HEALTH SYSTEMS AND SERVICES PROFILE OF

SURINAME

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ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES
DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT
PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE SUMMARY

Suriname estimated total population for 2001 is 433,998 inhabitants, with approximately 74% living in the urban areas. The unemployment rate in 1998 was 11%. The major ethnic groups are Hindustani (East-Indian descent) who account for approximately 37% of the population, and Creole (mixed white and black) 31%. The third largest ethnic group consists of Javanese, descendants from Indonesia with 15%. The Republic of Suriname has a parliamentary system. The legislative power is situated in the National Assembly consisting of 51 elected members. The executive power lies with the President, who is chosen by the National Assembly. The country is divided into 10 administrative districts, subdivided into 62 regions. Each region has its own council. The agencies responsible for political and administrative decentralization are the Ministry of Regional Development and the Ministry of Internal Affairs. A District Commissioner, the representative of the Government and the highest local authority, heads each district.

The main political and social problems that affect the health situation or the performance of the health services are the lack of an inter- sectoral approach in addressing the problems in the area of water supply, sanitation, environmental protection, food production, basic education, social housing and employment. In addition, other problems are the issues related to cost recovery as an instrument for social participation and cost containment, without excluding the poor and near poor. The socioeconomic decline that has taken place over the past 10 to 15 years has adversely affected all segments of society, including the health sector. Bauxite mining and processing is the main contributor to the economy accounting for more than 15% of GDP and 70% of export earnings. The public sector is the most important sector in terms of formal employment and contribution to GDP. The Dutch development aid is the main external financial contributor to the total budget income of the public sector.

The number one leading cause of death is still "Hypertension and Cardiovascular disease". Cerebrovascular disorders are in second place followed by external causes, malignant neoplasms and gastro-intestinal disorders.

The core institutions of the health care system are the Central Office of the Ministry of Health, the Bureau of Public Health and the Inspectorate. The central office and the inspectorate function at the level of global health planning and standard-setting, inspection and monitoring while the Bureau of Public Health is responsible for program development. The providers of health care includes the government subsidized primary health care organizations for the poor and near poor, namely the *Regional Health Service (RGD)*, which covers the coastal area and the *Medical Mission* who covers the population living in the interior. There is agreement among senior MOH staff that there is an urgent need for qualified professional staff.

The MOH finds it difficult to recruit and retain skilled people because wages and working conditions in the private sector are much more attractive.

The three major types of financing for health care include: The State Health Insurance Fund (SZF) that pays for a comprehensive package of health benefits for approximately 35% of the population that includes civil servants and a small number of people who enroll voluntarily. The fund is financed by wage tax contributions, subsidies from general tax revenues and voluntary premiums. The Ministry of Social Affairs (MSA) has the responsibility for health care, primary and hospital care for the poor and near poor free of charge. This covers approximately 42% of the population. Private firms and private health insurance represents approximately 20% of the population. The Surinamese people receive medical services from an array of public and private health care providers.

The origin of the reform process in Suriname can be traced back to the mid- 1990's, when Suriname was going through a painful structural adjustment program to correct macro-economic distortions (huge inflation, major budget deficits, etc.). Suriname has an explicit agenda for health reform. The objective is "to develop and initiate policy reforms to improve the efficiency, equity, quality and financial sustainability of health care in Suriname"[1]. Health sector reform is explicitly incorporated into the Government's Declaration 2000-2005 and in the Government's Multiannual Development Plan 2001-2005. Currently the reform is in its design stage. At this stage several studies have been executed to collect the necessary data to design the health reform policies that will result in a more efficient, more effective and sustainable health system. After completion of the studies, and based on the recommendations that result from the studies, policy decisions will be taken to design the health reform program and to implement the corresponding measures. So far the technical assistance program that supports the studies to design health reform is on schedule.

1. CONTEXT

1.1 Political Context

The Republic of Suriname has a parliamentary system. The legislative power is situated in the National Assembly consisting of 51 elected members. The executive power lies with the President, who is chosen by the National Assembly.

The country is divided into 10 administrative districts, subdivided into 62 regions. Each region has its own council. The agencies responsible for political and administrative decentralization are the Ministry of Regional Development and the Ministry of Internal Affairs. A District Commissioner, the representative of the Government and the highest local authority, heads each district. Each region has District Councils and Resort Councils, which are political bodies. Their members are elected through the political parties. Financial decentralization, including relative fiscal autonomy, is currently in the planning phase. In 2002, the Ministry of Regional Development will execute a project, financed by the IDB, to strengthen local government.

National planning and management of development is the task of the Ministry of Planning and Development Cooperation, with the Planning Office as its policymaking unit. This Office is responsible for the drafting of the national Multi-Annual Development Plan. Social policy is primarily implemented through the Ministry of Social Affairs, but the Ministries of Health and Ministry of Education also implement aspects of social policy.

Health policy is an integral part of national policy, which is formulated in the Government Policy Statement. Such policy is implemented at the subnational level through special programs, such as projects by the Ministry of Regional development, in close cooperation with other government and non-governmental agencies.

The main political and social problems that affect the health situation or the performance of the health services are the lack of an inter-sectoral approach in addressing the problems in the area of water supply, sanitation, environmental protection, food production, basic education, social housing and employment. In addition, other problems are the issues related to cost recovery as an instrument for social participation and cost containment, without excluding the poor and near poor. The socioeconomic decline that has taken place over the past 10 to 15 years has adversely affected all segments of society, including the health sector.

1.2 Economic Context

Bauxite mining and processing is the main contributor to the economy accounting for more than 15% of GDP and 70% of export earnings.[2] The public sector is the most important sector in terms of formal employment and contribution to GDP. The Dutch development aid is the main external financial contributor to the total budget income of the public sector.

GDP growth rates showed wide fluctuation from –3% in 1993, increasing to 13% in 1996, and drastically decreasing to 4% in 1998 and -1% in 1999.[3] Due to huge increases in the inflation rates during the nineties, the percentage of the population living below the poverty line dramatically increased. It is estimated that between 50-75% of the population lives below the poverty line.[4]

Selected Economic Indicators

Indicator	Year						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Per capita GDP in constant US$ prices	1,979	1,752	1,851	2,282	2,360	2,376	2,311
Economically active population, in thousands	93	90	90	98	93	99	99
Total public spending as a % of GDP	29.3	27.1	29.7	34.4	42.5	38.9	41.2
Public spending on social programs as a % of GDP	9.4	4.1	6.5	6.4	5.7	8.7	6.8
Annual rate of inflation (average to average)	143.6	368.5	235.6	-0.7	7.1	19.0	98.8

Sources: General Bureau of Statistics; PAHO, Health in the Americas, 1998, Volume II; http://www.devdata.worldbank.org, Final Report National Health Accounts 2000

1.3 Demographic and Epidemiological Context

Because the last census was held in 1980, no recent data exist for life expectancy at birth. It is estimated however to be 70.9 years, with females (73.5 years) expected to live longer than males (68.3 years).[5]

From 1980-1989 the average population growth rate was 1.3%. When emigration (mostly to the Netherlands) increased in the period 1989-1993 the growth rate decreased to an annual average of 0.3%. In the subsequent 4 years (1993-1997) the average growth rate increased again to 0.9% due to the fact that emigration figures were down to half of the previous period.

The average annual population growth rate for the years 1990-1999 was 0.8 nationally, and 0.8 and 1.1 for urban and rural areas, respectively. For the year 2001 it is estimated at 0.4.[6] The dependency ratio for 1995 was estimated at 60.7.

	YEAR						
	1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Crude birth rate (per 1000 mid-year population)	23.3	20.8	21.3	22.7	25.8	24.1	23.6
Total fertility rate	ND	ND	2.4	2.4	ND	ND	2.35
Crude death rate (per 1000 mid-year population)	7.4	7.0	6.6	7.0	6.9	6.6	7.0
Maternal mortality rate (per 100,000 live births)	63.8	86.6	45.9	42.6	74.1	88.1	108.4
Infant mortality rate (per 1000 live births)	21.4	22.8	18.0	16.4	22.0	15.9	22.4

Sources: Bureau of Public Health; General Bureau for Statistics, http://www.data.worldbank.org/, PAHO, Health Conditions in the Caribbean, 2001.

The Total Fertility Rate declined from 3.6 in 1980 to 2.6 in 1990, and 2.4 in 1995. In 1999 the Central Bureau for Civil Registry registered 10,144 births. Between 1993 and 1999 the crude birth rate hovered around 23.0 per 1,000 live births. In the year 2001 it declined to 18.8 per 1,000.[7]

The crude death rate has averaged around 7 deaths per 1,000 throughout the nineties. A survey on maternal mortality for the period 1995-1999 reported an average of 73 maternal deaths per 100,000 live births. However, it is well known that maternal mortality is underreported. In the past decade, the

highest maternal mortality rate was reported in 1992 (122 per 100,000 livebirths). The 1999 maternal mortality rate of 108.4 is still considered an underestimation.

The infant mortality rate reported for 1999 was 16.8 per 1000 livebirths. This is also considered to be an underestimation, since there is general under-reporting of mortality. Other sources show that infant mortality for 1999 was 27.4.[8]

The reporting of deaths experienced its major drop in 1995 when only 58% of death certificates were received. In 1998 and 1999 death reporting increased to 80%. Deaths' resulting from ill-defined causes for the period 1997-1999 is 15%. Out of these, almost half is labeled as unknown, mostly in the over 65 years age group.

The estimated death rate from communicable diseases remains at about 31 for the years 1997-1999, and most of these deaths are in adults aged 65 and older with acute respiratory infections. Children under 5 years compose about 16% of deaths due to communicable diseases declaring infectious intestinal diseases and septicemia as the cause of death.

Mortality due to malignant neoplasms increases annually with an estimated death rate of 51.4 in 1999, although it remains as the fourth leading cause of death for the years 1997-1999. Most of the deaths due to malignant neoplasms occur in the over 60 age group. There is a distinct pattern in gender and age for deaths due to malignant neoplasms. For persons aged less than 60, the ratio of males to females is 0.5, and for persons aged 60 and older the ratio is 1.7, for mortality due to malignant neoplasms.

Diseases of the circulatory system remain the leading cause of death for the 1997-1999 period, mostly those in the 45 and over age group. External causes rank number one in the 5–44 year's age group, with events of undetermined intent as the predominant cause of death.

The number one leading cause of death is still "Hypertension and Cardiovascular disease". Cerebrovascular disorders are in second place followed by external causes, malignant neoplasms and gastro-intestinal disorders.

HIV/AIDS first entered the top ten list in 1996 (ranking 9th), while in 1999 it moved up to the 8th place.

An important chronic communicable disease is tuberculosis. The incidence of tuberculosis increased largely between 1998 and 1999 although the number of registered deaths due to tuberculosis dropped from 9 in 1998 to 5 in 1999. The incidence of leprosy dropped steeply between 1995 and 1996 but has continued to rise since a low of 43 cases in 1996 averaged about 54 cases per year between 1997 and 1999.

Although there is currently no chronic noncommunicable disease surveillance at the national level, some data is available from the primary health care institutions. The Regional Health Services, which provides primary health care to the coastal populations, reported that 15% of all clinic consultations in 1999 were for hypertension, and 10% were for diabetes. The occurrence of chronic disease is prevalent

in approximately 50% of the villages located in the hinterland.[9] The prevalence of hypertension was 21.4 per 1000 population of the hinterland, and 2.5 for diabetes mellitus.[10] In 1996 11 new cases of malignant neoplasms of the lung, 45 new cases of female breast cancer, and 55 new cases of cervical cancer were reported.[11] For the year 2000, 13 new cases of malignant neoplasms of the lung, 75 new cases of female breast cancer, and 85 new cases of cervical cancer were reported.[12] A cervical cancer-screening project began in 1998, which could have contributed to the considerable increase in incidence of cervical cancer.

The five leading causes of infant mortality are: (i) certain conditions originating in the perinatal period comprising nearly 50% of all infant deaths; (ii) gastrointestinal diseases with 11%; (iii) septicemia (except neonatal); (iv) acute respiratory infections and congenital malformations, deformations, and chromosomal abnormalities; and (v) nutritional deficiencies and nutritional anaemia. 12% of the deaths in children under age 5 are due to gastrointestinal diseases, while 4% are due to acute respiratory infections.

1.4 Social Context

Suriname estimated total population for 2001 is 433,998 inhabitants, with approximately 74% living in the urban areas.[13] The unemployment rate in 1998 was 11%. Compared to 1996 and 1997, there was no change when respectively 10% and 11% of the economically active were unemployed. There is no data available on informal labor.[14]

The major ethnic groups are Hindustani (East-Indian descent) who account for approximately 37% of the population, and Creole (mixed white and black) 31%. The third largest ethnic group consists of Javanese, descendants from Indonesia with 15%. The population in the hinterland consists of Maroons (African ancestors) and 10%, Amerindians 2%. Smaller ethnic groups in the coastal area include Chinese 2%, and White 1%.

For the year 2000 preliminary survey results estimate the overall literacy of the population aged 15 years and older to be 94.2%.[15] However, in the interior, only 51% of the population is literate. Female literacy is lower than male and the literacy percentage declines with age.

Approximately 86% of children attend primary school; a slightly greater percentage in the urban areas (95%) compared to rural areas (91.5%). In the interior however, only 56% of children attend school. There is no difference between male and female primary school attendance.

2. THE HEALTH SYSTEM

2.1 General Organization

The Ministry of Health (MOH) is responsible for the availability, accessibility and affordability of health care. The main responsibilities of the MOH are the following: policy making, evaluation,

coordination, and setting of standards and values. The core institutions of the health care system are the Central Office of the Ministry of Health, the Bureau of Public Health and the Inspectorate. The central office and the inspectorate function at the level of global health planning and standard-setting, inspection and monitoring while the Bureau of Public Health is responsible for program development.

The providers of health care includes the government subsidized primary health care organizations for the poor and near poor, namely the *Regional Health Service (RGD)*, which covers the coastal area and the *Medical Mission* who covers the population living in the interior. Also, *Private General Practitioners* (GP), the majority of GP's are in private practice and serve people that are covered by the State Health Insurance (SZF), private firms or are self-paying. Specialists who provide outpatient and inpatient care. Primary Care clinics managed by large firms. *Government Run Vertical Programs*, such as special health services for the entire population e.g. STD's, leprosy, youth dental care, malaria, and immunization. Many NGO's are recognized by the government to provide specific health care services, e.g. the Foundation for Family Planning (Stichting Lobi), specialized in the field of reproductive health.

The contribution of the private sector is at the level of service-provider and its activities are mostly in the curative field, while the government subsidized Regional Health Services and Medical Mission provide curative as well as preventive health care services.

The majority of specialists provide outpatient consultations in the outpatient polyclinics that are attached to the nation's public and private hospitals. Inpatient hospital care is provided by five hospitals; three are public and two are private.[16]

2.2 System Resources

There is agreement among senior MOH staff that there is an urgent need for qualified professional staff. The MOH finds it difficult to recruit and retain skilled people because wages and working conditions in the private sector are much more attractive. There is a shortage of professionals in the MOH with the background needed to develop policy.[17]

HUMAN RESOURCES IN THE HEALTH SECTOR

TYPE OF RESOURCE	YEAR			
	1996	**1997**	**1998**	**1999**
Ratio of physicians per 10,000 pop.	10.4	2.52	NA	5.0
Ratio of nurses per 10,000 pop.	NA	15.63	NA	22.8
Ratio of dentists per 10,000 pop.	0.78	0.09	NA	0.8
Ratio of mid-level laboratory technicians per 10,000 pop.	NA	NA	NA	NA
Ratio of pharmacists per 10,000 pop.	NA	NA	NA	0.6
Ratio of radiologists per 10,000 pop.	NA	NA	NA	0.1
No. of Public Health graduates	NA	NA	NA	NA

Sources: CMO Report 1999, Ministry of Health; Health in the Americas 1998 edition. PAHO/WHO, Health Situation in the Americas: Basic Indicators 2001; IDB, Suriname Health Sector Assessment, 1999.

HUMAN RESOURCES IN PUBLIC INSTITUTIONS, 1999

Institution	Type of Resource					
	Physicians	**Nurses**	**Nursing Auxiliaries**	**Other health workers**	**Administrative personnel**	**General Services**
Regional Health Services	50	56	64	NA	NA	NA
Academic Hospital	NA	157	52	NA	NA	NA
Government Hospital	NA	127	100	NA	NA	NA
Nickerie Hospital	NA	21	8	NA	NA	NA
Medical Mission	NA	12	69	NA	NA	NA
COVAB	NA	8		NA	NA	NA
Psychiatric Institute	NA	78	30	NA	NA	NA
Bureau of Public Health	NA	20	8	NA	NA	NA
Total	NA	479	331	NA	NA	NA

Source: CIMS 2000.

Drugs and Other Health Products

The prices on drugs are totally controlled. The margin for imports is 22%, the pharmacy is allowed a further 35%. These percentages are calculated surplus the C.I.F. value. In the informal sector there is no control. The five top selling products are Atenolol (100 mg); Amoxicilline (500 mg); Nifedipine (10 mg); Paracetamol (500 mg); Vitamin B complex /Multivitamins. In 1999 a draft drug policy was submitted to the Minister of Health. The essential drug list includes 458 items. All health care institutions use the list. The first edition was issued in 1988. The latest edition (the third edition) of 1997 has already undergone the third revision. In fact the entire population has access to all drugs on the list. However, due to discontinuation in supply the coverage is lower.

INDICATOR	1993	1994	1995	1996	1997	1998	1999
Total n° of registered pharmaceutical products	585	591	597	632	651	692	773
Percentage of brand-name drugs	46%	50%	0%	51%	84%	29%	32%
Percentage of generic drugs	54%	50%	100%	49%	16%	71%	68%
Total spending on drugs (selling price to the public) (mln US$)*	0.71	1.49	4.02	5.69	5.20	4.85	2.80
Per capita spending on drugs (sale price to the public)	1.76	0.37	9.83	13.76	12.41	11.42	6.50
Percentage of public spending on health allocated to drugs	NA	NA	NA	NA	NA	NA	NA
Percentage of the expenditure executed by the ministry of health for drugs	NA	NA	NA	NA	NA	NA	NA

Sources: MOH, Registration Bureau of Pharmaceuticals; Drug Supply Company Suriname. * These are the sales of the Drug Supply Company. It does not include informal sales of private pharmacies.

The Drug Supply Company Suriname distributes all drugs on the national drug list to the private and public pharmacies, as well as to the hospitals. These institutes deliver the drugs to the patients, according to their membership in one of the Health Insurance Companies. A treatment protocol is included in a draft drug policy. There is a committee in place to formulate standardized therapies, up to

now no therapy protocol has been released. In both private and hospital pharmacies the presence of the pharmacist is required.

Equipment and Technology

AVAILABILITY OF EQUIPMENT IN THE HEALTH SECTOR, 1999

SUBSECTOR	TYPE OF RESOURCE			
	Beds available per 1,000 pop.	**Basic diagnostic imaging equipment per 1,000 pop.**	**Clinical laboratories per 100,000 pop.**	**Blood banks per 100,000 pop.**
Public		NA	NA	NA
Academic Hospital	420	NA	1	NA
Government Hospital	280	NA	NA	NA
Children's Pavilion	300	NA	NA	NA
Nickerie Hospital	70	NA	NA	NA
Coronie Hospital	9	NA	NA	NA
Regional Health Center Ellen	9	NA	NA	NA
Regional Health Center Albina	8	NA	NA	NA
Stoelmanseiland Hospital	20	NA	NA	NA
Djoemoe Hospital	3	NA	NA	NA
Brownsweg Hospital	2	NA	NA	NA
Bureau of Public Health		NA	1	NA
Medical Faculty Research		NA	1	NA
Red Cross Blood Bank		NA	NA	1
Subtotal	**1,121**	NA	**3**	**1**
Private		NA	NA	NA
Diakonessen Hospital	240	NA	1	NA
St. Vincentius Hospital	320	NA	NA	NA
Health Control Laboratory		NA	1	NA
Subtotal	**560**	NA	**2**	NA
TOTAL	**1,681**	NA	**5**	**1**

Source: ABS 1999

In 1984 an initiative from all the hospitals in Suriname was taken to establish an institute responsible for maintenance and repair of medical equipment in the health sector (GMTD). This institute is an example of public-private partnership. Both the Government and the private sector are participating in the institute.

There are local trained technicians. For more advanced equipment experts from the outside are attracted on a short-term basis. Suriname has in operation the following units, all are situated in Paramaribo: one dialysis unit (non-Governmental), two neonatal units (one public and one private), one advanced intensive care unit (public), and one CT Scan unit (non-Governmental).

2.3 Functions of the Health System

Steering Role. The MOH is responsible for formulating and setting the stage for the implementation of the health sector policy in Suriname. To perform this sorely needed function, the Ministry needs to have a functioning management and decision-making structure, a qualified staff of analysts, and an adequate health management information system. The Ministry does not currently have the staff nor the

information needed to properly monitor the health sector nor to set policy. Presently, senior ministry staff focuses on day-to-day problems.

Financing and Expenditure. The three major types of financing for health care include: The State Health Insurance Fund (SZF) that pays for a comprehensive package of health benefits for approximately 35% of the population that includes civil servants and a small number of people who enroll voluntarily. The fund is financed by wage tax contributions, subsidies from general tax revenues and voluntary premiums.

The Ministry of Social Affairs (MSA) that has the responsibility for health care, primary and hospital care for the poor and near poor free of charge. This covers approximately 42% of the population. Private firms and private health insurance represents approximately 20% of the population.

	1996	1997	1998	1999
Per capita public expenditure on health (in US$)	NA	NA	NA	NA
Public expenditure on health /total public expenditure	NA	NA	NA	NA
Total per capita health expenditure (in US$)	98.4	NA	NA	NA
Total expenditure on health as a % of GDP	7.3	NA	NA	NA
External health debt /Total external debt	NA	NA	NA	NA

Source: PAHO/WHO: Health Situation in the Americas: Basic Indicators 2001.

Health Insurance[18]

The Surinamese people obtain insurance from a range of sources including the State Health Insurance Fund (SZF), the Ministry of Social Affairs (MSA), private firms that self insure, private health insurance, and others that pay for health insurance, such as automobile and workplace accident insurers. Payment policies established by the SZF largely determine payment practices of the other payers. The package of benefits covered by the SZF is extremely comprehensive and includes preventive as well as curative services. The SZF does not cover preventive services that are provided to the entire population through government run vertical programs.

The MSA is responsible for safety net programs for the poor. In the health sector, the MSA certifies eligibility to receive subsidized services and functions as a payer to hospitals for this certified population.

The majority of private firms with employees that are covered under collective bargaining agreements have chosen to self-insure rather than purchase health insurance from a private company or from the SZF.

2.4 Delivery of Services[19]

The Surinamese people receive medical services from an array of public and private health care providers. Residents of the Atlantic Coast, approximately 90% of the population, can receive primary care services from public RGD clinics, from private doctors, or from salaried practitioners hired by

private employers. They can also receive hospital care from public or private hospitals and consult specialists in private practice or employed by public hospitals. People who live in the interior receive primary services through clinics run by the Medical Mission and use the private Diakonnessen Hospital. People who are certified by the MSA are entitled to free primary care services at RGD clinics. The Medical Mission serves the approximately 40,000 Surinamese residents that live in the interior of the country. Primary care services are provided through a network of health centers that are staffed by health workers. Public health doctors are consulted for difficult cases. Patients that need hospitalization are transported to Paramaribo and receive care in the private Diakonnessen Hospital.

PRODUCTION OF SERVICES, 2000

	Number	Rate per 1,000 population
Consultations and controls performed by medical professionals	574,902*	1.3
Consultations and controls performed by nonmedical professionals	NA	NA
Consultations and controls performed by dentists	NA	NA
Emergency consultations	39,456	0.1
Laboratory consultations	NA	NA
X-rays	NA	NA

Source: PAHO Core Health Data Initiative, 2001. * Includes Psychiatric Institute, Medical Mission, St.Vincentius Hospital, Government Hospital, Academic Hospital.

SERVICE PRODUCTION, 1999

INDICATOR	
Total no. of discharges	32,621
Occupancy index	52-70% **
Average days of stay	7.9 **

Source: CMO Report 1999, Ministry of Health; **Includes Academic Hospital, Government Hospital, and Diakonessen Hospital.

Surinamese citizens that have medical conditions that cannot be treated inside Suriname are entitled to be sent abroad for treatment if there is a high probability of complete recovery. This benefit is available to all citizens, regardless of insurance coverage, and is funded through the Dutch Treaty Funds. All referrals are currently to Holland but the MOH is investigating the possibility of sending patients to other countries in the Region.

3. MONITORING AND EVALUATION OF HEALTH SECTOR REFORM

3.1 Monitoring the Process

Monitoring the Dynamics. The origin of the reform process in Suriname can be traced back to the mid-1990's, when Suriname was going through a painful structural adjustment program to correct macro-economic distortions (huge inflation, major budget deficits, etc.). This had serious implications in regards to funds availability for the health sector. Particularly, funding of health service providers by the Government was under pressure.

In 1997 the report "Suriname Health Sector Assessment" prepared by the Inter-American Development Bank (IDB) made recommendations for policy reforms to restructure financing of the health sector. At the time, The Minister of Health expressed the Government's interest in receiving technical assistance from the IDB to implement the recommendations, emphasizing efficiency and rational use of public services. Eventually this led to the technical cooperation program existent between the Government of Suriname and the IDB to initiate health sector reform in the country by performing studies to support the planning process for health sector reform.

The opinion of the population was taken into account at the time the reform was proposed, since many of the Government insured people, i.e. the civil servants, covered by the State Health Insurance, and the poor and near-poor, covered by the Ministry of Social Affairs, expressed publicly their dissatisfaction with the current payment system and the lack of quality of the services provided. Also the providers (doctors, specialists, hospitals), who were dissatisfied with the payment they received, were on strike frequently and demanded changes in the financing policy.

Suriname has an explicit agenda for health reform. The objective is "to develop and initiate policy reforms to improve the efficiency, equity, quality and financial sustainability of health care in Suriname"[20]. Health sector reform is explicitly incorporated into the Government's Declaration 2000-2005 and in the Government's Multiannual Development Plan 2001-2005.

Staff of the Ministry of Health and health specialists of the IDB designed jointly the health reform process. IDB consultants produced drafts of policy options and health reform proposals. These were discussed and agreed with the Minister of Health, and other key persons and institutes in the health sector.

Surinamese health authorities and IDB health specialists defined the overall objectives of the health reform program. The specific objectives of the technical assistance program were prepared by the IDB experts and negotiated with the local health authorities.

During the preparation of the technical assistance agreement visits were paid to many stakeholders, such as State Health Insurance, National Hospital Council, Medical Mission, Bureau of Public Health, Regional Health Services, etc., to obtain their position and views for the design of the health reform proposals.

The support for health sector reform program includes a Plan of Action, with goals, dates and responsibilities for its implementation. Funding for the health sector reform program was received from the IDB. Currently the reform is in its design stage. At this stage several studies have been executed to collect the necessary data to design the health reform policies that will result in a more efficient, more effective and long term sustainable health system. After completion of the studies, and based on the recommendations of the studies, policy decisions will be taken to design the health reform program and

to implement the corresponding measures. So far the technical assistance program that supports the studies to design health reform is on schedule.

The results of the health sector reform studies have been discussed with the health and non-health stakeholders. Information to the general public has been provided through press releases and media coverage, although not in sufficient quantity. So far no feedback from the information provided to the population has resulted in changes to the reform process.

Evaluation criteria for health sector reform in Suriname were not defined from the outset of the technical cooperation program. The current studies will provide evaluation criteria for each of the subjects of health reform. No evaluation of the impact of reform has taken place, since the project is still in its design stage.

Monitoring the Content

Legal framework. No changes have been or will be introduced in the Constitution because of health reform. Some health laws might be changed (for instance: law on import of drugs, law on tariffs in health care, etc.). These changes will support one of the principal goals of health reform, namely to be more efficient with limited funds. The introduction of the law on tariffs in health care will be a much-needed support to contain health services costs. Equity is defined in the Constitution (Article 8: "No one can be discriminated on basis of sex, ethnicity, religion, education, political preference or economic status"). This principle is in line with the International Convention on Human Rights (Protocol of San Salvador) and the Convention on the Rights of the Child.

Right to Health Care. The *right to health care* is guaranteed in the Constitution (Article 36: "Everyone has the right to health"). No mechanisms have been launched, however, for disseminating this right. There are several programs to increase coverage, such as preventive services to the total population (Buro of Public Health), primary care for the rural areas (Regional Health Services) and primary care for the interior (Medical Mission). A *basic package of health benefits* is provided to civil servants, people from the rural areas and people from the interior. The basic package consists of preventive care, primary and secondary curative care, hospitalization and drugs.

Steering Role. The Ministry of Health is supposed to retake its steering role functions as leader of the health sector. As such the Ministry of Health will be strengthened in its capacities to make necessary policy decisions, to monitor public financing, to provide insurance to the civil servants and the poor, and to monitor the performance of the different health providers.

To strengthen its steering role within the framework of health sector reform the Ministry of Health is supported by a multi-disciplinary Health Sector Reform Committee, that oversees the results of the health sector reform program and provides guidelines for policy decision and implementation of the recommendations for reform. Changes in the health authority structure are proposed, for instance

integration of the State Health Insurance Fund (civil servants) and Ministry of Social Affairs (poor and near-poor) into one Social Health Insurance Fund. No new public institutions have been created as a result of health sector reform.

A well functioning health information system is lacking in the country. Currently the Ministry of Health, with support of the PAHO, is in the process of designing one. There is a reporting obligation of health institutions to the Ministry of Health, especially for those that receive Government support. However, reporting is not done structurally, and the Ministry has no tools to enforce proper and timely reporting. Public institutions must submit to the Ministry of Health their annual reports, including activities and use of funds. The National Audit Services must audit these annual reports. Some annual reports of public institutions have delays of many years.

Modalities of Decentralization. Steps are undertaken to review and modify, where necessary, the functioning of the health services to the people in the rural areas (Regional Health Services). These changes are related to more effective decentralized health services to the several regions, and are not necessarily linked to other efforts to decentralize public administration or other social sectors. Responsibilities, authorities and resources are not transferred to subnational levels, since this level of subnational, decentralized government is not existent in Suriname.

Decentralization is reasonably well developed at the Medical Mission, which provides health services in the interior, and to some extent at the Regional Health Services level, that serves the rural areas. The Bureau of Public Health is not largely decentralized, but has auxiliary branches in the three major cities of the country.

Social Participation and Control. Social participation is an objective of health sector reform. Social participation is stimulated through presentations of study results and policy options to social groups and civil society, to obtain some general feedback on the performance of the health system, and to gain support for reform proposals. Social participation in the decision making process is however limited. No social groups have been excluded on purpose from decision-making. Social participation has no formal status.

Financing and Expenditure. In the health reform process in Suriname there is large emphasis on health financing and expenditures. In several ways the information systems on financing and expenditures are strengthened through the introduction of a national health accounts system; analysis of the current payment systems; and design of an actuarial model for the State Health Insurance Fund. The total expenditures on health display a tendency to increase. Such increase is mostly funded by an increase in private expenditures (firms and households out-of-pocket). The population considers that the increases of household out-of-pocket payments for health care are unfair and unjust. The Reform intends to modify the distribution of public financing, with more emphasis on financing of preventive

and promotional care. Efforts are being undertaken to increase efficiency of spending in the health sector (such as purchase of drugs). New payment systems to providers will link payment to performance and hopefully will lead to better achievements of health goals and better quality of health care.

Service Delivery. Services of the Bureau of Public Health should be strengthened through more data collection, more prevention, and more health promotion. The primary care services of the Regional Health Services will concentrate more on preventive care, not only on curative care, as is now the case. Primary care will act more as the gatekeeper to the expensive secondary care. Services of the secondary care as such will not change much. It is proposed that payments for service delivery in the secondary care will be modified, utilizing package payments for the top ten reasons for admissions, outpatient packages instead of payment per bed day as is currently practiced.

Several programs are currently being developed to increase service delivery to vulnerable groups, such as: mother and child care programs, adolescent sexual and reproductive health programs, increased quality coverage to the poor and near-poor, to people in the interior, and for the establishment of nursing homes for the elderly, etc.

Models of care are being redefined; in such a way that primary care will include more preventive and promotive care instead of only curative care. Secondary care will be more focused on short stay and acute hospital care instead of long stays in hospital; introduction of day surgery, outpatient surgery etc. are part of this strategy. Better integration of primary and secondary care is part of the reform process (strengthen gatekeepers function of GP, improve follow-up of patients through an improved communication of the medical specialist to the GP that referred the patient.

Management Model. It is proposed that the different stakeholders in the health sector be organized in a formal National Health Council. The Ministry of Health has convened several meetings, but the council has not been implemented. The National Health Council would reflect participation of both public and private health facilities.

Management contracts/commitments in the public health system already exist between the payers (MOH, SZF, Social Affairs) and providers (BOG, RGD, Medical Mission, hospitals, GP's, specialists, pharmacies). In general the public establishments deliver services to the entire population. Public hospitals are legally allowed to sell their services to third parties in the private sector. There is already some form of autonomy for public health facilities, such as the public hospitals and the Regional Health Services. A Board monitors these institutions. However, self-management is limited, since the Minister of Health appoints the members of the Board, and sets crucial aspects such as tariffs and salaries. There is no intention to turn over the management of public health facilities to the private sector.

Human Resources. Some modifications to the education program of general practitioners will be introduced, to better reflect the need for strengthening preventive and promotional care. No significant

changes in labor law have been introduced, and no modifications have been proposed in the multidisciplinary orientation of professional practice. One of the goals of health sector reform is quality assurance, under which certification of general practitioners is proposed. Several professional bodies of health workers (Doctors Association, Nurses Association) are part of the National Health Sector Reform Committee.

Within the health sector reform framework a proposal has been included to improve the performance of general practitioners in the public sector. It consists in offering a bonus to the general practitioner if a predefined target for preventive care services for his/her patient population is reached.

Quality. Accreditation of health facilities (primary care centers, hospitals) is part of the health sector reform program. Health sector reform includes initiatives in the area of improved technical quality (better education of human personnel, better management of facilities and better monitoring of performance). Perceived quality of care of the households and the patients is included as part of the data collection activity within the health reform program.

3.2 Evaluation of Results

The health sector reform process in Suriname is still in its design stage, so there is no actual impact to report on the improvement in the levels of equity, effectiveness, quality, efficiency, sustainability and social participation. Likewise it is not possible to present data that reflects evidence for the impact of health reform on the mentioned indicators. Nevertheless in the information below an attempt is made to illustrate how the health sector reform program *may* have an impact on the indicators.

EQUITY

Coverage. The percentage of the population effectively covered by a *basic package of health services* will increase by targeting the needy people who do not have access to any form of health insurance and incorporating them into the social health insurance system. Coverage of prenatal care and infants under 1 year and the percentage of women using contraceptives are expected to increase in the long run, since preventive care will be strengthened.

Resource Distribution. Health sector reform will lead to several resource indicators, such as the total expenditure per capita on health and the percentage of public expenditures of the total health expenditures. These indicators will be used to develop resource distribution strategies. For example, how can public funding of health care be shifted from funding of hospitalization abroad of a limited number of patients to a universal coverage of immunization. It is not foreseen that health sector reform as such will have a direct impact on the number of physicians or nurses per 10,000 population. On the other hand, health reform should have an impact on the number of hospital beds per 10,000 population, especially since there is an excess of hospital beds in the country.

Access. Health reform will not expand the number of clinics or hospitals; it looks for ways to make the existing facilities more accessible to the population. The facilities should not be available for limited working hours, but should be available for longer stretches of time, thus reducing the risk of not providing care when needed most (emergency situations cannot be timed). Introduction of consult schedules for all patients will avoid long waiting times, which in turn will increase the health care seeking behavior of the poorer segments of society.

Resource Utilization. If facilities are more accessible and more affordable, it is expected that resources will be used more effectively, i.e. more outpatient consultations, more deliveries attended by trained personnel, etc.

EFFECTIVENESS AND QUALITY

Health reform focuses on increasing preventive care, which in turn should eventually lead to national reduction of infant mortality, maternal mortality, percentage of low birth weight, incidence of communicable and non-communicable diseases. These reduced figures should be reflected especially for the population that currently has less access to health care, for geographic reasons (interior) or socio-economic reasons (poor and near-poor).

*Technical Quality***.** An important aspect of the health reform program is the introduction of quality assurance programs. These programs will develop standard treatment protocols, will establish quality assurance committees for both primary care and hospital care, and will monitor the management of the health services, such as availability of essential drugs, incidence of hospital infections, etc.

Perceived Quality. Contrary to the civil servants insured at the State Health Insurance Fund, the poor and near poor do not have the possibility to select their primary care provider. The health reform process will make an attempt to allow provider selection. The percentages of facilities with operational programs for improving user relations, specific orientation procedures for users, users opinion surveys, or arbitration committees will not be affected directly by the health reform process; indirect effects may occur through the introduction of quality management programs. Health reform will include regular measurement of the degree of user satisfaction with the provided health services, for instance through exit interviews.

EFFICIENCY

Resource Allocation. Efficiency of financing of the health system is one of the most important elements of health reform in Suriname. New payment mechanisms (such as incentives for preventive care, treatment packages for hospital care) seek to maximize output/performance against minimal unit cost. Efficiency in the drug purchase procedures will lead to considerable savings without sacrificing quality of care. Efficiency can also be improved by developing health information systems, through which inefficiencies of the system can be detected. Health sector reform as such does not have an impact on rural and urban drinking water supply and sewerage system.

It is envisaged in health reform that the percentage of the health budget spent on public health services, and the percentage of the total health expenditures spent on primary care will increase.

The health sector reform program has no direct impact on intersectoral action. Programs for the prevention of highly prevalent pathologies are influenced by health sector reform, because of increased attention to the prevention of chronic diseases in the primary care package, and the development of standard protocols for pathologies as diabetes and hypertension.

Resource Management. The health sector reform program, through its accreditation program, looks for introduction of standardized operational systems for measuring activity performance in health centers and hospitals. The effect of health sector reform on the improvement of hospitals performance indicators, such as number of admissions, average days of stay, occupancy rate, will most likely be in such a way that there will be less emphasis on inpatient treatments, and more focus on outpatient specialist care and treatment on the primary care level.

The health sector reform program promotes contract negotiations between providers and payers, based on preset tariffs and volumes. Health sector reform stimulates that budgets will be based on planned activities, instead of on historical figures.

Sustainability. Health sector reform influences the medium and long-term development of the health system, such as possible incorporation of alternative medicine; improving the availability of financial information broken down by public and private expenditures on health, and to some extent by geographical units, through national health accounts. Also, by improving coverage for all the population, by increasing preventive programs and incorporating them into the basic package of primary care; introducing quality monitoring programs, and by improving the management of facilities (longer availability for acute care, scheduled medical consultations, etc.). Moreover, by improving the balance of income and expenditure of payers for social health insurance on the one side (State Health Insurance Fund and Ministry of Social Affairs), and of the providers on the other side (Regional Health Services, Medical Mission, and hospitals). Public health centers and hospitals already collect from third party payers (such as private health insurance, private firms, direct out-of-pocket payments). It is not foreseen that the Ministry of Health, nor any other public provider, will negotiate external loans on its own, and swap them thereafter for national resources.

Social Participation and Control. So far health sector reform has increased the degree of social participation and control in the health policymaking process. This social participation is reflected in the representation of many stakeholders of the health sector and of the civil society in the discussions, workshops and presentations about the future of our health care system.

* The profile was prepared by a group of fifteen professionals and national policy decision makers from the Ministry of Health, Ministry of Planning and Development Cooperation, Ministry of Regional Development, General Bureau of Statistics, Inter-American Development Bank Health Sector Reform Project, and the PAHO/WHO Representation in Suriname. Technical coordination of the national group was the responsibility of Director of Health, Ministry of Health of Suriname and the PAHO/WHO Representation in Suriname. Final review, edition, and translation are the responsibility of the Program on Organization and Management of Health Systems and Services of the Division of Health Systems and Services Development of PAHO/WHO.

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