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# Selecting Health Care Providers

Cristian Baeza and Fernando Montenegro Torres

September 2004





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## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## Selecting Health Care Providers

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Paper prepared for the World Bank's Resource Allocation and Purchasing Project

**Abstract:** A strategic purchaser seeks to achieve the necessary correspondence between the needed health care services and goods (interventions) and the providers. In order to achieve this “matching” it is important to define with precision and in great detail what are the interventions needed to achieve in the most efficient way the goals of the purchaser before entering in the contracting process. The greater the complexity of the intervention the greater the need to contract with integrated delivery systems and not with individual providers. In the absence of integrated delivery systems, purchasers can provide the coordination of services and other related managerial activities in order to offer a continuum of care to the target population. However, this “hands on” approach is a heavy burden for purchasers and ideally this approach should be only transitory in order to focus on monitoring outcomes rather than micro-managing the provision of health care services.

**Keywords:** resource allocation and purchasing, health care financing, strategic purchasing, selection of providers, private providers, purchasing efficiency, integrated delivery systems.

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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## FOREWORD

Great progress has been made in recent years in securing better access and financial protection against the cost of illness through collective financing of health care. This publication – *Selecting Health Care Providers* by Fernando Montenegro Torres and Cristian Baeza – is part of a series of Discussions Papers that review ways to make public spending on health care more efficient and equitable in developing countries through strategic purchasing and contracting services from nongovernmental providers.

Promoting health and confronting disease challenges requires action across a range of activities in the health system. This includes improvements in the policymaking and stewardship role of governments, better access to human resources, drugs, medical equipment, and consumables, and a greater engagement of both public and private providers of services.

Managing scarce resources and health care effectively and efficiently is an important part of this story. Experience has shown that, without strategic policies and focused spending mechanisms, the poor and other ordinary people are likely to get left out. The use of purchasing as a tool to enhance public sector performance is well documented in other sectors of the economy. Extension of this experience to the health sector is more recent and lessons learned are now being successfully applied to developing countries.

The shift from hiring staff in the public sector and producing services “in house” from non governmental providers has been at the center of a lively debate on collective financing of health care during recent years. Its underlying premise is that it is necessary to separate the functions of financing health services from the production process of service delivery to improve public sector accountability and performance.

In this Discussion Paper, Montenegro Torres and Baeza argue that efficiency and quality can be enhanced by competition among providers, including competition between providers in the public and private sector. They argue a strong case for the creation of a level playing field among providers during resource allocation and purchasing.

*Alexander S. Preker*

Lead Economist  
Editor of HNP Publications



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## INTRODUCTION

“From whom should medical services be purchased? In answering this important question, we argue that for, a strategic purchaser, the central objective is to achieve the necessary correspondence between the interventions the purchaser wants and the provider that can deliver the intervention within an appropriate timeframe, with the best quality standards, and at the lowest price possible. We call this correspondence the *intervention-provider matching*. Strategic purchasing in this context means that purchasers can and do act selectively in choosing their suppliers. Although this might seem all too obvious, in reality the necessary correspondence between intervention and provider is at the core of the problem of purchasing selectivity.

For a purchaser to “match” the intervention with the appropriate provider, some basic conditions must be met. First, the purchaser must be entitled institutionally, legally, and administratively to be selective and therefore to take part in the decisions regarding the selection of providers. Second, there must be multiple providers to choose from, a variety of providers offering comparable products. Finally, the purchaser and the providers must be able to establish a purchasing-providing relationship within the regulatory and legal environment in which the purchaser carries out its decisions.

We focus on three principal criteria for selecting a provider and establishing a successful relationship with the purchaser. They can be summarized as follows:

- Can the purchaser identify the intervention that has to be purchased and appropriately “match” the intervention to an eligible provider?
- Has the purchaser the necessary institutional and technical capabilities to be selective in the purchasing process?
- Is the purchaser entitled to be selective, and is there more than one type of provider to choose from?

## DEFINING AND IDENTIFYING ELIGIBLE PROVIDERS AND MATCHING THE INTERVENTION

Irrespective of the type or complexity of the intervention, the purchaser should carefully define the intervention before beginning the negotiation and contracting process with providers. The success or failure of this task of definition can greatly influence the contracting process, the purchaser-provider relationship, and the final results.

In a *fee-for-service payment system*, the purchasing process is highly fragmented and unintegrated. The provider ultimately decides which health care goods and services to buy and in what volumes. The relationship between provider and purchaser is essentially a mere reimbursement transaction not comprehensively influenced by health outcomes. At the other side of the spectrum, in developing countries where traditional historical budgets often provide operating funds for public providers, the decisions regarding the services to be financed are made *de facto* at the provider level. These decisions are the result of a combination of provider limitations and the population’s actual demand for services.

Both in fee-for-service in private health insurance in the United States and in historic budgets of public health ministries in Latin America (just to mention two radically different examples); the emphasis is placed on health care services and not on outcomes. In reviewing the budgeting process, ministries of health seldom attempt to measure the health status of a population using proxy variables (mortality of children under five years of age, maternal mortality). Typically, within the framework it is assumed that the financial risk is borne by the purchaser (fee-for-service model) or by the objective constraints imposed by the lack of resources in public facilities (historical budgets of ministries of health).

However, when a split between purchaser and provider occurs and an explicit separation emerges between the purchasing and the provision functions, more precise definitions of the health interventions to be purchased are needed. With a focus on outcomes and not on services provided, and a more precise definition of what to purchase, the purchaser can now strategize between health interventions. These interventions can be measured, monitored, and linked to outcomes in reimbursing providers, thus establishing new sets of incentives for better outcomes.

A strategic purchaser should establish a clear correspondence between the desired intervention and the selection of the best provider. The criteria and information a purchaser uses to buy individual services are different from those a used by a purchaser to buy more comprehensive health outcomes. Therefore the “matching” between the provider and the product or outcomes can occur within a broad spectrum of types of health care services. The purchaser may want to buy very precise interventions or services or may need to purchase more comprehensive outcomes such as health care services for individuals with specific diseases or for population groups (e.g., patients with AIDS, mental health care services, mothers and children from lower income groups) or integrated health care services to promote and take care of the health of a whole population living within a specific geographical area.

For well-defined services limited in scope such as weight and height control of children under five years of age (under-5), the strategic purchaser should seek a provider that can offer those specific services most effectively and at the lowest possible cost. In this case, contracting with medical specialists (here, pediatricians) may not be necessary to get what the purchaser wants. Other health care professionals such as a nurse, skilled nurses’ aide, or even a trained community member might provide the service more effectively and efficiently and most probably as a stand-alone provider.

On the other hand, if permitted by the regulatory environment and the purchaser can develop more strategic purchasing options, outcomes that are more comprehensive might be preferred over isolated services. If the purchaser wants to buy a complex set of interventions and focuses on outcomes such as maternal-and-child health indicators, a variety of providers representing many specialties and types of professional skills (e.g., pediatricians, obstetrician-gynecologists, and nurses) is probably a more suitable alternative.

For the provision of complex health outcomes, the network of participating providers needed is not merely an expansion or agglomeration of different types of primary health care physicians, specialists and ancillary services, and administrative professionals. Rather, it is a complex system that commands more than just medical knowledge and management capacity. Moreover,

the purchaser has to bear in mind that, both for the purchaser and for the provider, important opportunity costs are associated with providing a continuum of services via the integration of providers and services. The delivery of health care services to an entire population or subgroups of a population necessitates complex organizations having the capacity for integrating different functions and structures that are not always available in developing countries but which can emerge as a result of a new regulatory environment and the emergence of strategic purchasers focusing on broader outcomes.

### **WHAT ARE THE SPECIAL CHALLENGES OF AIMING TO PURCHASE OUTCOMES RELATED TO THE HEALTH OF POPULATIONS?**

The best way to use outcomes as a tool for strategic purchasing is to aim for the most comprehensive outcome interventions whenever these outcomes can be measured and monitored. In an ideal world, a healthy population would be the ultimate outcome. However, due to the multidimensionality of the health of a population, the contributions of health care services to this complex outcome are difficult to measure.

Nevertheless, some operational tools have been suggested for linking reimbursement of comprehensive services to combined measures of health within the environment of integrated delivery of health care services (Studnicki 2002). Shortell, for instance describes the health promotion accountability region (HPAR), a type of integrated delivery system at a regional level, as a geographical unit for reimbursement mechanisms that would be partially tied to improvements in population health status. These improvements could be measured by a combined index of morbidity and disability (Shortell 1992). Kindig suggests a financial mechanism that rewards integrated delivery systems for improvements in an index combining life expectancy, morbidity, and disability in what he labels as HALE, health-adjusted life expectancy (Kindig 1997, 1998). In any case, it seems more feasible to develop payment mechanisms for reimbursing integrated delivery systems than individual providers when considering broad outcomes such as those mentioned above.

In a very few and well-defined situations, however, a strategic purchaser may not wish to buy a comprehensive product from an integrated network of providers. For instance, when the probability of requiring an intervention is very low, but the intervention is costly and complex, purchasers and providers may be better off excluding it from the comprehensive outcome-focused contract. In that case, the purchaser may be better off managing directly access to services for that special health condition or contracting with a provider specializing in it, so that the provider has the minimum number of cases to maintain the technical skills and the economies of scale required for such complex interventions. Providers are better off because they do not have to bear the risk of providing such interventions, and the risk is pooled at the highest level possible by the purchaser itself.

The definition of the product or service that the purchaser wants to buy is related to the degree of the separation of functions. Some public institutions may purchase only services not offered by public providers, which represents a very limited form of purchasing. Other public organizations may have already started a process of separating functions and may have begun to contract out with private providers with the goal of eventually purchasing all services from private and public providers. Strategic purchasing and the definitions of the desired product must be carefully

analyzed within the context of the institutional and organization changes of the institutions and organizations in which the purchaser exists but must also be developed as a capacity-building tool within the context of longer term objectives. In this sense, strategic purchasing can be a useful tool in the health care reform process.

### **DO THE PROVIDERS HAVE THE ORGANIZATIONAL AND INSTITUTIONAL CAPACITY TO DELIVER THE INTERVENTION?**

As the intervention that the purchaser wants to buy increases in complexity and gets closer to broader outcomes, so too does the range of the providers' professional and technical profiles, the intricacy of the related administrative functions, and the institutional and organizational capabilities needed to work as an integrated network of health care services.

#### **The Hands-Off Approach**

The necessary network of health care service providers is not merely an expansion or agglomeration of different types of primary health care physicians, specialists and ancillary services, and administrative professionals. It is a complex system that requires more than just medical knowledge or management capacity. It requires a provider capable of integrating different functions and structures, bonded by the "glue" of the goal of achieving a variety of health outcomes within the limits of specific organizational and institutional incentives. If the provider has the required "integrating tissue" for delivering a continuum of care, the purchaser can have a more "hands-off" approach. The purchaser does not need to focus on the problem of integrating services and can concentrate on monitoring outcomes, thus avoiding "micromanagement" of the health care services to obtain the desired outcomes.

At the same time, when the purchaser buys isolated, limited interventions, the entire burden of integration needed to achieve the best outcomes falls upon the purchaser. If the purchaser cannot become the "integrating tissue" in the absence of capacity or willingness of providers to do so, the purchasing process will become fragmented and focused on isolated interventions.

#### **The Hands-on Approach**

In developing countries without such providers, organizational capacity typically does not exist. An environment in which many individual providers can offer only fragmented services poses a challenge to the purchaser to work with independent providers and simultaneously support them with organizational capacity that gives patients access to a seamless continuum of services. Alternatively, the purchaser can encourage the development of such organizational capacity during the contracting and purchasing process. Fragmented providers can eventually develop the required "integrating tissue" as a result of several actions by the purchaser and the establishment of changing financial incentives that promotes the integration of delivery organizations. This is what we call a "hands-on" approach on the part of the purchaser.

In most low-income countries, however, providers' low organizational and weak institutional capacity undermines effective coordination among providers, and frequently this applies to public purchasers as well. Before implementing broader separation of the functions of purchasing and providing services and aiming to work with independent providers, an investment in building up institutional capacity in the public and private sectors must be ensured.



## **CAN THE PURCHASER BUY THE DESIRED INTERVENTION FROM THE ELIGIBLE PROVIDERS?**

In middle- and low-income countries, physicians, nurses, and nurses' aides make up a vast group of independent providers, but in most cases their practice is largely unregulated and out-of-pocket expenditures pay for their services.

### **IDENTIFYING ELIGIBLE PROVIDERS AND THE PUBLIC AND PRIVATE INSTITUTIONAL AND ORGANIZATIONAL CAPABILITIES**

In some middle-income countries, groups of physicians have started to merge into new forms of association, sometimes integrated with inpatient services. This type of integration offers some opportunities for public purchasers, however, it is important that contracts with these types of providers be carried out in the appropriate regulatory environment. In most low- and middle-income countries, most physicians who work for publicly funded organizations also have their own practices. Contracting with this type of provider has to take into account the risks of contracting with private providers who are allowed to work both for public and private organizations. In such an unregulated environment, purchasing can promote perverse incentives. Additionally, identifying an eligible provider is directly related to the particularities of the geographical area and the population for whom the purchaser buys services. For instance, if the purchaser wants to identify primary health care physicians and specialists in areas with a high concentration of accredited physicians, human resources might not be a problem. However, the situation is different in remote rural areas where the population is scattered over large geographical areas or in hard-to-reach places.

In developing countries, public institutions (social security and ministries of health) and policymakers are quite familiar with vertically integrated systems, since it is the classical model for health services delivery under historical budgets. Rigid vertical integration models are not, however, the only type of integrated delivery that can meet the demands of strategic purchasers. *Virtual integration*, for instance, can occur in developing countries when public purchasers work with a network of private providers with different capacities to provide integrated health care services.

To provide health care services for a defined population, the purchaser can also aim to contract with a fully integrated network of private providers, also known as *integrated delivery organizations* (IDO). However, effective integrated systems require not only health care services management but also tools for collecting and analyzing data collection and financial and risk-management capabilities. In the context of developing countries, these prerequisites imply real limitations for integrated delivery organizations that have only rudimentary information, financial, and risk-management capabilities.

If the purchaser has enough purchasing power and buys health care services directly from independent providers and providers with some integrated services, the purchaser can determine the rules that will govern the delivery of health care services and the management of information. However, if the providers lack the resources to develop and manage health information systems, the purchaser may have to take over these functions.

When acquiring services from both public providers and private integrated delivery systems, a purchaser has to ask some important questions. How should consumers be allocated to the different parts of the mixed system? Should they be permitted to choose between seeing a “public” provider and signing with an integrated delivery organization? To what extent does geographical location limit the availability of eligible providers? The choice of options can vary according to socioeconomic considerations (e.g., household income) as in Colombia where the better-off must join the equivalent of a health maintenance organization, but the poor can also choose a public provider, or according to geographical location, as in Chile, where only public providers practice in rural areas.

Another important issue to be resolved is related to human resources. Should health care professionals be permitted to work both for an integrated delivery organization (that has a public contract) and as an independent provider with whom a public purchaser can establish a contract? This question is very important for most developing countries where physicians can both work in the public sector and simultaneously run independent practices and where lack of regulation gives physicians the wrong incentives to move patients back and forth between public and private environments.

These issues are closely related to inequities in the quality of health care services, especially when policies target demographic subgroups.

#### **ARE THERE ELIGIBLE PROVIDERS AND IS THE PURCHASER ALLOWED TO BE SELECTIVE?**

At first, it seems evident that a purchaser should be entitled to select the best providers available to serve its clients’ needs. Such a selective approach toward providers, however, is not always feasible for two main reasons: first, purchasers may not have a mandate to contract selectively and may be required to have funding agreements with all public providers regardless of their performance; second, even if purchasers have the legal mandate to contract with eligible providers, the provider market may not be competitive.

Lack of supply and natural monopolies in the provision of health care services can occur in the case of complex health interventions. Multiple providers are most likely when there are no or small barriers to market entry. Providers of highly complex interventions face significant barriers to entry and are not usually subject to contestability. In contrast, low-complexity interventions tend to behave like commodities, and providers face few barriers to entry, which makes for a highly contestable market.

Monopolies in provision can also occur due to limitations in selectivity by the regulatory and legal framework. The purchaser may not be entitled to be selective because of its legal and regulatory operating environment or because of its governance structure and accountability (Table 1).

**Table 1 Modalities between Purchaser and Provider Market Structures**

<i>Provider</i> \ <i>Purchaser</i>		
<b>Single</b>	Bilateral monopoly (e.g., rural Hungary)	Competitive purchasing with monopolistic provision (e.g., rural Chile)
<b>Multiple</b>	Monopolistic purchasing with competitive provision (e.g., urban Hungary, Brazil, Kyrgyzstan)	Competitive purchasing and provision (e.g., urban Chile, Lebanon)

Source: Author

If natural monopolies and legal and regulatory restrictions to selectivity occur and selectivity is impossible or will take long time to happen, imposing performance targets on providers is an alternative. These performance targets—imitating performance pressures from fully free selection purchasing—can be applied in contexts where, in the short run, the purchaser action is constrained to only periodic changes in the conditions and targets specified in the contracts.

Even when selectivity is not possible, correct incentives have to be created for the purchaser to set targets for providers through such noncompeting initiatives as management contestability and yardstick competition.

Management contestability implies competition not for market share at any specific time but competition over time. The management of a monopoly hospital may be open to public bid. The winner will not have any competitive pressures for market share for the duration of the contract because the hospital has a monopoly and no competitors can enter that market. However, the management company is still under competitive pressure as the contract and funding expire and will be advertised again. The management company's performance during the contract period will influence its chances of winning the next contract.

*Benchmark* or *yardstick competition* refers to the use of comparative provider performance indicators to put pressure on providers to improve performance, or as a basis for determining service prices. The introduction of *quasi-contracts* (performance agreements) has been used extensively in public sector reform to achieve this goal. This mechanism relies on the monopolistic purchasing power of single-payer purchasers that allows them to attach performance conditions to funding.

Trends in separating purchasing and provision in public sector reforms are oriented to these noncompetitive settings. It is frequently argued that the change in the incentive environment of providers (both public and private monopolies), even without selectivity, through management contestability, yardstick competition, or similar approaches, would be enough to create the right incentives for providers to significantly increase efficiency, quality, and responsiveness. But does it really work? The evidence suggests that such an approach is insufficient and that true competition and selectivity are required to set correct incentives for providers to improve efficiency (Baeza, et al. 2001).

When the purchaser's regulatory and legal environment limit selectivity and provider monopolies exist, the purchaser's main goal should be to achieve selectivity as soon as possible. During the transition, management contestability and yardstick competition can be solutions but only when designed as temporary alternatives. Several problems have to be solved to achieve selectivity.

In actuality, many public purchasers are forced to buy from specific public providers avoid creating operational deficits as a result of restrictive and rigid management rules for production inputs as frequently is the case with manpower (some examples and good case studies are the national health services of the United Kingdom, New Zealand, and Chile).

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