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Guide to Prospective Capitation
with Illustrations from Latin
America

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ACRONYMS

ARS	<i>Administraciones del Régimen Subsidiado</i> (Subsidized Regime Authorities, Colombia)
CB	Capitated budget
DDM	Data for Decision Making
EBAIS	<i>Equipo Básico de Atención Integral de Salud</i> (Basic Team for Integrated Health Care, Costa Rica)
EPS	<i>Entidades Promotoras de Salud</i> (Health Promotion Organizations, Colombia)
EPS	<i>Entidades Prestadoras de Salud</i> (Health Care Provider Organizations, Peru)
FPMD	Family Planning Management Development
HMO	Health Maintenance Organization
IAMC	<i>Instituciones Médicas Colectivas</i> (Collective Institutions of Medical Assistance, Uruguay)
HIS	Integrated health system
IMSS	<i>Instituto Mexicano del Seguro Social</i> (Mexican Social Security Institute)
IPS	<i>Instituciones Prestadoras de Servicios</i> (Health Service Provider Organizations, Colombia)
ISAPRE	<i>Institución de Salud Previsional</i> (Prospective Health Institutions, Chile)
LAC	Latin America and the Caribbean
MCO	Managed care organizations
MoH	Ministry of Health
OS	<i>Obras Sociales</i> (Sickness Funds, Argentina)
PAHO	Pan American Health Organization
PC	Prospective capitation
PHR	Partnerships for Health Reform
PMPM	Per-month-per-member (rate of payment)
Pop	Population
POS	<i>Plan Obligatorio de Salud</i> (Mandatory Health Plan, Colombia)
POSS	<i>Plan Obligatorio de Salud Subsidiado</i> (Subsidized Mandatory Health Plan, Colombia)
UPC	<i>Unidad de pago por capitación</i> (Capitated payment unit, Colombia)
USAID	United States Agency for International Development

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1. INTRODUCTION AND BASIC CONCEPTS

Prospective capitation is a method of financing under which health care providers receive a pre-determined payment for each patient who registers with them. In return, the providers agree to supply specified services to any member of the defined population, on an as-required basis during a period of time stipulated by a contract.

Prospective capitation exposes providers of care to the risks and consequences of spending in excess of the predefined and prepaid budget. To manage such risks, providers receiving payment through this mechanism seek clinically effective and cost-efficient ways of delivering their services by strengthening prevention and other primary care, favoring hospital-substituting clinical strategies, limiting referrals to higher levels of care, and controlling resource utilization by subcontracting providers.

International recognition of prospective capitation has grown in the past 15 to 20 years. Currently, it is used by health care systems that range from market-driven, such as the U.S. system, to government-dominated, such as the system in the United Kingdom. Under provider payment reforms in these trend-setting health systems, prospective capitation has produced important systemic effects, including increased emphasis on prevention and continuity of care, decline in admission rates, and decline in length of hospital stay. Because both positive and negative experiences have been widely documented, prospective capitation has become an accessible option for trial application in the LAC countries.

Capitation contains three crucial elements:

- 1) Payment is tied to a defined patient population, i.e., the money follows the patient;
- 2) Care is prepaid at a predetermined rate, hence, capitation is a method of prospective provider reimbursement;
- 3) The recipient of the capitated payments may be at financial risk if expenditures exceed payments and is therefore influenced by an incentive to manage care in a cost-effective manner.

Prospective capitation strongly supports the following health policy goals:

- ? Increase participation of general practitioners in determining clinical strategies, referral patterns, and allocation of resources among levels of care;
- ? Improve coordination of services among the primary, secondary and tertiary levels;
- ? Broaden access to care and liberalize consumer choice of provider while, at the same time, restricting indiscriminate “doctor shopping”, resulting in too many office visits, tests and prescriptions;
- ? Raise professional and economic satisfaction of health care providers;
- ? Increase cost efficiency in the health care sector.

1.1 PARTIAL CAPITATION

Depending on whether capitation as a method of funding applies to some or all types of services, a distinction is made between partial or full (total) capitation.

Under the 1992 U.K. National Health Service Regulations, general practitioners are paid a capitation fee per enrolled patient, supplemented with "fees for items of service" that apply to contraceptive and maternity services, immunizations, cervical cytology, and minor surgeries.

Partial capitation implies that prospectively determined per capita rates and budget only apply to some services provided by a given medical facility or a network of facilities. All other services are reimbursed outside the capitated budget, even though their rates may also be agreed upon in advance. In the United Kingdom, beginning in 1990, 45% of services provided by general practice were reimbursed using capitation. This share has grown ever since.

Because partial capitation includes elements of both capitated and fee-for-service reimbursements, two sets of diverging incentives emerge. When managing capitated services, the provider tends to contain costs in two ways. Firstly, the provider seeks to control its cost per unit of a service to make sure cost does not exceed a predetermined price by which the service is integrated in the capitation rate. Secondly, the provider seeks to prevent over-utilization of that service, since the service-specific component of the prepaid capitated budget is fixed to a predefined utilization rate. Excessive utilization would lead to financial strain.

When managing non-capitated services, providers will still actively work to control unit costs in order to stay within the fee-for-service rates that are usually set in the purchaser-provider contract. At the same time, the incentive to prevent over-utilization is reversed here since revenue is directly proportionate to the number of units of services provided.

A prudent payer would apply a variable approach to cost-containment by combining prospective capitation with fee-for-service. Most medical care would be reimbursed by capitation, thus, strongly encouraging a provider to adhere to cost-efficient strategies in maintaining patients' health. However, providers may be tempted to achieve across-the-board savings by limiting patients' access to services, including those of particular relevance for public health, rather than seeking creative strategies for cost-containment. To minimize this risk, a prudent purchaser would stimulate production of services that match public health priorities with the fee-for-service method of reimbursement.

1.2 FULL CAPITATION

Dental care is a relatively rare component of capitated funding. Since 1993, dentists in the U.K. have been paid on a capitation basis for providing most office care to children less than 18 years old. They also receive a monthly capitated payment for continuing care of adults, including emergency services and replacement of restorations that failed within a year. In addition to these payments, doctors may charge patients regulated fees.

Full (total) capitation implies that the capitation payment covers the entire package of services negotiated between a purchaser and a provider. Such packages may be comprehensive enough to include acute hospital stays, planned hospitalization, day hospitals and surgery care, outpatient office and home visits, immunizations, family planning and health promotion, drug prescriptions, and dental care.

In practice, purchasers can utilize full and partial capitation payment methods simultaneously. For example, all services of a general practice could be funded by prospective capitation, while nearby providers of secondary and tertiary care operating under contract from the same purchasing agency would be reimbursed on the basis of fee-for-service per episode of care or patient discharge. If the purchaser organizes all contracting providers into

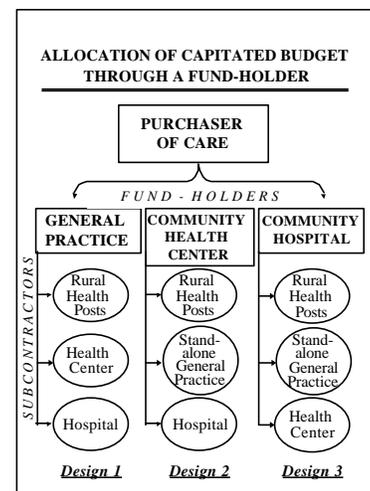
one referral network, the provider network would cover all levels of care, thus forming an integrated health system. Resources for this type of system would be planned and allocated on the basis of full capitation – i.e. the total resource requirement is the product of annual per capita health expenditure and the number of enrollees or local residents. From the standpoint of financial planning, an integrated health system is a fully capitated system. In the case of general practice, funds are disbursed on a full capitation basis, whereas other methods of fund disbursement are utilized in the case of secondary and tertiary providers. From the perspective of fund disbursement and budget execution, the system exhibits the features of a partially capitated provider network.

2. IMPLEMENTATION ISSUES IN CAPITATION

2.1 ALLOCATING THE CAPITATED BUDGET

A capitated budget under full capitation may be awarded to the following provider groups:

- ? A general practice, staffed with one or several primary care physicians (e.g., an internist, a pediatrician, and/or a family doctor), nurses, and ancillary personnel, that serves formally registered enrollees or residents in their geographical area;
- ? A health center that serves as a multi-specialty health facility, including both primary and specialty components of outpatient care;
- ? A general hospital with a periphery of primary care centers and posts serving a specific geographic area.



The key feature to this system is the existence of a fund-holding provider (i.e. a medical practice, health center, or hospital) that receives the capitated budget as a block payment and uses it to fund its own clinical activities and pay for services of referral providers. In relation to the purchaser of care, the fund-holder fills the role of prime contractor, whereas referral providers serve as subcontractors.

Alternatively, purchasers may choose to contract independently with each participating provider. In this case, the payer will allocate funds directly to each of its contractors, defining that provider's portion of the system-wide capitated budget.

The degree of provider autonomy within a capitated health system may vary widely, including: contractual relationships among totally independent medical practices and institutions, diverse forms of associations and partnerships among providers, or acquisition of some participating providers by others. The clinical, management, and financial environment dictates how providers create alliances with one another. Assuming, the budget is capitated at the level of the integrated health system, all participating providers become dependent on each other's clinical and financial behavior and performance. They need to coordinate clinical strategies among the levels of care, plan utilization and referral rates for high-volume and particularly costly interventions, and control quality of services system wide in order to ensure that funds from the limited budget are planned for and allocated to each provider fairly and predictably. All participating providers could suffer financially as a result of mismanagement and inefficiency by any one of them.

2.2 CAPITATION RATE SETTING

The capitation rate may be determined using either a bottom-up or a top-down approach.

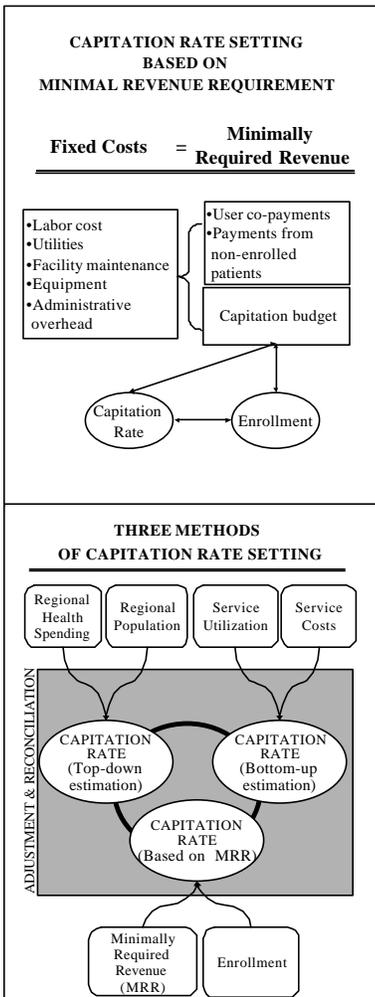
$$\begin{aligned}
 PMPM_1 &= Cost_1 \times Use_1 \\
 PMPM_2 &= Cost_2 \times Use_2 \\
 + PMPM_n &= Cost_n \times Use_n \\
 \hline
 PMPM_t &= Cost_t \times Use_t \\
 CB &= PMPM_t \times Population \\
 PMPM_t &= CB / Pop
 \end{aligned}$$

The *bottom-up* method focuses on each type of service included in prospective capitation. It estimates the cost of service n per member per month ($PMPM_n$) by multiplying the projected per capita utilization of that service (Use_n) by the service unit cost ($Cost_n$). The total of service-specific PMPM rates equals the aggregate PMPM rate ($PMPM_t$). This rate is multiplied by the number of enrolled population (Pop) to yield a cost-based monthly capitated budget (CB).

The *top-down approach* enables a methodological shortcut if service-specific data on cost and utilization are unavailable. A monthly historical budget may be divided by served population to produce a fairly accurate estimation of per capita spending and, therefore, a PMPM rate.

Further insight into prospective capitation rate setting can be gained by examining the link between provider revenue and financial viability. To prevent insolvency, a health care provider must recover its fixed costs, including labor, utilities, facility maintenance, equipment, supplies, and administrative overhead. The facility- or network-wide fixed costs become the *minimum revenue requirement* for sustainable operation. Some of this revenue will be generated outside the capitated budget – e.g. from enrollees’ co-payments and payments from non-enrolled or out-of-area patients. Providers would earn the remaining amount under prospective capitation. Dividing that remaining amount by the number of enrollees (or residents of the covered area) results in an estimated capitation rate. If administrative control or competitive pressure greatly affects pricing, the capitation rate may not be easily increased to make up for the lack of enrollees. Therefore, retaining and increasing the enrollment base becomes a particularly important strategy of leveraging provider revenue and meeting the minimal revenue requirement.

Estimations based on the aforementioned approaches (top-down, bottom-up, and minimum-revenue requirement) should interact to ensure an accurate and flexible approach to capitation rate setting. The estimation may begin with the simplest top-down calculation to ascertain the historical per capita spending on personal health services in the region. Then, the resulting capitation rate will be compared to the bottom-up calculation of per capita spending (an aggregate of all service-specific rates). A potential divergence could arise between the two estimations because of sampling differences. Top-down estimation is based on a specific area or region, whereas bottom-up estimation is based on the service costs and utilization rates projected for a specific provider or network of providers. The minimum-required revenue calculations could be used to reconcile the first two approaches.



All three estimated capitation rates should be utilized to ensure that the following occurs upon transitioning an integrated health system or medical facility to prospective capitation:

- 1) Each provider receives sufficient funding in their capitated budget to secure provision of a contracted package of services to all of their enrollees;
- 2) Services are provided efficiently, i.e. at rates that are competitive and/or affordable under available health resources;
- 3) Enrollment sizes are sufficient for allowing the capitated network or provider to break even while maintaining capitation rates at a competitive or mandated level.

2.3 RISK ADJUSTMENT

In the context of prospective capitation, to what extent capitation rate should be adjusted for variation of health risks within the regional and provider-specific populations becomes an important question. Keeping capitation rates uniform would unduly burden providers who need more resources because they deal with relatively unhealthy populations. On the other hand, if too many risk groups are distinguished, risk-adjustment becomes a complex affair, requiring vast amounts of information for maintaining and updating a highly differentiated capitation rate schedule.

A commonly recommended approach to risk-adjustment suggests that the capitation rate should be differentiated on the basis of a limited number of variables. They should be selected for their ability to explain health risks, reliability, administrative simplicity, and invulnerability to manipulation on the part of providers. Furthermore, differentiation should not encourage counterproductive changes in provider behavior.

A review of numerous studies in risk-adjustment distinguish the following three groupings of variables, rated by importance:

- 1) Socio-demographic factors, such as age, gender, place of residence, income, educational status, family size, and employment status, account for about 20% of the variation in health expenditures among individuals.
- 2) Past health expenditures as a proxy for prior utilization explain about 60% of the non-random variation in costs.
- 3) Chronic sickness status explains an additional 15 percent of the variation.

Importantly, risk-adjustment methodology should not be excessively biased towards prior health utilization and expenditures because it will perpetuate underfunding in disadvantaged areas and health plans. If other factors are not sufficiently incorporated into the

The adjusted average per capita cost (AAPCC) model used by the U.S. Medicare program calculates the capitation rate by incorporating a projected nationwide level of per capita reimbursements, a county price adjustment, and an enrollee-mix adjustment taking into account county variation in the distribution of beneficiaries by 5 age groups, sex, welfare and institutional status.

In England, general practices are paid a capitation rate adjusted for the number of elderly patients; children eligible for child health surveillance services, and patients living in deprived areas.

Under a "community rating system", rates of payment for health services may be determined on a per-person or per-family basis and must be equivalent for all individuals and families of similar composition. Nominal rate differentials may be established to reflect different administrative costs of collecting payments on behalf of the following categories of members: (i) individual members and their families; (ii) small groups of members (<100 persons); (iii) large groups of members.

methodology, allocation decisions increasingly will diverge from decisions based on appropriateness of care and will indiscriminately benefit providers with better access to technology.

A recommended risk adjustment methodology may include differentiation of the capitation rate by age/sex group based on disability and functional status as proxies of the health status; and previous year hospitalization rate, ambulatory resource use, and costs as the proxies of prior utilization and expenditure.

Accounting for these variables may best be accomplished by coding respective information in each patient record. Such coding should be conducted continuously and should include patient's sex, date of birth, presence of disability and/or other functional impairment, dates of hospital stays, admission diagnoses, dates of outpatient visits, and related diagnoses. As an important step in risk adjustment methodology, listed socio-demographic and clinical data should be matched with the information about costs of services by inpatient case mix group and outpatient episode of care. For example, disabled and functionally impaired persons appear to have roughly twice the health care costs of the functionally fit.

Upon transition to a prospective capitation system, lack of socio-demographic and clinical data can impair national risk adjustment work. To close this information gap, missing data may be imported initially from other countries. Alternatively, risk adjustment may be postponed until the required information can be collected from domestic sources using sample-based studies and/or regular patient and clinical reporting.

As a matter of national health policy, application of risk adjustment must be limited to reimbursement of providers by a third party. Higher health risks should not result in higher payments for consumers, be it insurance premiums or user charges at the point of service. When calculated as a premium rate in social health insurance, capitation rates must be equal for all individuals, based on the principle of *community rating*. Differentiation of user payments in line with the variation of health risks means *experience rating* – a bias against relatively unhealthy populations. Community rating versus experience rating signifies the largest difference between social health insurance and commercial health insurance; between *social solidarity*, whereby all individual risks are pooled and part of the premium revenue from the healthy goes to subsidize care for the ill, and *social discrimination*.

2.4 CLINICAL AND ORGANIZATIONAL STRATEGIES

To control the risks and to benefit from potential rewards of prospective capitation, providers of care have to be disciplined in their clinical and financial behavior. The important goal for capitated providers is to stay financially viable, i.e. to avoid spending in excess of a fixed capitated budget and maintain their enrollment base. In order to achieve these goals, providers have to contain costs, keep their customers satisfied, and attract more customers. The following strategies contribute to the aforementioned goals:

Synonymous to Integrated Health Systems are Integrated Delivery Systems, Integrated Health Care Organizations, Physician-Hospital Organizations in the U.S.; Health Service Organizations and Comprehensive Health Organizations in Canada.

Integration of Care. To improve quality, continuity and cost efficiency of health care provision in their community, local physicians, health centers and hospitals may create an integrated health system – an organization of affiliated providers formed to offer

a full continuum of services under terms and conditions agreed upon by its participants. An integrated health system allows hospitals and outpatient providers to legally integrate their operations, create consistent economic incentives for all participating facilities, and address the issues of community health planning with an emphasis on prevention and cost-effective treatment.

Standardization of Care. Because the financial environment of prospective capitation is fraught with the risk of overspending, service providers seek the most effective clinical strategies that are based on interventions with predictable outcome and cost. Such strategies, once identified, are inscribed in practice guidelines and are recommended to providers as industry standards. Many prospectively capitated integrated health systems and independent providers adopt these standards in their conscientious preference for cost-efficiency and/or in response to the payer's requirements regarding the delivery of care. Practice guidelines play an important role in promoting evidence-based medicine. Although practice guidelines are based on scientific knowledge, practicing physicians may not apply or accept them unless the guidelines are developed in a participatory mode and are understandable.

By 1997, 75 organizations in the U.S. have issued 1,800 sets of practice guidelines. Three out of every four HMOs use formally written practice guidelines.

Roles of Fund-holder. The fund-holder in the capitated health care system assumes the main financial risk associated with prospective capitation and, at the same time, has sufficient authority in deciding clinical and organizational strategies that could mitigate such risk. Appropriate fund-holder responses to the challenges of prospective capitation include the following:

- ? committing subcontractors to financial constraints faced by the prospectively capitated plan;
- ? involving physicians and health personnel from all participating facilities in managing the delivery of care and controlling its quality;
- ? increasing health planning and clinical responsibilities of general practice;
- ? reducing hospital admission rates and length of stay, and move inpatient care to outpatient settings.

The experiment with prospective capitation in 3 regions of Russia in late 80's caught providers of services by surprise. Polyclinics became fund-holders and received the entire health budget for their service areas. Unprepared for financial and clinical management at all levels of care, they decided to contain costs by outright limiting referral for hospital admission. Increased disabilities and deaths were reported due to denied or delayed hospitalization.

If it is detrimental to the quality and outcomes of health services, restricting access to care would be an inappropriate response to financial risks.

Restricting Patient Choice. Predictability of patient behavior is a critical determinant of predictability of cost of care and expenditure. The following behaviors are expected from the 'ideal' patient: avoid self-referrals to higher levels of care; refrain from seeking care outside the provider network contracted under the capitated plan; and scrupulously follow medical prescriptions.

Preserving Consumer Satisfaction. A delicate balance must be achieved between restriction of consumer choice and the growth of consumer dissatisfaction. Too much dissatisfaction may lead to public discontent with the principles and practice of

In the United States, managed care plans allow out-of-network care for their members but impose annual deductibles, higher coinsurance rates, and balance billing for such care (e.g., beyond 80% of customary costs within the network).

prospective capitation, and, in a competitive setting, to the reduction of enrollment. Aware of the potential danger of excessively managed consumer behavior, purchasers of care increasingly offer multiple options to the beneficiaries, e.g., more comprehensive access to services for members who use contracted providers, and more selective and cost-shared access through non-participating providers.

Sub-Capitation. Fixed and prepaid funding inherent in prospective capitation shifts financial risks from purchaser to the fund-holding provider of care. The latter seeks to delegate risks further by assigning sub-sets of capitated services and corresponding parts of the capitated budget to specific subcontracting providers. A specialist who sees a new patient, referred to him/her by a primary doctor, receives a diagnosis-related amount of money in monthly installments to take care of that patient for 12 months following the first physician encounter. Long-term physician/patient relationships promote the development of care strategies that are cost-effective for treatment of potentially expensive chronic illnesses. Unless there is a clear reason acknowledged by the primary doctor, the patient should not move from one specialist to another. If transfer to another specialist occurs, the annualized capitated funding will follow the patient to the new provider.

Similarly, part of the capitated budget may be prospectively allocated to a hospital. A hospital's *global budget* is defined by its caseload. Under the global budget, the hospital accepts the responsibility to treat a finite number of cases of certain average clinical complexity. This removes the hospital's incentive to increase its share of resources by admitting more patients and keeping them longer. If there is no fund-holder within a capitated health system, sub-capitation may be used by the purchaser for allocating funds directly to each contracted provider or group of providers.

Risk/Bonus Pool. General practitioners, ambulatory specialists, and hospitals form clinical and management teams that design and implement more effective and efficient ways of treating high-volume medical conditions. Such teams use scientific knowledge and evidence-based medicine to analyze the clinical problem and arrange for its long-term management. Providers at various levels of care pool part of their resources that they historically used to treat a particular condition. Then they decide on where and how this condition should be managed in order to save resources throughout the system. Activities are designed and funded from shared resources to achieve the savings. The savings strategy usually focuses on strengthening prevention, moving treatment to outpatient care, guiding patients towards self-care, and developing outreach monitoring and control. The pooled funds can be spent on modern medicines, diagnostic equipment, monitoring devices, family education, additional training of primary doctors, time of hospital-based doctors for outpatient consultations, and tutoring ambulatory specialists on new treatment and case-management techniques. These expenses ultimately result in savings because they lead to lower disease incidence and reduced frequency and length of hospitalization. Annualized net savings are periodically distributed to all contributors until the capitated budget is gradually reduced to reflect lower expenditure.

Restricting Drug Prescriptions. Pharmaceutical costs vary greatly depending on prescribing patterns of physicians. Prospectively capitated health care networks promote the use of generics drugs by maintaining positive and negative *drug formularies* (lists of medicines included in and excluded from reimbursement), rewarding patient self-restraint with lower co-payments, and sanctioning excessive prescribing.

Internal Cost Control. Various strategies may be used to control internal costs. These include: measuring individual physicians' use of medical resources; withholding a predetermined percentage (e.g. 5%) or amount from provider reimbursement and making its payment contingent upon achieving utilization or cost targets; establishing management information systems that can track patient outcomes and link them to utilization and cost; and, rewarding physicians for efficient behavior by adding part of the savings to their regular compensation.

3. HOW TO ESTABLISH AN INTEGRATED HEALTH SYSTEM BASED ON CAPITATION

To trigger the expected positive change in the financing and delivery of health care services, prospective capitation must be placed in a certain institutional shell and operational environment. The tool works best when the payer enters into contractual or other legal agreements with a network of providers, such as an integrated health system. Taking into account the diversity of legal, organizational, and financial configurations of an integrated health system, the design invariably entails the following components of preparatory work:

Legal Development. This consists of two phases: (1) assessing existing laws pertinent to the subject of prospective capitation and provider integration; and (2) developing a legal structure and contractual relationships consistent with regulatory requirements. Activities include legal analysis of enabling and restricting provisions currently in effect; determining the legal structure and tax status of an integrated health system; designing appropriate reconciliatory adjustments to mitigate existing legal restrictions; writing statutes and other bylaws, preparing and negotiating purchaser-provider contracts and referral provider sub-contracts; developing terms and conditions of enrollment; registering the integrated health system.

Health Service Delivery Development. This component includes activities aimed at identifying or updating priority health needs of the local community; stating an integrated health system mission that is reflective of the local community health needs; projecting enrollment size and per capita utilization of services; designing the preliminary provider configuration and establishing clinical and resource requirements for each participant in the system; selecting health care facilities matching those requirements; developing quality assurance and utilization control programs; and introducing patient and clinical reporting.

Organizational and Management Development. This includes design of the following elements of system operation: organizational and administrative structure; community support; proposal of Board of Directors composition and participation in governance; mechanisms for balancing administrative rigidity with the demands for change and growth; a strategic plan to replace the existing strategies of affiliates with those of the integrated health system; technology and resource requirements for management information and reporting; internal rules and procedures; and overall administrative staff needs (human resources, space and location, data processing and record keeping systems, etc.).

Below are some practical tips on how to establish a prospectively capitated integrated health system:

- > A desirable legal status for an integrated health system is a not-for-profit, tax-exempt organization providing medical services.
- > Since the focus of health care delivery in a capitated integrated health system will be shifting from the hospital to outpatient clinics and general practices, the regulations should enable transfer of assets among participating providers.
- > The number of "financially interested" persons and physicians who may serve on the system's Board of Directors may be subject to limitation.
- > The best way to keep physicians involved in the administration of the system may be to establish committees responsible for specified operations, e.g., clinical services and quality of care.
- > Develop labor compensation systems that address the realities of prospective capitation and reward efficiency.
- > Develop a marketing strategy that presents the system as a significant step towards (re)integration of medical care into the community.

Financial Development includes preliminary cost assessment and capitation rate projection; development of short-term and long-term financial plans that address the overall funding needs of the system; preparation of a consolidated budget and provider-specific budgets; design of accounting, invoicing, and collection systems; establishing mechanisms for procurement and for asset and inventory control; and developing rules and procedures of budget execution and financial audit.

Marketing Development activities focus on analyzing the demographic, economic, and market conditions in the local area; determining the benefit package, facility location, and promotional strategy with specific attention to organizing and managing the enrollment campaign and redress of consumer grievances.

All of these activities are closely interrelated and should be carried out simultaneously. Development of an integrated health system is a politically sensitive process. If some providers are not invited to participate, they may stir up overwhelming community opposition to the system. Therefore, those wishing to implement prospective capitation must assure that in addition to acquiring support of the main constituencies for the system, the public must understand the reasons for and the benefits of an integrated health system for community- and patient-centered provision of health care services. The process of developing an integrated health system should be transparent and participatory.

4. COUNTRY CASES

4.1 REGIONAL REVIEW

In the multi-tier health care sectors of some Latin American and the Caribbean countries, such as Brazil, Chile, Argentina, Uruguay Colombia and Peru, competition is limited largely to the health insurance system. This system consists of organizations that resemble *managed care organizations (MCOs)* that include both payer and provider functions. Each organization combines the activities of an underwriter (issuer of group and individual insurance policies) and those of an integrated service delivery plan. As an underwriter, an MCO collects premiums from those employers and their employees who have selected the MCO's plan. Over the past three decades, many LAC countries have enacted health insurance legislation that creates an opt-out mechanism granting employers a choice of private MCOs as an extension to social health insurance and as an alternative to public providers of services.

Competition between various MCOs, public insurance schemes, and provider entities creates pressure to limit premium rates. To keep rates low, MCOs use two basic strategies: (1) avoidance of potentially costly clients through experience rating; and (2) cost-conscious spending on medical care. The following paragraphs briefly address how both strategies are applied and how the growing importance of cost-containment creates favorable conditions for implementing prospective capitation.

While blunt rejection of applicants generally has become an obsolete practice, managed care plans continue to employ a variety of techniques to discourage participation of undesirable enrollees, such as exclusion of preexisting medical conditions from the benefit package or differentiation of premium rates in ways that discriminate against *bad* risks. Managed care plans increasingly use community rating to reduce public dissatisfaction, comply with regulatory requirements, and maximize market share. This creates relatively uniform rates in which individual risks are pooled across broad groups of the insured, establishing cross-subsidization of the relatively sick by the relatively healthy. Although extending coverage to additional population groups is a positive social outcome, MCOs are wary of the potentially negative impact of adverse selection on their finances. To buttress their bottom line, MCOs compensate for more liberal insurance coverage by tightening discipline on health care spending. Prospective capitation can play an important role in the health care sectors of Latin American countries precisely because it is a powerful method of cost-containment.

Since beneficiaries prepay insurance premiums, most MCOs that combine insurance and delivery functions can be considered 'naturally' capitated systems. Nevertheless, how premium revenue is allocated among participating service providers should be investigated further. The capitation principle may be enhanced by making funds available on a full capitation basis to a fund-holding primary care practice, or as a partially capitated budget for ambulatory services combined with fee-for-service, per diem, or DRG-related payments to the hospitals. Alternatively, premiums collected by MCOs on a per capita basis may be allocated to providers predominantly on a fee-for-service basis. To make such allocations predictable and compliant with budget constraints, MCOs negotiate the rate schedule and the volume of services with service providers prior to fixing them in the contracts.

Both documented and anecdotal evidence suggests that the mainstream practice in the LAC region increasingly utilizes pre-negotiated fee-for-service reimbursement in the ambulatory sector, and historical allocations to hospitals related primarily to their production base. As a provider payment tool, prospective capitation is just beginning to gain acceptance.

Reportedly, in Chile, Prospective Health Institutions (*Instituciones de Salud Previsional* – *ISAPREs*) that compete as private MCOs pay primary health posts an annualized rate per enrollee.

In Uruguay, Collective Institutions of Medical Assistance (*Instituciones Asistenciales Médicas Colectivas* -- *IAMCs*) are the main vehicle of employer-based health insurance and are financed by a combination of monthly per capita prepayments and user charges.

In Argentina, *Obras Sociales* (OSs), a network of approximately 300 employer-based statutory sickness funds operate as integrated insurance/delivery plans similar to preferred provider organizations in the United States. Comparison of reports on health care financing provides contradictory results. Some assure that OSs have moved away from fee-for-service in favor of capitation. Apparently, this shift occurred in the 90's. Amounts of per capita spending and benefit packages vary widely by OS. Often, such variations reflect operational inefficiency of the OSs due to their small size as well as weak premium revenue-generating capacity in certain industries and geographic areas. A mechanism of risk-adjusted transfers and consolidation in the market may be needed to ensure that performance by OSs is equitable and efficient. Some reports assert that the prevalent provider reimbursement method remains fee-for-service. The national rate schedule, or “El nomenclador nacional”, lists ambulatory and major inpatient procedures and is used as a reference price list by OSs, independent practitioners and health facilities. Following deregulation, negotiating parties maintain discretion over the setting of reimbursement rates.

In Brazil, private Medical Group Organizations operate similarly to Health Maintenance Organizations in the United States. At the same time, they behave as private medical cooperatives, resembling preferred provider organizations in the U.S. Both types of institutions operate on a prepayment basis, drawing their revenue from capitated premiums. In mid-90's, the public health sector of Brazil began seeing innovations in provider payment. For example, the Health Action Plan was introduced in São Paulo in 1995. The city municipal services, including hospitals and basic health services, were organized into cooperatives that compete for enrollment. Residents are encouraged to select a cooperative based on their needs. Then, the municipal government makes an annual payment to each cooperative at a pre-established rate per enrollee.

The following subsections review experiences of Colombia, Peru, Mexico, and Costa Rica.

4.2 COLOMBIA

The health regulatory reforms of 1993 mandated a two-tier system of social health insurance comprised of contributory and subsidized regimes. Payroll taxes finance the contributory regime and cover populations in the formal employment sector. Designed for low-income recipients, the subsidized regime is funded by budgetary transfers, which are supplemented with solidarity contributions from the contributory regime. Multiple entities

that collect premium revenues from employers, employees, and the government administer both the contributory and subsidized regimes. These administrative entities are referred to as Health Promotion Organizations (*Entidades Promotoras de Salud* – EPS) and Health Service Provider Organizations (*Instituciones Prestadoras de Servicios* – IPSs) in the contributory regime, and Subsidized Regime Authorities (*Administraciones del Régimen Subsidiado* – ARSs) in the subsidized regime. Both EPSs and an IPSs can operate in the contributory and subsidized regimes, thus, becoming an ARS. Increasingly, funds are allocated prospectively to EPSs, IPSs, and ARSs in the form of the *capitated payment unit* (UPC) – an annual amount to be spent on medical services per head of enrolled population, adjusted for sex, age, and geographic location. UPC rates are determined for a package of benefits subject to mandatory coverage under social health insurance. The contributory regime refers to this package as a Mandatory Health Plan (*Plan Obligatorio de Salud* -- POS). The subsidized regime calls it a Subsidized Mandatory Health Plan (*Plan Obligatorio de Salud Subsidiado* -- POSS). Currently, the per capita monetary value of the POS is twice the amount of the POSS. This gap will be closed in 2001 as a result of accelerated growth in per capita funding under the POSS.

The core budget of an EPS, IPS, or ARS can be calculated by multiplying the UPC by the number of enrollees. According to a recent survey, capitated payments account for 44% of IPS contracts. Capitation is supplemented with fee-for-service charges billed to institutional purchasers of care and/or patients. Because they are an integrated insurance/delivery plan, each EPS, IPS, and ARS either uses its own clinical base to provide services to the enrollees or contracts services out to independent physicians, polyclinics and hospitals. Participating facilities are reimbursed, predominantly, by fee-for-service method. Packaged fees, similar to sub-capitation, are used only on a limited basis.

According to Law 100 adopted in 1993, part of the UPC-based funding must be pooled to form a government-sponsored reinsurance fund to protect EPSs from eight catastrophic conditions, including premature childbirth and related neonatal conditions, AIDS, trauma, cancer, kidney disease, heart disease, and stroke.

4.3 COSTA RICA

A reform agenda was proposed in Costa Rica during mid-90's to provide universal and equitable access to basic care for the nation's entire population. The government has chosen to accomplish this goal by dividing the national territory into 90 Health Areas (*Areas de Salud*) and setting up 800 Basic Teams for Integrated Health Care (*Equipo Básico de Atención Integral de Salud*). From 1995-97, 427 basic teams were established in 52 health areas – predominantly in rural and marginalized communities. Each team denotes a primary care practice staffed with a general practitioner, a nurse, and a technician. Several basic teams share a Support Team (*Equipo de Apoyo*), comprised of a family doctor, nurse practitioner, dentist, pharmacist, microbiologist, social worker, and nutrition specialist. All basic and support teams located in the same health area form a Health Team (*Equipo de Salud*). Secondary and tertiary care provided by local specialized and regional facilities reinforces each Health Team.

The basic teams were created to be the center of public health and primary care activities in five settings: family, community, educational, workplace, and medical. However, the reform documents did not specify how these activities should be financed. Given their considerably different institutional and administrative ramifications, a variety of methods

may be assumed. Because social and medical prevention as well as curative care provided in the household, community and medical settings are geared to resident populations, prospective capitation, including fund-holding elements, would be a convenient financing option. This method could reinforce provider incentives for resolving the following problems identified in the 1996 Basic Team survey and by local policy analysts: lack of motivation among community and health personnel; consumer preference for curative services over prevention; excessive demand for medical consultations; referral patterns biased toward higher levels of care; lack of coordination among levels of care; and labor remuneration in the health care sector which is not based on productivity.

Piloting of competitive contracting (*Compromisos de Gestión*) commenced in 1996 in five health areas. With the planned extension to 14 more areas in 1998, these activities provide a favorable environment to demonstrate the opportunities and challenges of prospective capitation in the rapidly reformed primary care of Costa Rica.

4.4 PERU

The MoH Health Policy Guidelines for 1995-2000 identified the following pivotal directions for health care reform in Peru: “restructure the sector in order to make it more effective and efficient, enable extended coverage, increase quality of health care services, promote competition among providers of care, set up multiple health care networks, and increasingly move financing towards demand-side tools.” As a result, the MoH and affiliated technical assistance projects have made a consistent effort to create area-serving integrated health care systems, referred to as “health service networks” or simply “local networks”

(*redes locales*).

Risk adjusted capitation rates are computed by differentiating the regional average according to province-by-province variation of poverty rates and health risk ratios by socio-demographic population group. The following table shows that funding ratios are calculated for each province/population group by multiplying a population health risk ratio by province poverty factor:

PROVINCES OF THE PIURA SUBREGION	CHILDREN	STUDENTS	FERTILE AGE WOMEN	ADULT MEN	AGED	POVERTY FACTOR
HEALTH RISK FACTOR	1.80	.30	1.46	.70	1.26	
Piura	1.67	.28	1.35	.65	1.17	.93
Ayabaca	1.99	.33	1.62	.78	1.40	1.10
Huancabamba	2.00	.33	1.62	.78	1.40	1.11
Morropón	1.96	.33	1.59	.76	1.37	1.09
Sechura	1.78	.30	1.44	.69	1.24	.99

Resulting funding ratios are, then, multiplied by population size in the respective group and the region-wide per capita rate.

Aplicaciones Iniciales de Reforma en Regiones y Subregiones de Salud. Acuerdo de gestión con la Dirección Regional de Salud Piura y la Red Morropón-Chulicanas, MINSA, 1998: 22.

The MoH defines a health service network (red local) as “an alliance of public and private entities providing health care of different levels of complexity, diverse clinical contents; associated with various levels of operating cost, and integrated by a road network and community ties in functional and administrative ways that assure provision of the [entire] package of priority health services”.

The red local was conceived as a legal and administrative mechanism for aligning participating providers by uniform

public health, clinical and financial goals. Each red local represents a vertically integrated health care system, including rural health posts, community health centers, and a local support hospital. On behalf of participating providers, a red local administration enters into a management contract with the regional health administration. Among other provisions, the contract sets forth the list of participating providers; total “user population” assigned to the red local, including the estimated number of enrollees exempt from user charges; “user population” detailed by primary care health post; an itemized list of health care services and production measurement unit for each service; target volumes of care and unit cost by service; a list of quality indicators and their target values; the annual budget, including revenues from third parties and user fees; risk adjusted capitation as the basic payment method; and capitation rates by each province of the region.

4.5 MEXICO

The Mexican Social Security Institute (IMSS), the main purchaser of care in the national health sector, has made a significant progress towards decentralized financing and provision of medical services. The most noteworthy outcome of decentralization has manifested itself in the creation of *Medical Areas of Decentralized Management*.

In 1998, the IMSS planned to create 139 such Medical Areas – averaging of four per state – and grouped them under seven Regional Directorates. Each medical area typically consists of a secondary care hospital and several family care units. The areas will increasingly assume control over provision of primary and secondary-level care to the population of their service areas. As the number of medical areas increases, their clinical, management, and financial strength is expected to improve. In the near future, medical areas most likely will evolve into integrated delivery systems taking care of all the health needs of their eligible population and will be funded at a risk-adjusted capitation rate. Reportedly, prospective capitation has been the main tool of medical area annual budgeting since 1998. Over the medium term, the areas will assume the fund-holding function. As the fund-holder, a medical area will autonomously allocate its capitated budget between the in-house provision of primary and secondary care for an average population of approximately 260,000 members and contracting complex specialized and tertiary hospital care to one of the 41 IMSS specialty hospitals.

By August 2000, the first 15 medical areas are expected to undergo a comprehensive strengthening through implementation of the following systems and processes: organizational development; an economic and financial management model; an integrated information system; identification of health status and needs of the enrollment pool; integrated action plan matching local health priorities; a program of innovation in community health; clinical and cost-accounting framework for the introduction of DRGs in a participating zonal hospital; need assessment for the participating Family Medicine Units; and an analysis of the clinical and resource capacity by level of care in order to improve vertical integration of services and optimize the patterns of upward and downward referrals. Additional variables will be included in the capitation formula to account for differences in the health needs of the populations served by the medical areas.

In the medium term, based on the initial experience of medical areas, health services may be also contracted with private managed care organizations through prospective capitation. An MCO will provide a range of services specified in the contract with an

employer under the “opt-out” arrangement. The opt-out scheme (*prestación indirecta*) is considered among the most far-reaching elements of the 1997 health insurance reform in Mexico. The beneficiaries of IMSS, through their employers, are given the option of receiving a per capita fee that may be taken outside the IMSS provision system in order to obtain services from alternative public and private integrated care systems. Opting-out is projected to boost the expansion of private managed care, currently in its infancy in Mexico. MCOs will be able to compete with IMSS primarily on the basis of cost-efficiency, quality, and user-friendliness. Prospective capitation is expected to set the right incentives for MCOs to succeed competitively and, importantly, to coordinate provider incentives between the IMSS-affiliated medical areas and private MCOs. Such coordination will help ensure continuity of access to quality services in- and outside the IMSS.

5. CONCLUSION

This manual has presented prospective capitation from a methodological viewpoint as well as in the context of country evaluations. From the reviewed material, a conclusion can be drawn that the method has great potential in Latin America and deserves the meticulous capacity building needed to make it work. Substantial technical resources will have to be invested in prospective capitation by the countries that are making an initial attempt at implementation. The few LAC countries that have an established record of prospective capitation-based funding may benefit from critical self-evaluation of their past experiences. This would allow them to eliminate design flaws, policy-driven distortions, or inconsistencies in execution, preventing prospective from unfolding its full potential.

Hopefully, health financiers and administrators will be able to extract a checklist from this manual to evaluate the strengths and weaknesses of the capitated systems in their countries, regardless of whether those systems are operational, experimental, or in the planning stages. Some of the proposed elements of prospective capitation may already be present within the LAC region and may be developed in a more elaborate way than herein described. Others should be reconsidered and improved based on the insights and implementation tips included in this manual. Furthermore, the manual may present some eye-opening ideas and recommendations for elements that are missing altogether. Readers may find that some components of prospective capitation are recommended in the manual but are inapplicable in the political, cultural and professional environment of specific LAC countries.

Validation of the content of this manual in a candid discussion among the actual and future users of prospective capitation in Latin America would relate LAC experiences to the generic interpretation of the method and set the stage for its continued adaptation in health financing reforms occurring in the region. In other words, this manual should be viewed as an invitation to a more active and on-going discussion of prospective capitation and integration of various levels of health care under the umbrella of prospective capitation-driven incentives. The discussion should reflect the interests and concerns of specific stakeholders in the system about prospective capitation.

Health care purchasers – social health insurance agencies and private health insurance systems – are expected to promote prospective capitation as a means of tightening financial discipline while at the same time raising providers' interest in effective and efficient utilization of health care resources. The purchasers may be interested to discuss the balance between incentives and punitive elements of prospective capitation and what kind of regulatory and contractual framework needs to be created to capture and maintain this fine balance.

Providers of care – particularly fund-holding and subcontracting participants in an integrated health system – tend to focus on the clinical, financial, and marketing strategies of responding to the challenges of prospective capitation. Both purchasers and providers of services should look for ways to develop and standardize quality control, cost accounting, and management information instruments that will ensure that capitated health care networks become a sustainable component of a national health care sector.

Regional sharing of prospective capitation-related experience presents an important opportunity in Latin America and the Caribbean. Although several countries have been practicing prospective methods of provider payment for about two decades, most are new to such methods. By developing a better understanding of prospective capitation and the opportunities that it offers, both relative newcomers and experienced leaders could benefit greatly from such a regional discussion.

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