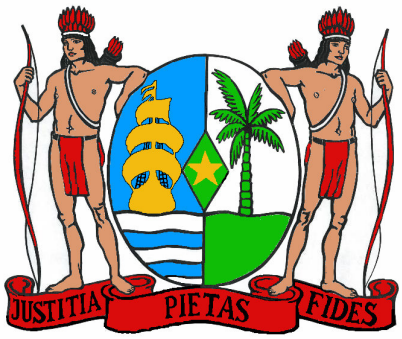
THE REPUBLIC OF SURINAME
MINISTRY OF PUBLIC HEALTH



HEALTH SECTOR PLAN 2004-2008

"HEALTH CARE: A JOINT RESPONSIBILITY"

Final version
June 2004

CONTENT

ACRONYMS

ABS	Algemeen Bureau voor de Statistiek (General Statistical Office)
ACP	African, Caribbean and Pacific
AMIS	Administratie en Management Informatie Systeem (Administration and Management Information System)
ARMULOV	Afbouwregeling Medische Uitzendingen-Lokale Opbouw Voorzieningen (Reduction Medical Sending Outs Arrangement – Building Local Facilities)
ARV	Antiretrovirals
AZP	Academisch Ziekenhuis Paramaribo (Academic Hospital)
AZV	Algemene Ziektekosten Verzekering (General Health Insurance)
GDP	Bruto Binnenlands Product (Gross Domestic Product)
BEG	Bijzonder Essentiële Geneesmiddelen (Special Essential Medicines)
BGVS	Bedrijf Geneesmiddelenvoorziening Suriname (Suriname Pharmaceutical Supply Company)
BIG	Beroepen in de Gezondheidszorg (Professions in Health Care)
BIZA	Ministerie van Binnenlandse Zaken (Ministry of Home Affairs)
GNP	Gross National Product
BOG	Bureau voor Openbare Gezondheidszorg (Bureau for Public Health)
CAMC	Carribbean Medical Council
CAREC	Caribbean Epidemiological Centre
CARICOM	Caribbean Community
CLAD	Centrale 's Lands Accountants Dienst (Central Audit Department)
CMO	Chief Medical Officer
COVAB	Centrale Opleiding voor Verpleegkundigen en Beoefenaren van Aanverwante Beroepen (Central Training for Nurses and Practitioners of Related Professions)
DHS	Demographic and Health Survey
DMoH	Directeur van Volksgezondheid (permanent secretary of public health)
EHBO	Eerste Hulp Bij Ongelukken (Accident and Emergency Department)
ETA	External Technical Assistance
EU	Europese Unie (European Union)
FIS	Financieel Informatie Systeem (Financial Information System)
FMeW	Faculteit Medische Wetenschappen (Faculty of Medical Science)
FTAA	Free Trade Association of the Americas
fte	Funktietakeneenheid / Full time equivalent
GGZ	Geestelijke Gezondheidszorg (Mental Health Care)
GMTD	Gemeenschappelijke Medisch Technische Dienst (Joint Medical Technical Service)
GVO	Gezondheidsvoorlichting en Opvoeding (Health Education and Information)
HIS	Health Information System
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HMA	Hare Majesteit Ambassade (Her Majesty Embassy)
HMIS	Health Management Information System
ICD	International Statistical Classification of Diseases and Related Health Problems
ICPD	International Conference on Population and Development
IDB	Inter-American Development Bank
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IsDB	Islamic Development Bank
JICA	Japan International Cooperation Agency
JTV	Stichting Jeugdtandverzorging (Foundation for Youth Dental Care)
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
KNMG	Koninklijke Nederlandse Maatschappij ter bevordering van de Geneeskunde (Royal Dutch Company for the Promotion of Medical Science)

LH	's Lands Hospitaal (State Hospital)
LHV	Landelijke Huisartsenvereniging (National Association of General Practitioners)
MERCOSUR	Mercado Común del Sur
MGZ	Maatschappelijk Gezondheidszorg (Social Health Care)
MMR	Maternal Mortality Rate
MoH	Ministry of Public Health
MOP	Meerjaren Ontwikkelings Plan (5 years Development Plan)
MRI	Magnetic Resonance Imaging
MSH	Management Sciences for Health
MT	Management Team
MVF	Ministerie van Financiën (Ministry of Finance)
MoH	Minister van Volksgezondheid en Milieubeheer (Ministry of Public Health and Environmental Management)
MWI	Medisch Wetenschappelijk Instituut (Medical Scientific Institute)
MZ/PHC	Medische Zending (Medical Mission)/Primary Health Care
NAP	Nationaal Aids Programma (National Aids Program)
NGB	Nationaal Geneesmiddelenbeleid (National Medicines Policy)
NGH	Nederlandse Genootschap voor Huisartsen (Dutch Society for General Practitioners)
NGK	Nationale Geneesmiddelen Klapper (National Medicines Index)
NGO	Non Governmental Organization
NHA	National Health Accounts
NHIS	National Health Information System
NIMOS	Nationaal Instituut voor Milieu en Ontwikkeling Suriname (National Institute for Environment and Development in Suriname)
NSP	National HIV/AIDS and STI Strategic plan
NZR	Nationale Ziekenhuisraad (National Hospital Council)
OB	Overheidsbegroting (government budget)
OD	Onderdirecteur (under-director)
O/P	Out-of-Pocket
OS	Ontwikkelingssamenwerking (development cooperation)
PAHO	Pan-American Health Organization
PCS	Psychiatrisch Centrum Suriname (Suriname Psychiatric Centre)
PEU	Project Execution Unit
PGZ	Primaire Gezondheidszorg (Primary Health Care)
PHC	Primary Health Care
PIS	Personeel Informatie Systeem (Personnel Information System)
PL	Planning
PLOS	Ministerie van Planning en Ontwikkelingssamenwerking (Ministry of Planning and Development Cooperation)
PSR	Public Sector Reform
PPP	Public Private Partnership
REG	Raad voor het Essentieel Geneesmiddelenprogramma (Council for the Essential Medicines Program)
RGD	Regionale Gezondheidsdienst (Regional Health Service)
RKZ	Rooms Katholiek Ziekenhuis St. Vincentius (St. Vincentius Roman Catholic Hospital)
RLA	Regeling Laagfrequente Aandoeningen (Arrangement for Low-frequency Disorders)
RvC	Raad van Commissarissen (Board of Supervisory Directors)
SEH	Spoed Eisende Hulp (emergency aid)
SHSR	Support for Health Sector Reform
SOI	Seksueel Overdraagbare Infecties (sexually communicable diseases)
SOZAVO	Ministerie van Sociale Zaken en Volkshuisvesting (Ministry of Social Affairs and Public Housing)
SPG	Sector Plan Gezondheidszorg (Health Sector Plan)
SRC	Specialisten Registratie Commissie (Specialists' Registration Committee)

SRD	Surinaamse Dollar (Suriname Dollar)
SRG	Surinaamse Gulden (Suriname Guilder)
SRH	Sexual and Reproductive Health
STG	Stichting Techniek in de Gezondheidszorg (Foundation for Technology in Health Care)
STI	Sexually Transmitted Infections
SZF	Staatsziekenfonds (National Health Insurance Fund)
SZN	Streekziekenhuis Nickerie (Nickerie Regional Hospital)
TB	Tuberculose
UN	United Nations
UNAIDS	United Nations Aids program
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children and Education Fund
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing (HIV/AIDS)
VMS	Vereniging van Medici in Suriname (Association of Doctors in Suriname)
VN	Verenigde Naties (United Nations)
VRA	Vereniging van RGD Artsen (Association of RGD physicians)
VvA	Vereniging van Apothekers (Association of Pharmacists)
VWS	Ministerie van Volksgezondheid, Welzijn en Sport in Nederland (Ministry of Public Health, Welfare and Sports in the Netherlands)
WHO	World Health Organization
WTG	Wet Tarieven Gezondheidszorg (Health Care Charges Act)

PREFACE

During the past few years the demand for qualitatively good, affordable and effective health care has considerably increased in our country. The citizens also require more from services offered by general practitioners, hospitals and other health care facilitators and the expectations as to the level of care are higher. We applaud this development.

The question is whether our country will be able during the coming years to improve and finance the level of services in a sustainable manner. After all, the pressure on the government budget is big and in addition to health care there are also other priorities that deserve attention, such as qualitatively good education, better infrastructure, promotion of employment, economic growth and the environment.

Within health care there is currently a number of subjects under discussion that needs urgent answers. What is our country able and willing to spend on health care? To what extent can and must our health care system still be financed with public funds? And what are eventually the responsibilities of the government and those of the population itself?

The past few years various initiatives were taken to answer some of these questions and to examine how our health care system can be improved in the future. The Ministry of Public Health, e.g., had already drawn up a rough policy plan and within the sector various studies had already been executed in which recommendations were made as to a necessary reorientation. There was, however, no related plan of action in which the various actors within the sector could recognize themselves.

After an extensive preparatory period in which among other things a CD-ROM was composed that included the available survey reports, studies and other background information about the sector, the drawing up of such a 5 years plan started early this year.

Policy-making (public) institutions, service organizations, care consumers, private enterprises, professional groups, development organizations and other stakeholders were actively involved in composing the sector plan. As of December 2003 through May 2004, a unique participative process developed itself within our society, with everybody thinking about and discussing issues such as affordability, accessibility, quality, financing, organization and responsibility of health care: now and on the mid-term.

This formation of ideas did not only take place within walls of the Ministry of Public Health, but also within the health care and service institutions. At various moments in a broader context discussions took place about the future direction of the national health policy, including during a National Conference that took place on March 20 this year.

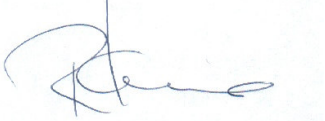
The result of this process is now before you in the form of a Health Sector Plan 2004-2009. In said plan a number of operational choices is made as regards the future structure, financing, organization and management of the sector.

Taking into consideration the big involvement with which this plan was drawn up, we may expect that there is now a great extent of agreement as to the necessary steps to be taken during the coming years to find the right balance between affordability and quality of our national health care.

In this respect it is self-evident that an optimal cooperation between the central government as the body in charge of policy-making, laws and regulations and monitoring, the care consumers, the service agencies and the citizens themselves, constitute the final key for this plan to succeed.

Our joint challenge for the coming years is and remains: “health care: our joint responsibility.”

The Minister of Public Health



Dr. M.R. Khudabux

EXECUTIVE SUMMARY

The Suriname economy and society are now stabilized after a period of great economic uncertainty. This stabilization and the positive economic development of the recent years have created opportunity for a more long-term perspective on the development of Suriname. An example is the 5 years development plan 2001 – 2005, giving high priority to further social economic development. In this socio-economic development the health sector is of crucial importance. The relevance of good health and adequate health care for everyone in Suriname is indisputable.

Despite the recognition of the relevance of health care and the relatively high expenditures for health care (US$ 180 per capita, NHA 2000), it is well known that there is still much to gain in Suriname health care. Basic health care is no longer guaranteed generally and sufficiently within the health care services. The standard and size of current facilities are deteriorating and no longer fit to meet the current demands. Ensuring a fair access to health care has become a burden for both state and individuals.

The Ministry of Health acknowledges this situation and formulated policies to address this. Policies in which the Ministry tries to let external development partners play an active and structural role in improving health care. In 2001 Suriname and the Netherlands agreed to further complete this by adopting a 'sectoral approach'. In this sectoral approach the development of a 5 years sector plan is the first step.

Formulating this 5 years sector plan marks the beginning of a unique process. Central Government, consumers of care, health care facilitators, developing partners and other involved actors took the initiative to make agreements on the headlines whereby the sector should be restructured, organized, financed and coordinated.

The Health Care Sector Plan (HCSP) involves a national strategy to reform and improve health care in Suriname in 2004 – 2009. This strategy is formed in cooperation and consultation with all stakeholders in health care and offers an umbrella for all activities in the sector. The Ministry of Health has a leading role in implementing the HCSP to strengthen cooperation within the sector and from the sector with outside actors. An improved coordination and planning will promote efficiency and effectiveness in implementing policies. By building a national strategic policy frame we may hopefully also be able to place activities of external developing partners in the sector within the frame, in order to be able to stop the parallel management structures for individual external projects, to harmonize procedures, monitoring and evaluation and to pool funds.

Furthermore, the HCSP needs to be seen as a model of change. It addresses changes that are desirable in the coming years, the way these changes can be implemented and what role the different stakeholders can play in this process. However, the plan only addresses proposed changes and despite the whole sector being the focus, it does not address the regular, every day activities within the sector. At the same time, the HCSP should not be seen as a fixed, inflexible blue print for reform. On the contrary, by involving specific procedures for review, it must be possible to take new developments and insights into account. The ultimate goal of health care reform and thereby the general development goal or mission of the HCSP is to improve the health status for the current and future citizens of Suriname.

This general goal is processed in three general principles for the changes, as formulated in the Position Paper of the Ministry of Health:

1) the Government focuses on its core business, being formulating policies, inspection, laws and regulations and the general direction and coordination of the sector;
2) The public health impact of the activities in the health care sector will be improved as a result of a stronger focus on cost effectiveness
3) The available budget for Public Health Care (as % of GDP) will not raise substantially

Based on these general principles the specific goal for the Health Care Sector Plan is:

To achieve an integrated and sustainable Health Care system of good quality and effectiveness, accessible for everyone and a continuous improvement of health for the whole population.

The main elements of this specific goal are explained as follows:
The term 'integrated Health Care System' is used to refer to the orchestra of actors involved in both health care and health promotion. These actors are not only to be found within the core health sector, but also in their surroundings. Health promotion is influenced by the other determinants of Health, such as life style, education, safe drinking water and sanitation. Government, suppliers (e.g. private hospitals) and private sector (e.g. NGO's) need to complement each other. Health Care Reform is also about making clear choices concerning the roles in this triangle.
A proper and effective health care consists of more than just a good monitoring of health care quality. It also requires strategic choices to strive for a cost effective production of preventive health care and a good division between primary and secondary health care.
Promoting access to health care also involves geographic, financial and socio-economic factors. The concept of 'access' is connected with the concept of equity. This is reason to give special attention to access to health care for socially marginalized groups.
The concept of 'sustainability' involves social-economic, financial, political, technical and cultural dimensions.

To achieve this goal the HCSP describes seven strategies giving a specific direction to the implementation of the proposed changes. The selection of the seven specific strategies reflects on the one hand a functional structuring of the Health Care supply (prevention and primary health care, hospital health care), the need and urgency to bring reforms in certain areas to force (support systems, human resources and quality) and on the other hand the need to achieve a managed development of the costs of health care with improvement of the financial access to health care (access to health care and cost effectiveness).

The seven strategies are:

1) Strengthening Primary Health Care and prevention
2) Improving Efficiency and quality of Secondary Health Care
3) Improving Financial access to Health Care
4) Financial Management (cost containment)
5) Strengthening Support Systems
6) Developing Human Resources
7) Improving and Assuring Quality

For an adequate implementation of this sector plan and these strategies a powerful management of the sector is crucial. The Ministry of Health will have to play a central and leading role by focusing on policy, legislation, coordination and supervision.

Strategy 1: strengthening primary health care and prevention
This strategy is intended to strengthen the supply, quality and accessibility of Primary curative and preventive care, with special attention for those groups that do not have a natural access to essential care (socially marginalized, women, adolescents, people from the interior). Therefore, four operational goals are formulated and further elaborated with specific activities, indicators and means.

1) The use of Primary curative and preventive health care, aswell the referral system to secondary health care is determined. This will clearly establish which care should be offered by Primary Health Care suppliers.
2) Primary Health Care of RGD and MZ is strengthened and special services and programs for specific target groups are developed.
3) Individual and collective prevention is improved in a sustainable way and priority programs for disease control (STD's, HIV/AIDS, TB, Malaria, Reproductive Health) and environmental hygiene are strengthened at all levels of Health Care.
4) Participation of citizens and local organizations in determining local priorities and executing health care programs is strengthened.

Strategy 2: Improving both efficiency and quality of hospital care
In addition to strengthening primary health care, there is an important role for hospital care in supporting primary health care. This strategy also aims at arranging the supply of hospital care and formulating procedures on expenditures in (top-) clinical care. The most important areas are further elaborated in four operational goals:

1) The service package, which must be provided in a qualitatively justified and cost-effective way, has been decisively stipulated and maintained
2) hospitals exploit scale advantages in all areas
3) hospitals have effective and modern management
4) As a substitution for the RLA, top clinical care will be developed on the basis of cost effectiveness and financial sustainability

Strategy 3: Promote the financial access to Health Care
The long term objective is to guarantee financial access to health care for relevant and decisively stipulated socially marginalized groups. The costs of health care consumption of these groups must be carefully monitored to curb over-consumption. The following objectives are part of this strategy:

1) The regulation for the poor and near poor is more strongly aimed at socially marginalized groups;
2) improper extra payments of patients to care providers have strongly diminished;
3) better exploitation of possibilities for financially administrative cooperation between the Ministry of Social Affairs and SZF for purchase of health care for the poor.

Strategy 4: Health Care Cost Control
It is possible to gain substantial improvement in quality of life without a substantial increase in the available resources for health care. To reach this goal, the objective will be to master the share of Health Care Expenses as part of the GDP. The year
2000 is used as a reference. In this year Health Care Expenses accounted for 8.6% of the GDP (9.4% including the RLA). Within this envelope the share of public expenditures will be managed to reach a GDP share of 4%, 2000 being the year of reference.
The following objectives are part of this strategy:

1) Promote an efficient production of Health Care in both Primary and Secondary Health Care by using mixed, performance related payment systems.
2) Expansions in (intramural) health care are only permitted, if financial feasibility and social desirability have been weighed by an independent commission.
3) Public Health Care Expenses are predictable and better coordinated, planned and realized.

Strategy 5: Strengthening Support Systems
For a proper operation of Health Care, adequate support systems are needed for 'purchases and logistics', 'communication' and information ('National Health Information System'). This strategy aims at strengthening the (relation between) support systems en is carried out following the next four objectives:

1) Safe, effective, essential and affordable pharmaceutical and other products, infrastructure and equipment are available.
2) MOH can rely on an adequate communication infrastructure (telephone, computer, Internet) to facilitate communication with other actors.
3) Both MOH and suppliers use vital information to support monitoring & evaluation, planning, management and policy.

Strategy 6: Development of Human Resources
This strategy aims at securing the presence of a qualified, professional and motivated work force. Apart from establishing sufficient human-power in the sector this strategy also aims at improving employment conditions. Staff together with necessary infrastructure and resources secure an adequate supply of health care. Aspiration is to establish a motivated, professional and qualified work force. Four objectives support this strategy:

1) A human resource development plan will be implemented
2) Capacity and content of training meet demand and feasibility
3) Public health expertise and management skills are strengthened

4) Employment conditions of staff, including government staff, are in line with the market

Strategy 7: Improve and secure quality
Quality and service in Health Care will be further improved by setting up an effective quality system. Five objectives are formulated under this strategy:

1) MOH strengthens the implementation of inspection, monitoring and legislation
2) Quality Management is part of development and execution in the institutes.
3) Professional groups play an important role in promoting health care quality
4) The insurances, including SOZAVO, have developed effective mechanisms to promote health care quality
5) The consumer/patient plays an increasing role in demanding health care quality

Executing the activities needed to achieve the objectives in the seven strategies demand an adequate implementation of the sector plan with a powerful management of the sector. To be able to do this, eight specific measures are proposed:

1) To play an initiating, coordinating and managing role within the sector, the central MOH office will be restructured.
2) The management responsibilities of the various institutions are clearly defined and tuned.
3) Where necessary, legislation will be adjusted and quality of supervision improved.
4) A better management and communication will promote collaboration within the sector and with other sectors
5) Procedures for planning, budgeting and reporting within the sector are univocal and well tuned.
6) Internal and external communication within the sector is improved
7) Support by external development partners fits in with the 5 years sector plan and external partners are involved in a mutual monitoring of the HCSP.
8) A system of sector wide participative 'monitoring and evaluation' will be operational

The ambitions and direction of the HCSP can only be effective if other issues outside the sector are also met. Furthermore, many issues depend on the limitations and motivation of the several actors. The most important issues are part of the HCSP. Nevertheless the execution of the plan will largely depend on the way the following risks are addressed.

1) Executing the HCSP demands a substantial effort of the MOH. It will be impossible to do this with the current workforce. One of the requirements to execute the HCSP will be to attract additional expertise. MOH will need to hire additional staff on competitive, performance-related conditions in 2004. Especially the development partners will need to play a prominent role in supplying practical and financial support to achieve this.
2) To maintain a feasible situation within the MOH it is crucial to stop the trend whereby the available resources for health care are relatively decreasing.
3) MOH will demand a bigger responsibility and independence of the institutions in the sector. Most institutions welcome this approach. On the one hand, a reserved attitude from MOH and politics will be necessary to give the management of the institutions the required space. On the other hand, the management of the institutions will need to make better use of the current prospects on their own.
4) At the moment, external aid in health care is based on individual projects. Executing the HCSP will demand better tuned procedures and execution from the development partners. It will be necessary to adjust a number of current or planned projects to prevent overlap and establish a better tuning with the HCSP on the short term. A flexible attitude from involved donors is crucial.

The Health Care Sector Plan (HCSP) is a plan of change. It addresses the intended changes, but leaves regular, day to day activities within the sector undescribed. These activities are supposed to be financed from the regular budget. The budget for this HCSP is limited to the activities aimed at achieving the specific purposes of the HCSP that cannot be financed from the regular budget.
An inventory of expenses and funding of the HCSP shows that a substantial part of the expenses can be financed by commissioned funds. Based on the available information on projects a substantial increase in

available external resources is to be expected. It is still insecure if this bubble will and needs to have a permanent status. Nevertheless, additional activities are proposed in the HCSP that do not yet have a secured funding. A rough estimate of the total amount necessary to carry out the HCSP can be found in the table below. This table also states the required additional funds. As there seems to be a substantial capacity within the commissioned project funds, it is not sure if it will be necessary to request additional funds. With cooperation from the development partners it may be possible to relocate within or between commissioned funds to make space for (partly) funding of additional activities.

Funding Sector Plan in Million Surinamese Dollars (SRD):

	Com	Add	Total
Strategy Strengthening Primary Health Care	43.2	1.1	44.3
Strategy Improving Efficiency Secondary Health Care	32.4	1.3	33.7
Strategy Financial access to Health Care	2.5	0.3	2.8
Strategy Financial Management	5.9	2.9	8.8
Strategy Support Systems	1.5	4.2	5.7
Strategy Human Resource Development	1.7	10.9	12.6
Strategy Quality	0.7	2.7	3.4
Strategy Capacity Strengthening MOH	4.0	2.1	6.1
Total	**92.0**	**25.4**	**117.4**
		Per year	26.1
Per year, per capita			53.2

Funding Sector Plan in Million USD:

	Com	Add	Total
Strategy Strengthening Primary Health Care	16.0	0.4	16.4
Strategy Improving Efficiency Secondary Health Care	12.0	0.5	12.5
Strategy Financial access to Health Care	0.9	0.1	1.0
Strategy Financial Management	2.2	1.1	3.3
Strategy Support Systems	0.6	1.5	2.1
Strategy Human Resource Development	0.6	4.0	4.6
Strategy Quality	0.3	1.0	1.3
Strategy Capacity Strengthening MOH	1.5	0.8	2.3
Total	**34.1**	**9.4**	**43.5**
		Per year	9.7
Per year, per capita			19.72

1. INTRODUCTION

Why this Sector Plan

After a period of decline at the end of the previous century, in the past few years Suriname has succeeded in realizing a positive economic growth that varies between an annual 3 and 5 percent (IMF: 2003). Due to this stabilization and favorable economic and social developments, more room has been created for a long-term policy perspective. The 2001-2005 5 years Development plan with high priority for further social and economic development, is among other things evidence thereof.

The health sector plays an important role in the social and economic development of Suriname. The importance of good health and adequate health care for everyone in Suriname is beyond dispute in this respect. This importance is among other things also reflected in the relatively high expenses for health care in Suriname. Per capita of the population an amount of about US$ 180 is spent on health care (NHA: 2001).

Despite the recognized importance of and the expenses for health care it is a fact that within the Suriname health care much can still be gained where e.g. the allocation of available financial resources or the organization of the sector is concerned.

Proportionally much use is made of relatively expensive hospital care. Taking into consideration the public funds, which are still limited, a better use of less expensive primary health care may create opportunities for the necessary innovations, the required capacity development and the future investments in the care services needed.

The health sector has a big variety of actors and stakeholders, such as government agencies, private institutions, non-governmental organizations (NGO's), national and international development organizations. They are all engaged in the financing and/or implementation of health care services. The mutual responsibilities of these various actors are often not entirely clearly defined. The organization of health care is thus strongly disintegrated. Consequently the health care sector is a system that is complex and difficult to coordinate.

Taking aforesaid macro-economic, budgetary and institutional realities into consideration, it has become imperative for some time now to answer the question as to how the financing and the organization of health care can be improved in a sustainable manner. The (2001) Joint Declaration between Suriname and the Netherlands lays down the agreement that this will be substantiated by a 'sectoral approach'.

Compared to the more traditional 'project-approach', the sectoral approach offers a number of advantages. Point of departure in this respect should be a broadly supported national strategy. Said strategy should clearly give direction and provide an umbrella for all activities within the sector. The Ministry of Public Health has a leading role in the formulation and implementation of this strategy so that both the intra and the intersectoral cooperation are more strongly emphasized. A better coordination and planning will also promote the efficiency and effectiveness in the implementation. This also plays an important role in the relationship with external development partners, who can consequently place their activities in a (broader) national policy framework. As a result thereof an important condition is met so that development partners can abandon parallel management structures for individual projects. At the same time harmonization of procedures, monitoring and evaluation and the pooling of funds can be developed.

Establishment of the health sector plan (SPG)

The go-ahead for the SPG was given early 2004. It turned out that there was much interest within the sector in cooperating with the establishment of a 'plan of change' in which future ambitions, plans, financing possibilities and implementation modalities would be laid down. In doing so already existing initiatives and policies were initially emphatically started from.
During the past few years initiatives had already been taken to improve the structure and the organization of the sector. The Ministry itself had drawn up a policy plan and a number of (sub) studies had been

performed in which recommendations were made as to a necessary reorientation of the sector. Furthermore some institutions had already taken initiatives to think about the own future. Finally there were some projects and programs in execution aimed at solving specific problems within the sector. Unfortunately little attention was paid to a comprehensive analysis and joint plan of action.

During the development of the SPG, within the sector there was an important formation of views on the following key questions:
What should the status of the sector be in five years?
Taking into consideration the available possibilities, what is society able and willing to afford to spend on health care?
To what extent can and must public funds continue to finance the care services system in the future?
Who does what within the sector: the government, executive bodies, the population itself?
In what manner can external funds be used in a more efficient and coordinated manner?
Which activities will be embarked upon in the first year?

Mode of operation
On the basis of all the available background information about the sector (gathered on a CD-ROM), the discussion about the sector plan initially took place within four broadly composed theme groups, consisting of representatives of the central government, health care facilitators, professional groups, health care consumers, the business community, private institutions, the university world and (inter)national development organizations. (See also appendix 7). These four theme groups examined a number of current subjects within the sector, such as the quality of health care, the nature and organization of the services, the financing of health care, procurement aspects, but also control and management aspects.
At the end of February feedback was given within the sector as regards the conclusions and recommendations of the theme groups, after which an interim report of findings was drawn up. This so-called position paper with accompanying questionnaire was then forwarded for comment to all parties that were directly and indirectly involved. A vast majority of the stakeholders responded in writing to the contents of the document. On March 20, 2004, the position paper and the reactions thereto were elaborately discussed during a National Conference. At said conference representatives of all organizations involved were present.

Just as during the preparation process, the actual drawing up of the sector plan was a participative and consultative process. Four workgroups consisting of (senior) managers of the ministries concerned, institutions and private organizations, were intensively involved in the formulation and (final) editing of the sector plan.

The formulation of this 5 years sector plan marks the beginning of a unique process with the central government, health care consumers, health care facilitators, development partners and other actors involved, taking the initiative to enter into agreements on the most important lines along which the sector should be structured, organized, financed and coordinated on the mid-term.

The SPG should furthermore be considered a 'plan of change'. It indicates which changes should be aimed at the coming years, how these should be implemented and which role the various parties play therein. It only touches upon the changes aimed at, though, and although it comprises the entire sector, it does not describe the regular, day-to-day activities.
At the same time it is important that the SPG does not intend to give a fixed, inflexible blueprint for reforms. On the contrary, by incorporating specific procedures for review, new developments and advancing views can be explicitly taken into account.

Structure of the SPG
After a short situation analysis in chapter two, chapter three outlines the higher objectives of the SPG. In addition to vision and mission, the policy points of departure are dealt with in short. Chapter four works out the various strategies, inclusive of operational objectives, accompanying activities, indicators and assumptions/risks. Chapter five is entirely devoted to the management, the organization and coordination

of the sector. Chapter six deals with the so-called resource envelope for the entire sector, inclusive of anticipated trends for the coming four years. After a final chapter seven about the most important risks in implementing the SPG, the latter also contains a series of appendices in which among other things detailed LogFrames for all strategies under chapter four and five are indicated. The most important activities from the LogFrames for the year 2004 are mentioned separately in the text in tables, while the numbering of the LogFrames is mentioned for reference purposes.

2. SITUATION ANALYSIS

2.1. General information

Suriname is an independent republic on the northern coast of South-America. The country is 163,000 km² or more in size. In the north it borders to the Atlantic Ocean, in the south to Brazil, in the east to French Guyana and in the west to Guyana. The capital is Paramaribo, situated in the northern coastal area. Suriname consists for a major part of tropical rain forest with accompanying high temperatures and high atmospheric humidity. Administratively the country is divided into ten districts, which are subdivided into 62 constituents.

2.2. Demographic and epidemiological overview

By far the biggest part of the estimated 482,000 inhabitants lives in the coastal region and in the capital of Paramaribo. About 350,000 people or more of Suriname descent live abroad, mainly in the Netherlands. The population is characterized by a big ethnic diversity, among others consisting of Creoles, Indians, Javanese, Chinese and Amer-Indians. The most important religions are Christianity, Hinduism and Islam. The official language is Dutch, but due to its multi-cultural character many other languages are spoken as well.

The average life expectancy is an estimated 71-72 years. The table below contains a number of data as regards maternal and child mortality rate:

Key indicators	
Birth rate (per 1,000)	22
Overall mortality rate (per 1,000)	7.0
Life expectancy at birth (in years)	71.1
Maternal mortality ratio (per 100,000 live births)	154.4
Infant mortality rate (per 1,000 live births)	15.9
Child mortality rate < 5 years (per 1,000 live births)	21

(Source: 2001 CMO-report)

The 2001 CMO-report shows that Suriname is confronted with a double disease burden. The prevalence of diseases typical of middle-income countries is dropping, while the more western diseases are gradually rising. This shows an epidemiological transition. HIV/AIDS are increasingly demanding victims.

2.3. Health care suppliers

The Stichting Regionale Gezondheidsdienst (The Foundation for Regional Health Service- RGD), private general practitioners and general practitioners, who are hired by employers to treat employees and their families, offer primary care in the coastal region of Suriname. Hospitals in Paramaribo and Nickerie offer intramural care. Inhabitants of the interior receive primary health care in the clinics of the Stichting Medische Zending (Medical Mission Foundation).

Suriname has a total of six hospitals. Four thereof are public hospitals: ‘s Lands Hospitaal (National Hospital), Academisch Ziekenhuis (Academic Hospital), the Psychiatrisch Centrum Paramaribo (Psychiatric Center Paramaribo) in Paramaribo and the Streek Ziekenhuis Nickerie (Nickerie Regional Hospital) in the district of Nickerie. In addition Paramaribo has two private hospitals, more in particular, St. Vincentius Ziekenhuis (St. Vincentius Hospital) and the Diaconessenhuis (Diaconessen Hospital). The latter functions as reference hospital of the Medical Mission.

The state-owned enterprise Bedrijf Geneesmiddelenvoorziening Suriname (Suriname Pharmaceutical Supply Company) and a big number of private importers and pharmacies mainly provide for the medicine supply.

The Bureau Openbare Gezondheidszorg (Bureau for Public Health Care- BOG) of the Ministry of Public Health is the most important public health institution.

2.4. Health care financiers

The National Health Insurance (SZF), the Ministry of Social Affairs (SOZAVO), the Ministry of Public Health (MoH) and the Ministry of Finance (MvF), are the most important agencies in charge of financing health care. The SZF compensates a broad set of services. Its customer base mainly consists of compulsory insured (civil servants and government officials) and voluntarily insured. About 30% of the population is insured through the SZF, which is financed by means of contributions.
SOZAVO is responsible for the financial support to the group of the poor and the near-poor, a group that covers an estimated 30% of the population. In addition to aforesaid institutions, an increasing number of private insurers is active. Most companies take out a health insurance with said insurers for their employees and families. The remaining part of the population is uninsured.

2.5. Health care expenditures

The current spending on health care is relatively high, measured in share of the Gross Domestic Product (9.4%) and expressed per capita of the population (US$ 180). A large part of the available funds is spent on secondary and tertiary health care. Spending on primary and preventive care covers about one third of the total of expenses. The share of the government in the financing of health care amounts to 43% or more.

2.6. Development partners

The Ministry of Public Health and the various institutions engaged in the sector maintain collaborative relationships with organizations at United Nations level (amongst others PAHO, UNICEF and UNFPA), with international financiers (including the IDB and the IsDB), with the European Union and with various bilateral donors. In addition there is a considerable number of technical and financial partnerships with foreign universities and municipal authorities. An overview has been included as appendix six.

3. MISSION AND VISION

3.1. Government Policy

The SPG is initially a further elaboration of the current government policy. It concerns not only a specific policy as regards public health care, but also interfaces with objectives of the government at a higher policy level such as Public Sector Reform (PSR) and agreements Suriname has entered into at an international level.

In implementing the 2001-2005 5 years Development Plan, further economic growth is one of the main pillars of the policy. For this purpose in the general sense a process was initiated in the direction of a more open market economy, aiming at a higher efficiency, and a proper division of tasks and coordination between the traditionally relatively large government machinery and the private sector.
This means among other things, that the government aims at restricting its role to core tasks, more in particular:

- Laying down laws and regulations
- Formulating and ensuring the implementation of a social and economic policy;
- Formulating and ensuring the implementation of a financial and economic policy;
- Formulating and entering into partnerships with the private sector; and
- Monitoring the compliance thereof.

The withdrawal of the government, however, is a complex process that requires much time. The further decentralization of the administration and the transfer of tasks and responsibilities to other actors in society is therefore less quickly realized than initially anticipated. The PSR-process that has been kick-started, is ongoing and it is not clear how the further implementation will take place during the term of this SPG. Within the health sector the SPG itself aims at giving important substance to the new role of the government and the PSR. Nevertheless there are also tasks that cannot be arranged within the sector only, including e.g. employment conditions policy and human resources management with performance-oriented incentives. As these elements are of crucial importance to the implementation of the SPG, the plan includes separate measures that may be considered the provisional substance of the PSR.
During the past period Suriname also committed itself to a number of international agreements, among other things in connection with the FTAA, MERCOSUR, CARICOM and ACP. These agreements will increasingly influence the sector and set extra (quality) requirements to the policy and the actors. Despite specific differences, the core of these new agreements is mostly a further liberalization of international trade as a result of which the movement of goods and services in the region will take place in a more freely manner. In time this may be of direct and indirect influence on health care by for example a possible free establishment of physicians from CARICOM-countries, international cooperation as regards research, standards and trainings, and decrease of taxes and tariffs on medicines and other goods.

Within the framework of the international policy, also specific obligations were entered into in the field of eradication of poverty and health care within the scope of the United Nations. Suriname among other things committed itself to the agreements made on the International Conference on Population and Development (ICPD) and the Millennium Declaration, at which among other things it was agreed that prior to 2015 the following objectives will have been realized:

- Pushing back poverty and malnutrition;
- Promoting primary education and basic health care for the entire population;
- Increasing the focus on gender issues;
- Decreasing child mortality rate;
- Combating HIV/AIDS, malaria and other infectious diseases;
- Improving the sustainability of the environment.

These international obligations are part of the MOP referred to earlier, but are also brought forward in particularly the "2001-2005 Policy document on Public Health" of MoH, in which the following specific policy intentions are mentioned:

- Promoting equal access to adequate care with special attention to the socially marginalized groups in the coastal areas and in the interior;
- Promoting efficiency and quality of care;
- Strengthening the cooperation between public and private sectors;
- Improving the controllability of the steadily increasing costs of care, particularly in the intramural sector;
- Paying special attention to vulnerable groups, including women, children, the disabled, the elderly and adolescents;
- Taking special measures to combat important diseases such as malaria, dengue, TB, the Weil's disease and HIV/AIDS.

The national and international policy frameworks mentioned here, are an integral part of the SPG, as further worked out in paragraph 3.2.

3.2. Vision and Mission of the SPG

The SPG starts from an analysis drawn up by the sector from which a general objective was formulated and three explicit points of departure have been extracted. These points of departure are translated and worked out in seven strategies that direct the implementation of the reforms in the health sector in Suriname.

The final goal of the reforms in the health care sector and with that the general development objective, or mission of the SPG, is improving the health status of the Suriname people now and in the future.

This general objective is further directed by the three points of departure (the "vision") for the reforms as worded in the position paper of the Ministry of Public Health:

1) The government focuses on its core tasks, including formulating policy, inspection, laws and regulations and the general direction and coordination of the sector;
2) The public health impact of the activities in the health care sector is enlarged by a strong emphasis on cost-effectiveness; and
3) The conviction that the available financial resources for health care (as percentage of the GDP) will not substantially increase.

On the basis thereof the specific objective of the SPG is:
Achieving an integrated and sustainable system of qualitatively proper and effective health care that is accessible to everyone and that promotes a continuous increase of the health gains for the entire population.

The most important elements are explained as follows:

- The term Integrated Health Care Services is used to refer to a concerted action between the actors that play a role in both health care and health promotion. These actors are not only within the core health sector, but also beyond that. After all, health promotion is also influenced by other health determinants, like lifestyle, education, safe potable water and sanitation. The government, the "market" (including private hospitals) and the social midfield (including NGO's) should complement each another. Public health reform is also about making clear choices as regards the roles in this triangle.
- A proper and effective health care comprises more than just a proper monitoring of health care quality, but also requires with the available means, to make strategic choices to pursue cost-effective production of preventive care, as well as in proportion to primary health care and hospital care.

- Promoting access to health care also involves geographic, financial, social and cultural factors. The concept of 'access' is linked to the concept of 'equity'. This SPG therefore emphatically focuses on access to health care for the poor and near-poor.
- The concept of 'sustainability' should be broadly interpreted and comprises socio- economic, financial, political, technical and cultural dimensions.

In order to achieve this objective of the SPG, it was decided to elaborate this in a number of strategies (see section 3.3) that gives specific direction to the implementation of changes as intended.

3.3. The strategies for change

This SPG classifies the various activities under seven strategies that are specified in chapter 4. These strategies are identified on the basis of the results of the available (sub) analyses of the sector from the past few years. In preparing the SPG, the sector further refined and demarcated these strategies. The choice for these seven specific strategies is of both a substantive and an operational nature. Important changes are e.g. provided for the supply and the suppliers of health care, with a functional distinction being made between preventive and primary health care on the one hand and hospital care on the other hand. Other subjects concern the entire sector and are so important that they are treated as separate strategies, such as support systems, human resources and quality. The necessity to achieve a controlled development of the costs of health care with the financial access to care services being improved, are points of departure of the SPG, but are specifically indicated in the strategies for access to health care and cost control.

1) Strengthening primary care and prevention. The anticipated result of this strategy is that the supply, the quality and the accessibility of primary curative and preventive care will have been strengthened, with special attention to target groups for whom access to essential care is not always self-evident (underprivileged, women, adolescents, inhabitants of the interior).
2) Improving both efficiency and quality of hospital care. The role of hospital care in supporting primary care is emphasized in this respect. This strategy also aims at sorting the supply of hospital care and establishing procedures as regards expanding high-quality care.
3) Promoting the financial accessibility of health care services. In this strategy financial accessibility to health care for the socially marginalized is the central issue.
4) Health care cost control. Taking into consideration aforementioned policy points of departure, the goal is to stabilize health care expenditures at the level of 2000 and to apply a cost-effective spending thereof.
5) Strengthening support systems. In order to have these services function properly, adequate support services are necessary as regards among other things 'procurement and logistics', 'communication' and information systems ('National Health Information System'). This strategy aims at strengthening (the relationship among) these support services.
6) Human resources development. This strategy aims at guaranteeing the presence of sufficiently qualified, expert and motivated personnel, and in addition to developing sufficient human-power in the sector, also at improving the employment circumstances.
7) Improving and safeguarding quality. By developing an effective quality system, the quality and patient-orientedness in health care are expected to have further improved.

An important condition for an adequate implementation of the SPG is a strong management of the sector. The Ministry of Public Health will have to play a central and leading role by particularly aiming at policy-making, regulations, coordination and supervision. In addition to the seven strategies mentioned earlier, the role of the Ministry of Public Health is consequently dealt with separately.

Although a distinction needs to be made between various strategies and the management of the sector, these are not isolated. Quality is e.g. not a strategy that can be worked out separately from other developments with care suppliers or financiers. At the same time the strengthening of primary care and prevention is an important elaboration of the strategy to handle the available funds more effectively and more efficiently. The strategies mentioned are therefore closely linked and sometimes also interdependent. Crucial interdependencies are discussed separately in the risk analysis.

In the next chapter each of the strategies mentioned, will be further worked out. For details as regards specific activities and the accompanying funds, we refer to appendix 1 ('LogFrames')

3.4. The health care sector

It is relevant to demarcate the health care sector so that everyone knows what is exactly meant under the sector within the meaning of the SPG. This follows on the definition in the Quickscan health care applied, with one exception: the sub-sector 'water' does not fall within the direct context of the SPG, but is considered a sub-sector that is involved in the health care sector by means of intersectoral cooperation. The health care sector consists of the following sub-sectors:

1) Preventive and public health care;
2) Training and education;
3) primary care;
4) secondary care;
5) tertiary care.

Preventive and public health care: health information and education, sanitation, nutrition, prevention of communicable and chronic diseases, maternal and child care inclusive of immunization and school health programs, environment, reproductive health care, youth dental care, care for addicts, for the disabled and occupational health care.

Training and education: for nurses, orderlies and health assistants, surgical assistants, youth dental care assistants, midwives, pharmaceutical assistants, lab assistants, medical and chemical analysts, physicians, physical therapists, EHBO (accident and emergency department) and community-based trainings.

Primary care: general practitioners' science, dentistry, obstetrics, industrial medicine, mental health care, pharmaceutical supply, paramedical assistance, home care, emergency assistance and the manufacture of optometric, orthopedic and other devices.

Secondary care: Outpatients' and specialist care, hospital care, supply of blood and blood products, hospital pharmacy, psychiatric care, laboratory and imaging diagnostics and nursing homes.

Tertiary care: super specialist or high-quality clinical care.

4. HEALTH CARE SYSTEM REFORM STRATEGIES

4.1. Strengthening primary health care and prevention

4.1.1. Background

In its 5 years development policy the Surinamese government chooses a strengthening of Primary Health Care and (individual and collective) prevention. The rationale of this choice is that it may be expected that health gain and a better quality of life can be attained in a cost-effective manner. The relevance of the development objective of the SPG (Health Sector Plan), - which is improving the health status of the Surinamese people -, is beyond dispute in this respect. The maternal mortality ratio (MMR) may be mentioned as an example of a stagnating health status; said ratio continues to be unacceptably high (154/100,000 in 2001; source: BOG -Bureau for Public Health-). Furthermore typically poverty-related diseases are openly manifest and at the same time chronic diseases are advancing, such as hypertension, diabetes and degenerative diseases, including cancer. In this connection health problems among specific target groups must be mentioned as well, such as diseases related to the proportional rise in the ageing population, and reproductive and sexual health problems among adolescents (Sexually-transmitted diseases; abortion; HIV/AIDS – the HIV prevalence among the adult population is an estimated > 1%). The incidence of tuberculosis is increasing as well, while the gender-related morbidity and mortality is striking.

The current supply (type, quality) of primary services insufficiently adjusts to this situation. In the first place primary care is insufficiently utilized due to a lack of planning within the health sector. This is evident from among other things the high numbers of patients, who are often referred to a specialist and this often without sufficient medical grounds. Furthermore it still has not been determined unequivocally which services exactly should be provided by primary care. In addition other factors (customs that arose, not enough confidence in the quality of primary care) play a role in the use of primary health care. E.g. 75% of the pregnant women prefer to give birth in a hospital, instead of in the current RGD (Regional Health Service) and the MZ (Medical Mission) facilities.

Another flaw of primary care is that it seems as if no responsive actions are taken regarding the needs of special target groups. Up to now there has been little development with respect to care services, more in particular, senior care services, disabled care services, home care and public mental health. Nevertheless, it seems that there are actually opportunities to substantiate such a target group approach and a further development of relevant services with the use of the current infrastructure (e.g. RGD-outpatients' clinics) and human-power. This obviously requires the necessary capacity as regards organization and management. In this respect there are also concrete possibilities for improvement. Organizations like RGD and MZ have already taken the necessary steps in that direction.

During the past few years essential programs pertaining to collective prevention such as health information and education (GVO), environmental inspection, inspection of food and foodstuff, strongly weakened. The degree of coverage of traditional programs, such as the national immunization program, is not optimal either. As regards disease control programs there are opportunities for innovations, such as the introduction of the concept of Integrated Management of Childhood Illness (IMCI). The implementation of disease prevention and control programs is generally disintegrated due to a strong project-oriented approach. One of the causes is a weak capacity (insufficient number of highly qualified and specialized staff) within MoH (Ministry of Public Health) and BOG, to formulate coherent programs in which current and future projects can be fit in coherently and efficiently.

The participation rate of the local population in the organization of local services has been limited as yet. Up to now little substance has been given to the concept of community health (local health care systems), which forms an integral part of Primary Health Care.

The RGD has, however, taken the first steps towards strengthening the management at regional level. This offers opportunities for a further development of local health care systems in which community participation gets a place.

The health status of the population is also influenced by determinants that cannot be directly affected by the health services. In this respect the availability of safe potable water, sanitary facilities, education and nutrition come to mind. An adequate intersectoral cooperation at all levels is necessary in this respect. In the Quickscan, e.g. concrete reference points for intervention are mentioned in view of water borne and water washed diseases (malaria, cholera, dengue, diarrhea, bilharzias, chemical mercury poisoning, etc.).

4.1.2. Strategy

The anticipated result of the strategy to strengthen the primary health care and prevention is defined as follows: "The supply, the quality and the accessibility of primary curative and preventive care are strengthened, with special attention being paid to the target groups (the underprivileged, women, adolescents, inhabitants of the interior, the elderly, and the disabled)"

The sustainable degree of coverage of the national vaccination program has been chosen as proxy-indicator to monitor this intention (target: fully vaccinated children under one year: >90%).

4.1.3. Approach

In order to achieve aforementioned strategy, four operational objectives have been formulated: each with its specific activities, indicators and necessary funds (government budget; expenses already paid for by existing projects and commitments; additional funds to be acquired).

Objective 1: the use of primary curative and preventive services, as well as the reference system to secondary care has been determined

In order to face the problems observed that primary services (within this context: curative services) are insufficiently utilized, it is among other things important to well-establish which services this segment of the health care system should (be able to) offer. Consequently Suriname fits in with international practice in which the characteristics of the care provided and by whom it may be provided are established ever more explicitly. A workgroup installed by the MoH "Basic Package for the Primary Health Care" has already done preliminary work in this area. This work needs to be completed within short. In addition it will be necessary to develop national protocols and algorithms to further strengthen the referral (and referral back) system. MoH will lead this process in consultation with the care suppliers and the SZF. Nevertheless determining the services to be offered and the making of protocols will not be enough to 'have primary care do what it is supposed to do'. Especially the financiers (SZF/private insurance companies) will increasingly play a regulating role to promote the rational use of (primary) health care, by tightening control, inspection and giving feedback ('mirror data') to general practitioners. This aspect is further elaborated under the strategy 'cost control'.
Finally both MoH and the financiers will need to give the general public the necessary information about the role of and the possibilities within primary care provisions.

Proposed process indicators:

- Existence and implementation of protocols for the 30 most common diseases;
- Existence of regulations as regards a structured supply of care services.

Activities in 2004-07-14

Responsible authority	Activity
MoH	(1.1) under the leadership of MoH the Workgroup 'Basic Package for the Primary Health Care' defines the supply of current services to be offered in primary health care. Deadline: September 1.

Objective 2: Primary care taken care of by RGD and MZ is strengthened and special services and programs for specific target groups are further developed

To improve the classic activities related to primary care, a series of specific measures will have to be taken. In the first place the planning and management capacity of the RGD has to be strengthened, both

at main office level and regional level. This will facilitate the already planned decentralization of planning and management towards the 'regional managers' to be appointed and will enable the management to better aim at its core tasks (coordination, data-analysis and feedback, planning and budgeting, procurement, etc.). Both the IDB-project and the Start-Fund project Institutional Strengthening of the RGD, have already provided in these activities.

The 'critical mass' of public health knowledge and skills under the primary care suppliers will also be strengthened both at the level of the managements of BOG, RGD, MZ and JTV, and among the primary fieldworkers. During the term of the SPG the necessary (training) investments will be made (see also strategy 'human resources development'), for which there are already partly funds available from donor projects (project BOG, Start-Fund project RGD), but for which additional resources have to be found as yet. Some projects already provide in training of staff at the level of important programs such as sexual and reproductive health (including UNFPA).

In addition to improving management and public health skills among the staff, the SPG also provides for the improvement of the infrastructure. In order to improve the geographic access of MZ services, a further expansion of the number of outpatients' clinics (building, equipment) has already been provided for (project IsDB).
The maternity care of five selected RGD-clinics is improved by renovating the equipment (JICA-project). Of course this will not immediately lead to an increase of the use thereof. A crucial factor is the presence of a sufficient number of midwives. The latter is not the case at present. This is further dealt with under the strategy 'human resources development'.
From existing funds small to medium-sized maintenance of various RGD outpatients' clinics will have to be performed. Currently some outpatients' clinics are in a somewhat neglected state, which hampers creative use of these facilities (the use of existing beds for care services, including care for the elderly; the use of certain rooms for special activities for adolescents; equipping the VCT centers for HIV/AIDS, etc.). Most probably already existing donor funds can be redistributed to facilitate this necessary maintenance. In cooperation with MoH, the RGD will have to give it all.

Process indicators:

- Percentage of referrals;
- Percentage of outpatients' clinics with special arrangements for specific target groups;
- Percentage of deliveries in coastal area and the interior assisted in maternity clinics of RGD and MZ

Activities in 2004

Responsible authority	Activity
RGD/MZ	(2.1) RGD and MZ draw up a 5 years business plan with rough budget, in cooperation with MoH. Focus: organization of the implementation of the many projects. Short-term external TA needed; costs 2004: Euro 30,000 (IDB Start-Fund project RGD)
MoH	(2.3) Continuation project JICA (procurement equipment MKZ). Costs 2004 (RGD part): US $517.000

<u>Objective 3: Individual and collective prevention is improved in a sustainable manner and prioritized programs for disease control and environmental hygiene are strengthened at all levels</u>

The BOG should play a key part in the organization of primary and secondary prevention. Supported by the recently started project 'institutional and organizational strengthening of the BOG' this institution will change into a directing and quality-promoting public health institution. One of the key responsibilities of the BOG will be developing national gender-sensitive programs as regards information (GVO), school services and disease control (SOI/HIV/AIDS); TB; Malaria, reproductive health).

As regards sexual and reproductive health, inclusive of SOI/HIV/AIDS, it is striking that there is a large disintegration due to a strong project-oriented approach in the field. One of the challenges of the BOG will be strictly and practically formulating umbrella programs (in cooperation with NGO's) in order to better gear existing and future projects and activities to one another. This is also relevant if we take into consideration the acquisition of funds from the Global Fund to expand SOI/HIV/AIDS-activities.

The BOG will have to revive activities in the field of environmental hygiene, environmental inspection and inspection of foodstuff and goods. In addition the project mentioned provides the BOG with an improved infrastructure of the Central Lab (reference lab for public health purposes).

The BOG will be able to elucidate policy as regards prevention and particularly clearly defining the role of the general practitioner in prevention. This will give prevention an additional impulse, partly taking into consideration the interest on the part of the financiers (SZF) in financing concrete preventive activities. Action-oriented research is another field as regards to which the BOG will be able to play a coordinating and facilitating role.

A special point of attention is gradual integration of public mental health within primary services. This national program was already accurately formulated in 2000, but it was not really started. The emphasis of this program is strengthening ambulant mental health care by training primary workers. The Psychiatric Center Suriname (PCS) will then, as a reference center, be better able to aim at patients who actually need nursing. The SPG provides for the integration and the preservation of this program, as well as the necessary renovations within the PCS (funds partly covered by the Start-Fund project development PCS).

It is important that intersectoral cooperation between MoH (also via RGD and MZ) and other line ministries is intensified, aimed at enhancing the health status of the population. Cooperation with the Ministry of Education (adjusting curricula at primary schools), the Ministry of Public Works (waste treatment and sanitation), the Ministry of Natural Resources (potable water), the Ministry of Labor, Technological Development and Environment (environment and labor) and the Ministry of Defence (drawing up and keeping scenarios for emergency relief), come to mind.

Process indicators:

- Degree of coverage of prioritized programs (NIP; SRH; specific disease control programs; TB, Malaria);
- Process indicators of the National Aids Program (NAP).

Activities in 2004

Responsible authority	Activity
MoH/BOG	(3.1) Continue inception phase BOG-project. Outputs for inception phase: 5 years development plan and budget; hiring project manager; hiring planned technical assistance for drawing up 5 years development plan. Costs 2004 (short missions external TA GZ/institutional development; start improvement office infrastructure; purchase logistics/equipment; start invitation to tender infra): about Euro 200,000.
MoH/BOG	(3.5) MoH/BOG complete the formulation of the national multi-sectoral STI/HIV/AIDS strategy, with special attention for the institutional organization. Costs: maximally US $ 150,000 (TA IDB)

Responsible authority	Activity
BOG	(3.7) BOG commences with the formulation of a gender-sensitive policy as regards Sexual and Reproductive Health and carefully gears all SRH projects and programs to one another. Costs: Project BOG and UNFPA

MoH/PCS	(3.8) Start implementation Start-Fund project PCS. Costs 2004: about Euro 200,000

Objective 4: Participation of the population and local organizations in determining local priorities and in the implementation of health programs is strengthened.

Participation of the population may be enhanced by promoting local health systems (read: coastal areas). The already planned strengthening of area management and the decentralization of planning and management already encourages the involvement of NGO's and other local groups (women's groups; youth organizations; etc.) in the implementation of activities. The MZ, e.g., has already engaged in activities to that effect. RGD and BOG will also be able to aim at further training and guiding of local organizations in the principles of promoting health and well-being.

Process indicators:

- Percentage areas with concrete plans for public-private partnerships and promoting community participation

Additional activities for 2004:
none.

4.2. Improving efficiency and quality of hospital care

4.2.1. Background

It is very important to maintain a good quality and sustainable hospital care in addition to an improved primary care. In fact these are the two echelons that jointly constitute the backbone of health care, with hospital care as reference level for primary care. It is therefore very important to maintain the relatively good intramural care in Suriname.
The organization of intramural care has, however, been the subject of discussion for years now. Hospital indicators seem to point out that there is an overcapacity of beds. Furthermore these key figures are not up-to-date and need to be revised (see below: approach). The past few years various proposals were made to come to a restructuring of the hospital sector in view of enhancing the efficiency (e.g. by clustering the services; designating some beds for nursing care). In 2001 the Council of Ministers approved a document "Policy points as regards hospital care". The purpose of these policy points was enhancing efficiency, among other things by establishing a standard as regards beds; regulations for the expansion of specialist services and high-tech equipment; introducing low-care beds; stimulating outpatients' treatments by changing the financial incentives, etc. Furthermore it was decided to terminate the open-end financing of operating losses. By the many discussions about the coverage of the hospital costs that ensued, during the past three years no considerable progress was made with substantive discussions or with the decision-making about a fundamental restructuring of the entire hospital sector. The same holds for other important issues such as quality policy.
As a result of insufficient management there is moreover a growth of high-quality clinical care, which is disorganized and has not been tested against cost-effectiveness. Without a clear policy, the budgetary pressure on the intramural care will increase; on the one hand by the strengthening of primary care aimed at and on the other hand by the developments in the (high-quality) clinical care. The challenge in this respect is to guarantee maintenance of quality and accessibility of essential intramural care (a basic package), while at the same time an important efficiency gain is achieved.

4.2.2. Strategy

The anticipated result of this strategy is that quality and efficiency of hospital care and care services are improved.

The process indicators are the following:

- Rating hospitals and/or departments on the basis of a well-defined and standardized process of outcome indicators;
- Technical quality of interventions;
- Standardized / comparable duration of hospitalization (per hospital; per patient category; per treatment package;
- Overdue maintenance as regards infrastructure and equipment;
- Bed occupancy (target: 80%).

4.2.3. Approach

In order to achieve aforementioned general strategy, four operational objectives have been formulated, each with specific activities, indicators and necessary means (government budget, expenses already covered by existing projects and commitments, additional expenses to be acquired).

Objective 1: Set of services that should be provided in hospitals in a qualitatively responsible and cost-effective manner, has been determined unequivocally and is maintained

It is very important that a good quality and at the same time cost-effective set of services is determined that should be delivered. For these purposes MoH will form and lead a workgroup consisting of specialists, hospital managers, SZF, SOZAVO and representatives of employers. This workgroup will in the first place be engaged in developing treatment protocols for the top 15-20 most common diseases that require specialist help (hospital admissions; outpatients' operations). Furthermore standards for duration of hospitalization etc. per disorder / treatment (also using international standards) will have to be determined. This workgroup will in addition thereto also develop referral-back protocols.

The development of this set of national protocols will also be the first step towards computing the costs of treatments in hospital care (see for these purposes the strategy "care cost control"). Said activities will commence in 2004.

Process indicators:

- Use a fixed set of services belonging to secondary care / high-quality clinical care;
- Use functional treatment protocols;
- Technical quality of interventions;
- Standardized / comparable duration of hospitalization (per hospital, per patient category, per treatment package).

Activities in 2004

Responsible authority	Activity
MoH	(1.1) Initiates and coordinates workgroup that develops treatment protocols for the top 15-20 most common diseases that require specialist help (including standards for duration of hospitalization, etc. per disorder / treatment

Objective 2: Hospitals utilize economies of scale by cooperation in all areas

Hospitals are interested in achieving efficiency gain by further cooperation and by implementing a sound restructuring plan. The SPG contains a series of feasible activities to accomplish that. The hospital management and the MoH will intensively cooperate to that effect.

On the basis of actualized and verifiable data MoH will draw up a phased plan to restructure hospital care. For those purposes an extensive study will be performed by experts to actualize the partly outdated hospital data and to make a thorough analysis (number of beds; occupancy rate; duration of hospitalization; distribution type of treatments and specializations over the various hospitals, cost structures per hospital, etc.).

After a plan for restructuring of hospital care has been determined by MoH, latter will investigate the investment needs at the various hospitals and will identify possible funding to eliminate arrears of maintenance. This happens to fit in with the activities mentioned under the strategy "care cost control" (under objective 4).

In cooperation with the hospitals, MoH investigates possibilities for cost-effective and practical cooperation for diagnostics. The hospitals themselves will take the lead as regards the development of other forms of cooperation, e.g. sharing some facilitating services. The same applies to cooperation in the field of procurement.
MoH will facilitate the hospitals in developing and implementing uniform and computerized financial and administrative systems, including a Patients Registration system. Additional funds will be identified (broad international expertise is required) to that effect.

Finally, in cooperation with the hospitals and other stakeholders such as the trade unions, MoH will initiate a process aimed at uniform employment conditions for the personnel (collective bargaining agreements with {para} medical personnel).

Process indicators:

- Existence of (regular consultative structures for) cooperation (diagnostics, facilitating services);
- Rating hospitals and/or departments on the basis of a well-defined and standardized process of outcome indicators;
- Standardized / comparable duration of hospitalization (per hospital; per patient category; per treatment package;
- Overdue maintenance as regards infrastructure and equipment

Activities in 2004

Responsible authority	Activity
MoH	(2.1) On the basis of actualized and verifiable data, MoH will draw up a phased plan to restructure hospital care. Costs: Euro 100,000 for study by external expert (additional budget SPG)

Objective 3: Hospitals have well-running and modern management
MoH will strengthen the management of the public hospitals by appointing (by the Minister of Public Health) experts in Boards of Supervisory Directors and Executive Committees. These executive committees will fulfill their role from a distance so that more than before they can focus on strategic matters and less on (operational) management issues. In addition the Minister will also strengthen the management of the public hospitals by fulltime managers with practical and proven (preferably international) management experience. The conditions for hospital management should be revised in this respect. A strengthened management is one of the preconditions to achieve a proper conduct of business.

In addition the government will have to give the public hospitals control over budget and personnel, as has already been implemented with the RGD, the BGVS and the SZF. This step will further contribute to a flexible conducting of business and controlling the costs by the hospital management. Furthermore MoH will make explicit policy agreements with public hospitals (quality, drawing up annual plans, annual reports, deadlines for auditor's reports, etc.).
The managers of public hospitals for their part will delegate operational and budgetary responsibilities within the organization.
Finally the hospitals will professionalize their contractual relationships with specialist practices so that more business-like, more transparent and performance-oriented contractual relationships can be entered into.

Activities in 2004

Responsible authority	Activity
Minister of Public Health	(3.1) Minister and MoH draw up profiles and appoint experts in Board of Supervisory Directors/executive committees and management of public hospitals and revise conditions for hospital management.

Objective 4: High-quality clinical care to replace RLA-scheme has been built up on the basis of cost-effectiveness and financial sustainability.
The current ARMULOV-scheme lays down that part of the treaty funds (Euro 745,000) needs to be utilized for Local Development Provisions (LOV-1 and LOV-2). A workgroup led by MoH formulates a project proposal for the development of high-quality clinical care. It is proposed to develop this project proposal after aforementioned phased plan for restructuring has been drawn up. That means that it will not be possible to respect the deadlines mentioned in the ARMULOV-scheme.

Furthermore MoH will prepare the installation and mandate of an independent and expert "reviewing committee" (see also "health care cost control" strategy). Said reviewing committee will assess all further proposals for the development of high-quality clinical care (see also strategy 4).

Projects for high-quality clinical care that have already been committed are implemented (see as regards the commitments the LogFrame belonging to this strategy). The reviewing committee mentioned earlier will strictly monitor the implementation with as most important object preventing unnecessary pressure on the government budget.

Process indicators:
- Reviewing committee has been installed;
- Existence of assessed proposals for development high-quality clinical care.

Activities in 2004

Responsible authority	Activity
MoH	(4.1) Workgroup led by MoH formulates project proposal as regards development high-quality clinical care (under ARMULOV-scheme)
Reviewing committee (to be further defined)	(4.2) Concrete proposals for the development of high-quality clinical care are assessed by reviewing committee (see strategy 4)
Reviewing committee	(4.3) Projects already committed as regards high-quality clinical care are implemented and monitored against additional pressure on government budget (see Appendix 6 for list of projects)

4.3. Enhancing financial accessibility of health care services

4.3.1. Background

In addition to efficiency as regards the care services, guaranteeing equity or solidarity is an important objective of the current policy. As far as this is concerned Suriname has a tradition with a relatively extensive arrangement for the poor and near-poor that arranges the access to health care services for the deprived and underprivileged in the community. In implementing the arrangement, the Ministry of Social Affairs is, however, confronted with a number of restrictions. In the past few years said restrictions were examined and documented in a number of studies under the "Studies for Support to Health Sector Reform'-project. On the one hand the formal criteria that are used to determine who is eligible for this arrangement are outdated and new, implicit criteria are often not applied in an unequivocal or transparent manner. As a result thereof it seems that a group of socially marginalized persons does not have proper access to health care. On the other hand a group of people makes use of the arrangement that may be expected to be able to insure or pay for health care independently. Due to the fact that the use of health provisions by the so-called 'cardholders' is not monitored, the expenses for care under this arrangement are very high and not or hardly controllable.
It is known in Suriname that patients beyond the formal arrangement, have to pay additionally to the health care provider to be able to receive the desired care. Although it is difficult to verify these practices, they sometimes seem to hamper the financial access to health care.

4.3.2. Strategy

The long-term objective is guaranteeing the financial access to health care for socially marginalized groups to be determined in a relevant and unequivocal manner. The costs of health care consumption by this group should be closely controlled to curb over- consumption.

4.3.3. Approach

Three operational objectives have been defined to implement this strategy.

Objective 1: the arrangement for the poor and near-poor is more strongly aimed at deprived and underprivileged

On account of the analyses of the use of the arrangement, the Ministry of Social Affairs has kick-started a process to first and foremost improve the access criteria. This process will be continued within the SPG among other things with support from the project 'Support for Implementation of Health Sector Reform'. The aim in this respect is to determine and to apply the access to the arrangement in an equitable, unambiguous and verifiable manner.

On the one hand the number of persons that is unjustifiably classified as poor and near-poor should be lessened, while at the same time the number of poor and near-poor that is unjustifiably excluded from the arrangement should be reduced.

In concrete terms the goal is, within the term of the SPG, to diminish the group of people of substance that is currently needlessly entitled to the arrangement (error type 2) from 36.3% to 5% (Bitran, 2001). The group of poor and near-poor that is not designated as such (error type 1), must be reduced from 22.9% to 10% (idem, 2001). It seems that the savings for public expenditures for unnecessary use of the arrangement should basically be sufficient to cover the additional costs for the desired expansion of the group of poor and near-poor. This operation should basically be implemented in a budget-neutral manner, with basically further savings not seeming to be impossible.

If further savings seem to be possible, then these financial resources may be used within the existing budgetary scope (budget neutral) to offer health care suppliers a better compensation for services rendered to cardholders. In this manner the actual remuneration for the health care supplier for the treatment of a cardholder can be brought more in line with the remuneration for a patient who is e.g. insured with the SZF. A decrease in the difference between compensation by the Ministry of Social Affairs and other financiers for comparable treatments of patients, constitutes an important condition to reduce incentives for improper additional payments. This process may be followed during the implementation of the SPG by annually determining the proportion between the remunerations for comparable production or performance (effective tariff) of various financiers. A roughly formulated final goal of a ratio of about 90% could be kept in mind in this respect.

Indicators:

- Lessening type 1-error (poor and near-poor that are not classified as such) of 22.9% to 10% and lessening type 2-error (cardholders who are unjustifiably classified as poor and near-poor) of 36.3% to 5%;
- All SOZAVO-programs make use of the targeting system.

Activities in 2004

Responsible authority	Activity
Ministry of Social Affairs	(1.2) Continues with process started to implement new poverty criteria. It receives technical and financial support of the IDB under the project "Support for the Implementation of Health Sector Reform".

Objective 2: Improper additional payments of patients to care suppliers are strongly reduced

Improper additional payments are not unfamiliar in the Suriname health system and cannot be cut back all at once. Both cardholders and SZF-patients are confronted with this issue by health care providers. It is

not realistic to presume that within the term of the SPG improper additional payments can be completely phased out. The objective of the SPG is to set a first step in phasing out these improper payments by launching a sector-wide awareness process about the fact that this is undesirable and wrongful.

Initially emphasis is laid on phasing out false additional payments by cardholders and also for SZF-patients. This first group consists of persons of limited means and an additional payment on top of the effective tariffs may hamper their access to health care services. A first step in this direction ensues from the revision of the arrangement for the poor and near-poor. To further phase out the false additional payments in a sector-wide and substantial manner, supplementary initiatives are necessary in the process of which all actors within the sector are appealed to. MoH pursues a policy aimed at promoting professional ethics, compliance with legislation and enhancing adjustments to the curricula of medical programs.
The financiers within health care exercise control and hospitals pursue an active policy whereby it is clear for each party involved that false payments do not constitute part of a normal conduct of business and are not tolerated within the institution.

Indicators:

- Ratio of effective SOZAVO- inpatient accommodation tariff / SZF-tariff increases from x% in 2004 to 90% in 2009;
- Independent and anonymous annual customer survey measures decreasing size and frequency of false payments.

Activities in 2004

Responsible authority	Activity
Hospitals	(2.2) Together with care consumers prior to the end of 2004 put into operation policy for their institutions aimed at countering false payments.
Training institutions	(2.3) Formulate proposals how to adjust curricula for the next study year to pay more attention to legitimacy of providing health care
Financiers	(2.5) Strengthening implementation medical check-ups

Objective 3: Better utilization of possibilities for financial and administrative cooperation between Ministry of Social Affairs and SZF as regards the procurement of care for socially marginalized groups
In the past few years the possibilities have already been examined to make use of the expertise of the SZF in procurement and payment of care by the Ministry of Social Affairs. Possible economies of scale also play a role in the joint implementation.

Up to now these initiatives stuck to the design stage. Both the Ministry of Social Affairs and the SZF have their own ambitions to improve the financial and administrative organization and (medical) control on their expenses independently. With support of aforementioned IDB-project further plans will be developed to commence with the cooperation between the SZF and the Ministry of Social Affairs as regards specific sub-areas.

Indicator:

- Ministry of Social Affairs and SZF cooperate as regards procurement and payment of health care services.

Activities in 2004

Responsible authority	Activity
Ministry of Social Affairs and SZF	(3.1) Start elaboration of possible plans for cooperation as regards sub-areas as formulated under “Support for Implementation to Health Sector Reform” project

4.4. Health care cost control

4.4.1. Background

The results of various surveys show that health care expenditures in Suriname are relatively high measured in share of the GDP (9.4%, NHA 2000) and expressed per capita (US $ 180, idem). (See also chapter 3). Within this relatively big envelope there is only little coordination as regards the public financing of health care. The most important parties in the financing of care do not have a structural cooperation as a result of which providing cost-effective care is also hampered. An important example thereof is the lack of a well-coordinated planning of important investments to expand the supply of health care. Furthermore there are many indications that partly due to the incentives in the current payment systems, many financial resources are spent on the relatively expensive intramural care, while part of these services can be offered in a less expensive manner within a fully fledged primary care.

4.4.2. Strategy

It is possible to make progress as regards the quality of life in Suriname during the coming years, without the need for available funds for health care increasing substantially. In order to achieve this they will strive for controlling the share in the GDP of the costs of health care services. The year 2000 is in this respect used as reference, when the expenditures counted for 8.6% of the GDP. Inclusive of the RLA-scheme, this share then amounted to 9.4%. Within this national envelope the share of the public expenditures will be actively controlled to around 4% of the GDP, with the year 2000 again being the reference.

4.4.3. Approach

Three operational objectives have been formulated under this strategy:

<u>Objective 1: Mixed, performance-dependent payment systems promote an efficient production of care services in both primary and intramural health care.</u>
An important operational objective is accomplishing that in health care mixed and performance-dependent systems of payment are used. This new systematics can enhance an efficient production of care services in both primary and intramural health care. In previous years various surveys were performed into how to improve the existing systems of payment. The results showed that within the sector there is wide-ranging agreement that the current systems of payment need to be adjusted.
In time the success of the measures should become visible in an ongoing decline of the referral percentage of primary care to intramural care, till finally less than ten percent. The mixed nature and performance-orientedness of the systems of payment should then further be reflected in the new contracts that financiers enter into with the health care suppliers.

The systems of payment need to be adjusted in both primary and intramural care. In primary care on the basis of the treatment package developed under strategy 1, the financiers and the MoH will have to work on developing and implementing operational cost prices to which the systems of payment have to be geared. These new systems will reward both performance (quality, production and terms of reference) and enable a transparent and uniform payment. The RGD will develop and implement for its part in primary care, stronger supervision, monitoring and evaluation capacity, with the role of the regions being expanded within a performance framework.

A similar process of activities will be followed for intramural care. On the basis of the treatment package developed under strategy 2, the financiers and the MoH will work on developing and implementing operational cost prices to which the payment systems for intramural care have to be geared. These new systems will reward both performance (quality, production and terms of reference) and enable a transparent and uniform payment.
In order to accelerate payments in the future, the financiers are reviewing the information and invoicing systems in consultation with the hospitals and determine on the basis thereof the necessary improvements for a new standardized system of payment. Hospitals then computerize their invoicing systems on the basis thereof, in the process of which possible assistance in the design and the implementation are taken into consideration.

The SZF continues the course taken to reform itself to an active health care consumer. It implements an Administrative and Management Information System (AMIS) and develops capacity for processing and analysis of the information supplied. In addition the SZF improves contract procedures, develops a quality program and strengthens the medical control service. Expectations are that the SZF, due to its position, can and must play a leading role in the reform of the health care payment systems.

Aforementioned activities comprise important steps to possibly in time come to a General Health Insurance (AZV-Algemene Ziektekosten Verzekering). MoH will closely follow the progress in creating conditions and take charge of an investigation into further development of conditions, a model and a possible implementation process for an AZV. Within such investigation attention will be paid as well to possibilities to improve the financing of among other things uninsurable risks and chronic diseases.

Indicators:

- The percentage of referrals from general practitioner to hospital/specialist drops from >30% in 2004 to less than 10% at the end of 2008;
- Renewed agreements of SZF with health care suppliers are complied with.

Activities in 2004

Responsible authority	Activity
Financiers and MoH	(1.4) Financiers and MoH start the development and implementation of cost prices and gear payment systems thereto on the basis of defined treatment packages for primary and intramural care.
SZF	(1.7) SZF starts the implementation of Administrative and Management Information System (AMIS)
SZF	(1.9) Reform of SZF to an active buyer is continued partly of the basis of project activities under Support to Implementation of Health Sector Reform Project, and strengthening medical control service

<u>Objective 2: Expansions in (intramural) care take place only after the social desirability and the financial feasibility have been weighed explicitly and independently</u>

All proposals for expansion of the nature and size of the supply of intramural care, including high-quality clinical care, shall priorly be submitted to a permanent, independent, reviewing committee. The committee subjects investment proposals to a test with the social desirability and the financial feasibility of the investment being determined systematically. It is not the intention to place all health care supply under full supervision of the government. It is, however, necessary that priorly all parties (MoH, financiers, hospitals, physicians, MvF) jointly assess whether investments in the care are necessary and/or desirable from each perspective and to what extent the costs for the investment and the current costs related thereto will additionally take up (semi)-public funds. This procedure will play an important role to counter unnecessary or less cost-effective expansions. The committee gets mandate, granting it the power to take binding decisions on these investment proposals. An initial impetus for the assessment scope has been further elaborated in Appendix 3. As soon as the Committee has been installed, it will initially engage in further elaborating the assessment criteria. The Committee deals with the proposals that are submitted for the development of high-quality clinical care under Armulov.

Indicators:

- Reviewing committee advises in 2005 on 100% of all major expansions in care supply according to fixed assessment scope;
- Realizations expressed as percentage of the government budgets in health care amount to minimally 97% in 2008.

Activities in 2004
The activities in the first year must focus on making operational the reviewing committee. People have to be sought that have suitable financial and/or medical knowledge, who are objective and avoid possible conflict of interest. At lease one representative of MoH takes a seat on said committee.

Responsible authority	Activity
MoH	(2.1) MoH prepares installation and mandate for an independent, expert Reviewing committee to assess investment proposals in the health sector
Reviewing committee	(2.2 + 2.3) works out assessment criteria, information necessities and assessment procedures and furnishes information to all relevant agencies in which the assessment process is explained
Reviewing committee	(2.4) Committee assesses investment proposals including development under Armulov

Objective 3: Government expenditure on health care is predictable and is coordinated, planned and realized
Public spending on health care is annually coordinated and planned by a formal workgroup chaired by MoH. The most important budget holders are members of this workgroup including representatives of the Ministry of Finance (Inspectors of Social Affairs and MoH, Economic Affairs), the Ministry of Social Affairs and the National Health Insurance Fund. The workgroup meets frequently to inform one another and to coordinate both during the preparation and during the implementation of the budget. Within the workgroup 5 years estimates for the health sector are drawn up and maintained and the debt position of the sector is actively monitored. In time the workgroup will also develop planning standards and indicators that can be used for the allocation of funds in the budget. The workgroup will also be able to contribute to developing the capacity to measure and analyze national spending on health care on the basis of the National Health Accounts-methodology.

As a first step to come to a suitable planning of maintenance and capital investments, MoH in cooperation with GMTD, will make an inventory of all existing infrastructure and medical equipment present in Suriname.

Indicator:
- Debt burden of health care institutions is reduced to about SRD 60 million in January 2004 to maximally SRD 5 million in 2009

Activities in 2004
During the first year the workgroup particularly has an informing function. Each budget holder informs through the workgroup the other budget holders about its most important financial bottlenecks and how the priorities are.

Responsible authority	Activity
MoH	(3.1 + 3.2) Forms and starts permanent workgroup for sector consultation regarding budget, 5 years estimate (inclusive of semi-public funds) and meets minimally once a month
MoH/GMTD	(3.4) Make inventory of all existing infrastructure and medical equipment in Suriname

4.5. Strengthening procurement and logistics, communication infrastructure and information systems

4.5.1. Background

The share of BGVS in the pharmaceutical market dropped to below 50%. Insufficient planning and management of procurement at BGVS on the one hand leads to a shortage of affordable essential medicines and on the other hand to a waste by exceeding expiry dates of redundant stocks (MSH/IDB 2003). Weak structures for procurement and financial management with certain health care institutions are also the cause of the shortages. Quality control and quality assurance of medicines are hampered by a lack of human-power and funds, while the laws and regulations urgently need to be amended (see Strategy 7).

The availability of means of communication and with that the access to information is bad in many places of the sector. There is little coordination as regards prevailing information systems and MoH does not have sufficient capacity for a suitable analysis and reporting of data collected, with consequently feedback being liable to be pushed aside.

4.5.2. Strategy

Support systems for:

- Procurement and logistics (including pharmaceutical supply and other necessities in health care);
- Communication; and
- Information systems (disease surveillance and health services, personnel and financial and administrative services) are strengthened in such manner that health care suppliers can adequately provide health care.

Indicator:

- Satisfaction among the health care suppliers

4.5.3. Approach

Three operational objectives have been formulated and worked out under this strategy:

<u>Objective 1: Health care has at its disposal safe, effective, essential and affordable pharmaceutical and other products, equipment and infrastructure</u>

The Conference on National Medicines Policy (NGB) will have to be preceded by a question round, with an inventory of capacity and funds with the implementing organizations being held. At the conference the NGB with the five-years' program linked thereto, will be discussed and the go-ahead for the implementation will be given. In the NGB, for the following areas, points of interest, objectives and strategies have been formulated:

1) Policy and management;
2) procurement, provisioning and accessibility;
3) quality;
4) rational use.

The IDB supports the strengthening of the Council for Essential Medicines Program (REG) and the registration for medicines, while VWS renders assistance for the restructuring of the Pharmaceutical Inspection. At MoH an expert in the field of pharmaceutical supply and international procurement will be stationed with as the most important tasks:

- coordinating the NGB-program;
- formulating procurement guidelines for the sector and conducting procurement trainings;
- directing procurement within the various projects (annual portfolio of about 10 million Euro) and pooling where possible; and
- rendering assistance in improving the procurement at the BGVS.

Anticipating the appointment of this expert, a short mission will set up the BGVS procurement planning system, including procedures linked thereto. In order to restore the administrative organization of the

BGVS, the Minister will install a new Board of Supervisory Directors consisting of experts (pharmacist, economist, business manager, physician and jurist). This new Board of Supervisory Directors will have as its policy assignment within half a year to solve the management problems, commencing with the reorganization of the procurement and indicating a course for reorganization of the production and further hiving-off and/or privatization of the BGVS.

The managing directors of the hospitals that are on the board of the Stichting Techniek in de Gezondheidszorg [Foundation for Technology in Health Care (STG)] will for the destitute 'Gemeenschappelijke Medische Dienst' [Communal Medical Service(GMTD)] indicate a course that may vary from selling to privatizing.

Finally the MoH will examine the possibility (including cost-effectiveness) to accommodate a medicines lab with the new construction project of the Central Lab. With this the lab in the BGVS can be discontinued. Transfer of the three analysts who work there may then be taken into consideration.

Activities in 2004

Responsible authority	Activities
REG	(1.1) Organization of a national conference where the National Medicines Policy (NGB) with the program linked thereto (see below) are discussed and the go-ahead for implementation is given; costs: Euro 4,000
MoH	(1.2) Appointment Expert procurement and logistics: costs: Euro 50,000
MoH	(1.4) Recovery administrative organization BGVS
MoH	(1.8) Investigation into the existing cost-effective option to integrate medicines lab in Central Lab

Indicator:

- Percentage tracer medicines available (in other words > 1 month consumption) with BGVS and in pharmacies.

Objective 2: MoH has at its disposal an adequate communication infrastructure (telephone, computer, Internet connection) to facilitate the communication with other actors.

MoH will ask a local expert in the field of communication-infrastructure to make an inventory of the current equipment at the ministry, including the state of the equipment and the need for equipment. On the basis thereof the expert will draw up an implementation plan, after which MoH can proceed to implementation.

Activities in 2004

Responsible authority	Activity
MoH	(2.1) Development plan for improvement of the infrastructure for internal and external communication. Costs 2004: Euro 10,000

Indicator:

- High staff executives of MoH have access to Internet.

Objective 3: Both MoH and the implementing institutions use vital information for monitoring and evaluation, planning, management and policy purposes

The investigation held in 2002 into existing National Health Information System (NHIS)-systems and the work as regards preparations for an NHIS will be actualized and further completed. On the basis thereof a development plan will be drawn up in which among other things steps for strengthening, standardization and coordination of various information systems for public health (HIS), financial and administrative (FIS) and in the field of human resources (PIS) will be indicated. Point of departure is that at local level relevant

information can be gathered systematically on the basis of which the local health care policy can be assessed and tuned and mutual achievements can be compared. In doing so use should be made of simple and cost-effective instruments and solutions. MoH will together with BOG play a coordinating role.

Activities in 2004

Responsible authority	Activity
MoH	(3.1 – 3.2) Actualization of the investigation performed in June 2002 into existing NHIS-systems (NHIS assessment report) and formulation of plan. Costs 2004: Euro 30,000 (external mission HMIS-expert)

Indicators:

- The existence and the use of a set of sector-wide indicators (input, process, output);
- Percentage of area teams that uses locally systematically gathered information for planning and management.

4.6. Planning and development of human resources

4.6.1. Background

There is a great need within health care for good qualified personnel. Although the number of physicians is within the WHO-norm (1 on 2000) there are shortages as regards certain categories of paramedics, such as environmental inspectors, pharmacist's assistants, lab-assistants, nurses and midwives in the periphery. There are not only deficiencies on the 'production side' – training paramedics and specialists – but there is also a brain drain of well-educated professionals. In the field of management and financial administration there is/are insufficient know-how and skills. The number of expert managers is not enough and current vacancies are either not filled or with great delay. This has a stagnating impact on the implementation of the policy, particularly where the final responsibility is increasingly placed with the implementing agencies. As regards the formal training of paramedical staff we may state that this is disintegrated and consequently not very efficient. The trainings for physicians and physical therapists by the Medical Faculty of Suriname, are running smoothly though, and strive for Dutch standards. The public health expertise among the general practitioners and nurses, however, is still not enough. In view of the expansion of primary care aimed at and the active roles of the general practitioner and nurses in prevention and public health, an active policy as regards extra training seems to be imperative. In the health care there are finally sharp contrasts between the employment conditions. On the one hand some specialists earn more than 'European' incomes, while on the other hand workers in health care can hardly make both ends meet.

An adequate, strongly established, urgent human resource development tailored to the acute needs, is a crucial precondition for a proper implementation of the SPG. Up to now no serious study has been performed into the field of human resources and no adequate human resources development plan has been drawn up.

4.6.2. Strategy

The anticipated result of this strategy has been formulated as follows: "Personnel together with the necessary infrastructure and means ensure that health care can be provided in an adequate manner. Sufficiently qualified, expert and motivated personnel will be aimed at."

4.6.3. Approach

Four operational objectives have been formulated under this strategy:

<u>Objective 1: A plan for the development of human resources is being implemented</u>
<u>MoH will invite local experts to execute a sector-wide study. Expectations in this respect are that in any case</u> the following questions are answered:

1) What are the current human resources in the sector?
2) What is the distribution according to age and sex?

3) What is the educational level and experience?
4) What are the employment conditions and what is their proportion with equivalent positions in the public and the private sector?
5) What kinds of trainings are there and what are the capacity and the quality?
6) What is the need for qualified workers in the sector and what is the ratio to the available human resources?
7) What steps can be taken to obtain the necessary human resources and keep these up to standard in a sustainable manner?

Use can be made of reports and recent studies, such as within the framework of PSR and the various project proposals. Expectations are that the results will constitute the basis for a 5 years human resources development plan. This plan will indicate the steps for the years 2005-2009 to:

1) gear the capacity and the quality of the trainings to the need, including provisions for refresher training and distance learning and sending out abroad;
2) define employment services while aiming at making these as uniform as possible for equivalent positions and responsibilities; and
3) where necessary, develop sound organizational structures and job descriptions.

Indicator:

- Percentage of staff present compared to the norms set in the Human Resources Development Plan

Activities in 2004:

Responsible authority	Activity
MoH in consultation with health care suppliers	(1.1) Start sector-wide inventory of present and necessary human resources

<u>Objective 2: Capacity and contents of the trainings are tuned to the needs and feasibility</u>
Basically the activities to tune capacity and contents of the trainings to the needs and feasibility, will follow the human resources development plan five years.
Expectations are that with a small expansion of the COVAB (estimated costs US $ 200,000) extra and refresher trainings of paramedics can be accommodated here. The idea to accommodate one training for paramedics with the COVAB, seems too far- fetched. MoH will reactivate the training for midwives. In this stage also assistant-midwives will be trained. On the longer term this medical training will be accommodated with the MKZ-Center to be established. MoH will, however, as is anticipated, revise the curricula and training modalities of environmental inspectors, inspectors and pharmacist's assistants. Within the framework of the necessity of strengthening the role of general practitioners in primary health care, MoH will together with VMS and FMeW already this year make preparations for the refresher trainings of general practitioners (partly in view of the introduction of the reregistration system), anticipating the introduction of the new physicians' curriculum in which the start for a formal general practitioner's training can only be expected in 2010. FMeW also has plans to expand the modules as regards epidemiology and statistics this year.

Indicators:

- Percentage general practitioners compared to the norms set in the Human Resources Development plan

Activities in 2004

Responsible authority	Activity
MoH together with VMS and FMeW	(2.2) Define refresher course package for general practitioners (anticipating the introduction of the formal general practitioners' training in 2010), one thing and the other in view of introduction reregistration system. Costs: Euro 20,000

FMeW	(2.5) Start revision curriculum epidemiology/statistics. Costs: Euro 20,000

Objective 3: Public health expertise and management skills are strengthened

Quick recruiting of students for nursing and obstetrics is imperative. With the coming of equipment and the renovation of clinics it is important to obtain the necessary human resources. Information and public health will get extra attention to strengthen primary health care and prevention. These areas are also fully focused on by various development partners. It may be taken into consideration to combine the trainings for public health and management skills (inclusive of trainings of trainers) that are planned in various current projects or those in the pipeline with the BOG, RGD and MZ/PHC and to invite guest trainers to that effect. In this manner more attention can be given to matters that specifically concern Suriname. In the same manner FMeW can conduct the refresher course for general practitioners in the form of a course 'district health care' (according to the example of one-month courses of well known public health schools). We propose to conduct the first 'district health care course' in 2004.

Indicator:

- Percentage high-level officers at BOG, RGD and MZ with post-graduate public health / training information science.

Activities in 2004

Responsible authority	Activity
RGD	(3.1) Recruits candidates for training obstetrics and MGZ nurses (additional to normal inflow). Costs: Euro 125,000
BOG	(3.4) Recruits candidates for nurses training MGZ. Costs: Euro 50,000
BOG	(3.5) In cooperation with the Anton de Kom University sending out of 2 high-level officers for post-graduate MPH (public health). Costs: Euro 50,000
BOG	(3.6) Sending out of 2 high-level officers for post-graduate (health information science). Costs: Euro 50,000.

Objective 4: Employment conditions of staff, inclusive of government staff are in line with the market

Everyone agrees that due to the distorted ratios in the remuneration of qualified personnel in health care, positive developments in the sector are gravely stagnated. Without expert personnel at MoH it will not be possible to implement the SPG. Therefore in recruiting and maintaining selected experts at key positions, the study for the human resources development plan cannot be awaited and a modus will have to be found to remunerate them better on conditions than possible within the administrative structures. In this respect key positions at MoH itself and the BOG come to mind. At all times sustainability, legal possibilities and harmonization with the Public Sector Reform (PSR) will have to be aimed at.

Recent experiences have shown that hiring and maintaining qualified personnel in government service constitutes an important bottleneck. Nevertheless it seems that in the sphere of fringe benefits on the short term a number of possibilities seem to occur to remunerate certain achievements additionally. In this respect the purchase of computers, foreign trainings, transport allowance, entertainment allowance or the right to 'sabbatical leave' in the future come to mind.

On the mid-term, however, more structural measures are necessary to address the existing problem as regards employment conditions. Pending the result of the PSR, MoH will in the course of 2004 take the following measures:

1) Determine which capacity is actually necessary to be able to carry out the core tasks of the MoH;
2) Compose a new personnel formation;

3) Introduce a 'performance-oriented' remuneration system for all workers under the new personnel formation of the Central Office;
4) Examine within the donor community the willingness for financial contribution to a fund from which proposed 'performance-oriented' remunerations can be financed;
5) Eliminate the existing distinction between donor projects and instead draw up uniform remuneration guidelines.

In addition to the expansion of the existing personnel formation of MoH, it is also deemed necessary to hire a number of (international) experts on a temporary basis. For 2004 the need for external assistance has been identified as follows:

- (hospital) management expert;
- financial (management) expert;
- procurement and logistics expert;
- health management information expert;
- public health expert;
- operational management expert.

For each of these (advisory)tasks specific terms of reference will be drawn up. Recruitment will take place on the basis of limited (international) invitation to tender.

Activities in 2004

Responsible authority	Activity
MoH and development partners	(4.2) Introduction of topping up salaries in hiring and maintaining selected experts at key positions at the Central Office of MoH, in anticipation of public sector reform

4.7. Improving and assuring quality

4.7.1. Background

The field of medical professionals in Suriname acknowledges the importance of effective, accessible and patient-oriented health care services. With the exception of the nursing profession and the medical mission, there are no adequate systems that systematically monitor and help improve the quality of medical care. Most professionals have not followed a separate training in the field of quality assurance and discussing medical errors or shortcomings is not self-evident. In addition there are no effective national inspection systems that control the quality of health care. The laws and regulations to monitor quality consist partly, but the Ministry of Public Health does not have the capacity or human-power to enforce the laws. Improvement of quality is within the field of health care often initially seen as the task and the responsibility of the government. Although the government plays an essential role in maintaining and improving quality, there seems to be only a limited awareness as regards the possibilities that actors and professional groups have to independently work on quality.

4.7.2. Strategy

The anticipated result of this strategy is that by developing an effective quality system, the quality and patient-orientedness in health care will be improved.

4.7.3. Approach

Five separate operational objectives have been formulated under this strategy:

<u>Objective 1: MoH performs its tasks as regards supervision, inspection and regulations</u>
The recommendations of the IDB-study 8 were for the greater part incorporated in the approach of this strategy. MoH starts with the establishment of a Steering Group Quality Policy, consisting of representatives of patients, financiers, institutions and health care providers. This Steering Group formulates a practical policy document and a program and five-years' objectives linked thereto (by making

use of IDB-study 8). In addition the initiatives that have been kick-started to strengthen the inspection, are continued. Expectations are that in addition to the nursing inspector, the positions for medical and pharmaceutical inspector are effectively filled. Where necessary the legislation will be amended (see also chapter 5). Within the framework of the quality, priority is given to the law on professions in health care (finalization BIG act) and the medicines act.

Indicators:

- Inspection of MoH is functional;
- Relevant legislation as regards quality is modernized (see chapter 'management of the sector')

Activities in 2004

Responsible authority	Activity
MoH	(1.1) Steering group quality policy is installed
MoH	(1.3) MoH hires staff to strengthen the inspection

Objective 2: At institutional level quality policy is developed and implemented

In anticipation of the results of the Quality Steering Group simple measures are taken that can increase the quality of the services, such as establishing complaint offices and necrology talks and papers. The IDB-program 'Support the Implementation for the Health Reforms' contains a range of measures for primary care, particularly RGD and MZ/PCH to improve quality assurance. In-service training of paramedics and non-medical personnel, and refresher courses of doctors will contain modules as regards the treatment of consumers/patients (see strategy HRD).

Indicator:

- Complaints offices operational

Activities in 2004

Responsible authority	Activity
Hospitals	(2.1) Start of practical quality-promoting activities
Hospitals, primary health care suppliers and health care consumers	(2.2) Installation complaints committees for the registration and handling of complaints

Objective 3: The professional groups play an active role in the promotion of quality in health care

The Association of Doctors (Vereniging van Medici –VMS-) in close cooperation with MoH, develops and implements a system of reregistration (and refresher courses) for health care providers and revitalizes the visitation committee of the Specialists Registration Committee (SRC). The VMS continues the development of protocols and standards, among other things in cooperation with sub-departments of KNMG and with the Caribbean Medical Council (CAMC)

Indicator:

- Visitation mechanisms functional

Activities in 2004

Responsible authority	Activity
MoH	(3.3) Continues the development of protocols and standards among other things in cooperation with the sub-departments of KNMG and with the Caribbean Medical Council (CAMC). Costs: SRD 150,000 (Additional budget)

Objective 4: The financiers, inclusive of SOZAVO, have developed effective mechanisms to promote health care quality

The care consumers expand the agreements with health care providers about quality supply. Protocols and standards will be the basis thereof. SOZAVO coordinates with SZF about cooperation as regards establishing and effectuating a Medical Control Service.

Indicator:

- Regular presentation of 'mirror data' by SZF and other care consumers.

Activities in 2004

Responsible authority	Activity
SZF	(4.1) Continuation discussions on relations for agreements on quality to be incorporated in contracts with service providers
SZF and SOZAVO	(4.2) Continuation discussions about partnership with regard to establishing and effectuating a Medical Control Service

Objective 5: The consumer / patient increasingly plays a role in enforcing quality

MoH will encourage the improvement of the awareness of patients. This will partly be done by information as part of the communication strategy with respect to the SPG (see chapter 5) and by support of patient organizations in cooperation with health care consumers.

Activities in 2004

Responsible authority	Activity
MoH	(5.1) Starts information activities about the right use of health services and about rights of patients (as part of the MoH communication system as regards SPG, supported by PAHO); Costs: Euro 10,000 (IDB-project)

5. ADMINISTRATION, ORGANISATION AND MANAGEMENT OF THE SECTOR

An important condition for an adequate implementation of the SPG is a strong management of the sector. The Ministry of Public Health will need to play a central and leading role by particularly aiming at policy formulation, regulations, coordination and supervision. Important aspects of the administration, organization and management of the sector are among other things:

1) the role of MoH;
2) the management responsibilities of implementing bodies;
3) the laws and regulations;
4) the intra and intersectoral communication;
5) the planning and management;
6) the communication (internal and external);
7) the coordination of external support with the SPG; and
8) a sector-wide and participative Monitoring and Evaluation.

5.1. Background

Within the framework of the MOP the aim is to have the MoH play a stronger role in the field of policy formulation, laws and regulations, coordination and control. Implementation of policy and the rendering of services are left to other actors within the health care sector. Non-core tasks will gradually be hived off and accommodated with private institutions, NGO's and the business community. The Central Office will have to play a more initiating, coordinating and steering role within the sector. By this changing role of the Central Office of MoH other and higher demands will be set as regards its management capacity. In order to fulfill said role properly, restructuring of the Central Office is a must.

In addition to strengthening the Central Office, disintegration within the sector will have to be curbed in all kinds of other areas. The sector is characterized by a big variety of government agencies, private institutions, non-governmental organizations (NGO's), national and international development organizations, which are engaged in the financing and/or implementation of health care. Consequently there is a system that is both complex and difficult to manage.
In the first place a better distinction should be made between the responsibilities of the government for policy, legislation and supervising on the one hand, and the executive responsibilities of the institutions on the other hand. Also the structural and constructive role that the Public Private Partnerships will be able to play, deserves more attention within the sector. Another point of attention concerns streamlining the current parallel mostly project-bound procedures and structures for both planning and management, but also for Monitoring and Evaluation (M&E). The management, monitoring and executive responsibilities of externally financed projects and programs are arranged differently. Composing an overall overview of the scope of the external assistance has been realized only recently. The volume of external support will considerably increase during the coming years. Under the current circumstances there is insufficient absorption capacity to integrate these external, disintegrated initiatives within the SPG and to give shape to the management and control in an effective manner. Streamlining the planning cycle will therefore get the necessary attention.

Managers within the sector are still insufficiently familiar with the systematics and the points of departure that must be used in drawing up work plans, budgets and (substantial and financial) progress reports. Agreements in pursuance of the articles of association about timely reports are still insufficiently complied with.

In addition there are still no mechanisms to uniform M&E according to the principles of the sector approach: the gradual replacement of project-bound evaluation by a process of regular sector-wide and joint (in other words with the participation of the various stakeholders, including the external partners) reviews of the entire sector.

The current laws and regulations fail in some respects. In this first 5 years SPG emphasis is laid on the legislation that needs revision within short time. The sector currently has a system of laws and regulations that is among other things related to the professions in health care, medicines, regional health care, vaccination, foodstuff, hospital care and medical costs. A number of state decrees, resolutions and decisions are based on these laws. There is currently no clear statutory provision as regards health care for the poor and near-poor. It is also necessary to adjust the legislation as regards (new) professions and medicines. In chapter four this has already been mentioned indirectly.
On the other hand the care of people who are insured under the health insurance fund does have a clear legal basis (more in particular Decree C-8, 1980, no 120). As far as the health insurance fund is concerned there is a clear role division between the Minister and the SZF. The SZF is responsible for determining the health insurance fund package (the rights), setting the contribution and the negotiations on the agreements and rates. The Minister is authorized to expand the circle of insured and through the approval policy, exercise influence on the package and the setting of the contribution. If negotiations between SZF and service providers would reach deadlock, the Minister is then able through guidelines to indicate which direction he favors as regards the contents of the agreements (and rates). Also about cooperation of service providers to prevention activities, good quality of the provision of care services and avoiding unnecessary costs, additional conditions could be laid down and agreements made through the financing instruments (direct financing by the State of health care to the poor and near-poor; agreements between SZF and service providers). The currently applicable legal framework contains sufficient possibilities to strive for realization of last-mentioned objectives.

At policy level, in addition to MoH also various other ministries are involved in health promotion. The importance of strengthening cooperation between sectors and ministries at all levels for health promotion has already been mentioned in this plan. Within the sector there is furthermore a large number of private companies and institutions engaged in strengthening health care. Within the health care sector and within the institutions involved therein, there still is insufficient exchange of knowledge and experiences. 'Communication' seems to have been neglected in any case. The Ministry of Public Health itself could be more pro-active as regards public relations. The same applies to general health information but also to internal and external communication. In addition to the fact that as a result the involvement of the public in health care issues would probably increase substantially, a good press and communication policy can at the same time eliminate possible misunderstandings (about the use of health care; about the SPG, etc.).

5.2. Strategy

In order to make proper progress with the general development objective of the SPG, it is of crucial importance – in addition to the seven strategies – to strengthen the general administration operations and organization as well as the management of the sector. This will be substantiated by taking specific measures as regards aforesaid eight points for attention.

5.3. Approach

Eight objectives have been identified to actually improve the administration and organization of the sector:

<u>Objective 1: The Central Office of MoH will play a leading, initiating, coordinating and steering role within the sector.</u>
Point of departure is that the specific objectives of MoH and the positions of the various under-directorates derived therefrom, are clearly established. In addition the internal management responsibilities, directing, decision-making and consultative structures will be further elaborated.
During the term of the SPG a modified organization structure for the Central Office will be aimed at. The Central Office will consist of the following three under-directorates, more in particular:

- the under-directorate Planning, Monitoring and Evaluation;
- the under-directorate Budgetary and Economic Affairs;
- the under-directorate Central Administrative Services.

Furthermore the Inspection (medical; nursing; pharmaceutical) will be part of the Central Office.

Each of these under-directorates will be directed by an assistant manager, who together with the permanent secretary of Public Health will constitute the Management Team (MT). The MT ensures a proper internal coordination of the activities.
The under-directorate "Planning, Monitoring and Evaluation" will consist of ten officers. These will be engaged in the (policy) support in the field of primary care, hospital care, pharmaceutical supplies, human resources development, management information, research and the general (contractual) management of externally financed projects. From this under-directorate all externally financed projects and programs will be coordinated. The project coordinators that are currently still involved in the execution of externally financed projects (UNFPA, UNICEF, IDB, treaty funds) will in the future report to the DMoH through the assistant manager. In time it is advisable to entirely integrate these workers within the under-directorate Planning, Monitoring and Evaluation. During the term of the SPG it might be examined to what extent the Project Implementation Unit that is established in the course of 2004 within the framework of the IDB-project, could also perform support activities for other externally financed projects. In order to further strengthen the planning function of MoH, also the 'External Relations' assistant will be added to the under-directorate Planning, Coordination and Evaluation.

The newly to be established under-directorate "Budget affairs" will be strengthened with at least five experts in health care financing and economics. This directorate is assigned the task to render assistance and to develop policies as regards financial (sector) planning, analysis, budget monitoring and performing financial feasibility studies.

The already existing under-directorate "Central and Administrative Services" (consisting of the sub-divisions Human Resources, Financial Affairs, General Affairs, Housing and the Technical Services and the Agenda) remains largely the same within the new structure. The support administrative tasks that this under-directorate still performs for the (semi) governmental health institutions will gradually be transferred to the institutions themselves.

In addition to aforesaid line departments, at central level three units will be accommodated, more in particular Legal Affairs, Communication and Internal Audit.

With the formation of the three under-directorates it may be expected that the permanent secretary of Public Health will increasingly be engaged in policy development and internal coordination. The permanent secretary of Public Health will in the future have to ensure that the activities of the respective under-directorates are as far as possible geared to one another and that the coordination within the sector is further improved.

Within short the tasks and functions of the under-directorate and its workers will be described and formally laid down. Thereafter a training program will commence, with middle and high executives of the Central Office being made familiar with matters such as planning, (personnel) management, (financial) management and team building.

Except for the officer in charge of hospital care for which probably external recruitment will be necessary, the proposed new formation will for a substantial part be filled by experts already present within the Ministry and the sector. In consultation with the development partners concerned (IDB, UNICEF, UNFPA) it will be examined to what extent their project staff can be more involved in the regular activities of MoH.

Aforesaid change process will entail the necessary extra work, including drawing up new job profiles, establishing planning, management, coordination and consultation structures and organizing on-the-job training. Furthermore, in the course of 2004, MoH will be confronted with the start of a number of extensive programs. For said reason for a period of minimally two years, an expert with operational management experience will be added to the Management Team. This expert will be financed at the expense of the project "Institutional Strengthening of MoH".

Pending the result of the PSR, (temporary) measures have to be taken to come to an improvement of the employment circumstances and conditions of officers who fulfill a strategic role in the process of change of the MoH. It is desirable that the top of the Ministry will enter into consultations within short with the Ministry of Home Affairs and the most important development partners. In case it is not possible to successfully effectuate these temporary measures, implementation of the SPG will be unacceptably pressurized.

Indicators:

- Functional MT (staffing; routine consultations);
- Number of highly qualified staff employed with MoH/Central Office;
- Functional Medical, Pharmaceutical and Nursing Inspection (staffing; supervisory activities).

Activities in 2004

Responsible authority	Activity
MT	Drawing up a work plan for 2005
Minister	Appointing responsible managers and officers for each of the service components
DMoH/ODA/PZ	Drawing up job descriptions for all employees of the Central Office and establishing a personnel data file for the Central Office
DMoH/OD-PL/ODA	Developing and causing to have a management training conducted for all heads of departments
DMoH/ODA	Improving the office space of the various under-directorates and purchasing new office equipment
OD-PL	Developing a data file for externally financed projects and programs
DMoH/MT	Conducting structured progress consultations with development partners about future embedding of activities in SPG
MT	Preparing and implementing an annual review of the SPG
DMoH/Communication assistant/PAHO	Developing a communication strategy and plan
Minister	Consultation with Biza and donor community about improvement employment conditions key officers MoH

Objective 2: Management Responsibilities of implementing bodies are clearly defined and properly geared to one another

To come to an effective allocation of tasks, jobs and responsibilities of the various actors within the sector (particularly health care consumers and health care facilitators) will be clearly defined and geared to one another. Institutions that up to now had a (semi)government status, will be further hived off and get result-responsibility within the frameworks agreed with MoH to that effect. MoH and parties concerned will make formal agreements about mutual (management) responsibilities.

In addition MoH will pursue an active policy to more actively involve the business community and private agencies in the implementation of certain policy components, more in particular where primary care and the (formal) participation of the social midfield in task forces are concerned.

The AZP, 's Lands Hospitaal, SZN and the Psychiatric Center Suriname will on the mid-term develop into independent organizations with their own administrative, management and budgetary responsibilities. The public health responsibilities of the Dermatological Service (i.c. the coordination of the national SOI/HIV/AIDS program) will be integrated within the BOG.

Each of these institutions will in the course of 2004 draw up a business plan that will indicate which activities will be developed in the coming years, which resources are necessary for that purpose and how these will be financed. Approved business plans will constitute the basis for result-oriented (cooperation) agreements with MoH.

Indicators:

- Number of government institutions with a semi-autonomous status;
- Number of business plans versus the planned number;
- Percentage of institutions with a clearly defined mandate.

Activities in 2004

Responsible authority	Activity
AZP, LH, SZN, PSC, BOG	Developing an integral business plan 2005-2008
Minister, Management Institutions	Establishing a phased plan with regard to the further hiving off process of institutions concerned
Management institutions/MoH	Introducing and conducting structured periodic progress consultation between MoH and Institutions
Management institutions	Drawing up the report of the management over 2004

Objective 3: Laws and regulations are sufficiently adjusted and the quality of the supervision has been improved

During the term of the SPG it will be examined to what extent the current legislation offers judicial scope to realize the policy intentions. The judicial assessment will have to examine at which level (through measures of the Minister, or through agreements between SZF and service providers) policy can best be implemented. Formally the government has in the current (legal) situation the least possibilities to exercise influence on the privately financed health care. There are, however, no obstacles with regard to consultation between the public financiers and the private financiers about matters of common interest. Consultation is possible about a basic package of care that can be introduced sector-wide. In order to enforce the desired policy, as far as the health insurance is concerned, for the short term nevertheless some adjustments to Decree C-8 can be taken into consideration. The obligation to enter into an agreement still applies as regards all service providers and service providing agencies. Amending the contracting obligation should be taken into consideration. When sufficient care has been contracted, the health insurance fund could stop entering into further contracts. If the automatism with which contracts are entered into is cut across, this may favorably affect the willingness of service providers to make agreements about quality and efficiency of care services. When the instrument of the 'guideline' as regards the contents of the agreements to be entered into does not suffice to achieve adequate agreements and tariffs, then a more thorough controlling authority of the government as regards particularly the tariffs, is taken into consideration.

For the shorter term priority will be given to modernizing the legislation as regards professions and medicines. Furthermore the preliminary act on professions will be completed and submitted for approval to the competent authorities. By means of a cooperation agreement between MoH and the Dutch Ministry of VWS, further technical assistance will be rendered to the Legal Affairs Department of MoH and initiatives will be taken to improve the quality of the workers within this division. It will be stimulated to include the subject health law in the curriculum of the faculty of law and/or the medical faculty of the Anton de Kom University.

Indicators:

- Amended laws and regulations;
- Legal capacity at MoH (staffing; training/additional training).

Activities in 2004

Responsible authority	Activity
Legal department in cooperation with VWS	Legal analysis into the possibility to realize desired health care policy within the current legal frameworks and regulations

Legal department /VWS	Start modernizing Medicines legislation
Minister/SZF/Legal department	Introducing restricted amendments to the decree as regards the SZF (obligation to enter into a contract)
DMoH/Legal department/VWS	Drawing up mid-term planning for legislation program

Objective 4: Intra and intersectoral cooperation are effective

The coming period the management within the sector will be improved by establishing more structure in the policy consultation between ministries involved. Furthermore more systematic exchange of information and knowledge between MoH and the various implementing bodies and between these organizations mutually, will be aimed at.

During the term of the SPG the tasks, functions and responsibilities of the various actors that are involved in health care promotion / (both within and outside the health care sector) will be better defined and the consultation at policy and executive level will be better structured.

In order to also better substantiate the intrasectoral cooperation, board members of institutions and managers will be trained in (multi-stakeholder) planning, management and communication.

MoH will annually organize a sector review, with all parties concerned being informed about the progress within the sector and having the opportunity to exchange thoughts with each other about subjects of common interest, such as e.g. the development of the health status of the Suriname population.

Indicators:

- Numbers of formal sessions between ministries about promoting health status;
- Idem; at lower level between cooperating institutions, businesses, etc.

Activities in 2004

Responsible authority	Activity
Minister	Periodic progress consultation between MoH and the professional groups

Objective 5: Planning, budgetary and reporting procedures within the sector are unequivocal and well-coordinated

Within the sector uniform guidelines are developed for integral planning, management and reporting. The planning system will be improved and responsible managers will be trained in the use of newly issued guidelines for planning, management and monitoring. In addition, within the under-directorate budget affairs of MoH, the control of timely submitting progress reports, annual plans and audits will be structurally improved.

The Ministry of Finance, MoH and the managing directors of the various institutions, will mutually enter into agreements about a planning and budget cycle for the sector. Within each of these organizations budgetees will be appointed that bear responsibility for drawing up the annual budget, monitoring the expenditures and for the financial reporting. This group will cooperate intensively with and receive technical assistance from the under-directorate “budget affairs” of MoH.

Indicators:

- The use of uniform procedures for planning, management and monitoring by the managers of the implementing agencies;
- Efficiency of reporting (e.g. percentage institutions with an annual report).

Activities in 2004

Responsible authority	Activities
OD PL/OD-F	Ensuring participation of all budgetees within the sector in the course “budget planning” organized by the Ministry of Finance
OD PL/OD-F	Making an inventory of planning and reporting systems and procedures that are being used within

	the sector

Objective 6: Internal and external communication are improved

With the start of the SPG and the new policy points of departure related thereto, the importance of good communication from the central government is strongly increasing. That is why both external (within the sector) and internal (within MoH) communication will be given high priority. The specific means and channels that will be used in this respect are laid down in a strategic communication plan with linked thereto a concrete work plan for the first year.

Recent experience in drawing up the SPG has shown that good communication is an important condition for a certain type of activity to succeed. During the preparation and effectuation of this plan all parties involved were after all regularly and in different manners (folders and brochures, articles in the press, radio and T.V. workshops and conferences) informed about the progress. This line will from now on be maintained and strengthened. With the coming of a communication assistant within MoH, the technical assistance of PAHO related thereto and support from VWS, within the foreseeable a communication strategy will be drawn up. The institutions concerned will be actively involved therein.

Indicators:

- Existence and adequate implementation of a communication plan;
- Extent of knowledge under health care workers and public about specific subjects that are explained with the implementation of the communication plan.

Activities in 2004

Responsible authority	Activity
Minister/DMoH/Communication assistant	Regular press releases and newsletters about further course and start SPG
MT/communication assistant/ those responsible for the sector	Formulation of a communication strategy and plan

Objective 7: External support is optimally fit in within the 5 years SPG and external partners are involved in joint sector-wide reviews

The SPG among other things aims at gradually integrating existing initiatives of (inter)national development partners within the SPG and achieving a uniform and integral planning, (financial) management and control system for the entire sector. Applications for new projects will in the future be tested against the SPG and submitted for approval to the ministries of Finance and Planning and Development Cooperation. From now on the budget of institutions will indicate which activities are financed from external sources. The ministries of PLOS, Finance and Public Health have meanwhile developed a mechanism to link external money flows to the government development budget. Reports about externally financed projects will in the future constitute a regular part of the planning and budget cycle effective within the sector.

MoH will play an important leading role in the donor coordination. Various instruments are available for those purposes, such as the annual joint review (see below).

Indicators:

- Existence of an up-to-date overview of all externally financed projects;
- Existence and use of guidelines for preparation and assessment of projects;

Activities in 2004

Responsible authority	Activity
OD PL	Establishing a data file for externally financed projects and programs
OD PL	Drawing up uniform guidelines for the preparation of new projects
MT	Testing new projects against the SPG

Objective 8: A system of sector-wide and participatory 'Monitoring and Evaluation' is operational

The SPG will be evaluated annually by means of a so-called joint review. This process as regards to which other countries have already gained experience with a sector approach in the health care sector, will be organized by the MT of MoH, in cooperation with the actors involved in the sector. In December 2004, the first annual joint review will take place. As far as the preparation is concerned, MoH will, if necessary, apply for assistance of independent empirical experts. The first review will still be internal and will give all development partners and stakeholders the opportunity to report on the activities of the past period and to share experiences with the sectoral approach. This meeting will also give the opportunity to adjust the SPG where necessary. E.g. the relevance and operational capacity of the sector-wide process indicators included in this SPG (see for this purpose also the LogFrames in Appendix 1) need to be further analyzed. One of the most important findings of the first joint review is therefore a clear set of indicators agreed upon, for which also the necessary baseline values have been gathered.

In time it is expected that the monitoring of the SPG will develop to one unequivocal system in the process of which the nature, scope and method of monitoring meet the information needs of the various parties involved. The implementation of the monitoring and evaluation can then take place jointly by sharing and making available the necessary means for one another.

Cooperation in the implementation of monitoring and evaluation may be started with at an early stage by coordinating existing or anticipated project monitoring.

Indicators:

- Quality perceived (by MoH, by partners) of the first annual review;
- Sector-wide indicators with related baseline information are agreed upon and are monitored.

Activities in 2004

Responsible authority	Activity
OD PL	Adjusting the existing set of indicators of the SPG

6. FINANCIAL RESOURCES AND ALLOCATION

6.1. Sources and assumptions

The points of departure of this SPG and the further elaboration in the strategies emphasize the possibilities to achieve better results in the health sector, without deploying many additional funds during the term of the sector plan. In the further application, in practice of this point of departure the outcomes of the most recent, complete overview of the financing of health care, the 2000 National Health Accounts, have been taken as reference. The target figure e.g. for establishing the upper limit for the total expenditures for health care are directly deduced from the total expenditures for health care in the year 2000. The total health care expenditures (inclusive of the RLA-scheme) expressed in percentage of the GDP then amounted to 9.4%. These expenditures comprise all public and private expenditures in health care and may therefore only be used as a target number for the cost control as the private expenditures are not directly controllable. The public funds (expenditures by various ministries from government budget) and semi-public funds, the National Health Insurance Fund, are basically controllable. The point of reference for these expenditures in the year 2000 is around 4% of the GDP.

The data from the year 2000 for the public and semi-public expenses were where possible supplemented by more recent data. The reliability of these data is not always equally high, because payments sometimes actually take place after years. Within the cash system of the government from year to year this leads to big fluctuations.

For the projection of the available funds in health care during the term of this sector plan, use was made of a top-down computation on the basis of a prediction published by the IMF in 2003 of the most important macro-economic indicators for the years 2004-2008. The most important suppositions therein are:

- The Suriname economy grows in both 2004 and 2005 with about 5% and then after three years drops again to a growth of almost 3% on an annual basis;
- The annual inflation drops from 15% in 2004 to 10% in 2006 and the years thereafter;
- The total government expenditures drop from 35% of the GDP in 2004 to 33.3 percent in the last two years.

With the help of this macro-economic prediction and the reference figures mentioned above and supplementary data, a further estimate was made of the extent and the composition of the resource envelope for health care in Suriname. For these purposes also explicit estimates were included from an inventory of the external funds that have already been committed for health care in the coming years.

Given the assumptions and the uncertainties in the available figures, the figures presented are illustrative, or in other words a best-guess projection. Nevertheless they give an indication of the available funds on the basis of the points of departure of the sector plan.

6.2. Available funds

The figures presented below reflect the available funds in current prices for the period of 2003 to 2009.
Expenditures health care (in millions of SRD)

	2003	2004	2005	2006	2007	2008	2009
Ministry of Social Affairs	31.1	34.0	39.4	44.6	50.4	57.0	64.5
Ministry of Public Health	20.9	34.0	45.7	51.6	58.4	66.0	74.6
Other public expenditures	2.0	12.5	14.5	16.4	18.6	21.0	23.7
Subtotal public expenditures	4.0	80.6	99.7	112.7	127.4	144.1	162.8
National Health Insurance	68.5	76.7	87.2	98.6	111.5	126.1	142.5
Total (semi-) public expenditures	132.5	157.3	186.9	211.3	238.9	270.2	305.3
Public expenditures as % GDP	2.18%	2.25%	2.40%	2.40%	2.40%	2.40%	2.40%
(Semi-) public expenditures(% GDP)	4.50%	4.39%	4.50%	4.50%	4.50%	4.50%	4.50%
External Financing	22.0	51.6	70.9	38.5	35.2	25.3	13.6
- RLA	14.1	15.7	20.8	23.5	26.5	18.0	13.6
- Other external sources	7.9	35.9	50.2	15.0	8.7	7.3	-
Total (semi-) public expenditures and external	**154.6**	**208.9**	**257.8**	**249.8**	**274.2**	**295.5**	**318.9**

Taking into consideration the increasing internal debt burden of the sector in the past few years, in this preview the reference point of 4% for the public and semi-public funds was somewhat stretched to 4.5% of the GDP to take a more realistic point of departure.

The figures furthermore elaborate that the Armulov-scheme will become less extensive in the last period of the sector plan because meanwhile local capacity will have been developed in Suriname.

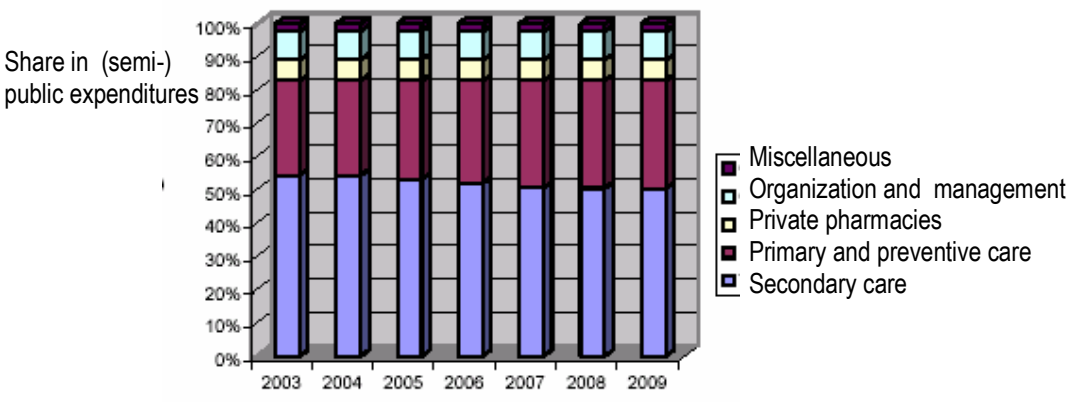
	2003	2004	2005	2006	2007	2008	2009
Total expenditures health care as % GDP	9.50%	10.08%	10.46%	9.57%	9.41%	9.17%	8.95%

Table above indicates that even if the domestic expenditures for health care are controlled, the total expenditures will probably increase considerably to 10.5% in 2005. The most important reason is the big increase in external funds that is expected in the years 2004-2005. As regards the years thereafter it will be important to find a proper sustainable mix in the financing that does justice to the points of departure of the sector plan.

6.3. Allocation

An important point of departure of the sector plan is to consume more, relatively inexpensive care services in primary health care. In the graph below, this idea is made visible by a gradual shift of financial funds to primary health care, in the process of which it is endeavored to cause the share of secondary care (hospitals and specialist care) to gradually shrink from 54.3% in 2000 to somewhat more than 50% in 2009. In time possible savings in secondary care could accomplish that in this segment of health care relatively fewer expenditures are made.

Allocation of funds 2003-2009



6.4. External funds

The strengthening of primary care will probably for the greater part be achieved by external financing. On the basis of the available project information a substantial increase of the available external funds is expected during the coming years. It is not certain whether this 'bubble' can and should become of a permanent nature. Nevertheless additional activities have been proposed within the sector plan of which the financing has not been secured as yet. In the table below a first rough estimate is given of the total amount necessary to implement the sector plan. It is also indicated how much additional financing is necessary. It is not entirely certain to what extent this also truly require additional funds, because there seems to be a substantial unused portion within the committed project funds. A reallocation within or among these funds that have already been committed, may probably (partially) finance the 'additional' activities.

The monies that may possibly become available to finance the phasing out of the RLA-scheme and the development of local capacity for high-quality clinical care, will be based on financial overviews of MoH. In this respect it should be taken into account that for these activities still (to be approved) projects have to be submitted. The figures applied reflect the current level of expenditures (in real terms) under the scheme, in the process of which a phasing out after 2006 is started from, when the development of the local capacity is starting to be put into effect.

The tables below indicate how much external financing has currently already been committed per strategy. An assessment has been made to that effect of all current projects or those in the pipeline for each strategy. Thereafter it is also indicated how much money is still necessary to implement extra or additional activities within the sector plan. The totals mentioned correspond to the detailed amounts as mentioned with the activities in the LogFrames (appendix 1). It is important to mention the fact that in this respect only (potential) external funds are included. These figures do not include regular activities within the sector that are paid from regular government budgets.

Within the figures presented below no further division is made according to external monies and counterpart-funds, if any, from the Suriname government budget. Loans and donations were added with one another.

Financing Sector Plan in millions of Suriname dollars (SRD)

	Committed	Additional	Total
Strategy strengthening primary care	43.2	1.1	44.3
Strategy increase efficiency secondary care	32.4	1.3	33.7
Strategy financial access to care	2.5	0.3	2.8
Strategy cost control	5.9	2.9	8.8
Strategy support systems	1.5	4.2	5.7
Strategy human resources development	1.7	10.9	12.6
Strategy quality	0.7	2.7	3.4
Strategy strengthening MoH	4.0	2.1	6.1
Total	**92.0**	**25.4**	**117.4**
		Annually	*26.1*
		Annually, per capita	*53.2*

Financing Sector Plan in millions of Euros

	Committed	Additional	Total
Strategy strengthening primary care	13.1	0.3	13.4
Strategy increase efficiency secondary care	9.8	0.4	10.2
Strategy financial access to care	0.8	0.1	0.9
Strategy cost control	1.8	0.9	2.7
Strategy support systems	0.5	1.3	1.8
Strategy Human resources development	0.5	3.3	3.8
Strategy quality	0.2	0.8	1.0
Strategy strengthening MoH	1.2	0.6	1.8
Total	**27.9**	**7.7**	**35.6**
		Annually	*7.9*
		annually, per capita	*16.15*

Financing Sector Plan in millions of USD

	Committed	Additional	Total
Strategy strengthening primary care	16.0	0.4	16.4
Strategy increase efficiency secondary care	12.0	0.5	12.5
Strategy financial access to care	0.9	0.1	1.0
Strategy cost control	2.2	1.1	3.3
Strategy support systems	0.6	1.5	2.1
Strategy human resources development	0.6	4.0	4.6
Strategy quality	0.3	1.0	1.3
Strategy strengthening MoH	1.5	0.8	2.3
Total	**34.1**	**9.4**	**43.5**
		Annually	*9.7*
		annually, per capita	*19.72*

7. RISK ANALYSIS

The Health Sector Plan is ambitious in the objectives that have been set in different areas for the coming years. Nevertheless the plan is feasible. Explicit attention will, however, have to be paid to monitoring and controlling a number of risk factors.

It is self-evident that the implementation of the SPG will be positively influenced by a continuation of the positive developments in the general economic situation. In a general sense, the political situation prior to and after the 2005 elections may also influence the implementation of said plan.

On the short term the most important risks concern the implementation of the SPG. This requires a big effort from the Ministry of Public Health. It may not be expected that this effort can be mustered with the current human-power within the ministry. Hiring additional expertise at MoH is a requirement to implement the SPG. In anticipation of the further implementation of the Public Sector Reform, in 2004 MoH will have to hire additional expertise on the basis of competitive, performance-oriented, conditions of employment. For practical and financial support particularly the development partners will have to play a prominent role. In addition thereto much attention will have to be paid to increasing the motivation of workers by improving the employment conditions and circumstances with respect to the Central Office, but also the rest of the sector.

Due to a weak planning and reception structure for the implementation of externally financed projects, during the past few years development partners proceeded to entering into direct partnerships with implementing bodies, and this without involving the central government.
In a number of cases this entailed a switchover of MoH-officers to (better paid positions within) externally financed projects and programs. This development is counter-productive for the further capacity building within the sector. In combination with the pull from the private sector, the question is whether MoH will in the coming period succeed in maintaining sufficient expertise. Particularly the development partners could in their policy explicitly take into account their appeal to the limitedly available expertise within the sector.

External assistance in the health care sector has up to this moment been based on individual projects. The implementation of the SPG therefore demands that the development partners start gearing their procedures and approaches to the more coordinated processes in this sector approach. On the short term a number of current or already committed projects will need some adjustment to prevent overlap and to achieve a better coordination with the SPG. A flexible attitude of the development partners is indispensable in this respect.

A number of important conditions is further in the area of the public finances. It is crucial that the current revenues of the government (fiscal and non-fiscal funds) do not further deteriorate, which might cause a further pressurizing of the available resources for the sector. The trend of the past two years in the process of which it seems as if relatively fewer funds are made available to the sector, will have to be stopped to maintain a workable situation within the sector. Furthermore the Ministry of Finance can promote the effectiveness of the proposed activities by increasing the predictability in the implementation of the budget.

The financing of the regular activities in the health care sector are paid for from the regular budget funds. The SPG includes the activities that are specifically aimed at achieving the objectives and that cannot be financed from the regular budget funds. The financing of the sector plan is therefore additional to the regular budget funds.

The inventory of the costs and financing of the SPG indicates that a large part of the costs will be covered by financing that has already been committed. On the basis of the available project information a considerable increase of the available external means happens to be expected in the coming years. Nevertheless within the SPG additional activities have been proposed of which the financing has not been secured as yet. It is not entirely certain to what extent this also truly requires additional funds, because

there seems to be a substantial unused portion within the committed project funds. With a flexible attitude of the development partners, by means of a reallocation within or among these funds that have already been committed, the 'additional' activities may probably (partially) be financed.

The development of performance-oriented incentives within the payment systems for care suppliers is an urgent matter. In itself the current agreements between financier and care supplier often already offer some room to come to a better production of care. Nevertheless a structural improvement of the systems cannot be accomplished without a better technical demarcation of which care exactly should be offered by whom at which spot, as will be undertaken under strategy 1 and 2.

Upon strengthening the implementation of the scheme for the poor and the near-poor (see strategy 3), the possibilities for (financial and administrative) cooperation between the Ministry of SOZAVO and SZF should be paid close attention to. Without a proper coordination of these activities the technical obstacles for partnerships between SZF and the Ministry of Social Affairs would be increased.

A bigger responsibility and independence is demanded during the coming years from the institutions in the sector. Most institutions have a positive attitude as regards this development. On the one hand from the Ministry and politics this sometimes requires a bigger reticence so that the management of the institutions get the necessary freedom. On the other hand the management of the institutions will have to better utilize the existing possibilities under its own steam.

It is furthermore beyond dispute of course that the acceptance of the VPG within the sector and the further participation of the institutions and the professional groups, of both physicians and non-medical staff, is very important to give substance to the implementation of the SPG.

APPENDIX 1: LOG FRAME

Strategy 1 - Strengthening primary health care and prevention.

	Intervention Logic	Objective Indicators	Sources for verification	Assumptions
Development Objective	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable.	Morbidity & Mortality (IMR, MMR, HIV prevalence) Indicators on strategy level.	Surveys NHIS	
Strategy	The supply, the quality and the accessibility of primary curative and preventive care have been strengthened, with special attention for target groups (underprivileged, women, adolescents, inhabitants of the interior, the old-aged, the disabled)	Degree of coverage of fully vaccinated children under 12 months: >90%.	NHIS	
Operational Objectives	1. The use of primary curative and preventive services, as well as the referral system to secondary care has been determined. 2. Primary health care taken care of by RGD and MZ has been strengthened and special services and programs for specific target groups have been further developed. 3. Individual and collective prevention are improved in a sustainable manner and priority programs for disease control and environmental hygiene have been strengthened at all levels. 4. Participation of the population and local	1.1. Existence and implementation of protocols for the 30 most common diseases. 1.2. Existence of rules and regulations with regard to an organized supply of health care. 2.1. % referrals 2.2. % clinics with special arrangements for specific target groups 2.3. % childbirths in the coastal area and the interior assisted in a maternity	▪ SZF ▪ Annual sector-wide reviews ▪ External mid-term review (2006) ▪ Annual reports care suppliers and contracted NGO's ▪ Evaluation reports specific projects	Carrying capacity of the implementing bodies (BOG, MZ, RGD, NGO's)

	organizations in determining local priorities and in the implementation of health care programs has been strengthened	clinic of the RGD and MZ. 3.1. degree of coverage of priority programs. 3.2. process indicators of the NAP 4.1. % areas with specific plans for public-private cooperation and participation from the public.		
Activities	1.1. Under the leadership of MoH the Workgroup "Basic Package for Primary Health Care" defines the minimum 'package' that must be offered to primary services. 1.2. MoH leads the process of developing national protocols/algorithms in consultation with the care suppliers and SZF. 1.3. The financiers (SFZ/private insurers) promote rational referral behavior by tightening control, inspection and feedback ('mirror data') to general practitioners (see strategy 4 – cost control – for details). 1.4. MoH and financiers (insurers) give information to the public about the role of primary provisions (see strategy quality promotion, activity 5.1) 2.1. RGD improves its management capacity (monitoring, evaluation, supervision, planning & management, quality assurance)	Budget: 1.1 1.2 € 10,000 1.3 See strategy 4 2.1 $ 185,000 € 450,000		Financing sources: 1.1 – 1.2 : IDB (as part of the US 4 650,000 budget for development of costed packages) 2.1 IDB (1st project component) Start-

	2.2 RGD and MZ promote the capacity of primary workers in the field of planning and management and public health 2.3 RGD and MZ strengthen their infrastructure/ equipment for maternal and child care (infrastructure, equipment, training). 2.4 RGD facilities are used for the introduction of innovative services for adolescents (sexual health, HIV/AIDS), the homeless and addicts (see also integration of the current public mental health program) and other target groups 2.5 RGD and MZ conduct public health training for staff 3.1 BOG transforms into a directing and quality-promoting public health institute (further development of gender-sensitive programs as regards: MGZ, GVO, school services, disease control, including IMCI; public health evaluation, environmental hygiene, environmental inspection and inspection of foodstuffs and articles; infrastructure improvement including Central Lab; strengthening management capacity) 3.2 MoH/BOG develop concrete prevention policy, with therein an explicit role for general practitioners 3.3 BOG coordinates the implementation of action-oriented investigation by primary care suppliers and NGO's	2.2 p.m. 2.3 US$ 6,560,043 US$ 517,000 (RGD part JICA) 2.4 p.m. (part UNFPA program) 2.5 $ 155,000 p.m. 3.1. € 3.1 million 3.2. see 3.1 3.3. see 3.1	fund project RGD 2.2 government budget donor projects: UNFPA, PAHO,.. 2.3 IsDB, JICA, UNFPA 2.4 UNFPA 2.5UNFPA (SRH training) government budget 3.1 BOG-project 3.2 BOG-project

	3.4 MoH (also via RGD and MZ) actively cooperates with other line ministries, including Ministry of Education (curriculum primary schools) Ministry of Natural Resources (strengthening degree of coverage safe potable water), Ministry of Labor, Technological Development and Environment (environment and labor; prevention occupational health hazards), Ministry of Defense (drawing up and keeping scenarios disaster relief) to promote health care	3.4. see 3.1	3.4 Government budget
	3.5 MoH/BOG complete the formulation of the national multisectoral STI/HIV/AIDS strategy, with special attention for the institutional organization	3.5. US$ 150,000 3.6. US$ 4,676,831 (4 years)	3.5 IDB: (2nd component 2.2.3)
	3.6 Implementation (by multiple stakeholders) of the national STI/HIV/AIDS strategy		3.6 Global Fund
	3.7 BOG formulates a general and gender-sensitive policy as regards Sexual and Reproductive Health and tunes all SRH-projects and programs carefully to one another.	3.7. p.m 3.8. € 600,000 € 400,000	3.7 BOG-project 3.7 UNFPA-project 3.8 Start-fund project PCS Additional budget (sector plan budget) to complete public mental health program over 4 years
	3.8 The national mental public health program formulated in 2000 is nationally introduced in a phased manner and preserved with PCS/TPO as lead. Renovation and newly built PCS is part of this program.	3.9. p.m. p.m. (not yet acquired) € 400,000 appr. US$ 970,000	3.9 government budget Global Fund (malaria, tb)?
	3.9 RGD, MZ implement prevention programs and disease control programs. 4.1. RGD equips areas as functional health systems (inclusive of gradual introduction of	4.1 – 4.3 p.m.	Alliance Française

	decentralized planning and management) 4.2 RGD involves NGO's and other community organizations in the development of local health services. 4.3 RGD and BOG train community organizations in public health (target groups policy; gender; relationship poverty and health)		PAHO (16 projects 2004-2006, inclusive of funds from USAID 4.1-4.3 government budget donor funds from current projects (to be deployed on the basis of 5 years development plan RGD)

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Strategy 2 - Improving the efficiency as well as the quality of hospital care.

	Intervention Logic	Objective Indicators		
Development Objective	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable.	Morbidity and Mortality (MR, MMR, HIV prevalence) Indicators on strategy level	Surveys NHIS	
Strategy	Increasing quality and efficiency of hospital care and care services	- patient satisfaction - rating of hospitals and/or departments - availability data - technical quality of interventions - standardized/comparable duration of hospitalization (per hospital; per patient category; per treatment package) - overdue maintenance infrastructure and equipment - salaries in line with market - bed occupancy (target: 80%)	- surveys - visitation reports - annual reports hospitals - audit reports - quality reports - NHIS	
Operational Objectives	1. Service package that should be supplied to hospitals in a qualitatively responsible and cost-effective manner is determined unequivocally and is maintained. 2. Hospitals utilize economies of scale by cooperation in all fields 3. Hospitals have well-running and modern conduct of business 4. High-quality clinical care to replace RLA-	- use of a fixed service package belonging to secondary health care/high-quality care in clinics - use of functional treatment protocols - existence of creative forms of cooperation (diagnostics, general and technical services) - assessed proposals for building of high-quality care in clinics	- annual report MoH - annual reports hospitals - minutes of consultation between MoH, hospitals, financiers, employers, ….	Proposals for development clinical care within the framework of ARMULOV are developed after a phased plan restructuring hospital care has been

	arrangement is built on the basis of cost-effectiveness and financial sustainability			determined*
Activities	1.1. The MoH forms and leads a workgroup consisting of specialists, hospital managers, SZF and representatives of employers, that performs the following activities: a) development of treatment protocols for the top 15-20 most common diseases that need specialist help (hospitalization, outpatients' treatment) b) setting of standards for duration of hospitalization etc, per disease/treatment (also using international standards) c) development of referral-back procedures 2.1 On the basis of actualized and verifiable data, MoH draws up a phased plan to restructure hospital care 2.2 MoH investigates investment needs and possible financing to eliminate overdue maintenance, on the basis of proposed restructuring hospital care. 2.3 Hospitals in cooperation with MoH look for creative possibilities to share facilitating services. 2.4 MoH in cooperation with hospitals	Budget: 1.1. € 40,000 2.1. € 100,000 (ETA Study) 2.2. Supplementary to strategy 4 2.3. p.m. 2.4. € 50,000 (ETA Study)		Financing sources: 1.1 Additional budget sector plan 2.1 Additional budget sector plan 2.4 Additional budget sector plan

	investigates cost-effective and practical possibilities for cooperation as regards diagnostics. 2.5 Hospitals try to come to cooperation as regards procurement (see strategy 5) 2.6 Hospitals develop and implement uniform and computerized financial and administrative systems, including a Patients' Registration System. 2.7 MoH in cooperation with hospitals and trade unions works towards uniform labor conditions personnel (collective bargaining agreements with [para] medical personnel 3.1 Minister MoH appoints experts in Board of Supervisory Directors/Board and management of public hospitals and revises conditions for hospital management. 3.2 The government gives public hospitals control over budget and personnel. 3.3 MoH makes explicit agreements with public hospitals. 3.4 Managers of public hospitals delegate operational and budgetary responsibilities within the organization. 3.5 Hospitals professionalize contractual relationships with specialist practices. 4.1 Workgroup under the leadership of MoH formulates project proposal as	2.5. p.m. 2.6. € 200,000 (ETA Study) 2.7. p.m. 3.1. p.m. 3.2. p.m. 3.3. p.m. 3.4. p.m. 3.5. p.m. 4.1 – 4.2 € 745,000 + p.m.	2.6 Additional budget sector plan 4.1 (ARMU)LOV + additional budget 4.3 Start-fund NL, JICA and

	regards development high-quality clinical care (under ARMULOV-arrangement) 4.2 Concrete proposals for development high-quality clinical care are assessed by reviewing committee (see strategy 4) 4.3 Projects already committed with respect to high-quality clinical care are implemented and monitored as regards additional pressure on government budget	4.3. € 9,069,846 committed projects high-quality care are: - radio-therapeutic center (IsDB) - support neurosurgery AZP (NL) - basic equipment MCH for LH and SZN (JICA) - upgrading MKZ at LH (NL) - institutional strengthening SZN - Kitchen and Laundry AZP (NL) - Cooperation projects universities Heart missions AZP And ARMULOV (NL) see 4.1	IsDB

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Strategy 3 - Financial Accessibility to Health Care

	Intervention Logic	Objective Indicators		
Development Objective	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable.	Morbidity and Mortality (MR, MMR, HIV prevalence) Indicators on strategy level	Surveys NHIS	
Strategy	Financial accessibility of health care for socially marginalized is guaranteed			
Operational Objectives	1. Arrangement for the poor and the near-poor is more strongly aimed at the socially marginalized 2. False extra payments of patients to health care suppliers are strongly reduced	1.1 Decrease type 1 error (poor and near poor that are not classified as such) from 22.9% to 10% and decrease of type 2 error (card holders that have wrongfully been registered as poor or near poor) from 36.3% to 5%. 1.2 All SOZAVO programs use the targeting system. 2.1. ratio of effective SOZAVO lay day rates/SZF rate increases from xxx% in 2004 to 90% in 2009. 2.2. Annually, independent and anonymous client survey measures decreasing size and frequency of false payments.	1.1 TC report 2000 as baseline and DHS for objective 1.2 Independent evaluation	Professional groups in health care participate in policy to counter false payments In development of financial and administrative systems with the Ministry of Social Affairs and SZF the same or compatible systems are ensured

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	3. Better utilization of possibilities for financial and administrative cooperation between the Ministry of SOZAVO and SZF for the procurement of care for the socially marginalized	3. Ministry of SOZAVO and SZF work together in the purchase and payment of health care.		
Activities	1.1 Ministry of Social Affairs develops and implements information and payment system for those entitled to benefits (IDB) 1.2 Develop and implement (pro-actively) targeting system for identification and determining those entitled to benefits by working out poverty map (IDB). 1.3 Develop and implement plan to expand arrangement for poor and near-poor in case of emergency to uninsured that do not meet the poverty criteria. 2.1 Financiers implement an effective payment system (see 4.4.3) 2.2 Hospitals develop and report about implementation policy to counter false payments 2.3 Educational institutions adjust curricula to pay attention to legitimacy and efficiency of providing health care services 2.4 MoH strengthens inspection (see 4.7.1) 2.5 Financiers strengthen medical control (see 4.4.1) 2.6 MoH furnishes specific information to public as regards rights and obligations of		Costs: 1.1 US $ 580,000 1.2 US $ 240,000 1.3 US $ 30,000 2.2 Euro 50,000 2.3 Euro 15,000 2.6 Euro 40,000	Financing: 1.1. IDB 1.2. IDB 1.3. IDB 2.2 Additional 2.3 Additional 2.6 Additional

	patient and physician. 3.1 Ministry of Social Affairs and SZF examine the feasibility and possible implementation of accommodating with the SZF (parts of) the procurement and payment (primary health care and hospital care) of services rendered to SOZAVO patients (IDB)		3.1 US $ 80,000 Total: US $ 930,000 Euro 105,000	3.1 IDB committed additional

Strategy 4 - Health care cost control

	Intervention Logic	Objective Indicators		
Development Objective	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable.	Morbidity and Mortality (MR, MMR, HIV prevalence) Indicators on strategy level.	Surveys NHIS	
Strategy	The expenditures for health care remain stabilized at the level of 2000 and are spent in a cost-effective manner	1. Total expenditure remains equal to 2000 as % of GDP (9.4%). 2. public expenditure as % GDP equal to level of 2000 (- 4.5%)		Revenues Suriname government from taxes and non-tax funds are increased
Operational Objectives	1. Mixed, performance-dependent payment systems promote an efficient production of care both in primary and intramural health care 2. Expansions in (intramural) care only take place after financial feasibility and social desirability have been weighed explicitly and independently 3. Government expenditures in health care are predictable and are coordinated, planned and realized.	1. the percentage of referrals of G.P.'s to hospitals/specialists drops from 30% in 2004 to below 10% at the end of 2008. 2. renewed agreements of SZF are observed. 3. Reviewing Committee provides recommendations in 2005 on 100% of all major expansions in the supply of care according to determined framework for assessment. 4. Realizations in terms of % of Government budgets in health care	SZF-reports medical bureau RGD annual report Annual reports of Reviewing Committee Financial Plan, sub-budgets and report Court of Audit	2. Process of budget reforms is continued 3. Ministry of Finance "rewards" sectors and budget holders that plan in a realistic manner and remain within the budget lines

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		amount to a minimum of 97%. 5. Burden of debt of health care institutions is reduced from SRD (35+28 million) in January 2004 to a sustainable level in 2009.		
Activities	1.1 Financiers and MoH develop and implement cost prices and gear payment systems thereto to achieve a performance-oriented and transparent payment system for primary care, partly on the basis of treatment package defined under strategy 1.2 RGD develops and implements primary care supervision, monitoring and evaluation-capacity, inclusive of strengthening the role of regions and performance framework (IDB). 1.3 MoH leads investigation into further development conditions, model to be used and possible implementation process for an AZV 1.4 Financiers and MoH develop and implement cost prices and gear payment systems thereto to achieve a performance-oriented and transparent payment system for the intramural care on the basis of treatment package defined under strategy 2 1.5 Financiers review in consultation with hospitals information and invoicing system and determine improvements necessary for new standardized payment system 1.6 Hospitals computerize invoicing system on the basis of standardized payment	1.1 US$ 100,000 1.2 US$ 650,000 1.3 US$ 50,000 1.4 US$ 100,000 1.5 US$ 100,000 1.6 US$ 300,000	2.1 IDB 2.2 SZF 2.3 IDB 2.1 Additional 2.2 Additional 2.3 Additional 2.4 Additional 3.1 O.B. 3.2 Additional 3.3 Additional 3.4 Additional 3.5 Additional 3.7 IDB Total: Committed additional	1.1 IDB 1.1 IDB 1.2 Additional 1.3 Additional 1.4 Additional 1.5 Additional

	systems 1.7 SZF implements an Administrative and Management Information System (AMIS) (IDB) 1.8 SZF introduces economic study service for processing and analysis of information in AMIS 1.9 Reform the SZF to an active consumer by improving contract procedures, revision payment systems, development quality program and strengthening medical control service (IDB) 2.1 MoH prepares installation and mandate of independent expert Reviewing Committee to assess investment proposals in health care 2.2 Installed Reviewing Committee elaborates assessment criteria, information necessities and assessment procedure 2.3 Committee furnishes information to all relevant bodies in which assessment process is explained 2.4 Committee assesses investment proposals 3.1MoH forms permanent formal workgroup and chairs said workgroup, aimed at having budget holders mutually coordinate in the care of their expenditures during the preparation and implementation of the	1.7 US$ 1.030,000 1.8 US$ --- 1.9 US$ 260,000 2.1. EUR 10,000 2.2. EUR 25,000 2.3. EUR 10,000 2.4. EUR 200,000 3.1 EUR ---		

	budget 3.2 Workgroup annually formulates and maintains a realistic 5 years estimate (5 years) for the public funds in health care 3.3 Workgroup develops planning standards and indicators for the allocation of funds in health care 3.4 MoH/GMTD: Make an inventory of all existing infrastructure and medical equipment 3.5 MoH/GMTD: On the basis of inventory draw up a plan for capital investments with related maintenance plan 3.6 Develop capacity to measure and analyze national health care expenditures on the basis of National Health Accounts methodology	3.2 EUR 10,000 3.3 EUR 25,000 3.4 EUR 25,000 3.5 EUR 25,000 3.6 US$ 150,000 Total: US$ 2,190,000 EUR 880,000		

Strategy 5 -Strengthening of support systems

	Intervention Logic	Objective Indicators		
Development strategy	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable	Morbidity and Mortality (MR, MMR, HIV prevalence) Indicators on strategy level	Surveys NHIS	
Strategy	Support systems for: ▪ Procurement and logistics (including the supply of medicines and other necessities in health care) ▪ Communication, and ▪ Information systems (disease surveillance and medical services, personnel, financial and administrative services) are strengthened, as well as the relationships between these systems	Satisfaction of health care workers	Annual reports Annual sector review	Stable SRD
Operational objectives	1. Health has available safe, effective, essential and affordable pharmaceutical and other products, equipment and infrastructure 2. MoH has at its disposal an adequate communication infrastructure (telephone, computer, Internet-connection) to facilitate the	1.percentage tracer medicines available (i.e. >1 month consumption) at BMoHS and in pharmacies. 2.High officials at MoH have access to Internet.	BGVS VvA MoH (IDB PMU reports) RGD, BOG, MZ AZP etc. Annual reports Annual reviews	

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	communication with other actors. 3. Both MoH and the implementing bodies use vital information for the monitoring & evaluation, planning, management and policy	3a. The existence and consumption of a set of indicators across the sector (input, process, output). 3b. percentage of area teams that use systematically collected data locally for planning and management purposes.		
Activities	1.1 REG organizes a national conference where the National Medicines Policy (NGB) with program linked thereto (see below) is discussed and the go-ahead for the implementation is given. 1.2 MoH strengthens REG, pharmaceutical inspection and medicines registration: MoH hires procurement expert / REG coordinator; with the help of the IDB monitoring and supplementary national quality control systems are developed; MoH recruits pharmaceutical inspector and with the help of VWS inspection is reorganized; MoH hires head registration bureau and with the help of the IDB registration of medicines is reorganized. 1.3 FMeW makes an inventory of the use of traditional medicines. 1.4 Minister and MoH appoint experts in Board of Supervisory Directors and management BGVS assigned the task to give priority to strengthening	Budget: 1.1. € 4,000 1.2. + 1.5 US$ 465,000 (IDB) 1.3. SRD. 3,000 1.4. € 20,000 (additional)		Financing sources: 1.1 Government and project Institutional strengthening MoH 1.2 + 1.5: ▪ IDB program (component 1.2) ▪ VWS ▪ Additional 1.3 government 1.4 additional 1.6 additional 2.1 additional 2.2 additional

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	procurement management of BGVS 1.5 MoH develops guidelines for uniform procurement systems for health care institutions including standardization and guidelines for donations (within the framework of IDB-procurement project) 1.6 REG in cooperation with VMS/VvA promotes rational use of medicines by developing protocols 1.7 The board of STG (i.e. managing directors hospitals) evaluates cooperation hospitals in the field of maintaining the buildings and the equipment and takes a decision on selling or privatization GMTD (see also strategy 2) 1.8 MoH studies the current cost-effective option to have the BGVS medicines lab be incorporated in the building of a new Central Lab and proceeds to decision-making 2.1 MoH draws up a plan to improve infrastructure for internal and external communication 2.2 MoH implements this plan 3.1 MoH actualizes the survey performed in June 2002 on existing NHIS-systems ("NHIS assessment report"). 3.2 On the basis of the results of activity 3.1 and earlier proposals (PAHO), MoH – in	1.5. (see 1.2) 1.6. € 200,000 1.7. p.m. 1.8 p.m. 2.1 p.m. € 10,000 (local TA) 2.2 € 200,000 3.1 – 3.2 € 30,000 (formulating mission)	3.1 additional 3.3 additional Note. Start-fund projects RGD and BOG and UNFPA-program also contain budgets for HIS development (included in strategy primary care)

	cooperation with the stakeholders mentioned in the NHIS assessment report – draws up a feasible and practical 4-years' development plan for the NHIS (including strengthening/standardization various information systems – HIS, PIS and FIS – and gearing towards one another) 3.3 MoH implements the NHIS 5 years development plan	3.3 € 600,000 (4-year TA)	

Strategy 6 -Human Resources development

	Intervention Logic	Objective Indicators		
Development strategy	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable	Morbidity and Mortality (MR, MMR, HIV prevalence) Indicators on strategy level	Surveys NHIS	
Strategy	Sufficiently qualified, expert and motivated personnel is available	Satisfied personnel	Polls	Public Sector Reform creates possibilities to improve working circumstances and employment conditions
Result (operational objective)	1. A plan for the development of human resources is being implemented 2. Capacity and content of trainings are tuned to needs and feasibility 3. Public Health expertise and management skills are strengthened 4. Employment conditions senior staff including those of the government are in line with the market	- % staff present with regard to determined standards in Human Resources developing plan. - additional training for % G.P.'s in public health. - % RGD/MZ maternity clinics with 1.0 unity of function duties (fte) (or more) obstetrician. - % professionals at BOG with post-graduate public health/training in education.	Annual report MoH/CMO Annual reports BOG, RGD, hospitals	Cash flow subsidy COVAB for basic training improved
Activities	1.1 MoH starts sector-wide inventory of available human resources 1.2 In consultation with health care suppliers, MoH estimates the needs for training (education, refresher courses) of senior staff for the mid-term 1.3 A rolling human resources development	Budget: 1.1 – 1.3 (TA required) € 50,000		Financing sources: 1.1 – 1.3 Project Institutional strengthening MoH

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	plan is drawn up and maintained.		
	2.1 MoH supports expansion plan COVAB 2.2 MoH, Association of Doctors and FMeW define and introduce refresher package for general practitioners (anticipating the introduction of formal GP-training in 2008-2010) among other things in view of the introduction of the reregistration system 2.3 MoH reactivates the training for midwives at LH; on the longer term this training is accommodated with MKZ center LH 2.4 MoH revises curricula and training modalities of environmental inspectors, inspectors, pharmacist's assistants and midwives 2.5 Medical Faculty strengthens modules as regards epidemiology/ statistics	2.1 COVAB: $ 200,000 (project proposal already drafted) 2.2 (support LHV/NGH): € 20,000 per year x 4 : € 80,000 2.3.p.m. 2.4.(TA): € 20,000 2.5.(TA): € 20,000	2.1 Additional budget sector plan 2.2 Additional budget sector plan 2.4 Additional budget sector plan 2.5 Additional budget sector plan
	3.1 RGD recruits candidates for the training for midwives and MGZ nurses (additional to normal inflow) 3.2 MoH coordinates extra schooling to lab assistants (30:RGD; MZ), midwives, pharmacist's assistants, administrative personnel RGD (Start-fund project) 3.3 Management training area managers RGD 3.4 BOG strengthens its public health expertise: training 100 environmental inspectors; 15 inspectors; training of mid-level managers (10 nurses MGZ; some mid-	3.1. € 2 million (50 x 4 x € 10,000) 3.2. € 300,000 (of which € 180,000 is covered by starting fund projects RGD/BOG)* 3.3. RGD: training area managers: € 20,000 3.4. € 250,000	3.1 Additional budget sector plan 3.2 Additional budget sector plan + projects RGD/BOG 3.3 Start-fund project RGD 3.4 Additional budget sector

	level epidemiologists); 3.5 BOG, RGD and MZ strengthen public health expertise among higher executives (about 15 program coordinators) by offering post-graduate education public health and epidemiology (abroad & distance learning) in cooperation with Faculty of Medical Science 3.6 BOG strengthens expertise in the field of information training 5 information experts and 10 public relations officers 3.7 MoH in cooperation with Medical Faculty organizes extra training for GP's on public health subjects. Option: 1-month afternoon/evening course "District Health Care" 3.8 Medical senior staff and personnel of NGO's regularly receive refresher courses in the field of sexual and reproductive health, IMCI, HIV/AIDS, NPI, tb, malaria, etc. 3.9 Within MZ, RGD and BOG the training capacity for public health is further strengthened 4.1 Recognition of (post-graduate) public health as specialization, leading to adjustment salary scales 4.2 MoH and development partners introduce top-up of salaries in hiring and maintaining selected experts in key positions at Central Office/MoH in anticipation of implementation public sector reform	3.5. € 400,000 3.6. € 200,000 3.7. (organization 2 District Health afternoon/evening courses per year for groups of 25 G.P.'s per course): € 100,000/year: € 400,000 3.8. p.m. 3.9. US$ 305,000 4.1. p.m. 4.2. p.m.	plan 3.5 Additional budget sector plan: Euro 250,000. Project BOG: Euro 150,000 3.6 Additional budget sector plan 3.7 Additional budget sector plan 3.8 Projects: PAHO, Global Fund, UNFPA, Alliance Française, UNICEF…. 3.9 IDB project phase 2

Strategy 7 -Improving and safeguarding quality

	Intervention Logic	Objective Indicators		
Development strategy	The health status of the entire Suriname population has evidently increased, by the formation of an integrated system of qualitatively good and effective health care that is a) accessible to everyone (geographically, financially, culturally); b) contributes to maximizing health gains to the entire population; and c) is sustainable	Morbidity and Mortality (MR, MMR, HIV prevalence). Indicators on strategy level.	Surveys NHIS	
Strategy	By developing an effective quality system the quality and patient-orientation in health care are improved	- consumer/patient satisfaction. - specific national policy on quality promotion.	Surveys Annual review of the sector	-
Operational Objective	1. MoH performs its tasks as regards supervision, inspection and regulations 2. At institutional level quality policy is being developed and implemented 3. The professional groups play an active role in the promotion of quality in health care 4. The financiers, inclusive of SOZAVO, have developed effective mechanisms to promote quality in health care 5. The consumer/patient increasingly play a role in enforcing quality	- Inspection MoH functional. - Inspection of mechanisms functional. - Complaints Departments operational. - Relevant legislation on quality modernized (see Chapter 'management of the sector'). - Regular presentation of 'mirror data' by SZF and other financiers.	- Annual reports - Annual reports consumer organizations - Bulletin of acts and decrees - Reports of intervision visits - Necrology discussions/papers	-
Activities	1.1 MoH forms a Steering Group Quality Policy, consisting of representatives of patients, financiers, institutions and care providers; this Steering Group	Budget: 1.1 € 20,000		Financing sources: 1.1 additional 1.3 Project Institutional

	formulates a practical policy document and a program and 5-years' goals linked thereto (making use of IDB study 8) 1.2 MoH will continue the process started to come to a law on Medical Professions 1.3 MoH hires senior staff to strengthen inspection 1.5 MoH modernizes the medicines legislation 1.6 MoH stimulates to include health law in the curriculum of the Faculty of Law and the Medical Faculty 2.1 Hospitals develop practical quality promoting activities, necrology discussions, lectures 2.2 Hospitals, care suppliers and care consumers in primary health care install complaints committee for complaint registration and processing 2.3 RGD and MZ improve quality assurance 2.4 In-service training of paramedics and	1.2 p.m. 1.3 p.m. 1.5. – 1.6 € 20,000 2.1 p.m. 2.2 p.m. 2.3 US$ 180,000 (TA formulation quality system) 2.4 SRD. p.m.		strengthening MoH 1.5-1.6 Project Institutional strengthening MoH 2.1 Hospital budget 2.2 LH-Start-fund project; Start-fund project Nickerie hospital; budgets hospitals and primary care suppliers 2.3 IDB 1.14 2.4 additional 3.1 additional 3.2 additional 3.3 additional 4.1 o.b. 4.2 additional 4.3 care consumers budget 5.1 IDB (part 2nd component 5.2 additional

	non-medical personnel and refresher courses of doctors contain modules regarding their behavior towards consumers/patients (also see strategy HRD) 3.1 The VMS develops and implements a system of reregistration (and refresher courses) of care providers in close cooperation with MoH 3.2 The current visitation committee (of the SRC) revitalizes the process of visitation, supported therein by MoH 3.3 The Association of Doctors continues the development of protocols and standards, among other things in cooperation with sub-departments of KNMG and with the Caribbean Medical Council (CAMC) 4.1 SZF and private insurers (and SOZAVO in time) include agreements about quality in contracts with service providers 4.2 SOZAVO installs an own Medical Control Service, preferably in close cooperation with SZF. 4.3 Care consumers regularly make data-analyses and present mirror data to care suppliers 5.1 MoH furnishes information about the right use of health services and about patients' rights 5.2 MoH supports the establishment of independent patient organizations, in cooperation with the financiers (SZF; private insurers)	3.1 SRD. 400,000 3.2 SRD. 400,000 3.3 SRD. 1,000,000 4.1 p.m. 4.2 SRD. 500,000 4.3 p.m. 5.1 US$ 100,000 5.2 SRD 400,000		

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APPENDIX 2: ACTIVITIES SECTOR PLAN IN 2004

Strategy 1. Strengthening primary health care and prevention

	Responsible	Activity	2004 JULY	AUG	SEP	OCT	NOV	DEC
1.1	VZ	Under the direction of the MoH the workgroup "Basic package for Primary Health Care" defines the supply of current primary services.	C	C	C			
2.1	RGD/MZ	RGD and MZ draft multipurpose operational plan with overall budget in cooperation with the MoH.						
2.3	VZ	Continuation project JICA (procurement equipment MKZ)	C	C	C	C		
3.1	MoH/BOG	Continuation inception phase project BOG	C	C	C	C	C	C
3.5	MoH/BOG	MoH/BOG complete formulation of national multisectoral STI/HIV/AIDS strategy with special attention for the institutional organization.	C	C	C			
3.7	BOG	BOG starts formulation of a general and gender-sensitive policy on Sexual and Reproductive Health and tunes all SRH projects and programs carefully into one another.						
3.8	MoH/PCS	Start implementation Start Fund Project PCS.	C	C	C	C	C	C

Strategy 2. Improving the efficiency as well as the quality of hospital care

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.1	MoH	MoH initiates and coordinates workgroup that develops treatment protocols for the top 15-20 most common diseases requiring treatment by a specialist (including standards for duration of hospitalization per disease/treatment)						
2.1	MoH	On the basis of actualized and verifiable data MoH drafts a plan of action for hospital care reform.						
3.1	Minister for Public Health	Minister and MoH draft profiles and appoint professionals in the Board of Directors/management of Government-owned hospitals and reviews conditions for hospital management.						
4.1	MoH	Workgroup headed by MoH formulates project proposal on advancing high-quality care in clinics (under ARMULOV regulation)	C	C	C	C	C	C
4.2	Reviewing Committee	Specific proposals for advancing high-quality care in clinics are reviewed by reviewing committee (see strategy 4)						

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4.3	Reviewing Committee	Projects on high-quality care in clinics already committed are implemented and monitored for additional pressure on national budget.						

Strategy 3. Promoting financial access to health care

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.1	Ministry of Social Affairs	Continues the process already initiated to implement new poverty criteria.	C	C	C	C	C	C
2.2	Hospitals	Before the closing of 2004, together with purchasers, draft policy for their own institution aimed at discouraging false payments.						
2.3	Educational institutes	Formulate proposals on how they adjust curricula for the next academic year in order to devote more attention to the legitimacy of providing health care.						
2.5	Financiers	Strengthen implementation medical inspections.	C	C	C	C	C	C
3.1	Ministry of Social Affairs and SZF	Start with working out plans for cooperation in subsectors as formulated under the Support for Implementation to Health Sector Reform project.						

Strategy 4. Control of the Costs for Health Care

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.9	SZF	Reform of SZF to a more active purchaser is continued on the basis op project activities under the Support for Implementation to Health Sector Reform project, and strengthening of medical inspection department.	C	C	C	C	C	C
1.7	SZF	SZF starts implementation of Administrative and Management Information System (AMIS).						
2.1	MoH	MoH prepares installation and mandate for independent, professional Reviewing Committee to assess investment proposals in the health care sector.						
2.2+ 2.3	Reviewing Committee	Works out assessment criteria, information requirements and reviewing procedures, and provides information to all relevant authorities in which the reviewing process is explained.						
2.4	Reviewing Committee	Committee assesses investment proposals, including advancement under ARMULOV.						
3.1	MoH	Forms and starts permanent workgroup for sector consultations on budget, 5 years estimate, including semi-public means, and meets at least once a month.						
3.2	MoH/GMTD	Make an inventory of all existing infrastructure and medical appliances available in Suriname						

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Strategy 5. Strengthening of Support Systems

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.1	REG	Organization of a national conference in which the National Policy on Medicines (NGB) as well as the program coupled to it (see below) is discussed and the starting signal is given for implementation.						
1.2	MoH	Appointment of Expert in Purchasing and Logistics at MoH.						
1.4	MoH	Restoration of administrative organization BGVS.						
1.8	MoH	Research into the current cost effective option to integrate medicines laboratory into Central Lab.						
2.1	MoH	Development of plan for improving infrastructure for the benefit of internal and external communication.						
3.1+ 3.2	MoH	Actualization of the research conducted in June 2002 on current NHIS systems (NHIS assessment report) and formulation of plan.						

Strategy 6. Development of Human Resources

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.1	MoH in consultation with health care providers	Start inventory of existing and required manpower across the sector.						
2.2	MoH together with VMS and FMeW	Defining continuing education package for general practitioners (in anticipation of the introduction of the formal general practitioner training in 2010), among other things, in view of the introduction of the re-registration system.						
2.5	FMeW	Start review curriculum epidemiology/statistics.						
3.1	RGD	Recruits candidates for obstetrics and nursing MGZ training (additional and normal intake).						
3.2	BOG	Recruits candidates for nursing MGZ training (additional and normal intake).						
3.5	BOG	Sending out two higher staff members for post-graduate MPH (public health) in cooperation with the Anton de Kom University.						
3.6	BOG	Sending out two higher staff members for training in post-graduate health care education.						
4.2	MoH and	Introduction of increase of salaries in recruiting and maintaining selected professionals in key						

	development partner	positions of the Central Office, in anticipation of the implementation of the Public Sector Reform.						

Strategy 7. Improving and safeguarding quality

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
1.1	MoH	Steering Committee on Quality Policy is installed.						
1.3	MoH	MoH recruits professional staff to strengthen inspection.						
2.1	Hospitals	Start of practical quality promoting activities.						
2.2	Hospitals, primary health care providers and purchasers	Installation complaints committee for registration and processing of complaints.						
3.3	VMS	Continuation of the development of protocols and standards, among others, in cooperation with sub-divisions of KNMG and the Caribbean Medical Council (CAMC).	C	C	C	C	C	C
4.1	SZF	Continuation talks on including agreements on quality in contracts of service providers.	C	C	C	C	C	C
4.2	SZF and SOZAVO	Continuation talks on cooperation regarding the establishment and implementation of a Medical Inspection Department.	C	C	C	C	C	C
5.1	MoH	Start educational activities on the correct use of health care services and on patient rights (as part of the communication strategy of MoH with regard to the sector plan, supported by PAHO).						

Administration, Organization and Management of the Sector

	Responsible	Activity	JULY	AUG	SEP	OCT	NOV	DEC
8.1	MT	Drafting a work plan for 2005.						
8.1	Minister	Appointing responsible managers and officials for each of the subdivisions.						
8.1	DMoH/ODA/PZ	Drafting job descriptions for all employees of the Central Office and establishing a database for the Central Office.						
8.1	DMoH/OD-PL/ODA	Developing and executing a management training course for all department heads.						
8.1	DMoH/ODA	Improving the office space of the various sub-directorates and purchasing new office equipment.	C	C	C	C	C	C

8.1	OD-PL	Developing a database for externally financed projects and programs.						
8.1	DMoH/MT	Holding structured progress consultations with development partners on future imbedding activities in the sector plan.						
8.1	DMoH/Communication assis-tant/PAHO	Developing a communication strategy and communication plan.						
8.1	Minister	Consultation with BiZa and donor community on improving employment conditions for officials MoH.	C	C	C	C	C	C
8.2	AZP,LH,SZN,PSC,BOG	Developing an integral operational plan 2005-2008.						
8.2	Management of Institutions/MoH	Introducing and holding structured progress consultations periodically between MoH and institutions.						
8.2	Management of Institutions	Drafting a Management Report over 2004.						
8.3	Legal dept. in coop. with VWS	Legal analysis into possibility to realize the desired health care policy within the valid statutory rules and regulations.						
8.3	Legal dept./VWS	Start modernization of Medicines legislation.						
8.3	Minister/SZF/Legal dept.	Limited amendments to the Decree on SZF (obligation to contract).						
8.3	DMoH/Legal dept./VWS	Draft medium range planning for legislative program.						
8.4	Minister	Periodic progress consultations between Ministry of Public Health and professional groups.						
8.5	OD OL/OD-F	Seeing to it that all budget holders within the sector participate in the course “budget planning”, organized by the Ministry of Finance.						
8.5	OD PL/OD-F	Taking inventory of the systems of planning and reporting, and procedures that are in use in the sector.						
8.6	Minister/		C	C	C	C	C	C

	DMoH/ Communicatio n assistant	Regular press releases and newsletters on further progress and start sector plan.						
8.6	MT/ Communicatio n assistant/partie s in charge of sector	Formulation of a communication strategy and communication plan.						
8.7	OD PL	Drafting uniform guidelines for the preparation of new projects.						
8.8	OD PL	Adjusting current indicators of the SPG.						
8.8	MT	Preparing and executing an 'annual review' of the sector plan.						

* 'c': ongoing activities

** Other activities will be started up in 2004

APPENDIX 3: ELEMENTS FOR ASSESSMENT FRAMEWORK

In strategy 2 and 4 of the Health Sector Plan (SPG) it is proposed to introduce an assessment for future expansions in the intramural care in Suriname. This short note will elaborate on the goal and the possible nature of this assessment. It does not, however, comprise a concrete procedure for assessment as yet.

Background of the assessment framework
There is no structural cooperation between the most important parties in the financing of health care. Consequently the supply of cost-effective care is sometimes hampered. An important example thereof is the lack of a well-coordinated planning of important investments to expand health care supply. With the use of public funds individual actors in the sector sometimes plan and finance expansions in the sector. In doing so it sometimes is not clear beforehand whether the investment is indeed so desirable that public funds should be used and whether no overcapacity is created. It is often also not clear how high the operational costs will be for the use and whether these will be financed by the most important public financiers such as SZF and the Ministry of SOZAVO. In such a situation important decisions are taken imperceptibly, which (later on) substantially increase the costs of health care.

Purpose of the assessment
The assessment wants to improve efficiency with expansions in the supply of intramural care being geared to the social desirability and the financial feasibility on the long term. In this respect it is important that this happens in a coordinated process on the basis of data and suppositions that are explicit and verifiable.

It is emphatically not the intention to place all health care supply under the full supervision of the government. It is, however, necessary that in advance jointly by all parties involved (MoH, financiers, hospitals, physicians, MvF) it is assessed whether investments in health care are necessary and/or desirable from any perspective and to what extent the costs for the investment and the current costs attached thereto will additionally claim (semi) public resources. This procedure will play an important role to counter unnecessary or less cost-effective expansions.

Nature and organization of the assessment
All proposals for the expansion of the nature and extent of the supply of intramural care, including high-quality clinical care, are priorly submitted to a permanent, independent, reviewing committee. Said committee will get the power to take binding decisions as to these investment proposals and how they can be financed.

A further decision will have to be taken about the place and composition of the committee. Various options are possible, such as an independent committee advising to the Ministry of MoH or an entirely independent body.
The members of the committee must have proper financial and/or medical knowledge, they must be objective and not be directly involved in the outcome of the assessment.

Upon assessing a distinction can be made among three kinds of investments or expansions:
Replacement investments (capacity remains the same);
Expansion investments (current capacity is expanded);
Investments in new technology (capacity that was priorly not available).

The assessment should lead to cost control, but may not result in a (too) bureaucratic decision-making process. For these purposes a threshold value for the assessment should be established, with only investments exceeding a certain volume being assessed.

It is furthermore important that the assessment criteria are clearly communicated to the implementing institutions, so that to them it is clear:
Where they have to file their investment proposal;
Which information their investment proposal should include (estimated investment costs, estimated operational costs, anticipated number of handlings, staff requirements, etc.);
What the assessment criteria are;
How the assessment process runs; and
When to expect a decision.

Replacement investments
These investments are necessary to continue the existing capacity. Basically no assessment is necessary for replacement investments. The social desirability has already been established and the investment can in all reasonableness be introduced in a more or less budget-neutral manner.

Expansion investments
These investments are acceptable from a social point of view, when it has been established that the existing supply or capacity is insufficient and leads to bottlenecks (e.g. manifested in undesired long waiting periods) that gravely damage the quality of health care.

Examples of social assessment criteria are among other things:
Is there currently a bottleneck with the agency that submitted the application?
Is there no overcapacity with implementing agencies in the near surrounding?

If both questions are answered in the positive, the expansion investment can be tested against its financial feasibility:
Are there less expensive acceptable alternatives available (price/quality-analysis)?
Is the institution capable to bear the investment costs and the operational costs?
If not, are the financiers and/or the government able and willing to pay the additional costs?

Investments in new technologies
These investments are acceptable from a social point of view, if it has been established that there is sufficient need thereto (persons dying due to a lack of certain care, persons being forced to seek expensive care abroad, etc.).
Social assessment criteria:
How big is the group of people that cannot be treated at present? If the group exceeds a certain number, then the investment is desirable from a social point of view. In this respect the criterion of accessibility of the investment should be taken into consideration as well. If the investment in the new technology becomes available, how many people from the group that cannot be treated currently, will then have access to the new technology?
If this group is not big, can these people then rely on a good treatment in the neighboring countries or the Netherlands? If this is not possible, this is also an indicator that the investment may be desirable from a social point of view.

If it has been established that the investment is desirable from a social point of view, the investment in the new technology can be tested against its financial feasibility and cost-effectiveness:
Are there less expensive acceptable alternatives available (price/quality-analysis)?
Are insurance institutions willing to include the treatment in their insurance package?
Is the institution capable of bearing the investment costs and the net operational costs?
If not, is the government capable of reimbursing the additional costs?
If not, are there external financiers that are willing to fund the investment? If yes, on which conditions?

Other assessment criteria
In addition to social and financial feasibility criteria there are still other assessment criteria conceivable, such as:
The presence of sufficient and qualified staff;

The capacity and possibilities to operate and maintain equipment, if any;
Etc.

The elements from an assessment procedure described above do not accomplish as yet that an explicit weighing-up is made between the various investment proposals. Given the limited financial resources, this may lead to granting funds to a first investment proposal that is submitted, while a second proposal may have more priority. In order to overcome this it may be built in that assessments for big investments of e.g. high-quality clinical care, take place once to twice annually. Although time-wise this is not an optimal choice, it may be achieved that investment proposals with a high social priority take precedence as far as the implementation is concerned.

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APPENDIX 5: POINTS OF DEPARTURE FINANCIAL RESOURCES

The findings of the most recent complete overview of the financing of health care, the National Health Accounts 2000, were taken as reference for the financial projections that are presented in the SPG. The target figure e.g. for establishing the upper limit for the total expenditures for health care are directly deduced from the total expenditures for health care in the year 2000. The total health care expenditures (inclusive of the RLA-scheme) expressed in percentage of the GDP then amounted to 9.4%. These expenditures comprise all public and private expenditures for health care and may therefore only be used as a target number for the cost control as the private expenditures are not directly controllable. The public funds (expenditures by various ministries from government budgets) and semi-public funds, the National Health Insurance Fund, are basically controllable. The point of reference for these expenses in the year 2000 is around 4% of the GDP.

The data from the year 2000 for the public and semi-public expenses were where possible supplemented by more recent data. The reliability of these data is not always equally high, because payments sometimes actually take place after years. Within the cash system of the government from year to year this leads to big fluctuations.

For the projection of the available funds in health care during the term of this sector plan, use was made of a top-down computation on the basis of a prediction published by the IMF in 2003 of the most important macro-economic indicators for the years 2004-2008. The most important suppositions therein are:

- The Suriname economy grows in both 2004 and 2005 with about 5% and then after three years drops again to a growth of almost 3% on an annual basis;
- The annual inflation drops from 15% in 2004 to 10% in 2006 and the years thereafter;
- The total government expenditures drop from 35% of the GDP in 2004 to 33.3 percent in the last two years.

With the help of this macro-economic prediction and the reference figures mentioned above and supplementary data, a further estimate was made of the extent and the composition of the resource envelope for health care in Suriname. For these purposes also explicit estimates were included from an inventory of the external funds that have already been committed for health care in the coming years.

For the projection of the total health care expenditures in the table in section 6.2 use was made of the following suppositions for the spending by the various parties. Of course these assumptions are tentative.
Given the assumptions and the uncertainties in the available figures, the figures presented are illustrative, or in other words a best-guess projection. Nevertheless they give an indication of the available funds on the basis of the points of departure of the sector plan.

The figures presented below show the underlying assumptions for the available funds in percentages of the GDP for the period of 2003 through 2009.

	2003	2004	2005	2006	2007	2008	2009
Ministry of Social Affairs	1.06%	0.95%	0.95%	0.95%	0.95%	0.95%	0.95%
Ministry of Public Health	0.71%	0.95%	1.10%	1.10%	1.10%	1.10%	1.10%
Other public expenses	0.41%	0.35%	0.35%	0.35%	0.35%	0.35%	0.35%
Subtotal public expenses	*2.18%*	*2.25%*	*2.40%*	*2.40%*	*2.40%*	*2.40%*	*2.40%*
National Health Insurance Fund	2.33%	2.14%	2.10%	2.10%	2.10%	2.10%	2.10%
Total (semi-) public expenses	**4.50%**	**4.39%**	**4.50%**	**4.50%**	**4.50%**	**4.50%**	**4.50%**
External Financing	0.75%	1.44%	1.71%	0.82%	0.66%	0.42%	0.20%
- RLA/Armulov	0.48%	0.44%	0.50%	0.50%	0.50%	0.30%	0.20%
- Other external sources	0.27%	1.00%	1.21%	0.32%	0.16%	0.12%	0.00%
Total (semi-) public expenses and external funds	**5.25%**	**5.83%**	**6.21%**	**5.32%**	**5.16%**	**4.92%**	**4.70%**
public health envelope/ total government envelope	6.2%	6.6%	7.2%	7.2%	7.2%	7.2%	7.2%
Total on the basis of constant private share	**9.50%**	**10.08%**	**10.46%**	**9.57%**	**9.41%**	**9.17%**	**8.95%**

APPENDIX 6: OVERVIEW EXTERNAL ASSISTANCE HEALTH CARE

Partners in health	Type of support	Term of contract	Recipient	Budget	Term	Estimate payment 2004	Estimate payment 2005	Estimate payment 2006	Estimate payment 2007	Estimate payment 2008
United Nations Institutions										
PAHO	Technical cooperation around reproductive health care, maternal and child care and health information	2002-2007	Lobi foundation/MZ/PHC/BOG/RGD							
PAHO	Decreasing the negative effects of small-scale gold-mining			Euro 369,214	24 months	Euro 184,607	Euro 184,607			
UNDP	Financing NSP HIV/AIDS		MoH, NGO's							
UNFPA	program-support for reproductive health care and contraceptive policy	2004-2006	MZ/PHC/RGD/BOG/NGO's	Euro 1,465,012	48 m	Euro 354,896	Euro 304,827	Euro 256,553		

UNICEF	Various maternal and child care projects	2004-2007	MoH,SOZA, Education	Euro 369,000						
Global fund	HIV/AIDS	First two years have been approved		Euro 1,794,514						
Global fund	Malaria			Euro 4,081,550	60 months	Euro 1,544,470	Euro 951,200	Euro 605,160	Euro 539,560	Euro 457,560
Financial institutions										
IDB	Definition service package, reorganization RGD, introduction and updating management (information) and registration systems within SOZA and SZF	2004-2009	RGD,BOG,SZF,SOZA, MV (Central Office)	Euro 4,100,000	48 months	Euro 412,375	Euro 2,570,392	Euro 843,381	Euro 273,852	
IsDB	Establishment radiotherapy unit within AZ and outpatients' department in the interior via Ministry of Regional Development	2003-2008	AZ	Euro 4,894,578		Euro 997,818	Euro 3,896,759			
IsDB	Primary health care centers in the hinterland of		Ministry of Regional Development/MZ	Euro 5,379,235	66 months	Euro 653,616	Euro 1,050,138	Euro 1,050,138	Euro 1,050,138	Euro 1,050,138

	Suriname									
European Union										
EC/EDF-8	Drugs demand reduction project	2004-2007	NAR, PCS	Euro 745,000	43 months	Euro 162,491	Euro 282,621	Euro 185,894	Euro 113,994	
Bilateral donors										
Japan	Investment in 4 mobile clinics, equipment for maternal and child care	2004-2006	RGD/SZN/LH	Euro 2,244,586	12 months	Euro 1,122,293	Euro 1,122,293			
France	Malaria control in eastern Suriname	2003-2007	RGD/BOG/MZ		36 months	Euro 126,984	Euro 126,984	Euro 126,984		
Germany	Improvement industrial health care	Being prepared		Euro 1,717,000	24 months	Euro 858,500	Euro 858,500			
The Netherlands										
	ARMULOV-scheme	2004-2005		Euro 4,800,000						
	a. institutional strengthening BOG b.Central lab	2003-2007		Euro 2,419,658 Euro 651,170	24 months	Euro 1,443,486 Euro 159,055	Euro 488,086 Euro 492,115	Euro 488,086		
	Institutional strengthening Central Office MoH	2001-2005	MoH	Euro 1,200,000	48 months	22,000	44,000	44,000		
	Institutional strengthening RGD	Being prepared	RGD	Euro 450,000	40 months	Euro 164,767	Euro 208,767	Euro 76,467		
	Support neurosurgery	2004	AZ	Euro 115,000	4 months	Euro 115,000				
	Institutional	2004	PCS	Euro	24	Euro	Euro			

	strengthening PCS			603,000	months	379,000	224,000			
	Upgrading mother and child care	2004-2006	LH	Euro 364,736	36 months	Euro 168,706	Euro 184,024	Euro 12,006		
	Institutional strengthening SZN	2004-2006	SZN	Euro 482,096	36 months	Euro 178,259	Euro 250,950	Euro 65,888		
	Renovation kitchen and laundry AZP	2004-2005	AZP	Euro 1,066,328	12 months	Euro 533,164	Euro 533,164			
Interministerial cooperation										
MoH-VWS	Institutional strengthening MoH and VWS	2004-2006	MoH		30 months					
University cooperation										
RUG	Support physical therapy		AZ							
RUM	Curriculum development		SZN							
Utrecht	Support physiology/cardiology		AZ							
ACL	Support obstetrics/gynecology		BOG							
AMC	Support cardiology		AZ							
Municipal cooperation										
Amsterdam	Support GGD									
The Hague	Support pharmaceutical research									
	Establishment urological center Suriname (UROSUR			Euro 1,462,872	12 months??	Euro 1,427,872	Euro 35,000			

	foundation)									
	Technical cooperation		Diakonessenhuis							
	Follow-up research diabetes									
						Total 11,009,358 13,808,426 3,754,557 1,977,544 1,507,698				

APPENDIX 7: PERSONS WHO PARTICIPATED IN FORMULATING THE SECTOR PLAN

1 Stichting Regionale Gezondheidsdienst Abdoelaziz- Djabarkhan I,
2 Maarten Luther Kerk Abendanon C.L.
3 Inter Religiueze Raad Ahmadali. S.
4 Stichting Medische Zending Primary Health Care Suriname Akrum R.
5 Inter Religieuze Raad / Arya Dewaker Algoe Mahesh
6 Stichting Maxilinder Altenberg J,
7 Ministerie van Volksgezondheid Amanh F,
8 Nationaal Instituut Milieu en Ontwikkeling in Suriname Ang S,
9 Ministerie van Volksgezondheid Anomtaroeno. M
10 Ministerie van Volksgezondheid Bab. A.
11 Ministerie van Volksgezondheid Badripersad G.
12 Suralco Bailey C.J.
13 De Nationale Assemblee Bakker W,
14 Ambassade van het Koninkrijk der Nederlanden Bandhoe N,
15 Ministerie van Volksgezondheid Baptista R,
16 Ondernemer Beck
17 s' Lands Hospitaal Beerenstijn I.
18 Inter Religiueze Raad Bemmel. L
19 Algemene Bond van Verpleegkundigen in Suriname Boldewijn H.
20 Health Control Bouterse N.
21 Faculteit der Medische Wetenschappen Brandon P,
22 Europese Commissie Brons D,
23 Ministerie van Volksgezondheid Bueno de Mesquita F,
24 Stichting Claudia A Burleson T.
25 Carec /PAHO Caffe. S mw
26 United Nations Population Fund Caspar P.
27 Surinaams Vereninging van Fysiotherapeuten Chang T.
28 Streek Ziekenhuis Nickerie Changoer R.
29 Stichting Bedrijfsgezondheidszorg Charante van J, dhr
30 Ministerie van Planning en Ontwikkelingsamenwerking Chauthi J,
31 Ministerie van Volksgezondheid Codfried-Kranenburg R,
32 Academisch Ziekenhuis Paramaribo Codrington J,
33 Ministerie van Volksgezondheid Codrington- Kemble
34 VPSI Codrington W.S.
35 Ministerie van Arbeid Technologische Ontwikkeling en Milieu Courtar J.
36 Vereniging van Medici in Suriname Dams E,
37 Ministerie van Volksgezondheid de Vries- Smith
38 Ambassade van het Koninkrijk der Nederlanden Deekman E.
39 Ministerie van Volksgezondheid Doekharan J,
40 Ministerie van Volksgezondheid Dompig H.
41 ETC Crystal Dubbeldam R.
42 Ministerie van Volksgezondheid Dulder D.
43 M.O.Consultancy Dwarkasing W.W .
44 Ministerie van Financien Ebicilio C.
45 Stichting Medische Zending Primary Health Care Suriname Eer van E,
46 UNICEF Eersteling- Hammen.

47 Stichting Pro Health Eiloof D.
48 Firma I. Fernandes & Son Ensberg D.
49 CKC International Commodities NV Faria
50 Stichting Projekta Ganga Sh,
51 Vereniging Arya Dewakar Gangadin T.
52 Nationale Voorlichtings Dienst Gangapersad S. Sh,
53 Ministerie van Volksgezondheid Gangaram Panday A.
54 Kamer van Koophandel en Fabrieken Gangaram Panday B.
55 Diakonessenhuis Gangaram Panday R.
56 Ministerie van Volksgezondheid Gangaram Panday S,
57 De Nationale Assemblee Geerlings-Simons J,
58 ETC Crystal Gerhardt Ch.
59 H.J. de Vries Group Goedhart E.
60 Ministerie van Regionale Ontwikkeling/ Hinterland Goedhoop S.
61 Surinaamse Tandarsten Vereniging Gooswit F.
62 Centrale van Landsdienaren Organisatie Gorison Y.C.
63 SMG Greb S.
64 Pepsur Grep D.
65 Ministerie van Handel en Industrie Groenefeld M.
66 Surinaamse Rode Kruis Guicherit A,
67 Surinaams Alcohol Bedrijf NV Halfhide
68 Ministerie van Financien Hardwarsing K
69 Registratie Commissie Hassrat J.
70 Stichting Regionale Gezondheidsdienst Heide C.R.
71 Ministerie van Natuurlijke Hulpbronnen Held M.
72 Gemeenschappelijk Medisch Technische Dienst Hendrison H.L.
73 Ministerie van Volksgezondheid Heymans H.
74 Ministerie van Volksgezondheid Hindori M,
75 Ministerie van Buitenlandse zaken Hoef van der V.
76 Algemene Bond van Verpleegkundigen in Suriname Holband S.
77 Vereniging van Verpleegkundigen in Suriname Hoogwoud N,
78 Stichting Claudia A Hooplot P,
79 Skills Lab/ MWI Irving E.
80 Ministerie van Volksgezondheid Jaddoe D.
81 Stichting Vincentius Ziekenhuis Jesserun E.
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84 Academisch Ziekenhuis Paramaribo Joemmankhan E,
85 Fatum nv Johanns A.
86 Ministerie van Volksgezondheid Jokhoe A
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88 Kamer van Koophandel en Fabrieken Kalka R.
89 Streek Ziekenhuis Nickerie Kalpoe G.
90 Ministerie van Sociale Zaken en Volkshuisvesting Kanhai G.P.
91 Pan American Health Organization Kanten van E,
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93 Ministerie van Volksgezondheid Khudabux M.R.
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95 VPSI Kok Sey Tjong V.
96 Academisch Ziekenhuis Paramaribo Kom de J.
97 Registratie Commissie Komproe L.

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99 Vereniging van Verpleegkundigen in Suriname Kumbangsila
100 Militair Hospitaal Landveld ,
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103 Stichting Staats Ziekenfonds Lie Hon Fong M,
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106 Ministerie van Planning en Ontwikkelingssamenwerking Maks . M
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109 Stichting Claudia A Maurice N.
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112 Assuria NV Merhai M.
113 Ministerie van Volksgezondheid Miranda de J,
114 Ambassade van Indonesie Mirzal Z.
115 Ministerie van Volksgezondheid Moestadjap L.
116 Stichting Regionale Gezondheidsdienst Mohammed Ashim- Sardjoe M.
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122 Ministerie van Volksgezondheid Nanhoe- Gangadin S,
123 Inter Religiueze Raad Noersalim P.
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142 Diakonessenhuis Poen F,
143 Ministerie van Volksgezondheid Poepon M.
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150 Stichting Pro Health Ramdas S.
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153 Psychiatrisch Centrum Suriname Reeder H,
154 CKC International Commodities NV Rellum L.C.
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156 Ministerie van Sociale Zaken en Volkshuisvesting Ritter van . R
157 Stichting Vincentius Ziekenhuis Robles de Medina
158 Ministerie van Binnenlandse Zaken Rodjan N.
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160 Self Reliance Roemer M.
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165 Ministerie van Financien Rostam P,
166 s' Lands Hospitaal Rozenblad C,
167 Huize Ashiana Rust D.
168 Inter Religiueze Raad Saam J.
169 Dermatologische Dienst Sabajo L,
170 Ministerie van Sociale Zaken en Volkshuisvesting Saimbang T.
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179 Ministerie van Buitenlandse zaken Shameem T.H.
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181 Vereniging van Regionale Gezondheidsdienst artsen Simbhoedath Panday M,
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187 Buro Alcohol en Drugs Snijders P,
188 Stichting Medisch Wetenschappelijk Instituut Sodrono A.
189 Ministerie van Sociale Zaken en Volkshuisvesting Soekrasno M.
190 Anton de Kom Universiteit Suriname Soentik
191 Inter Religiueze Raad Soerdjbalie C.
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193 Ministerie van Onderwijs en Volksontwikkeling Soetosenojo R.
194 Vakcentrale C- 47 Souprayen C.
195 Ministerie van Volksgezondheid Sowirono T.
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197 Stichting Staats Ziekenfonds Starke M,
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200 Ambassade van Indonesie Sunjoyo S.
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204 Stichting Prohealth Terborg J,
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219 Vereniging Surinaams Bedrijfsleven Welzijn F.
220 Vice - Voorzitter / Assemblee lid Wijdenbosch R,
221 Ministerie van Financien Wijnerman
222 Stichting Regionale Gezondheidsdienst William- Asgerali S.
223 Huis arts William R.
224 Ministerie van Volksgezondheid Wolff G.
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227 Buro voor Openbare Gezondheidszorg Zeefuik M.
228 Ambassade van Venezuela Zurita C.