accountable for the overall health outcome of a patient or to incentivize them to coordinate care beyond their specialty. Moreover, because each health care sector uses a different set of quality measures to evaluate care, it is difficult to obtain a comprehensive picture of overall patient care.

Figure 4. Organizational Structure: Department of Health and Human Services



Source: U.S. Department of Health & Human Services

Multiple Stakeholders Influence the U.S. System

Outside of government institutions, several key stakeholders play important stewardship roles in the health system. Many of these stakeholders are represented politically by their own private institution or organization, and include private insurers, consumer advocates, medical professional groups, hospitals, and employers (Figure 5). The influence and scope of work of these organizations – which can include advocacy, research, self-monitored oversight programs, and other services such as continuing education – have continued to grow over the years as health care spending becomes an increasingly significant component of the U.S. economy.

While such active industry and consumer engagement is in many ways constructive in the development and advancement of the U.S. health system, having too many stakeholders with significant sway over policy can be a detriment to progress as well. For example, in 1994, the Health Insurance Association of America (HIAA) used an advertising campaign to play on patient fears that reform would result in rationing and rally opposition against the Clinton health reform plan. Although the plan failed for a number of other reasons, including the relative exclusion of several key stakeholders during the decision-making process, the public campaign was highly effective in scuttling reform. Although the majority of stakeholders currently support the general goal of health care reform, it has been difficult to generate a plan that a large majority of stakeholders can agree on, given the significant financial and other implications of specific reform approaches.

Figure 5. Key Stakeholder Associations and Responsibilities

Health Care Sector	Key Association(s)	Key Responsibilities
Physicians	American Medical Association (AMA)	Largest physician organization in the United States. Advocates the interests of physicians, sets ethical standards, promotes public health, and publishes the <i>Journal of the American Medical Association</i> .
	American College of Physicians	Largest U.S. medical-specialty organization and second-largest physician group, which includes internists, internal medicine subspecialists, medical students, residents, and fellows.
	American College of Cardiology	Association with 36,000 members, including physicians, registered nurses, clinical nurse specialists, nurse practitioners, physician assistants, doctors of pharmacology and practice administrators, specializing in cardiovascular care. Advocates for quality cardiovascular care – through education, research promotion, development and application of standards and guidelines – and works to influence health care policy.
	American College of Surgeons	An educational association of surgeons created in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Total membership is more than 76,000.
	American Society of Clinical Oncology	Represents physicians who treat people with cancer, with 20,000 members worldwide. Efforts are also directed at advocating for policies that provide access to high-quality care for all patients with cancer and at supporting the increased funding for clinical and translational research.
	American Academy of Family Physicians	National association of family doctors with more than 94,000 members. Membership requirements are more stringent than most associations, and require members to complete 150 hours of continuing education courses every three years in order to remain on the active member list
Nurses	American Nurses Association	Largest professional organization, representing the interests of the nation's 2.9 million registered nurses.
Hospitals	American Hospital Association (AHA)	National organization representing hospitals, health care networks, and their patients and communities. Advocates on behalf of members in national health policy debates and judicial matters, provides education for health care leaders, and serves as a source of information on health care issues and trends.
	Association of American Medical Colleges (AAMC)	Nonprofit group of medical schools, teaching hospitals, and academic societies. Provides assistance for members in the areas of education, research, and patient care activities.
Quality/ Accreditation	National Committee for Quality Assurance (NCQA)	Private, non-profit organization dedicated to improving health care quality. Accredits and certifies a wide range of health care organizations, primarily focusing on payers

Health Care Sector	Key Association(s)	Key Responsibilities
		(e.g., health insurers, managed care organizations).
	The Joint Commission (JCAHO)	Independent, nonprofit organization that aims to improve the safety and quality of care. Accredits and certifies care organizations and programs, primarily focusing on facilities.
	National Quality Forum (NQF)	Nonprofit organization that aims to improve the quality of healthcare for all Americans. Sets national priorities and goals for performance improvement, endorses national consensus standards for measuring and publicly reporting on performance, and promotes the attainment of national goals through education and outreach programs.
Patient Advocacy	AARP	Nonprofit, non-partisan membership organization that helps people age 50 and older improve the quality of their lives; 35 million members.
	American Diabetes Association	Nonprofit association that leads the fight against the deadly consequences of diabetes and supports those affected by diabetes. Funds research to prevent, cure, and manage diabetes; delivers services to hundreds of communities; provides objective and credible information; and gives voice to those denied their rights because of diabetes.
	American Heart Association	Organization dedicated to heart/coronary health and improving public awareness on how to have the healthiest heart possible. Educate public about heart/coronary health and conducts research on this subject matter.
	American Cancer Society	Nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.
Insurance	America's Health Insurance Plans (AHIP)	National association representing medical insurers, long-term care insurers, disability income insurers, dental insurers, supplemental insurers, stop-loss insurers and those providing reinsurance. Advocates on behalf of members and conducts relevant industry research.
	National Association of Insurance Commissioners (NAIC)	Nonprofit organization composed of state insurance commissioners with regulatory power over insurers in their state.
Foundations	Robert Wood Johnson Foundation	Foundation that seeks to improve the health and health care of all Americans by building evidence and producing, synthesizing and distributing knowledge, new ideas and expertise. Harnesses the power of partnerships by bringing together key players, collaborating with colleagues, and securing the sustained commitment of other funders and advocates to improve health.
	Commonwealth Fund	Independent, nonprofit research and educational institute that develops and advances public policies based on the nation's founding principles of limited constitutional

Health Care Sector	Key Association(s)	Key Responsibilities
		government, economic freedom, and personal responsibility for one's actions.
	Kaiser Family Foundation	Leader in health policy and communications. Develops and runs its own research and communications programs, sometimes in partnership with other nonprofit research organizations or major media companies.

Health Reform Challenges

Despite a well-developed infrastructure and a high level of public and private stakeholder involvement in the regulation of the health system, the United States still faces a number of complex health system challenges, some of which could potentially be addressed through newly enacted health care legislation.

High Cost of Health Care. The recent health reform debate has centered largely on the growing cost of health care. It is estimated that spending on health care will consume approximately 18 percent of GDP in 2009, or \$2.5 trillion – and, at current rates of growth, health care will exceed one-fourth of GDP by 2025. Federal spending accounts for about one-third of those totals, and federal outlays for Medicare and Medicaid alone are projected to nearly double from \$720 billion in 2009 to \$1.4 trillion in 2019, exceeding available funds. The income and payroll tax exclusions for employer-provided health insurance,³⁴ which is not counted in health care expenditures, account for another \$250 billion per year in foregone federal revenues³⁵ and are by far the largest and among the fastest-growing tax expenditures.³⁶ The Office of Management and Budget predicts that these tax expenditures will increase by 90 percent between 2007 and 2013.³⁷

This challenge is compounded by the fact that Medicare, Medicaid, and the tax expenditure for employer-provided health insurance grow automatically with health care utilization and costs. As a result, the magnitude of the government's financial commitment has expanded along with health care spending, which has risen about 2.7 percent faster than the overall economy for the past half century.³⁸ If spending growth continues on the current trajectory, combined spending on Medicare and Medicaid alone is projected to account for as much as 13 percent of GDP by 2040, with the majority of this growth stemming from per person costs of providing health care, rather than from the aging of the population or other factors.³⁹

The recently passed health care legislation aims to reduce costs aims to reduce long-term health care cost growth through a number of new reform initiatives that more directly link spending on health care to performance, including accountable care organizations, bundled payments to hospitals and other providers, comparative effectiveness research, changes to the tax treatment of employment-based health insurance, and changes to how Medicare benefits and payments are updated. The legislation also includes administrative steps that can further lead to reductions in health care spending.

Spending Not Related to Quality. While spending growth has achieved some real gains in health, much of it is not clearly linked to such improvements. Some estimates indicate that as much as 30 percent of Medicare spending does not contribute meaningfully to patient

outcomes.⁴⁰ There is also wide variation in how similar health problems are treated in different regions of the country, which in turn leads to variation in the volume of care used to treat similar patients. Residents of regions in the highest-spending quintile receive about 60 percent more care than those of regions in the lowest-spending quintile.⁴¹ At the same time, underuse of proven-effective treatments is also common, leading to costly, preventable complications and worse health outcomes. For example, despite only modest out-of-pocket costs, many patients do not adhere to proven-effective treatments for diabetes, high cholesterol, blood pressure, asthma, and other chronic conditions. It has also been shown that Medicare beneficiaries receive evidence-based effective treatments for their chronic diseases only about half the time, even though these treatments are covered by Medicare.

Unequal Access. It is estimated that more than 46 million Americans were without insurance at some time in 2008.⁴² Although most Americans obtain health insurance through their employers (61 percent), not all workers have access to employer-sponsored coverage. In fact, the majority of the uninsured are in working families, with two-thirds of the uninsured having at least one full-time worker in their family and 14 percent having only part-time workers. This is in part because low-income workers – those at greatest risk of being uninsured – are much less likely to be offered job-based coverage and are less able to afford their share of the premiums. Moreover, more than half of uninsured workers have no education beyond high school, making it difficult for them to get jobs that are more likely to provide benefits. Uninsured adults are more likely to report having no regular source of health care, and as a result, are more than twice as likely to delay or forego needed care, leading to higher rates of avoidable hospitalizations. The uninsured also experience more financial risk; for example, they are almost three times more likely than the insured to be unable to pay for basic necessities because of their medical bills.⁴³

Yet, in light of new health care legislation, access to health care coverage should improve significantly. Specifically, the Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019. By 2019, the legislation will also result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, and 16 million obtaining coverage through enrollment in Medicaid and the Children’s Health Insurance Program. These changes are estimate to reduce the budget deficit by \$124 billion over ten years.⁴⁴

Despite the significant challenges outlined above, and given the current reform opportunities through the new health care legislation, we find it instructive to review the ways that existing stewardship mechanisms have evolved in the United States. Developing countries with mixed health systems face similar cost, quality, and access challenges. Mechanisms for collecting national-level information about fragmented providers, consulting stakeholder groups, and regulating entry and quality of providers, could therefore inform the development of stewardship mechanisms in the developing world. While the rest of this report focuses on aspects of the U.S. system that developing countries may consider adapting, these countries should also heed lessons from the challenges outlined above.

Learning from U.S. Experiences to Strengthen Stewardship Mechanisms in Developing Country Mixed Health Systems

As discussed earlier, developing countries with complex mixed health systems have not sufficiently focused on strengthening stewardship mechanisms. This lack of focus on stewardship leads to a number of poor outcomes. In this section, we highlight three types of mechanisms that can address key stewardship barriers for developing country mixed health systems:

1. Information Collection
2. Regulation of the Entry and Quality of Providers
3. Policy Consultation and Policy Analysis

We chose these stewardship mechanisms because they:

- Address priority stewardship barriers in developing country mixed health systems;
- Address operational capabilities (both pre-/post-legislation) necessary for stewardship;
- Have ample documentation of the stewardship barriers and associated stewardship mechanisms in the literature;
- Have access to field experience relevant to the stewardship barriers and mechanisms;
- Are non-political nature of the mechanisms (can be more easily adopted); and
- Their mechanisms match well to particular U.S. experiences that may be useful or instructive examples for other countries.

This paper does not provide an in-depth assessment of stewardship experiences in any specific developing countries with mixed health systems; however, it highlights examples from several countries with recent experience, including Ghana, India, Nigeria, Tanzania, Vietnam, and Nepal. These countries have expressed an interest in stewardship and have begun to take steps to improve their stewardship mechanisms.

For each stewardship mechanism, the paper describes its importance for developing countries with mixed health systems, the barriers countries face in implementing these mechanisms, the relevant experiences of the United States in using these mechanisms, and the potential key lessons for developing countries.

Numerous ideas and potential lessons drawn from U.S. experiences are also summarized, and can serve as building blocks for developing countries' stewardship mechanisms. These ideas cannot be simply transplanted, but could be adapted based on other countries' health system contexts and priority needs.

Information Collection

In order to be an effective steward of a mixed health system, the public agencies charged with stewardship need good information about the private sector, including who uses the private sector, what services they seek from the private sector, why they choose the private sector, the quality of the care provided by the private sector, and the broader implications of private sector

use for equity, financial protection, and public health.⁴⁵ Without this valuable information, it is almost impossible to set strategic policy direction that fits the needs of a particular health system. Mapping providers, knowing client populations, and documenting the services that they provide can allow governments to accredit providers, monitor quality, help fill the gaps in coverage, provide training and resources for high priority interventions, and help identify opportunities for contracting out services. In addition, collecting information about private providers and their clients can help governments monitor population health through disease surveillance and the collection and dissemination of vital statistics, including birth and death records.

Despite the importance of collecting information about the private sector, developing countries with mixed health systems often have little systematic information about private health system actors and their activities. Information collection can be expensive and time-consuming,⁴⁶ due to the high level of fragmentation in the private sector and a lack of systematic processes for collecting data.⁴⁷ In addition, there are generally few resources available for data collection and few incentives to compel governments to collect data about the private sector for their own stewardship purposes. Incentives for information collection may be greater, however, in cases where the government finances some private provision of care (e.g., through contracts or vouchers) and operates as an insurer rather than provider.

In some cases, data collection is motivated by a development partners' needs rather than the government itself.⁴⁸ However, project-specific information collected by development partners does not easily lend itself to the creation of an interoperable, comprehensive information system that collects and measures data in a standardized way. If there are interoperable systems, researchers and providers may have problems aggregating the data because measures are defined and collected differently.

In some cases, the challenges of data collection stem from a resistance by private sector actors to be forthcoming in sharing information. For example, a survey of private sector actors in Ghana found that they rarely share information with the government. They reported that there were no incentives to share data, for when they do share information, they generally receive little feedback.⁴⁹

The lack of systematic processes for data collection is a major barrier to good access to information. Often, private actors are only weakly linked to existing state information systems.⁵⁰ In addition, if there are no private-sector provider associations or large umbrella organizations, it can be particularly difficult for the government to interact with the fragmented private sector to collect information.

Promising Information Collection Practices in Developing Countries

While there are many challenges associated with information collection, not all developing country governments and donors have turned a blind eye to the need for better information about the private sector. The governments of Nepal and Nigeria have recently undertaken studies to assess the role of the private sector and the level of private provision of care. The Ministry of Health and Promotion in Nepal commissioned a report evaluating the private sector's role in health and identifying opportunities for improving public private partnerships.⁵¹ In addition, the government commissioned a study that surveyed private providers and the factors that drive

households to private sector care. The survey found that although private sector providers were expensive, they provided a high quality of care, and illuminated the need for both the Ministry of Health and the providers themselves to better track data on private provider utilization.⁵² The government of Nigeria has recently begun moving forward with a similar type of survey of private providers.

There are also a number of recent private sector information collection activities funded by various donor agencies. USAID, through PSP-One, has funded numerous private sector assessments in various developing countries. Recently, the French Development Agency commissioned studies of the private health sectors of four African countries. The World Bank Group – through its Health in Africa Initiative – is now commissioning even more in-depth private-sector surveys in Kenya, Ghana, and Mali.

While all these activities are important steps forward in understanding the private provider landscape in a number of countries, they are generally still one-time studies, rather than ongoing data collection mechanisms. In addition, while a few governments have taken the initiative to collect information about the private sector, the majority of these activities have been driven by donors. Going forward, ongoing data collection will need to be owned by national ministries of health and prioritized on an ongoing basis.

Information Collection in the United States

Health care informatics in the United States is highly fragmented. A number of entities are involved in the collection and dissemination of health care information, including private informatics companies, provider associations, health systems, payers, and advocacy groups, as well as local, state, and federal agencies. This information can range from the population health level to the health sector level to the patient health level, and can be collected in both a voluntary and involuntary manner. Although the collection and dissemination of information in each category is generally managed by a distinct network of entities, these networks do overlap and build on one another.

Public Health Data. A large majority of public health data is collected on a regular, mandatory basis. For example, through the National Notifiable Diseases Surveillance System, providers are required by law to report on cases of nationally notifiable diseases. This list is revised periodically through a collaborative effort by public health officials at state health departments and the Centers for Disease Control and Prevention, and data from this survey are used to produce weekly morbidity reports published at the national level. However, despite the importance of public health data for monitoring health trends, in particular infectious diseases, allocating resources, and tracking progress toward national health goals, funding for data collection and dissemination activities can vary widely from state to state. One challenge that the United States faces as public health activities continue to expand is ensuring adequate and consistent funding to support better measurement of program impacts and the more timely identification of policy gaps.⁵³

Other significant sources of public health care data come from the Census of the U.S. Population, which collects basic demographic information such as race, sex, and age; the National Vital Statistics System, which compiles data on births, deaths, marriages, divorces, and fetal deaths;

the National Health Interview Survey, which provides information on major health problems, including incidence of acute illnesses and injuries, prevalence of chronic conditions, and utilization of health services; and the Behavioral Risk Factor Surveillance System, which monitors high-risk behaviors that are related to chronic disease, injuries, and death. Other surveys target specific populations of concern; for example, the Medicare Current Beneficiary Survey provides comprehensive information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of Medicare beneficiaries.⁵⁴

While the primary reason for collecting this information is to detect and address ongoing threats to public health and better target public health activities, data-linking can be a powerful tool when data sets are fragmented and there is a lack of overarching information architecture. For example, the National Health Care Survey, which is built on four separate record-based surveys – the National Hospital Discharge Survey, the National Ambulatory Medical Care Survey, the National Nursing Home Survey, and the National Health Provider Inventory – provides information on the use and quality of health care, and the impact of medical technology in a wide range of health care settings. In addition, private companies such as Ingenix, Thomson Reuters, and IMS Health can build on this public data infrastructure by adding industry and private health plan data for both commercial and government use. For example, Ingenix provides private insurance companies, health plans, providers, hospitals, and federal and state agencies with data informatics support, which can range from physician data sharing and medical cost management to medical trend analytics and consulting to fraud and abuse detection and investigation.

Information about Providers. Other data collection, such as information on hospitals and practicing physicians, are collected on a voluntary basis. However, because of the financial implications for non-participation, most if not all providers and hospitals abide by these reporting regulations. For example, the unique physician identification number (UPIN) system was used by Medicare to identify physicians accepting Medicare insurance. Without this unique number, providers could not file for payment; because 96 percent of providers participate in Medicare, this system was a highly effective mechanism for monitoring all practicing providers in the U.S.⁵⁵ The UPIN system was recently discontinued and replaced with the National Provider Identifier system. This new system address some of the accounting challenges associated with the previous system, such as multiple providers practicing under a single joint UPIN for their group practice. The U.S. tax code also provides a useful regulatory structure through which health care providers and facilities can be tracked.

Providers and health facilities are also incentivized to report using explicit financial incentives. For example, through the Centers for Medicare & Medicaid Services' Physician Quality Reporting Initiative, providers can earn additional incentive payments for reporting on quality measures for covered services furnished to Medicare beneficiaries. Recent reform efforts have built on this and other similar pay-for-reporting programs by linking payment to actual results. The American Recovery and Reinvestment Act of 2009, for instance, provides approximately \$36 billion in new payments for health information technology intended to improve quality and slow growth in costs. These payments would be made available through Medicare and Medicaid to physicians and hospitals who demonstrate meaningful use of health information technology.

Despite this extensive data infrastructure, the U.S system is highly fragmented into industry silos. This is particularly true for quality and outcomes-related data. For example, Medicare, Medicaid, and commercial-payer claims are rarely combined to generate a meaningful portrait of the care patterns for a variety of technical, practical, political, and privacy concern related reasons. The American Medical Association has strongly opposed the release of Medicare claims data because of concerns that this data could be used to develop provider ratings systems that would potentially portray doctors inaccurately or negatively impact provider payment. Yet, even if there was broad-based support for public and private data aggregation, the task is extremely time-consuming and technically challenging, in part because until recently, multiple physicians could share a single identification number through the UPIN system.

Because of these challenges, quality and outcome information is often aggregated and analyzed by payer, care site, or population of interest. For example, Medicare has developed a number of online tools aimed at helping patients become more actively engaged in their health care by selecting providers of care site based on performance data. These tools include Hospital Compare, which allows users to search for condition-specific hospitals' performance information and results on patient satisfaction with their care; Medicare Home Health Compare, which gives users detailed information about the quality of care provided at Medicare-certified home health facilities; and Medicare Nursing Home Compare, which tracks and ranks all Medicare- and Medicaid-certified nursing homes in the country based on health inspections, staffing, and quality measures.

What Can Developing Countries Learn from the U.S. Experience?

As developing countries think about how to institutionalize data collection from private providers, there is much to learn from the United States, both from its successes and challenges.

Successes. Private companies in the United States have incentives to help with data collection because the data are valuable to them for improving their services, better targeting their marketing, and securing more market share. Similarly, some private companies and NGOs have interests in knowing more about private providers in developing countries. For example, drug companies and medical product providers want information so they can market their products. Large international NGOs who use private providers to distribute health interventions (e.g., Population Services International and Marie Stopes International for family planning) want information about who is providing care, and how much and what type of care is being provided. Governments of developing countries could consider partnering with these types of organizations to collect information. These organizations might bear some or all of the cost and provide the capacity – including technology – to do the data collection. In addition, organizations like Google are now working to set up mapping systems for the world's health care providers.

While there are some risks to partnering with private companies for data collection, (e.g., drug companies may market expensive or unnecessary drugs to poor people), there could be some added benefits of governments partnering with both reputable brand-name and generic pharmaceutical companies. The act of partnering can give the government a more powerful seat at the negotiating table and, by extension, more tools for monitoring companies' activities. For example, a government relationship with pharmaceutical companies for data collection could help governments better monitor and/or control the type of marketing that is done through

advertising and drug detailing. In addition, if developing country governments partner with reputable companies, making it easier for companies to market their products, it could help to bring higher quality and better regulated products on the market and reduce the share of counterfeit and/or harmful products.

The United States also relies upon large provider groups or health systems to provide data. Building on this model, developing country governments could partner with large private hospital systems to collect information. While there are not currently many developing countries where large provider systems exist, systems like Apollo or Fortis in India and NetCare in South Africa have an incentive to collect information about potential referral providers. Their incentives grow stronger if more of the population becomes insured because their pool of paying patients grows.

Much of the data on private providers in the United States also comes from the strong incentives of providers to participate in Medicare and Medicaid. Ninety-six percent of U.S. providers participate in Medicare and are required to report claims data to the government in order to receive payments for services rendered. If developing countries begin to pay for care through national insurance systems (e.g., Ghana), providers will have more incentive to register and share information. Countries could further increase reporting by providers by offering additional financial incentives for reporting, similar to the new Centers for Medicare & Medicaid Services' (CMS) Physician Quality Reporting Initiative. In addition to creating incentives for providers to report data, low-income countries can build in other mechanisms for data collection when they design national health insurance plans. For example, India is using smart-cards for its nationwide, state-implemented Rashtriya Swasthya Bima Yojna plan, which will provide a tremendous amount of electronic data on providers, care patterns, and patients.

Finally, provider and consumer associations also often play an information collection and dissemination role in the United States. Associations in developing countries could increase capacity for data collection and dissemination. Developing country governments could also work directly with existing private provider associations to strengthen their capacity to collect data for their own use as well as the governments'. This is potentially a longer-term and more sustainable approach to data collection than the current reliance on donor partners to hire independent consultants for one-time studies.

Challenges. The fragmentation of U.S. data collection systems should not be emulated. Interoperable data platforms should be established now, in early phases of development, rather than waiting to try to integrate numerous legacy systems. The Rockefeller Foundation initiative on eHealth – aimed at helping governments to create interoperable health information systems – should be quite helpful in this regard.

In addition, U.S. health information privacy laws – most notably the Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 – have made limited efforts to advance the health information infrastructure by limiting how patient medical information can be shared across providers. While patient privacy is an important consideration, developing countries should be sure that privacy laws are balanced with the ability for providers and researchers to link information to improve care coordination and health outcomes. HIPAA privacy laws have

proved to be challenging because they were not designed to address the eventual transition from traditional, one-on-one communication between providers toward broad, network-based record keeping and data sharing.⁵⁶ This has raised difficult questions, including how the legitimacy of the information user and data use is verified and what body is responsible for ensuring compliance for data access and use.

Box 1. Information Collection: Ideas from U.S. experiences that could be adapted in developing countries

Strategies

- Developing an overarching health system vision and flexible plan for data collection, integration, and use is a best practice. However, given the rapid pace of technological development, countries should concentrate on developing information standards rather than infrastructure.
- Determining how data will ultimately be utilized (e.g., informing evidence-based treatment, care management, regulation, or quality improvement by providers) should drive how data are collected. Billing-based data (claims), for example, are not sufficient for monitoring quality and outcomes.
- Data-linking can be a powerful tool when data sets are fragmented and there is a lack of overarching information architecture. For example, public health data systems (e.g., Census, DHS, vital records) can be linked with health services data (e.g., hospital discharge surveys, claims data) to provide a more complete picture of health care access and utilization.
- There are good opportunities for developing countries to “leapfrog” other countries on information collection through cross-country sharing.

Partnerships

- Health insurance systems can be a vehicle for governments to collect information about private sector delivery of care (e.g., through provider enrollment processes and claims data). As low-income countries conceptualize broad-based national health insurance systems, data collection mechanisms should be built into their design and implementation.
- Large delivery systems and provider groups may have the incentive to collect information about possible referral providers. Governments can partner with these large systems to collect information and map providers.
- Private entities can fill information gaps by merging public data sets with data from the private sector to be used for both public and private purposes. Private entities can also potentially create a market for data.
- Professional provider associations can play a key role in collecting and disseminating health information. Governments could work with existing private provider associations to strengthen their capacity to do data collection for their own use as well as the governments’.

Box 1. Information Collection: Ideas from U.S. experiences that could be adapted in developing countries (continued)

Operations

- Health insurance plans are a particularly powerful vehicle for incentivizing providers to report on priority data. Incentives for provider reporting on certain indicators (e.g., pay for reporting) may help with the collection of public and private sector data.
- Patient privacy laws, such as HIPAA, should be formulated in a way that does not hinder data sharing for purposes of patient care coordination and the use of data for research and analysis.
- A system of assigning unique provider identifier numbers can facilitate information collection about the delivery of care at the individual provider and patient level. However, before assigning an identifier number, most developing countries must first find the providers.

Regulation of Provider Entry and Quality

Regulation is an important stewardship tool for governments to ensure access to and quality of health care providers. Regulating quality across the whole health system – including the existing private sector – rather than exclusively regulating public providers can potentially save public sector resources and improve health outcomes in the long term. Provider licensing, accreditation, and quality monitoring are the most common tools used for regulating providers.

Developing country mixed health systems generally have little or no regulation of the entry of health care providers across the health sector (public and private) or of the quality of care provided. A recent survey regarding regulatory constraints found that countries reported a high degree of concern about their own ability to apply regulatory measures to practitioner licensing, facility registration, and facility accreditation.⁵⁷ For those countries that do have some regulation, there typically has been little enforcement. This has led to a high degree of inconsistency in quality among various providers.

Licensure

Licensure refers to a process for evaluating an individual health care professional's qualifications for providing care, and issuing a license to practice if qualifications are met. Licenses can also take the form of permits, registrations, or certificates, depending on the country/jurisdiction and practitioner type. In developing countries, governments often license their formal sector providers at the point of successful completion of a service training program; however, their licenses rarely expire. In addition, developing countries with complex mixed health systems often have no mechanisms for the licensure of private sector providers.

Accreditation

Accreditation is a way to recognize that certain standards have been met by an agency, institution, or program. It is a tool frequently used by developed countries to evaluate providers'

credentials and their record for quality health care service provision. It is usually considered a voluntary way for organizations to self-regulate.

Accreditation is increasingly viewed as an important form of government stewardship in developing countries' mixed health systems. Accreditation provides a means for evaluating providers' compliance against an accepted set of quality benchmarks and performance and safety standards by offering a way to create goals for continuous self-improvement and stimulate raising standards. Accreditation also provides a means for organizations to differentiate themselves from their competitors on the basis of quality.

Quality Monitoring

Quality is defined by the Institute of Medicine as, "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Quality monitoring is a process of ongoing evaluation of the quality of health care services delivered by providers.

There can be marked variations in quality among providers in developing country mixed health systems. For example, while there is evidence that providers generally know what protocols to follow, they do not always adhere to them. In India, which relies heavily on private sector providers, a review of 205 public and private providers in Delhi found that providers, on average, only followed 26 percent of the tasks medically required for a patient with symptoms of tuberculosis and 18 percent for a child with diarrhea. In the review of the quality of medical advice given in the cases of children with diarrhea, physicians in the private sector were found to know less about recommended clinical practices than those in the public sector; however, the private sector physicians had a comparatively higher rate of practicing what they knew.⁵⁸ There is also evidence that providers across both Asia and Africa under-dose treatment medications, do not adhere to treatment guidelines, and unnecessarily prescribe antibiotics.⁵⁹

As stewards of mixed health systems, governments face a number of important challenges associated with improving quality of care and ensuring comparable levels of quality among private and public providers. In principle, governments are responsible for some basic level of monitoring the quality of all care delivered (public and private) and motivating quality improvement across the health care system. However, frameworks for quality assurance and quality regulation are often absent in developing countries. Where they do exist, some complain that the quality guidelines for private providers are sometimes more stringent than for public providers. Other challenges include a lack of private provider access to quality improvement-focused information and public sector (often donor-sponsored) provider trainings.⁶⁰

Professional associations, as self-regulating bodies, can play a part in improving quality in mixed health systems. For example, an initial analysis of the relationship between professional associations and maternal mortality found that many countries lacking strong obstetric associations have high maternal mortality ratios.⁶¹ However, in developing countries, there is often a low level of organization among providers. Provider groups that do exist tend to emerge more often in the private, formal sector and less frequently in the informal provider sector. For developing countries with mixed health systems and large informal sectors, it is much more challenging for self-regulating bodies to form.

Promising Regulatory Approaches in Developing Countries

While comprehensive regulatory approaches are non-existent in most developing countries, there have been some successful examples of more narrowly-focused regulatory programs.

Developing country governments, encouraged by the World Health Organization and donor partners, often work with the private sector to develop clinical care guidelines (e.g., for TB, HIV/AIDS treatment, reproductive health, family planning, and management of childhood diarrhea and respiratory infections). In Ghana, the Ministry of Health worked with the private sector midwives' association to improve quality of care through trainings, linkages to the public health system, and provision of needed supplies and commodities.⁶² Furthermore, the Thai Business Coalition on AIDS, which coordinates actions between multiple private sector actors and the government, initiated an accreditation program for workplace HIV/AIDS treatment and care programs. Although the coalition monitors the program, the Thai Ministry of Public Health provides the actual accreditation service.⁶³ While small-scale interventions like these in Ghana and Thailand are important steps toward addressing quality issues in the private sector, the scale-up of these initiatives remains a challenge.

Tanzania has implemented the accredited drug dispensing outlet program to better regulate drug-sellers – a model that many other countries are watching closely. In 2001, the Tanzanian Ministry of Health and Social Welfare identified severe problems with the country's 4,600-plus government-authorized private drug stores, including ongoing stock-outs of essential medicines at public health facilities, limited access to medicines in rural areas, poor dispensing practices, fragmented knowledge and competence, substandard medicines, illegal provision of prescription medicines, and inadequate regulatory framework and resources. In response, rather than closing the community-based drug shops, the Tanzania Food and Drug Authority created accredited drug-dispensing outlets and provided informal dispensaries with the training necessary to meet accreditation standards. With support from public and private sector stakeholders as well as significant donor funding, the initiative employs a holistic approach to change the behavior and expectations of individuals who buy from, own, regulate, or work in retail drug shops by building on existing infrastructures, developing new regulations and standards of practice, and introducing a combination of training, appropriate incentives, consumer pressure, monitoring and supervision, and regulatory coercion, with efforts to affect client demand.⁶⁴

The Joint Commission International (JCI) was established in 1997 as a private, not-for-profit international division of the Joint Commission, the U.S.-based private entity that is responsible for improving patient safety by inspecting and accrediting hospitals. JCI works in more than 80 countries and uses accreditation standards that are based on Joint Commission standards except for those based on U.S. laws and requirements. Currently, JCI is working with two international partners – the Fundación para la Acreditación y Desarrollo Asistencial (FADA) in Spain and the Associação Brasileira de Acreditação de Sistemas E Serviços De Saude (CBA) in Brazil – in an effort to offer care sites the opportunity to receive both national and international accreditation awards while also helping to bridge cultural and language divides. JCI also offers a disease- or condition-specific care certification, which evaluates a specific disease program as opposed to the overall quality and safety of an entire organization. Lastly, JCI has partnered with the World Health Organization to support patient safety through the High 5s Project, which aims to

improve patient safety by implementing innovative, standardized operating protocols for five patient safety solutions over five years.⁶⁵

Regulation of Provider Entry and Care Quality in the United States

Regulation of entry into the U.S. health system and oversight of care quality within the system is achieved through a combination of voluntary and mandatory efforts. Mandatory licensure and other requirements set the benchmark for inclusion, and voluntary accreditation provides a mechanism for identifying above average care. Many of the regulatory efforts in the United States are carried out by private or public-private entities that have been legitimized by the government. These efforts may be of interest to developing countries that are struggling to implement government-driven regulatory mechanisms.

Physician Entry. In the United States, the path to become a licensed health provider or care site is well-defined and well-regulated for each provider type (e.g., physicians, physician assistants, nurses, and allied health professionals). Figure 6 shows the entry process for a physician.

The standard U.S. medical school curriculum lasts four years, with the first two years focusing primarily on classroom learning, and the last two spent in clinical settings. The Liaison Committee for Medical Education (LCME), which is sponsored by the private Association of American Medical Colleges and the American Medical Association, is responsible for accrediting medical schools and ensuring that their curriculum meets a baseline educational standard. Although accreditation is technically voluntary, gaining accreditation is critically important because medical students can only qualify for federal education grants and loans, be licensed by most state boards, and participate in residency training if they attended an accredited medical school. In these ways, the government legitimizes these private voluntary regulation efforts.

The residency training process, which occurs after medical school, is also highly regulated. The Accreditation Council for Graduate Medical Education (ACGME), a private, nonprofit council, is tasked with evaluating and accrediting medical residency programs. Although ACGME accreditation is voluntary, teaching hospitals, academic medical centers, health care systems, and other institutions must be accredited to receive graduate medical education funds from the Centers for Medicare & Medicaid Services (CMS), which totaled \$9 billion in 2008. In addition, residents must graduate from ACGME-accredited programs to be eligible to take their board certification examinations. Furthermore, many states require completion of an ACGME-accredited residency program for physician licensure. Given the importance of medical training, the ACGME's board of directors has reserved seats for representatives from the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. In addition, the federal government has a non-voting seat on the board; this representative is appointed by the U.S. Department of Health & Human Services.

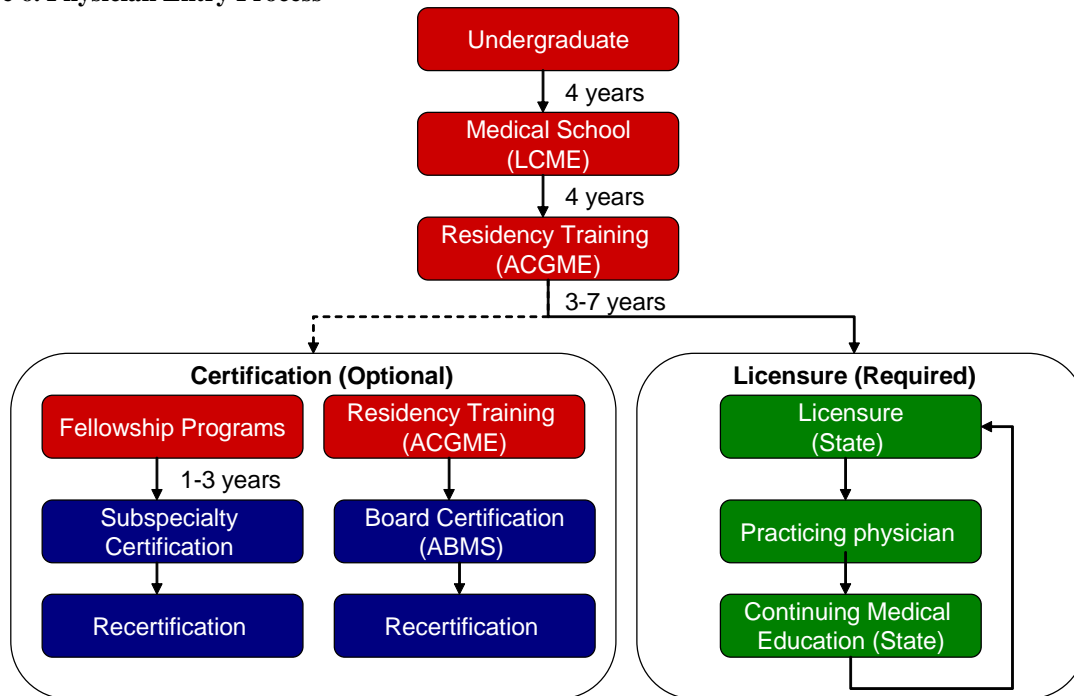
In order to become a licensed physician, individuals must pass the U.S. Medical Licensing Exam, which is administered at the state level and organized by the National Board of Medical Examiners. Physicians apply for licensure in the state they wish to practice in and each state has

specific rules and regulations. To help bring some uniformity to the states, 70 medical boards joined in creating a national nonprofit organization, the Federation of State Medical Boards.

Physicians in the United States may also choose to become board-certified. Although this is an optional process, those who are certified are viewed as demonstrating exceptional expertise in a particular specialty and/or subspecialty of medical practice. While medical licensure sets the minimum competency requirements to diagnose and treat patients, it is not specialty-specific. The American Board of Medical Specialties (ABMS) is the main entity tasked with overseeing the certification of physician specialists. The primary function of ABMS – a nonprofit organization comprised of 24 medical specialty member boards – is to assist in developing and implementing educational and professional standards to evaluate and certify physician specialists.

In sum, the U.S. government plays a passive role in the regulation of physician entry, but uses a number of mechanisms to legitimize private processes and incentivize different actors to participate in them. These include making licensure a requirement for federal loans and payments from federal insurance programs, as well as maintaining seats on the boards of key organizations. The physician licensure process is generally thought to work well to keep unqualified providers from practicing medicine. However, one criticism is that various professional associations and accrediting bodies have prevented task-shifting – allowing health professionals like nurse practitioners, physician assistants, and nurse anesthetists to perform simple procedures, which some would argue is more cost-effective – in an effort to protect their market share.

Figure 6. Physician Entry Process



Note: The organizations in the parentheses provide accreditation for the box which it is listed. “LCME” stands for Liaison Committee on Medical Education. “ACGME” stands for Accreditation Council for Graduate Medical Education.

Hospital Accreditation. A similar accreditation process exists for hospitals. Because an overwhelming number of hospitals participate in the Medicare program, CMS is also able to largely regulate hospital quality by requiring that hospitals participating in its Medicare program be accredited.⁶⁶ Most other private insurers also require accreditation to be eligible for payment, so the incentives for a hospital to be accredited are very strong. Most hospitals are evaluated by the Joint Commission, but they can also be evaluated by the American Osteopathic Association or a state survey agency.

The Joint Commission approves hospitals for accreditation based on an extensive review process, which includes on-site surveys designed to evaluate patient care quality as patients move through the hospital system, and key operational systems that directly impact the quality and safety of patient care. Surveys are unannounced and occur every 18 to 39 months. The 18 standards-based performance areas include infection prevention and control, medical staff, and leadership. The Joint Commission is governed by a 29-member board of commissioners that includes physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a consumer advocate, and educators. Consistent with other organizations with accrediting authority, they have designated seats for key health care associations. The Joint Commission's board of directors has representatives from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association.

While accreditation offers many potential benefits, it also has its limitations. U.S. experiences with accreditation can be instructive. Joint Commission accreditation, for example, is considered a baseline indicator of quality and not a standard of excellence. Only the lowest-quality facilities do not receive accreditation. In addition, critics of accreditation say that because it is a voluntary process, it can lead to uneven quality across providers. Some also say it erodes federal and state oversight authority and diminishes public accountability. Others complain that accreditation is expensive (the benefits do not outweigh the costs), evaluation methods are flawed, emphasis is placed on structure and process rather than outcomes, and there is little meaningful enforcement or ongoing quality monitoring.⁶⁷

Quality Monitoring. Although extensive regulatory mechanisms exist, the United States struggles to accurately measure care quality past the initial regulatory stage of licensure, accreditation, and certification. Information about the performance of doctors, hospitals, and other health care clinicians is vital for those who get care, give care, and pay for care. The U.S. government, in its roles as purchaser, regulator, and provider, is well-positioned to determine and monitor the quality of care.⁶⁸

Linking the quality of care and reimbursement is critical to efforts to control the rising cost of health care. The goal of these efforts is to better link reimbursement to the delivery of quality care, improve the data sharing infrastructure so that providers are able to better coordinate care, and align quality and cost measures across payers and health care settings so that providers have a consistent rubric that they can use to tailor quality improvement efforts and patients can make informed decisions about their health care.

Many quality measures have broad consensus support for implementation, and different private- and public-sector groups have designed models for assessing performance and reporting data. However, the consistent, effective, and efficient implementation of these measures in a way that provides a complete picture of care at the patient level has been very challenging.

The Quality Alliance Steering Committee (QASC), a public-private collaborative effort among a variety of key stakeholders, is working to make consistent and useful information about the quality and cost of health care widely available. QASC is comprised of established and emerging sector-specific quality alliances, as well as leaders among physicians, nurses, hospitals, health insurers, consumers, accrediting agencies, and the public sector. Together, these stakeholders are working to ensure that quality measures are constructed and reported in a clear, consistent, and person-focused way. This will help inform both consumer and employer decision-making, as well as the efforts of practitioners to improve care that is delivered. The QASC is supported by staff at the Engelberg Center for Health Care Reform at Brookings.

A number of other quality organizations and entities focused achieving better quality measurement, more effective public reporting, and quality improvement are working alongside the QASC. For example, the National Quality Forum (NQF), a private nonprofit that receives significant grant funding from government and private sources, has been furthering this effort by endorsing and maintaining quality measures and incorporating these specifications into electronic health records. Over the last 10 years, NQF has endorsed more than 500 quality measures, leading to improvements in care quality and lower costs. In addition, the private Leapfrog Group works with employers to promote transparency of and access to health care information, as well as to reward high-quality providers.

Regional collaborative and state quality improvement and infrastructure development projects have helped to move data aggregation and public reporting efforts forward and have informed national efforts by identifying best practices and lessons learned. For example, two statewide pilot projects underway in Florida and Colorado will compute results for 17 NQF-endorsed measures and composite measures of ambulatory care using aggregated data from multiple health plans. These pilots lay the foundation for a consistent national approach to combining summary data on performance from Medicare and private payers to produce a more complete and accurate picture of the quality of care.

Effective health care reform demands a broad focus on fundamentally changing the way access to and delivery of health care is financed and organized. This requires, among other things, new payment systems that support better quality and lower costs, effective implementation of health information technology, use of evidence to inform provider and patient decisions, and the rapid identification and expansion of valuable innovations in health care delivery. The United States is making progress toward these goals by supporting efforts to develop a nationwide infrastructure for measuring and reporting on quality and costs.

In addition, private provider network programs in many countries mimic accreditation by creating incentives for private providers to adhere to quality standards. For example, in Pakistan, Population Services International (PSI) runs the world's largest clinical social-franchising program to give consumers a simple reference for the quality of care provided in a clinic. Clinics

that meet PSI's quality standards receive a green star logo that alerts individuals of PSI's evaluation and approval. PSI monitors quality with mystery patients and provides on-going training for practitioners.⁶⁹ Many other examples of clinical social-franchising can also be found in a number of countries.⁷⁰ This model appears to be growing quite quickly due to the resources of key donors such as USAID, the U.K. Department for International Development, and the German-owned development bank, KfW.

What Can Developing Countries Learn from U.S. Experiences?

Most developing country governments have struggled to implement and then enforce health sector regulations for a number of reasons, including lack of capacity, lack of resources and focus, and the specter of corruption. It is therefore imperative that the U.S. government play a passive role in the regulation of physician entry, hospital accreditation, and quality monitoring by legitimizing private processes and incentivizing different actors to participate in them. For example, by making licensure a requirement for federal loans and payments from federal insurance programs and maintaining board seats for key organizations.

Establishing stronger private regulatory mechanisms may be a way to accelerate progress toward improved quality. Private mechanisms could receive funding directly from donors, or from dues paid to member organizations, and may be more insulated from politics and possible corruption than government bodies.

The American Medical Association (AMA) is an example of a private-sector actor that has filled important regulatory gaps over the past 150 years. The organization evolved from a primarily self-regulatory entity and inspector of medical school quality to a supporter of independent regulatory entities like the Liaison Committee for Medical Education. This transfer of certain regulatory functions was possible because the AMA had earned a reputation as an honest and trusted broker for provider and patient interests.

While the U.S. private physician licensure process is generally thought to be effective in keeping unqualified providers from practicing medicine, one criticism that may be justified is that the strength of the various professional associations and accrediting bodies may prevent task-shifting, a much-discussed mechanism that developing countries are increasingly using to address physician shortages. In the United States, some have proposed task-shifting as a way to control costs and increase efficiency. Strong associations and accreditation processes can control quality, but they can also increase costs if they create barriers to entry and enforce overly stringent requirements designed to protect the revenues of specialized professionals.

Box 2. Regulation of Provider Entry and Quality: Ideas from U.S. experiences that could be adapted in developing countries

Strategy

- Governments do not need to build individual accreditation bodies. Private organizations can conduct accreditation as long as governments legitimize the process. Governments can give legitimacy to accreditation efforts through governance or incentive mechanisms. For example, federal student loans are only available to students who attend Liaison Committee for Medical Education-accredited medical schools.
- It is important to consider how to sequence regulatory efforts. Overzealous regulatory efforts may disadvantage and/or scare away certain types of providers (e.g., lower-level or informal sector providers), a potentially unintended consequence. For example, various professional associations and accrediting bodies may prevent task-shifting in an effort to protect their market share.

Partnerships

- Diverse stakeholder participation within private accreditation bodies, including government and professional association representation, can build trust and accountability in the quality of provider education programs (e.g., U.S. Liaison Committee for Medical Education and the Accreditation Council for Graduate Medical Education).
- Collaborative public-private efforts (e.g., Quality Alliance Steering Committee, National Quality Forum) can be used to achieve better quality measurement, more effective public reporting, and quality improvement.
- Pilot efforts underway in the United States to combine data on performance from public insurers (Medicare and Medicaid) and private insurers may be instructive as a means for producing a more complete and accurate picture of the quality of care in mixed health systems.
- Provider groups like the AMA can help with the regulation of the entry and quality of providers. Countries with weak or nascent provider associations should consider how to leverage diaspora providers (such as physicians of African or Asian descent practicing in the United States or United Kingdom) to support the development of regulatory mechanisms, such as through an exchange program. These professionals can help translate best practices to their home countries.

Operations

- Accreditation of health care facilities provides an objective and efficient means for evaluating providers' compliance against an accepted set of quality benchmarks and performance and safety standards and can stimulate the raising of quality standards.
- Mixed health systems with insurance systems should take advantage of their influential role as purchaser, regulator, and provider to determine and monitor quality of care. As governments start to pay private providers (e.g., through insurance), there may be greater incentives for accreditation. In addition, linking provider reimbursement with the quality of care can incentivize quality improvement and control health care costs.

Policy Consultation and Policy Analysis

Through policy consultation processes, stakeholders can set a policy agenda that is most relevant to the needs of a particular health system. These processes also allow for operational coordination across sectors regarding the provision of care, such as referral processes, roll-outs of new policies or interventions. The government may be able to independently judge in which direction the health system should be steered, but it may require feedback on what policies and tools will most effectively fulfill these goals. These decisions require input from the private sector, consumer/patient representatives, and the research community. In some sense, policy consultation is a key component of information collection. The public sector should not only be aware of what private-sector actors are doing, but the public sector should know what the private sector is thinking. Formal consultation processes and strong policy analyses can help bridge the information divide and build trust between the public and private sectors.

Policy Consultation Challenges

While there are many different kinds of public-private partnership initiatives in the mixed health systems of developing countries, ministries of health and state and local governments still face major challenges in engaging stakeholders in data-driven health decision-making and priority-setting. Formal mechanisms for policy dialogue between public and private sectors are often relatively weak and private sector actors are frequently excluded – in many cases these include national health policy advisory councils, public comment processes on proposed laws or regulations, or national reform planning processes. Informal mechanisms for policy consultation may exist in some countries through personal relationships and ad hoc consultations on an as-needed basis.

In addition, operational consultation processes are similarly lacking. For example, when governments plan to roll-out new treatment guidelines, viable mechanisms are not always in place to coordinate with private providers, non-governmental organizations, and the formal for-profit sector. In addition, typically there are no mechanisms to coordinate with informal sector providers.

Traditionally, the public sector has a poor working relationship with the private sector. A general suspicion toward the private sector and a lack of consistent communication further exacerbates this. Governments may often be unfamiliar with how to engage in building relationships with the private sector, as they may be more familiar with using “command and control” approaches.⁷¹

Survey data suggest that the private sector is often equally apprehensive toward the public sector. Concerns about corruption and limited capacity in the public sector sometimes lead private-sector actors to avoid dialogue with the public sector.⁷² A survey of private-sector actors in Ghana revealed that even when private-sector representatives are invited to policy discussions with the public sector, their presence receives less attention than the presence of public sector actors.⁷³

An inherent challenge of consulting with the private sector in developing countries is the lack of strong professional and consumer associations. Provider associations allow governments to hear

the distilled views of providers without having to expend resources on consulting with each one individually. Consumer associations can identify those policies and programs that are most useful or potentially detrimental to patients and program beneficiaries themselves. Provider and consumer associations can also take on advocacy work that can bring critical patient needs to the public's attention.⁷⁴ Particularly in decentralized health systems, cooperative efforts may have a stronger voice than the work of one or two stakeholders alone. The advocacy role of associations, however, must be viewed through a cultural lens. In some developing countries, it may not be culturally acceptable to directly challenge the government's policy decisions. Nonetheless, engaging with professional and consumer associations can help governments determine which issues are the most critical to address. If there are no private sector associations or large umbrella organizations, there may be a high opportunity cost for the government to interact with key stakeholders.

Policy Analysis Challenges

In addition to evaluating the opinions and views of private-sector actors, the public sector can benefit from independent policy analysis to help clarify which policy decisions will best further health sector goals. The intent to pursue reform alone is insufficient to generate successful policies. Rather, a comprehensive network of think tanks, universities, and other nonprofits and civil society organizations is critical for reviewing existing policies and programs and generating new dialogue. Generally, few institutions and mechanisms for high-quality and impartial policy analysis exist in developing country mixed health systems. For example, out of the approximately 5,400 think tanks registered globally, only 7.76 percent of them operate in Africa.⁷⁵

Not only are think tanks generally scarce in developing countries, but they are also usually poorly funded and staffed.⁷⁶ A survey of 50 institutions that engage in health policy and systems research in low-income countries revealed that, on average, the institutions surveyed had a portfolio of 2.8 projects and had an annual budget of about \$72,000. Of the institutions surveyed, 16 percent had two or fewer full-time equivalent staff members.⁷⁷ Think tanks in low-income countries usually lack endowments and the staff must devote a significant amount of time to maintaining financial security, both of which take away from producing high quality policy analysis.⁷⁸

Consequently, health policy analysis in low- and middle-income countries remains in its infancy. There is a relatively small body of work on agenda-setting and formulation of policy; a slightly larger, scattered, body of work exists on implementation. This suggests that the policy analysis that does exist in developing countries is more strongly rooted in micro- rather than meso-level analysis.⁷⁹

Where health policy analysis is taking place, a lack of dialogue among policymakers and researchers means that there is often a disconnect between policy questions and research questions. For example, a survey of mental health researchers in lower middle-income countries found that policymakers had generally not been involved with the planning and execution of their research. In addition, the same study found that two-thirds of the respondents do not belong to any research network, which may consequently isolate their work and prevent critical dialogues.⁸⁰

Promising Examples of Policy Consultation and Analysis from Developing Countries

Policy Consultation

Professional and consumer associations provide one vehicle for countries to seek and receive feedback about policies and programs. In India, the Self Employed Women's Association (SEWA)⁸¹ was established as a trade union in the 1970s for women earning their own income outside of the organized sector. Women who participate tend to come from low income populations and are particularly vulnerable to exploitation.⁸² As SEWA has evolved, it has increasingly fulfilled a number of needs for its members, including providing access to health care, child care, micro-credit, legal services, and skills training. In addition to supplying health services directly, SEWA also offers members access to a community-based health insurance plan financed by member premiums and the interest accrued from depositing premiums into the bank.⁸³ SEWA has expanded its reach throughout India and offers a model for bringing workers together as a consumer association for health care and other services.

The Christian Health Association of Ghana (CHAG) is a voluntary professional association composed of faith-based health organizations that are often the first point of care for low-income, rural patients in Ghana.⁸⁴ The association plays a consultative role by bringing together health providers to provide feedback to the government on health policies, and in some cases also lobbying for new policies and conducting advocacy work. It also serves as a critical provider of care for the Ghana Health Service, participating in the National Health Insurance plan and serving as the country's second largest provider of health services. After more than 30 years of efforts to open dialogue between CHAG and the government, a Memorandum of Understanding (MOU) is now in place to provide a structure for collaboration and cooperation between the government and CHAG. This MOU recognizes that strong private-public sector collaboration is necessary in order to achieve universal health coverage and many other health system objectives.

Policy Analysis

Policy analysis and research efforts in developing countries can be structured in different ways. Some countries have health policy organizations that are independent, non-governmental or semi-autonomous organizations. For example, the International Health Policy Program (IHPP) in Thailand researches national health priorities and both participates in and promotes health policy dialogues.⁸⁵ The IHPP is an independent, semi-autonomous body within the Ministry of Public Health and the Health Systems Research Institute, and serves as a defacto repository of knowledge for health policy in Thailand and international health policies at large.

Another such organization, the Bangladesh Institute of Development Studies fosters informed policy implementation by producing policy research and disseminating the findings.⁸⁶ It works independently under an endowment, which allows for financial autonomy from the government, and the Minister of Planning occupies its high-level chairmanship. The Institute produces original research concerning the social and economic policies of Bangladesh and hosts a variety of workshops and seminars. It also engages with both the government of Bangladesh and a number of multilateral and bilateral organizations.

Health policy analysis and research in low-income countries is also conducted as part of international and joint partnerships. USAID's PSP-One project aims to increase private sector participation in providing high-quality reproductive health and family planning care in developing countries.⁸⁷ In addition to commissioning specific private sector studies, the project hosts online interviews where health system stakeholders like ministry officials and private sector experts can exchange information and ideas. These dialogues bring private- and public-sector actors together to discuss specific issues and promising solutions.

Additionally, two final examples are the Council for Health Research and Development (COHRED) and the African Science Academy Development Initiative (ASADI). COHRED was established in 1993 to build health research capacity in order to improve health and health system performance in low-income countries.⁸⁸ The organization partners with governments, research institutions, and local communities to provide technical assistance and to facilitate peer learning and global partnerships, and receives funding from a variety of donor organizations.

ASADI⁸⁹ was founded in 2004 with funding from the Bill and Melinda Gates Foundation, and brings together the U.S. National Academies (including the Institute of Medicine) with African science academies to augment the African academies' capacity to formulate evidence-based policies and analysis. This initiative encourages participatory analysis through research, regional conferences, and joint learning sessions between U.S. and African academies. Strengthening in-country institutions allows countries to gain expertise in the research most relevant to local challenges and builds the capacity and the environment for rigorous policy consultation.

U.S. Policy Consultation Processes and Mechanisms for Policy Analysis

The pluralistic nature of the U.S. health care system has created a patchwork of policy consultation processes for public and private stakeholders to participate in the health care system. These processes can range from the formal to the informal, and can involve both the public and private sectors. However, the most successful initiatives often are public-private partnerships. Figures 7 and 8 show the different types of policy processes used in the United States, as well as associated examples that may be interesting approaches for other countries with mixed health systems to consider.

Figure 7. U.S. Policy Consultation Processes

	Type of Mechanism		U.S. Examples	Description
Policy Consultation Processes	Formal	Policy level	Federal Register	Provides stakeholders with the opportunity to participate in the post-legislative process by providing publicly available information on federal agency regulations, proposed rules, public notices on hearings and public meetings, and Presidential documents, with opportunity to comment.
			Open Door Forums	Provides an opportunity for the provider community to engage with Centers for Medicare & Medicaid Services' administrators over specific programmatic challenges and potential solutions for these challenges.
		Beneficiary level	Office of Medicare Ombudsman	Provides a venue through which Medicare beneficiaries can learn more about their benefits and file grievances if they are unable to access their benefits or believe that they received poor quality care.
	Informal	Stakeholder discussions	White House Regional Forums on Health Reform	Provides a venue for key health care stakeholders and elected officials to come together and discuss what must be done to change the health care system.
		Operational processes	Day-to-day government consultations with private providers	For example, consultations with drug retailer associations during the roll-out of the Medicare Part D prescription drug benefit or state and local health department mechanisms for working with private providers during public health campaigns (e.g., H1N1 vaccine distribution).
		Advocacy	Days on the Hill	Uses broad membership of stakeholder groups to influence the policy process through coordinated and strategic visits to federal representatives.

Figure 8. U.S. Policy Analysis Mechanisms

	Type of Mechanism		U.S. Examples	Description
Policy Analysis Mechanisms	Public	Government agency	Congressional Budget Office	Provides Congress with objective, nonpartisan, and timely analyses on the budget impacts for every bill reported by a Congressional committee.
		Federally-funded research and development centers	National Cancer Institute	Investigates the genetic, molecular, environmental, and behavioral factors that contribute to human cancers, as well as identifying new targets for cancer diagnosis, treatment, and prevention.
	Private	Nonprofit institutions, think tanks, foundations	Institute of Medicine	Conducts independent research and policy analysis and provides guidance to the federal government on guidance on important medical topics.
		Associations	American Medical Association	Advocates on behalf of physicians; influences health care policy and practice by establishing ethical standards, setting policy goals, promoting public health, and publishing the <i>Journal of the American Medical Association</i> .
			AARP	Advocates on behalf of individuals ages 50 and older; contributes to the policy debate by identifying policy priorities, conducting independent research, and developing issues briefs.
	Public or Private	Media	<i>Washington Post</i> , <i>New York Times</i> , <i>Wall Street Journal</i> , National Public Radio (NPR)	Can provide an unbiased source of reliable policy analysis on pressing public issues, such as health care reform. Most are for-profit companies, however some, such as NPR, receive both public and private funding.
	Public-Private	Federal Advisory Committees	National Committee on Vital and Health Statistics	Advises the Department of Health and Human Services (HHS) on issues regarding health data, statistics and national health information policy.
			American Health Information Community	Makes recommendations to HHS on how to accelerate the development and adoption of health information technology.
		Congressional agencies	Medicare Payment Advisory	Advises Congress on issues affecting the Medicare program,

	Type of Mechanism		U.S. Examples	Description
			Commission (MedPAC)	produces analytical reports on access to care, quality of care, and other issues affecting Medicare beneficiaries.
		Nonprofit	National Quality Forum	Nonprofit quality organization that sets national priorities and goals for performance improvement, endorses national consensus standards for measuring and publicly reporting on performance, and promotes quality goals through education and outreach programs.
			Quality Alliance Steering Committee	Nonprofit, collaborative effort aimed at implementing measures to improve health care quality and efficiency. Comprised of sector-specific quality alliances, as well as physicians, nurses, hospitals, health insurers, consumers, accrediting agencies, and the public sector.
		Universities	Johns Hopkins Bloomberg School of Public Health Department of Health Policy and Management, Georgetown Health Policy Center, Dartmouth Institute for Health Policy and Clinical Practice, Stanford Center for Health Policy/Center for Primary Care and Outcomes Research	Academic institutions, some publicly funded and some privately funded, are major contributors to policy thinking and policy research. A number of universities have departments, centers, and/or institutes devoted specifically to health policy analysis.

Policy Consultation

Effective health system stewardship relies on the effective engagement of the public and private sector in the policy consultation and consensus building process. The U.S health system relies on both formal and informal mechanisms for encouraging active stakeholder participation. Because of this reliance on private insurers and private providers for delivery of all levels of care, consultation with the private sector is an integral part of nearly all policy and administrative processes. In fact, much of the day-to-day work of a typical policymaker at the local, state, or federal level is consultation with private-sector actors. Below, we describe several consultation mechanisms.

Formal Policy Consultation. Stakeholders are given multiple opportunities to provide feedback and suggestions regarding the U.S. health system. For example, during the post-legislative, rule-making period, the Federal Register gives stakeholders an opportunity to participate in the regulatory process through the daily publication of federal rules and regulations. The public can track pending regulation and during a defined period, and both individuals and stakeholder organizations are able to comment on proposed rules and share their views on various policy and program considerations. Government agencies must address significant issues stakeholders raise during the comments period and discuss any changes made in response to them when they publish final regulations in the Federal Register.

Another example of a formal process for policy consultation are the Centers for Medicare & Medicaid Services' (CMS) "Open Door Forums," which build on Federal Register activities by providing an opportunity for the provider community to engage with CMS leadership over specific programmatic challenges and potential solutions for these challenges. Forums also provide an opportunity for participants to clarify technical or process questions regarding specific rules and instructions for particular programs or recently proposed regulations. Participants also have an opportunity to raise concerns during the formal comment periods associated with the rulemaking process. Finally, the forums provide CMS leadership with the opportunity to proactively engage beneficiary advocates to address opportunities and challenges associated with supporting access, improving medical outcomes, lowering costs, and improving quality within CMS programs. CMS complements this effort by hosting educational and training events throughout the country. These events are designed to help support the successful implementation of new program provisions and promote active communication between the agency, its Regional Offices, and the health care community.

Finally, at the care delivery level, the CMS Office of the Medicare Ombudsman's (OMO) provides a venue through which Medicare beneficiaries can learn more about their benefits and file grievances if they are unable to access their benefits or believe that they received poor quality care. Specifically, Ombudsmen work with organizations such as State Health Insurance Assistance Programs (SHIPs) and Quality Improvement Organizations to ensure that complaints and appeals are resolved promptly and that information regarding benefits, coverage, premiums, deductibles, and coinsurance are available. The OMO is also tasked with producing an annual report for Congress and the Secretary of Health & Human Services that describes OMO activities and provides recommendations on how to improve the Medicare program.

Informal Policy Consultation. In addition to formal consultation, the U.S. health system also benefits from a variety of informal policy processes, both political and operational. These informal consultative processes are not required by law, but they happen as a matter of course.

Stakeholder discussions can play an important role in building broad stakeholder consensus on important and often contentious issues. They can be used strategically by both public- and private-sector organizations to provide a forum for key players to air their concerns, discuss possible solutions, and generate support for a particular issue or strategy. For example, in preparation for health care reform in 2009, Senate Finance Committee Chairman Max Baucus and Ranking Member Chuck Grassley co-hosted a bipartisan summit to discuss reform options.

The summit was part of the Finance Committee's year-long series of hearings, roundtables, and events in preparation for Congressional action on health reform.

Another example of this is the series of White House Regional Forums on Health Reform hosted by President Barack Obama. The series was a collaborative effort with Democratic and Republican governors from across the country and was intended to bring together key health care stakeholders and elected officials from both sides of the aisle to discuss what must be done to change our health care system. In addition to hosting Regional Forums, the Obama Administration has also tasked the White House Office of Health Reform with hosting a series of stakeholder discussions at the White House intended to engage small business owners, rural Americans, physicians, and other key stakeholders, identify their concerns, and generate acceptable strategies for addressing the growing cost of health care and improving access to coverage. Topics of concern have included health disparities, women's health, health care in rural America, and health care for small business owners and workers.

Stakeholder organizations can also engage with the government through lobbying efforts such as "days on the Hill" events during which members visit federal elected officials in order to engage on a specific policy issue. Often times, these events are organized in conjunction with annual member meetings held in Washington, D.C., during which the organization develops their specific policy agenda for the year.

In addition, the government frequently and informally consults with individual providers and patients and their associations in preparation for the implementation of new programs or public health campaigns. For example, during the process leading up to the implementation of the new Medicare Part D pharmacy benefit in 2006, the government held a series of stakeholder forums with pharmacists, local health departments, area agencies on aging, and patient groups to discuss the contents of the drug benefit and to seek stakeholder input on practical issues surrounding its delivery.

Informal consultation processes can be constructive because they allow many stakeholders to share their views on policy issues, and in some cases, shape the design and implementation of policies and programs. However, some informal consultations can be very political and can ultimately hinder policy progress. Even more troublesome, powerful stakeholders can pair informal consultation processes with political campaign contributions, which can unfairly influence the legislative process.

Policy Analysis

In addition to the effective engagement of the public and private sectors in the policy consultation and consensus-building process, rigorous policy analysis and research is a key mechanism of strong health system stewardship.

Publicly Sponsored Policy Analysis. Policymakers in the United States rely on a number of government agencies that provide unbiased policy analysis. One such example is the Congressional Budget Office (CBO), which was established to provide Congress with objective, nonpartisan, and timely analyses on the budget impacts for every bill reported by a Congressional committee. Cost estimates for pending legislation assess a number of factors,

including the potential impact on discretionary spending, mandatory spending, and federal revenues (incorporating estimates by the Joint Committee on Taxation for legislation that would change the federal tax code). These estimates are then used to determine whether the proposed legislation is consistent with the budget resolution, and have become an integral part of the legislative process. The CBO releases its estimates through annual, publicly-available reports and briefs, monthly reviews, letters, presentations, and background papers, and testimonies before Congress.

Public-sector sponsored policy analysis can also come from Funded Research and Development Centers (FFRDC), (which operate as government think tanks), created and funded by the U.S. government to meet specific long-term technical needs that cannot be met by any other single organization. Although the majority of these Federally Funded Research and Development Centers (FFRDC) focus on security and defense related issues, some are health-focused as well. For example, the National Cancer Institute at Fredrick, which is part of the National Institutes of Health (NIH), was formed to investigate the genetic, molecular, environmental, and behavioral factors that contribute to human cancers, as well as identifying new targets for cancer diagnosis, treatment, and prevention.⁹⁰ Unlike private think tanks, FFRDCs receive most, if not all, of their funds from the government.

Privately Sponsored Policy Analysis. Nonprofit institutions — including disease and patient advocacy groups, think tanks, and foundations — also contribute to the health policy dialogue by conducting independent research, convening stakeholders, and disseminating information to both health care providers and policymakers. For example, although the Institute of Medicine (IOM) was established by the federal government to provide guidance on important medical topics, it is free to conduct its own independent research and policy analysis. The IOM is a unique model — though many of the studies it carries out are requested by government agencies, the government is completely removed from the research and recommendation process. IOM meetings that include discussions of recommendations and draft reports are often open to the public, and, in this way, the IOM provides a unique forum for engaging experts, policymakers, and other important stakeholders from both the public and private sectors.

Private think tanks can also play a critical role in the health system stewardship by providing rigorous, independent health policy analysis. Many think tanks are nonprofit organizations and are generally funded by private donors and members of private organizations. As a result, some assert that private think tanks can more freely propose and explore controversial ideas, compared to those conducting government-funded research.

Public-Private Collaborations. Finally, advising bodies can also be public-private collaborations, including Federal Advisory Committees (FACs) and Congressional agencies. For example, FACs provide policy advice to the President or the Administration and typically focus on specific policy issues. In the health care sector, CMS' standing committees provide advice and recommendations in a number of areas, including physician services, proposed medical coverage, beneficiary education, and management. Committee membership includes beneficiaries, physicians, pharmacists, providers, consumer and industry representatives, and other experts in the health care delivery field.

The National Committee on Vital and Health Statistics (NCVHS), which was established by Congress to advise the U.S. Department of Health and Human Services (HHS) on issues regarding health data, statistics and national health information policy, provides another example. Specific committee functions include stimulating or conducting research on health data and statistical challenges, making proposals for improvement on current health statistics and information systems, and informing HHS data policy decision-making as well as private sector and state data policy decision-making. As a national advisory committee, the NCVHS is uniquely positioned to serve as a forum for public-private, cross-sector collaborations and as a leader in efforts to improve health information compatibility across private sector, state, and federal health systems. The committee is comprised of 18 individuals with expertise in fields including health statistics, privacy and security of electronic information, population-based public health, health data standards, and epidemiology. All meetings of the NCVHS are open to the public.

To address another major health system issue, the adoption of health information technology (IT), HHS chartered the American Health Information Community (AHIC) in 2005 to make recommendations on accelerating the development and use of health IT. Another FAC example, AHIC provided guidance on a wide range of factors that either presented barriers or facilitated the adoption of health information technology, including strategies for developing a standards and certification process, building a business case, establishing business processes, and addressing social/cultural, privacy/security, and medical/legal issues. AHIC was composed of 18 members representing a broad spectrum of public and private health care stakeholders committed to the advancement of health information technology. In 2008, AHIC completed its charter and transitioned from a Federal Advisory Committee to a private-public organization, the National eHealth Collaborative (NeHC). This transition was supported by a grant through the Office of the National Coordinator for Health IT. The goal of the NeHC is to build on the accomplishments of AHIC by providing a credible forum for stakeholders to discuss strategies for supporting the development of an interoperable national health information network and leveraging available funds for investments in health IT (e.g., the American Recovery and Reinvestment Act of 2009).

Several Congressional agencies also provide guidance on specific federal programs. For example, the Medicare Payment Advisory Commission (MedPAC), which was established by Congress to advise on issues affecting the Medicare program, is comprised of experts from public and private sectors, academia, and from across the United States. In addition to advising on issues such as Medicare payments, the Commission produces analytical reports on access to care, quality of care, and other issues affecting Medicare. Commissioners are appointed to three-year terms and receive support from an executive director and a staff of analysts. In addition, commission members and staff seek input from specific individuals interested in the program, including staff from Congressional committees, CMS leadership, health care researchers, providers, and patient advocates. Their research and analysis culminates in the publication of two reports each year to Congress. MedPAC also advises the Congress through other avenues, including comments on reports and proposed regulations issued by HHS, and testimonials and briefings for Congressional staff.

Box 3. Case Study: The American Medical Association

The American Medical Association (AMA) was founded in 1847 by Nathan Smith Davis to promote the art and science of medicine and the betterment of public health. Early AMA activities focused on efforts to establish standards for preliminary medical education and physician training and to promote medical ethics. During this initial period, the AMA also worked to regulate health care quality through broad public education efforts and steps to limit entry into the medical field to only those who were qualified and properly trained. The AMA was also an early supporter of medical research and published key findings in the *Journal of American Medical Association*, which remains one of the leading medical journals.

As the AMA entered the early 1900s, it became even more engaged in medical education. It founded the AMA Council of Medical Education to inspect and grade medical school and published the results in the “Flexner Report.” This involvement in medical education continued into the late 1940s, when the AMA Council on Medical Education and the Association of American Medical Colleges jointly established the Liaison Committee on Medical Education (LCME) to accredit medical training programs. The establishment of the LCME marked a change for the AMA, which transitioned from serving as the direct regulator of medical school education, to becoming a supporter of a distinct organization formed to regulate and oversee this education.

By the 1960s, the AMA was a powerful professional association and widely considered an honest broker. As the AMA became more involved in health policy, it formed the American Medical Political Action Committee (AMPAC) to represent its interests in the political process. For example, AMPAC played a critical role in helping to block universal coverage reform efforts in the 1990s under the Clinton health reform proposal.

More recently, the AMA has focused its efforts on a number of public health and advocacy efforts that have ranged from developing education campaigns to address specific conditions, such as smoking, alcoholism, and HIV/AIDS, to developing the Patient’s Bill of Rights. It has also become a vocal supporter of efforts to reform health care and expand insurance coverage.

The AMA operates as a membership organization and is open to physicians, residents, and medical students. In return for a small fee, the AMA supports members in a number of ways. For example, the AMA provides basic resources that can assist members with practice management and billing. The AMA also provides additional consultation for a fee. Most importantly, the AMA acts as a powerful advocate for physicians, working on issues such as Medicare physician payments and medical liability issues.

What Can Developing Countries Learn from U.S. Experiences?

Policy consultation could be described as “part of the DNA” of the U.S. health system.

Policymakers and government officials spend a large percentage of their time consulting with, working with, and negotiating with private actors. HHS does not have a separate “public-private partnership unit” to work with the private sector, as is often proposed in developing countries. In the United States, most public officials consider it part of their job to consult with, influence the behavior of, and better collaborate with the private sector. Developing countries with large private sectors could benefit from this approach, where public officials view the private sector as part of the health system, not a sideline.

The U.S. processes, formal and informal, for commenting on proposed rules and regulations (e.g., the Federal Register) and new program design and implementation (e.g., Medicare Part D stakeholder forums) can be effective in seeking and addressing stakeholder issues. Developing countries could consider some of these approaches for institutionalizing consultation processes and increasing stakeholder engagement. The U.S. Federal Advisory Committees (FACs) provide an interesting model for public-private collaboration and a mechanism for providing access to expertise and advice for the government.

Despite the strong U.S. culture of policy consultation and policy analysis, developing countries should be wary that too much informal consultation and too much stakeholder power can significantly hinder reform efforts and policy processes. Furthermore, money in politics (even in the form of legal campaign contributions) mixed with informal consultations (e.g., lobbying) can hamper the policy process and distort stakeholder positions at the cost of maximizing the value of the health care system. These negative lessons could be instructive for other countries that seek to promote more informal policy consultation.

In addition, developing countries can learn from an ongoing policy analysis challenge in the United States. The Congressional Budget Office (CBO) uses a set time horizon of only 10 years for its analyses and budget projections. Many argue that this time horizon is too short because some valuable and potentially cost-effective programs, like obesity prevention, will generally not yield tangible results until years later. Therefore, when the CBO “scores” some health care bills, particularly those that focus on public health and disease prevention, the returns on such investments are often not readily apparent. Developing countries can avoid this mistake by setting longer analytic time horizons, if possible, and by identifying good intermediate measures for shorter time horizons.

Box 4. Policy Consultation and Analysis: Ideas from U.S. experiences that could be adapted in developing countries

Enablers

- Money, power, knowledge, and votes are important motivators for engaging stakeholders. For example, Medicare payments and government funding for Medicare and Medicaid are motivators the U.S. government uses to bring providers to the table. In addition, certain consumer associations have convening power because they constitute important voting blocks (e.g., AARP).
- Establishing trust is critically important. Having a third party organization that is trusted and respected by both sides (e.g., Brookings Institution) can help to facilitate dialogue and build trust between the public and private sectors.

Box 3. Policy Consultation and Analysis: Ideas from U.S. experiences that could be adapted in developing countries (Continued)

Organizations

- Public-private policy advisory bodies, such as the U.S. Federal Advisory Committees and MedPAC, can be legitimized by government but include many private actors.
- One way for the public sector to effectively and efficiently engage in a dialogue with the private sector is to consult with professional provider associations. Professional associations offer access to a unified voice for the provider community and they can promote discussion and resolution of major issues affecting their practice area. When legitimized by governments, professional associations can be a regular “go-to” resource for government.
- Government entities, such as the CBO, can provide objective policy analysis and fiscal projections of proposed legislation. However, care should be taken to ensure time horizons for analysis can account for longer-term health outcomes.
- Private, non-governmental organizations – including think tanks, research institutions, and universities – can respond objectively to government policy priorities and conduct independent research. The available capacity of these entities in terms of professional expertise and funding, for example, are key factors for success.

Conclusions and Recommendations

Developing countries with complex mixed health systems could address several stewardship gaps in order to strengthen their entire health systems. This paper focuses on three types of mechanisms: (1) information collection, (2) regulation of provider entry and quality, and (3) policy consultation and analysis. For each, we have highlighted a number of examples and potential lessons to be learned from U.S. experiences.

In addition, we have formulated three cross-cutting recommendations that can help developing countries operationalize stronger stewardship mechanisms and drive improvements in health care. These represent long-term structural and institutional investments that, over time, could significantly assist in addressing the major stewardship gaps identified in this paper. Given that these are long-term investments, impacts on quality of health may not be immediately evident. However, such investments ultimately may mitigate the potential negative outcomes of weak stewardship mechanisms and lead to higher-quality health care throughout the health system.

Recommendations

1. Support efforts to establish and strengthen professional and consumer associations.

Associations can be important vehicles for collecting and disseminating information, obtaining and providing policy input, generating policy analysis, and self-regulating and improving quality of care. However, professional and consumer associations are non-existent or only beginning to emerge in most developing countries. Fostering an environment where these associations can be established and can successfully grow may help provide necessary checks and balances to various stakeholders.

In the absence of strong and effective government regulation, professional associations can self-regulate to develop professional, ethical, and quality standards for physicians and other providers. They can also encourage informal providers to operate more formally. As governments begin to assume a stronger role in regulating providers, they can leverage professional associations as a vehicle for communicating with providers, such as establishing or revising clinical care guidelines or disseminating new quality standards, and strengthening training programs so that health care professionals are well-prepared to meet regulatory standards. The evolution of provider regulation in the United States is a good example of this model; early on, the American Medical Association played a large role in ensuring care quality and good business practices through self-regulation. However, as the health system grew and developed, the U.S. government began to play an increasingly larger role in regulation, while still relying on professional associations to fulfill specific functions.

Professional associations can also play an important role in defragmenting the health system, as it is much simpler for the government to interact with several associations than with thousands of individual providers. Consumer associations can also play a key advocacy role in policy processes by informing and educating patients on how to make better decisions about health care. Through education and advocacy work, consumer associations can also serve as a check on providers, ensuring that care is being delivered in a safe, effective, and consumer-friendly way.

While strong professional and consumer associations may be a vehicle for quality improvement and better information collection and consultative processes, there are some potential tradeoffs of more developed associations. In addition, as the United States has learned in its efforts to implement major health reform, there may be instances where professional or consumer associations become barriers to the policy reform process, should they become too strong. However, strengthening professional associations is likely a better investment than maintaining the status quo of little regulation and oversight.

For associations to develop and be sustainable, a significant up-front investment and a long-term business plan are required. Key considerations and steps for establishing a professional organization are outlined in Box 5.

Facilitators:

Several major barriers to the development of professional and consumer associations include: 1.) lack of legitimacy given to professional associations by governments; 2.) funding constraints, which result in a lack of resources for establishing and maintaining associations; and 3.) lack of capacity and knowledge for how to establish and sustain associations. Below are potential facilitators to address these barriers.

- Governments can open the door to policy consultation with professional and consumer associations by welcoming their input in the policy process – both formally and informally – creating a symbiotic relationship and giving legitimacy to the associations. Formally, the government can include consultation with provider and consumer groups in legislation or regulations requirements. Informally, the government can call upon professional and consumer associations to participate in stakeholder dialogues. Governments can also provide financial incentives for the establishment and sustainability of associations, as well as provide strategic direction for backed funding opportunities. In some limited cases, the government can play a role in the decision-making and priority-setting processes as a liaison member to the board.
- Development partners can collaborate with governments to formulate strategies to engage existing practitioner groups and associations.⁹¹ They can also provide financial incentives for establishing and sustaining professional and/or consumer associations. Development partners should be aware of the fact that it may be difficult for grant recipients to report on traditional deliverables, such as specific, tangible health outcomes. Furthermore, it may also be challenging for recipients to generate measureable results in the short-term, as the impacts of these efforts will likely not be seen until several years later, and even these results may be difficult to quantify. Therefore, donors will have to be more creative in how they measure impact. Donors could instead consider short-term, process-based deliverables, which could include developing a strategic plan that addresses a specific organization’s strategy for sustainability. This plan could include establishing specific accreditation processes, developing care pathways, producing key information on practicing providers, or issuing reports on the number of members recruited or the number of meetings held.

- Emerging professional and consumer organizations could leverage untapped networks to the extent that they exist. For example, diaspora providers, such as physicians of African or Asian descent practicing in the United States or United Kingdom, could help translate practices to their home countries and support the development of regulatory mechanisms. Consumer groups like farmer co-ops and women's and youth groups can consolidate buying power and political influence to more effectively participate in policy consultation.
- Consumer organizations, including community-based insurers, unions, co-ops, and collectives, large employers, and the media can drive demand for quality by educating patients on how to shop for high-quality, high-value care.
- Professional and consumer associations can develop their capacity by identifying revenue sources that will help with start-up costs and ensure their own long-term sustainability. Potential revenue sources include dues, conferences, and publications; continuing education; collecting and selling information; policy analysis and research; and product development, such as procedure codes.

Box 5. Key Considerations and Steps for Starting a Professional Organization

Despite the importance of and key role that professional organizations can play in the policy consultation and quality improvement process, building a professional organization can be a daunting task. This is particularly true in countries where political and/or advocacy-based organizing has been traditionally discouraged and support and resources for this type of work are limited. Below, we describe some initial steps and key considerations that professional organizations should address as they take steps to form or expand their organizations.

- **Secure funding.** Seed money is an important consideration for nascent professional organizations. How much money is needed, however, depends on the goals and scope of the organization. The cost of starting an organization that is primarily interested in improving health literacy among patients, for example, may be considerably lower than that for an organization that is interested in developing its own quality measures. Initial funding requirements can also vary based on the availability of in-kind contributions. Start-up costs can be contained by leveraging existing infrastructures and investments such as meeting space or help from support staff. Developing country governments and donors can support these efforts by providing seed money to finance initial development activities and linking this money to achievable milestones that are relevant for professional associations.
- **Develop a mission.** Organizations should think carefully about developing a mission that captures their core values and goals, which then can be translated into strategic efforts and activities. The mission should be broad enough that it is relevant to those outside of the organization – such as the general public, policymakers, other stakeholders – yet specific enough that it addresses the particular needs of its members. The mission statement should stand the test of time. The American Medical Association’s (AMA) mission, for example, is to promote the art and science of medicine and the betterment of public health. Although the activities that support this mission have changed over time, the core values and goals of the organization are still very much the same.
- **Ensure financial sustainability.** To ensure that the organization is financially sustainable once the initial seed money has been used, organizations must also develop a strategic business plan. Having such a plan in place may also help support efforts to secure initial seed money as well as demonstrate to prospective members that the organization has a clear, developed plan for action and impact. Long-term funding can come from a number of sources, including dues and payment for extra services from members, as well as research grants from foundations, the government, and other stakeholders that can benefit from research conducted by the organization.
- **Build trust.** To truly have a broad and sustained impact on the health care system, organizations must demonstrate that they are a trusted source of information both among their membership and with other stakeholders, such as the government and the public. They must also show that they are invested in the system beyond their own financial well-being and are contributing a unique and important service. Professional associations in the United States and other developed countries have traditionally operated quite differently than unions/bargaining units. Rather than using strikes and similar tactics to increase salaries and benefits, professional associations have increased the status and professionalism of providers through self-regulation and accreditation, focusing on ethics, and taking a seat at the policy table. Professional associations, for better or for worse, have also created some barriers to entry in the profession, which can improve overall quality and safety, but can also drive up prices.

Box 5. Key Considerations and Steps for Starting a Professional Organization (continued)

- **Show impact.** It is important that the organization thinks in terms of both short- and long-term goals and demonstrates impact based on those goals. Short-term activities help to establish an organization's presence and can quickly demonstrate to prospective members and the greater health care community what the organization can contribute. Organizations should think creatively about opportunities to take advantage of "low-hanging fruit" that require little up-front resources but can make a significant impact. Equally important are efforts to reach longer-term goals. By strategically investing in both short- and long-term projects, the organization can ensure that its efforts are all moving toward a common goal while demonstrating the value of the organization.
- **Be flexible.** Finally, it is important to recognize that the goals and roles of professional organizations can change over time as the needs of their members and others they are serving and collaborating with evolve. Although the AMA was instrumental in closing poor performing medical schools, for example, they have since reassigned that function to a different organization. Professional organizations should be cognizant of changing needs and be flexible to reevaluating their role as an organization.

2. Expand private mechanisms for the accreditation of providers.

Accreditation is increasingly viewed as an important form of stewardship in developing country mixed health systems. Accreditation provides an objective and efficient means for evaluating providers' compliance against an accepted set of quality benchmarks and performance and safety standards. It also offers a way to create goals for self-improvement, and stimulate the raising of quality standards. Accreditation can serve as a powerful tool for providers to differentiate themselves from competitors based on care quality.

Governments do not have to build accreditation bodies. Private, non-governmental organizations may be in a better position to monitor quality and grant accreditation as long as the government legitimizes the process. Working with private accrediting organizations may allow governments to insulate themselves from politics and possible corruption, draw in diverse stakeholder participation, and mobilize resources to focus on quality. In the United States, for example, the Joint Commission has diverse representation on its board of directors, including all major professional associations. The government legitimizes the Joint Commission by requiring that hospitals be accredited as a condition of participation in Medicare and Medicaid. Similarly, the Liaison Committee for Medical Education (LCME) accredits medical schools and is legitimized by government through stipulations that medical students can only qualify for federal grants and loans or be licensed by state boards if they attend a LCME-accredited medical school.

Strengthening private regulatory mechanisms may be a way to accelerate progress toward improved quality. Private mechanisms could receive funding directly from donors or from dues of member organizations. Key considerations and steps for establishing an accrediting organization are outlined in Box 6.

Facilitators:

The major barrier to the development of accreditation entities is funding constraints. U.S. funding for accreditation comes from providers themselves who voluntarily pay fees to

accrediting entities because they need accreditation in order to participate in Medicare and Medicaid. They have an incentive to pay for accreditation services because their participation in Medicare and Medicaid allows them to receive payments for eligible services rendered. In developing countries, there is currently minimal accreditation. Accrediting entities that do exist mainly operate for large, international, urban hospitals, and often serve the medical tourism industry. Key issues include how to fund the accreditation of smaller-scale operations that are likely to be unable to pay for accreditation, and how to develop standards that are appropriate for clinics and other facilities in rural areas. Below are several potential facilitators to address these barriers.

- Governments can give legitimacy to private accreditation efforts through governance or incentive mechanisms. Governments can participate in the accreditation process by serving on the board of the accrediting body. Governments can also create incentives for accreditation by tying provider payment or bonuses to accreditation by implementing health insurance schemes that help to ensure that public money is being spent on legitimate and high quality services, and/or undertaking a program of public reporting of accredited providers.
- Donors can provide seed money or funding incentives for the establishment of national or regional accreditation processes. To achieve economies of scale, accrediting organizations can be created at the regional level, such as southeast Asia, especially for developing standards.
- Donors can also provide funding to providers and provider associations to undertake the accreditation process, or can link their financial support for specific interventions or care sites to accreditation. For example, donors could give funding preference to care sites that employ only accredited providers.
- Donors can support capacity-building and core infrastructure investments, recognizing the strategic stewardship role of governments, such as ministries of health. Weak capacity to steward the whole health system is a major barrier to health systems improvements. Donors can provide ministries of health and/or other governmental or non-governmental institutions with resources to develop leadership capacity and strengthen their stewardship functions.
- Providers can voluntarily seek accreditation in an effort to improve quality of care and improve business practices within their profession. They can also design referral processes that favor accredited providers. In addition, providers can pursue accreditation in response to financial incentives offered by government or donors.
- Consumers can increase demand for accreditation by using it as a tool for screening and selecting providers.

Box 6. Key Considerations and Steps for Starting an Accrediting Organization

Building on the key considerations and steps outlined above in Box 5, nascent accrediting organizations may also want to address the following considerations:

- **Take advantage of economies of scale.** Given that the infrastructure requirements for an accrediting organization can be costly and time-consuming to develop, and given that initial returns on investments may take some time to materialize, countries and nascent organizations should consider opportunities for developing broad and/or regional-based accrediting organizations instead of country- or health care setting-specific organizations. This strategy is particularly beneficial in areas where health quality improvement and regulation initiatives are just beginning to take form, as the challenges and barriers to quality improvements are more likely to be shared across care sites. Taking advantage of national health insurance efforts – where there is a demand for accreditation of providers and where new standards can be leveraged more broadly – can help to facilitate the creation of country-level or regional-level accreditation organizations.
- **Leverage existing work.** Organizations should also be mindful of existing efforts to improve or regulate care and take steps to build on these efforts rather than replicate or recreate them. In most cases, quality measurement and safety standards, where they exist, should be standardized across similar regions and care settings. Careful attention should be paid, however, to ensure that the standards are appropriate to the care settings.
- **Establish legitimacy.** In order for accrediting organizations to significantly impact care quality and safety, they must be recognized by other regulating bodies and key stakeholders, and there must be a value case for providers and care settings to want to be accredited. In the United States, the government provides this legitimacy and fulfills this value case by linking payment for public health care programs, such as Medicare and Medicaid, to accreditations.
- **Show impact.** Key to developing the value case for participants and establishing relationships with regulators and stakeholders is demonstrating that accreditation actually leads to better health outcomes and ideally lower costs. This impact can be shown in a number of ways, such as conducting studies comparing health care quality and safety at institutions that are accredited against those that are not. Accrediting organizations can also facilitate this process by initially choosing “low-hanging fruit” as suggested in Box 5. Over time, accrediting organizations can broaden their focus to promote continual quality improvement.

3. Strengthen the capacity of independent think tanks and research institutions to perform policy-relevant analysis.

Setting a public policy and decision-making agenda with broad based support requires high-quality and impartial policy analysis; however, this is often lacking in developing countries. Domestic leadership for engaging a pool of policy analysis experts within the country is critical.⁹² Fostering an environment where rigorous, unbiased policy analysis is conducted and disseminated is a key mechanism for instilling private stakeholders with trust in public policy and improving overall stewardship. The United States has an exceptionally robust health policy analysis and research environment, with many organizations such as the Brookings Institution, Institute of Medicine, National Quality Forum, and a multitude of university-based departments

and institutes that provide high quality independent analysis and research to inform policy decision-making.

A comprehensive network of think tanks, universities, and other nonprofits and civil society organizations is critical for reviewing existing policies and programs and generating new dialogue. A large body of work is currently focused on strengthening policy and research capacity in developing countries. The Think Tank Initiative, supported through the Gates and Hewlett Foundations and the International Development Research Center, supports already existing independent think tanks and research institutes.⁹³ The African Science Academy Development Initiative, supported by the Gates Foundation, brings together the U.S. National Academies (including the Institute of Medicine) with African science academies to augment the African academies' capacity to formulate evidence based policies and analysis.⁹⁴ The Rockefeller Foundation is also supporting efforts to build policy analysis and research institute capacity in developing countries through its Transforming Health Systems Initiative.⁹⁵ Key considerations and steps for starting an independent think tank or research institution are outlined in Box 7.

Facilitators:

Securing stable, long-term funding is the major barrier for developing country think tanks and research institutions. Unlike those in the United States, policy institutes in developing countries rarely have endowments, and it is extremely challenging to establish a stable source of revenue. Other barriers to establishing think tanks and research institutes include a relatively weak level of demand from the government and other stakeholders for policy analysis and research. In addition, the capacity for conducting policy analysis and research may be limited by a lack of training programs, policy and research networks, and other opportunities to build analytic and research skills and experience.

- Governments can prioritize objective policy analysis as part of program management and policymaking by commissioning policy reports when information is needed to inform decision-making. Governments can invest in building internal capacity to conduct policy analysis or commission objective policy analysis by outside entities.
- Health sectors can use existing sector planning and evaluation processes, such as International Health Partnership (IHP+) health sector reviews and/or country coordinating mechanisms, to identify priority policy questions and means of obtaining needed policy analysis.
- Donors can provide funding incentives for building capacity of developing country think tanks, policy and research institutes, professional and consumer associations, university programs, and research networks to conduct rigorous, policy-relevant analysis. This can include seed funding to establish policy institutes and/or long-term funding or endowments for the ongoing activities of policy institutes.
- Researchers and policy analysts can link with international or regional bodies and networks and/or self-organize to facilitate knowledge transfer and data sharing.

Box 7. Key Considerations and Steps for Starting an Independent Think Tank or Research Institution

Many of the considerations in Boxes 5 and 6 for establishing associations and accrediting organizations are relevant to starting an independent policy research organization or institute. As with associations and accrediting entities, securing funding through seed money and establishing a business plan to achieve long-term financial sustainability are key steps during the start-up phase. Building trust and legitimacy and showing results early are also key success factors. Some specific considerations relevant to starting an independent think tank or research institution include:

- **Conduct a market analysis.** Assess the demand for policy analysis and/or research and determine likely competitors, if any. What is the basis of competition, such as knowledge, price, experience, and/or political connections?
- **Determine available capacity.** To what extent is a well-qualified workforce available with relevant technical skills and experience? Is there a pool of potential staff or consultants with strong analytic and communications skills, and other specialized skills, such as knowledge of statistics, economics, research and evaluation methods, and practical experience, including government and private sector work, relevant to the policy and research topics of interest?
- **Assess the operating environment.** What are the legal/regulatory, data use, and accounting requirements for incorporation and ongoing operations? Are there membership-based associations, networks, or other forums to exchange ideas and experiences and to assist with developing new initiatives and presenting work?
- **Maintain independence.** Legitimacy will depend upon the organization's ability to conduct rigorous, impartial, and politically neutral analysis. Setting an independent research agenda, demonstrating a commitment to peer review, and publishing research findings will be important. It will also be important to not be financially dependent on a sole source of funds. Dependence on some government funding does not mean that the organization cannot be considered independent.
- **Be flexible and open to shifting policy and research priorities.** As the demand for policy analysis and research shifts – with changes in political leadership, for example – and/or as the funding environment changes, it is important to be versatile and flexible in order to accommodate the changes and adapt to the changing market while still maintaining independence. The government's health reform strategy can significantly influence analytic and research priorities, which can shift rapidly with changes in political leadership. Independent policy organizations in the United States, like the Brookings Institutions and the Institute of Medicine, have diverse portfolios and expertise to allow them to adjust to changes in demand.
- **Create an advisory group.** Establishing a reputable group of advisors with a mix of relevant skills and experience to provide advice on strategic directions and funding opportunities will help to establish the legitimacy of the organization.

Addressing these cross-cutting areas can significantly aid efforts to improve health system stewardship across the spectrum of care delivery, whether public or private, formal or informal.

By working to improve stewardship mechanisms as the health care market continues to grow and evolve, and by engaging a broad range of key stakeholders in the decision making process, governments can help shape this growth and ensure that it occurs in a positive and sustainable way.

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