

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

PROJECT ACTION CODE
Add Revision No.
 A C - Change
 D - Delete

DOCUMENT CODE
1

2. COUNTRY/ENTITY
USAID/Peru

3. PROJECT NUMBER
527-0319

4. BUREAU/OFFICE
A. Symbol B. Code
LAC 05

5. PROJECT TITLE (maximum 40 characters)
STRENGTHENING PRIVATE SECTOR
HEALTH INSTITUTIONS

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
A. Initial FY 91
B. Final FY 95
C. PACD 97

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)
FUNDING SOURCE LIFE OF PROJECT
A. AID 15,330
B. Other 1.
U.S. 2.
C. Host Country *See page iv & 13
D. Other Donor(s)
TOTAL

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. ACTIVITY CODE	D. 1ST FY 91		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	HEDD			-	1,000
(2) CS	HEIM			3,025	11,330
(3) PN	PNPD			-	3,000
(4)					
TOTALS				3,025	15,330

10. SECONDARY ACTIVITY CODE
HESS, HERI, NUBF, NUGM

11. SPECIAL INTEREST CODES (maximum 7 codes of 4 positions each)

A. Code	CHS	INS	PRT	PVO	TWN	WDP
B. Amount	2555	2555	2555	2555	2555	2555

12. PROJECT PURPOSE (maximum 480 characters)

To test the operational and financial feasibility of different mechanisms to improve access, efficiency, quality, and coverage of PHC that can provide models for public-private sector collaboration and cost recovery.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: Thirteen person team during six weeks, for differing time periods, including: a Health Financing expert, a Health Care Organization expert, a Drug Supply expert, a PVO consortium expert, a Primary Care Health Care specialist, an Anthropologist, a Project Development specialist (Officer), an Economist assisted by two TDYs from AID/W and three local staff.

Funds

PD&S Funds (Health Account) for Consultant services.
Operating Expenses for TDYs from AID/W and local staff

14. ORIGINATING OFFICE CLEARANCE

Signature Edgar Necochea
Title Acting Chief, HR/HPN
Date Signed MM DD YY 07 09 91

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN

S = Suspended CA = Conditionally Approved
 A = Approved DD = Decision Deferred
 D = Disapproved

17. COMMENTS

18. ACTION APPROVED BY

Signature Craig S. Buck
Title Mission Director

19. ACTION REFERENCE

20. ACTION DATE

MM DD YY 07 30 91

USAID/Peru
Project Identification Document
Strengthening Health Institutions Project
(527-0319)

25 July 1991

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Project Identification Document (PID)
Strengthening Health Institutions Project (SHIP)
(527-0319)

Executive Summary

Project Context. The Government of Peru (GOP) is in the initial stage of implementing structural and policy reforms designed to foster sustained economic growth. Strengthening the authority and capacity of regional institutions and promoting the active participation of the private sector in the provision of health services, especially preventive services, are fundamental tenets of GOP policy.

The Strengthening Health Institutions Project (SHIP) is a new intervention in the Peruvian health sector. It has been designed to implement and test approaches that support common GOP and USAID/Peru strategic objectives for promoting high quality preventive and curative health services accessible to unserved and/or underserved populations in selected regions of Peru. The SHIP project will work to increase child survival and family planning coverage, which are both intrinsic and explicit objectives within each project component.

The five year, US\$15.33 million SHIP project will have three components and will operate in two separate geographic regions. The proposed components are modifications of activities that have proven to be operationally effective in Peru and other countries of the region. One component will be initiated in the South (e.g., Arequipa, Puno) as Phase I; another will be implemented in the North (e.g., Piura, Chiclayo) as Phase II. The third project component, to be included as part of Phase I, will focus on disseminating and utilizing the results from the southern and northern project areas to influence GOP policy formulation and the development of new health policies which more adequately address the issues of preventive health care services, the collaborative role of the private sector (both non and for profit agencies) in health care delivery, and the provision of cost effective sustainable services to broader segments of society.

The project's components are designed to accomplish the following:

- (a) improve the efficiency, quality, and coverage of health care services in the two regions;
- (b) assess the extent to which services can be sustained by revenues generated from health care services, and
- (c) foster a more effective, collaborative, and productive relationship between private sector personnel involved in health care service delivery, and public sector officials charged with defining health care policies, service standards and norms.

Project Activities. Phase I in the South will initiate and carry out a grants management program. This component will be designed to encourage Non-Governmental Organizations (NGOs), currently implementing primary health care services, to develop service delivery

approaches which ensure the widest possible coverage at affordable costs. Grants provided will help the NGOs increase the efficiency and cost-effectiveness of services. Full financial sustainability is not anticipated; however, sustainability will be one criteria among several to be addressed by the sub-grants.

In the North, a not-for-profit firm will be established during Phase II of the project. A self-financing primary health care organization (PHO) will deliver essential medicines and efficient, high quality primary health care services, including family planning and maternal and child health care assistance, to Peruvians with limited financial resources. Each facility in the network will offer similar or complementary services. Fees will be charged which correspond to the demand from each respective clinic and community.

Total revenues from all clinics will cover operating costs, and will allow the network to subsidize the cost of services when fees collected are insufficient. This component will be designed to achieve sustainable services through revenues. The PHO component will also assess the extent to which groups from the lower socio-economic strata can access high quality health services provided under the project. This will be substantiated in the Project Paper.

In addition to establishing the two health care service delivery mechanisms, SHIP will conduct a limited number of health sector studies, each of which will include activities: (a) occurring in the two project areas, (b) designed to develop and assess approaches to increasing the efficiency, coverage, or sustainability of basic health services, and (c) focusing on influencing the development of regional health policies. All studies will also help determine the unmet demand for health care in the regions; quantify household patterns of health care utilization and expenditure; provide a more in depth market feasibility study of Phase II; and assess the health impact of the provision of private sector health care. This project component may also examine the feasibility of establishing a provider-managed insurance plan in the South, similar to the one currently operating in the Lima-Callao region. The results of the studies, as well as the lessons learned through project implementation, will comprise the basis of SHIP's policy formulation and dissemination activities, and possibly help form new implementation models.

Project Management. SHIP will be implemented in two phases through the use of two cooperative grant agreements. The agreements will not be implemented through the same organization since each activity is conceptually and managerially distinct. Phase I of the project, including the studies of the third component, will be awarded through a sole source procurement with CARE, as the only private voluntary organization technically and administratively qualified under the 123(e) exemption in FY '91. Phase II of the project (i.e. cost recoverable health care services in the North), will be competed and awarded during FY '92.

Each implementing institution will be responsible for sub-contracting for technical assistance, operations research (i.e. studies), and training. USAID/Peru is expected to provide technical support and substantial program involvement. As currently planned, the project will require three personal service contractors (PSCs) to work with the staff of the Health, Population and Nutrition Division of USAID/Peru.

Project Duration and Budget. SHIP will have a 63 month LOP (PACD 12/31/96) and a total project budget of approximately US\$ 15.33 million. The counterpart contribution required by the project component awardees will be addressed in the Project Paper. In addition, there will be a substantial amount of counterpart contribution from clients paying for preventive and curative services.

**USAID/Peru
Project Identification Document**

Strengthening Health Institutions Project (SHIP)
(527-0319)

I. PROGRAM FACTORS

A. Conformity with Peru Country Programs

Peru is confronted by serious economic and social problems. A historical legacy of centralizing economic and political power in the government and elite elements of society has left Peru with few effective institutions either in the public or private sector. The Fujimori administration which took office in 1990 immediately developed a comprehensive economic stabilization program, including major reforms to reschedule Peru's foreign debts and reestablish its credit standing in world financial markets. The policy agenda of the new government is consistent with many U.S. foreign policy interests, including strengthening the functioning of and commitment to democratic institutions, controlling narcotics production and trafficking, supporting family planning programs, and updating agricultural technology.

The Government of Peru (GOP) is reducing centralized control through a policy of decentralization designed to devolve significant decision-making authority and resources to the regional level. The policy will enable regional health authorities to develop and implement all programs, including health care. In addition to fostering this policy shift, the new administration has made numerous changes in regulations, many of which effect positive changes in health care services by encouraging the prescription and use of generic drugs, reducing import restrictions on essential medicines, improving cost recovery by public sector health services, and broadening private sector participation in the health field. The USAID/Peru program will support and strengthen these efforts, especially activities aimed at decentralizing authority and responsibility and facilitating the active involvement of the private sector.

B. Relationship to CDSS and Mission Strategy

The Country Development Strategy Statement (CDSS) for FY 1992-1996 identifies five strategic objectives that respond to the LAC Bureau objectives, namely:

- policy and structural reforms to promote economic stability and sustained growth;
- reactivation of the private productive sector to generate employment and foreign exchange;

- replacement of coca-based employment with legal alternatives;
- strengthening democratic institutions that reinforce economic freedom; and
- improving health status through access to primary health care.

USAID/Peru's program to increase the participation of the poor in economic growth includes the strategic objective of improving health status by increasing access to and coverage of primary health care, child survival, and family planning services. In addition, the Mission's Health Sector Strategy includes support for: structural reform; a social safety net that provides subsistence food aid; and program support (projects).

Implementation of all health activities will emphasize increased access to preventive health services, and the reorientation of the public sector away from direct provision of curative services, toward policy oversight and preventive care. The project will support increased participation by the private commercial and private voluntary sectors in providing health services on a cost-recovery basis. The project will help increase the efficiency of public sector health services to the poor, and strengthen collaboration between public and private sector health entities.

SHIP will achieve project objectives by developing and testing alternative delivery mechanisms for primary health care in the private commercial and non-governmental sectors, supporting the establishment and operation of successful models of service delivery, and encouraging public-private sector collaboration. In coordination with USAID/Peru's family planning support, food aid, and non-project assistance, the project will support the achievement of improved health status through long term, cost effective improvements in the provision of primary health care.

C. The Problem

For most Peruvians, access to adequate food, housing, education, and health services is limited by poverty and exacerbated by ineffective public and insufficient private sector institutions. The social and economic costs of these constraints disproportionately affect children; who represent 39% of the population (under fifteen years of age). Approximately 40% of all deaths occur among children under the age of six. Although the infant mortality rate decreased 50% over the past 30 years, it is still one of the highest in Latin America. Between 1986-89 the number of people living in households with critically malnourished children rose 144%, to 6.6 million people. A high maternal mortality rate of 30 deaths per 10,000 live births results from illegal abortions due to inadequate family planning, unassisted delivery, malnutrition, and inadequate prenatal care.

Nearly one-half of all Peruvians have no access to potable water and more than half have no access to sanitary sewage disposal. The conditions are much worse in rural areas, where more than two-thirds of the population lives without access to potable water, sewage disposal, or access to basic health services or health education through mass media. These unsanitary conditions precipitate a range of diseases and due to a lack of basic hygiene leave rural residents susceptible to disease outbreaks such as the current cholera epidemic, which has affected more than 200,000 people and taken nearly 2,000 lives.

The Ministry of Health (MOH) and the Peruvian Institute of Social Security (IPSS) are officially responsible for providing health care to 85% of the population, but are unable to fulfill this mandate. Statistics for 1989 estimate that the MOH served less than 30% of the population while the IPSS covered about 18%.¹ However, even these figures may be substantially overstating the actual coverage. At least six million of Peru's 22 million inhabitants -- 27% of the population -- who live mostly in rural areas, have little or no access to modern health services, either preventive or curative.² Forty percent of Peruvian women receive no prenatal care and over half have no assistance from trained birth attendants.

The public sector is the largest direct provider of health services in Peru and has traditionally accounted for two-thirds of the total expenditures for health. This figure was US\$487 million in 1984 (the most recent year for which complete figures are available). Best estimates for 1990, following a two year period of sharp decline in the GNP, indicate that the public sector share of total health expenditures had decreased slightly to 60%. The IPSS spends approximately 30% of the total expenditures, followed by the MOH with 25%, and the armed forces and police with 5%. Private expenditures have constituted the last one-third of total expenditures for health (US\$245 million in 1984), consisting primarily of pharmaceutical procurements and payments to private commercial providers. Discounting the expenditures on pharmaceuticals, the public sector portion of total health expenditures represents approximately 89%. Estimated health expenditures per capita per year range from US\$60 for MOH service, US\$69 for IPSS, \$50 for health insurance and employer plans, and \$10 for PVOs (which may reflect internal subsidies). The range of costs for similar services indicates that significant inefficiencies exist in the public health system.³

Critical health care priorities are not being addressed by the public sector due to inadequate budgets, inefficient management, and poor allocation of resources. Peruvian public sector health services do not have sufficient resources even to maintain the existing level of

¹Peru Health Sector Assessment. The Development Group, January 1991, pp. 30-31.

²Ibid., p. 47.

³Ibid., p. 46.

health care coverage. The MOH budget for 1991 is only 68% of the amount that was spent in 1984, calculated in constant dollars. Similarly, IPSS revenues have dropped dramatically due to unemployment and poor investment. At the same time, resources to support public sector health programs have decreased substantially, while the Peruvian population has increased by 14% since 1984.⁴

Most existing public sector health care resources are being used to pay the salaries of staff, which increased by 12% during the period 1985-90. A policy of investing limited resources in satisfying salary requirements has not allowed the public sector to purchase essential supplies and equipment.⁵

In spite of the public sector's efforts to retain staff and deliver health care services, wages are inadequate to satisfy needs. Workers frequently strike to obtain increased salaries and improved working conditions. Labor discontent and repeated work stoppages have reduced the overall level of public health services and left many facilities unmaintained and oftentimes non-operational.⁶ Recent efforts by the GOP to reduce the public sector labor force through incentives for early retirement have experienced some success, but have resulted in the departure of the most active and dynamic elements of the MOH personnel, particularly clinicians and service personnel.

Inefficient allocation of limited GOP resources within the public sector health care system is another constraint to providing accessible and high quality health care services. Approximately 90 per cent of GOP financial and human resources are currently allocated to hospital-based curative care in urban areas. As a result, 70 per cent of Peruvian physicians are located in Lima. Since the MOH allocates only 10 per cent of its budget to priority primary health care and preventive programs, public sector resources are disproportionately subsidizing curative care while neglecting basic care for the rural and indigent populations.

The commercial sector includes private for-profit physicians, physician group associations, clinics, hospitals, pharmacies and traditional healers. The commercial sector is also more involved in curative, hospital-based care than NGOs and not-for-profit organizations. Until 1985, the commercial sector was growing in Peru, with the number of private clinics increasing by 6% from 1980-1985. In some areas private clinics are used by marginal income

⁴Ibid., pp. 42-44.

⁵Ibid., pp. 44-45.

⁶See the article in El Comercio (30 de mayo de 1991) entitled "Restriccion de servicios esenciales en hospitales obliga a pacientes a llevar sus alimentos y medicinas."

families, however, the fees are up to ten times higher than MOH charges for equivalent health care service.

As neither the public or commercial sectors have been able to meet the broader needs for health care services, especially for rural or poor sectors of the population, private voluntary organizations (PVOs) have expanded programs in an attempt to increase health care coverage. Given the public sector's limited ability to provide health services, the private, non-governmental sector has been encouraged to fill the gap and extend health care coverage. The NGO sector is made up of a diverse group of for-profit and non-profit Peruvian and international non-governmental organizations (NGOs). These entities provide health-related social services, including maternal and child health, family planning, immunization, and nutrition services. One recent study estimates that NGOs cover approximately 18% of the population and account for 11% of total expenditures for health care.⁷

Although there are a considerable number of these organizations, they tend to be clustered in specific geographic areas, and lack the resources needed to provide self-sustaining high quality services. While precise figures are not known, it is estimated that more than 500 health care entities are currently operating in Peru. The largest number of NGOs (between 50-75) are working in the Puno area. In the Arequipa region, 35 NGOs are registered with the Regional Health Office (UDES), while in the northern part of Peru, the number of health-related NGOs is considerably smaller. The PID design team identified only two NGOs with substantive health programs in the Piura area, and approximately ten in the region of Chiclayo.

Although many NGOs are considered effective providers of health care, cost of services are not clearly defined and total coverage is estimated to reach only 4% of the population. Moreover, recent reports indicate that a substantial portion of the NGOs have limited management and technical skills, with little if any attempt made to coordinate activities with other NGOs or the public sector health care clinics or agencies.

The availability of affordable pharmaceuticals is a fundamental element of an effective health care service delivery system. At present, the supply of essential medicines in public and private sector programs is inadequate. The MOH's budget for medicines is limited and regional distribution mechanisms are ineffective, resulting in significant shortages of pharmaceuticals in most hospitals, clinics, and health centers. The economic instability of recent years has contributed to exorbitant pricing, curtailing demand. Prices of commercially-sold pharmaceuticals remain well above world market prices, and obviously unaffordable to the vast majority of Peruvians.

⁷Op. cit., p. 47.

A new MOH pharmaceutical policy, initiated and supported by UNICEF, is expected to address some of the structural problems associated with public sector health care programs. New policy proposals call for dismantling most of the import controls and duties. Market forces will be relied upon to establish a consistent and rational pricing structure. In addition, the government plans to strengthen its capability to set and enforce policy and monitor health care standards of quality. The MOH has started a campaign to encourage doctors and patients to use approved, lower cost generic medicines. The MOH has also eliminated the requirement that only registered pharmacists can own and operate drug dispensaries. It is expected that these changes will encourage higher levels of private sector production and/or importation, promotion, and distribution of pharmaceuticals.

In sum, the Peruvian health sector is facing a crisis. The centralized, urban-focused public health system is without the means to support existing health service requirements. The public sector continues to invest heavily in the operation of expensive curative care facilities. Resource allocations do not allow for support for preventive care for the rural and urban indigent populations. At the same time, private alternatives, such as health insurance are only available to a small percentage of the population that comprise the formal wage-earning sector. In addition, many insurance plans fail to cover family members, and other for-profit providers are reluctant to invest in what has until recently been an unstable economy. Lastly, there is limited impact from NGO health care services due to poor coordination with other health care providers, lack of basic quality standards and norms, and little linkage with the private commercial or public sectors.

D. USAID/Peru Program and Project Strategy

A restructuring and reorientation of the Peruvian health sector is required. A first step is the design of new **mechanisms to provide quality health care services on a sustainable basis to middle and lower income families, especially residents in the marginal-urban and rural areas of the country.** Efforts must be made to increase the coverage and quality of care, without increasing public expenditures in real terms. Improvements in health service delivery can only result from increased efficiency, improved cost-recovery, and ensuring that subsidized services reach the indigent and rural populations.

At the same time, unique opportunities for basic structural change exist. The regionalization process now underway is transferring most health service delivery and program management responsibilities to regional offices and municipal governments. Under the new policy, the central office of the MOH will be responsible for defining national health policy, ensuring the quality of goods and services, conducting economic and financial analyses, carrying out strategic planning, defining standards and norms, and providing technical assistance to regional health programs. Combined with the goals for decentralized management, the GOP is encouraging collaboration and resource sharing with other institutions (e.g. NGOs, communities,

and other donors), with greater emphasis placed on the provision of primary health care to the most vulnerable groups. While supporting the regionalization approach and efforts to incorporate the regions into the process of formulating regional health policy, USAID/Peru recognizes the need for a substantial commitment of resources over the long-term if health care constraints are to be resolved.

The USAID program strategy will support the current directions in policy and program implementation to increase health care efficiency and coverage in Peru by:

- **increasing the role of private commercial and non-governmental organizations in the direct provision of health services.** It is estimated that by 1996, the private sector will provide approximately 75% of the health care services in Peru. The role of the public sector will be directed more toward policy issues, quality control, and serving the poorer segments of the population who currently have little or no access to health services.
- **supporting health care interventions which address priority health care problems through the establishment and enforcement of standards of treatment.** Primary health care will focus on the most significant causes of mortality and morbidity. These are defined as acute respiratory infections (ARI), acute diarrheal diseases, and problems related to perinatal and reproductive health.
- **allocating a higher percentage of health expenditures for preventive rather than curative care.** By 1996, the MOH will be spending 40% of its budget on primary health care. (Currently, the MOH only spends 10%.)
- **implementing health care services which are provided to a much larger segment of the population on a self-sustainable basis.** This will require establishing cost-recovery mechanisms and market-determined price structures for the non-indigent. It is expected that the MOH will be recovering 40% of its costs by 1996, a recovery level well in excess of the current 5%.
- **influencing the public sector to provide services, especially preventive services, to rural populations and indigent patients.** The efficiency of public sector services should be increased through reliance on least-cost delivery mechanisms. For example, services to the rural poor and the indigent could be contracted out to private providers to the extent that they can provide higher quality services more efficiently.

The SHIP strategy will reinforce policy and program directions by: a) developing and testing alternative mechanisms for primary preventive and curative health care service delivery;

and b) supporting the establishment and ongoing operation of approaches that are efficient, sustainable, and increase health care coverage.

In selecting the proposed project activities, USAID/Peru thoroughly reviewed its experience in working with the public sector, NGOs and PVOs, as well as with the private sector. USAID/Peru has had substantial experience working with the public sector on primary health care programs. Although some have led to the successful completion of a number of project objectives, in general, the initiatives have been constrained by administrative bottlenecks, especially at the MOH central level. This experience, coupled with the inability of the public sector to deliver services effectively and efficiently, has prompted USAID/Peru to identify other collaborators and mechanisms for improved health care services and coverage.

USAID/Peru's experience in working with the private sector has been positive. The successful PVO Family Planning Service Expansion Project has served to consolidate and make more efficient the activities of six major PVOs. These PVO entities are part of an umbrella organization responsible for procuring and distributing commodities, directing a price committee for setting standard fees, administering and channeling project funds to member PVOs, and conducting occasional studies for program evaluation and expansion. To date, the project has streamlined the work of the member PVOs, and improved the capacity of these organizations to provide family planning services and serve the needs of clients. The "Puentes de Salud" project, implemented through the Seton Institute for International Development (SIID), was reviewed and will be drawn upon in the SHIP design as a successful model for networking the resources of PHC-oriented PVOs. In addition, the design team is reviewing lessons learned from working with the private sector in commercializing modern methods of contraception through a local PVO, APROPO.

SHIP's private sector health service delivery component is based on the PROSALUD Project in Bolivia, which has achieved significant results in increasing the efficiency and impact of health services in the Santa Cruz area. The project has also been instrumental in changing governmental policy regarding the role of the private sector in health service delivery.

The activities proposed under the SHIP offer the best opportunity for the provision of affordable, efficient, high quality, and broader coverage health care services. At the same time, project activities will strengthen the capacity of health care delivery organizations, especially private sector entities, to provide these services. The project will also provide support for regional authorities in the formulation of policies leading to sustainable and increased health service coverage.

II. PROJECT DESCRIPTION

A. Project Goal and Purpose

Program Goal: To improve the health status of Peruvians by increasing access to efficient and high quality primary health care.

Sub-goal: To increase the private sector provision of basic health services, reorient the public sector programs toward policy development and oversight (especially at the regional level), and improve the efficiency and impact of health services.

Project Purpose: To improve the efficiency, quality, and coverage of health services through the development and testing of at least two different health service delivery mechanisms, the implementation of cost recovery (sustainable) mechanisms and the reduction of direct provision of services by the public sector.

The SHIP Project will have the following three components: 1) the first component focuses on the South (e.g. Arequipa, Puno) and will be initiated as Phase I; 2) the second component will take place in the North (e.g. Piura, Chiclayo) during Phase II of the project; and, 3) the third project component will carry out technical and policy studies, and the results will be disseminated and incorporated into project activities planned for the northern and southern project areas, and serve to strengthen the policy dialogue process and influence regional officials in the formulation and promotion of new health policy. The third component will commence during Phase I of the project.

These three components are designed to:

- (a) improve the efficiency, quality, and coverage of health care services,
- (b) assess the extent to which services can be sustained by revenues generated from the health care programs, and
- (c) foster a more effective, collaborative, and productive relationship between private sector personnel involved in service delivery, and public sector officials charged with defining policies and approaches related to service standards and norms.

Component One objective: Increase the efficiency, quality, and coverage of primary health care services offered by NGOs in low-income areas (peri-urban and rural locations). Through a program of small grant assistance to NGOs and PVOs, and a process of policy dialogue both within the public and private sectors, the project will demonstrate the effectiveness of private sector health care delivery mechanisms, and influence public sector policy decision-makers in the establishment of policies which encourage the adoption and replication of

successful approaches. Component one will also assist health care entities (private and public) in collaborating and coordinating more effectively and in developing and implementing programs to reach indigent populations.

Component Two objective: Develop a self-sustaining, private sector health service mechanism as an alternative to the public sector approach. Project supported activities will help deliver high quality primary health care services and essential medicines to Peruvians with limited financial resources.

Component Three objective: To broaden the impact of lessons learned regarding improved efficiency, cost-recovery, quality, and coverage, by carrying out a series of technical and directed studies and disseminating the results for enhanced and informed policy dialogue and policy decisions.

B. Expected Achievements and Accomplishments

The end-of-project-status (EOPS) will include the development and testing of alternative mechanisms for improving the efficiency, sustainability, quality, and coverage of health care services. Knowledge gained from testing alternatives and supporting effective service delivery mechanisms will be disseminated among private and public sector health care providers in Peru, and will contribute to the formulation of regional health policies. Below are the projected accomplishments by the end of the project.

- **Private primary health care providers in the southern project region are experiencing improved efficiency and coverage of health care services through the development and implementation of new delivery mechanisms.**
- **A not-for-profit organization will be providing high quality primary health care, on a self-sustaining basis, to populations in the northern project region. The organization will have developed a system of cross-subsidies based on surpluses generated from a majority of clinics, in order to extend services at below market cost to low-income families. A combination of operations research and management information systems will be used to analyze the results of this type of system and the necessary factors for success.**
- **A centralized system for monitoring and evaluating the health care mechanisms developed in each project area. Regular information reported on the impact of cost-effectiveness, coverage, quality, and cost recovery.**
- **Project feasibility fully tested for alternative delivery and health financing mechanisms. Health care providers in both public and private sectors adopt new health care delivery systems.**

- **Both public and private sector health care providers are engaged in productive policy dialogue and collaborative programs based on the lessons learned during the course of project implementation.**

As a result of project activities, specific improvements will be brought about in health care coverage, efficiency, and quality of primary health care. All outputs will be achieved on a sustainable basis.

C. Project Content

The project will be implemented in two large regions of Peru. Phase I of the project will most likely include the region of J.C. Mariategui in the South (with the regional seat in Puno). Phase II will incorporate the regions of Grau and Nor-Oriental del Marañon in the North, and within the departments of Lambayeque and Piura. The sites in the southern and northern regions were selected on the basis of their potential for success in establishing experimental, self-sustaining health care delivery mechanisms and activities.

A Health Map of Peru, developed by the Central Reserve Bank in 1984, shows a direct correlation between access and utilization of health services, and the availability of productive economic activities. The map indicates that in the highland areas of Peru, predominantly agricultural economies have populations with average incomes well below the national level, as well as a high rate of migration and illiteracy. This same area also has the greatest need for health resources and services. In general the populations of the coastal areas have a relatively high socio-economic status, a history of participating actively in the formal economy, and the best health coverage indicators.

Grau and Marañon have been proposed as possible sites for establishing the self-sustaining private sector primary health organization. The areas of Piura and Chiclayo are accustomed to paying fees for health services. In addition, as noted in Table I below, there appears to be significant unmet demand for services in Chiclayo. For example, while 33% of the population of Chiclayo reported an illness of some kind, only 16% of these people reported receiving treatment through a health care center.

Table I PRELIMINARY ANALYSIS OF HEALTH SERVICE USE

Total Population (Chiclayo, 1990)		645,000
Estimated % with Illness	33%	212,850
Estimated % Ill Seeking Care (Last 12 months)	16%	32,250
<u>Place of Care</u>	<u>%</u>	<u>Number</u>
Public Hospital	31.0	10,000
Public Health Center	6.5	2,100
Health Post	20.0	6,500
Private Clinic	27.5	8,900
Private Pharmacy	5.0	1,600
Private Other	<u>10.0</u>	<u>3,200</u>
	100.0	32,300

A decision of whether or not to initiate project activities in the Lima-Callao region will be reviewed during the project paper design stage.

Component One - South. In the South, a relatively low-income population is being served by NGOs, and to a lesser extent private commercial providers and public sector facilities. The efficiency and effectiveness of these health care providers are limited by the low level of coordination, limited management and technical capability, and regional health policies which are inappropriate. SHIP activities in the South are designed to improve the efficiency of primary health care providers by strengthening the managerial and technical expertise of the NGOs involved in health care service delivery. The NGOs will also be encouraged to develop and implement creative approaches to improving the quality and coverage of health services on a sustainable basis. A policy dialogue will be initiated with regional authorities to strengthen the analytical and decision-making process.

A block grant program will be established to support the NGO initiatives to improve the quality, efficiency, and coverage of health care services, and for the rapid implementation of new and more effective health service delivery mechanisms. All NGOs providing health care services will be able to submit proposals and compete for grants of between \$ 50,000 and \$ 100,000. The grants will be used to finance technical assistance and implement activities needed to increase efficiency and improve management capabilities, and to strengthen the quality and coverage of service.

The SHIP project management office based in the region will develop a standard protocol for grant proposals, objectives for proposal submission, and clear and consistent criteria for evaluating proposals and awarding grants. All NGOs providing health care services in the

project area will be invited to submit proposals. The requirements for counterpart contribution will be addressed in the Project Paper. Proposals will be judged against criteria which will include, but not be limited to, the following:

1. The development of a preliminary analysis/plan for sustaining the health care delivery services with high quality coverage provided to a significant number of people
2. Suggested approaches to achieving collaboration with other NGO and public sector health care providers
3. An estimate of the counterpart contribution of the health care entity itself for covering the costs of implementing health care delivery mechanisms
4. A management plan that includes an analysis of existing constraints, technical assistance and training requirements, and a description of the proposed management information and financial systems for monitoring progress, evaluating efficiency, and assessing impact of services against indicators of quantitative achievement.

The SHIP project management office will also provide technical assistance, and conduct in-country training programs in priority areas for staff of NGOs working in health care delivery programs in the region. Priority technical fields may include child survival, maternal health, family planning, nutrition, income generation, and health education. Assistance in management will most likely include organizational development, financial management, human resource development, and program evaluation.

This project component will also include periodic workshops, where local NGOs will have the opportunity to coordinate programs, explain and exchange service delivery strategies and action plans, and share information regarding health care policies and procedures. In addition, the experience of the NGOs will be shared with authorities responsible for the formulation and promulgation of regional health policy.

Component Two (Phase II, North). Self-sustaining Primary Health Care Organization.

The project will establish a private fee-for-service primary health care organization (PHO), operating as a not-for-profit, surplus-generating business, which is capable of providing high quality preventive and curative care on a self-sustaining basis. The PHO will support the operation of clinics in communities which have viable markets for health care services. Another key criteria for clinic location is that the community or some other entity is committed and able to provide land and/or a clinic facility, and will be actively involved in health promotion. Preliminary market studies will assess the overall feasibility of this activity, provide information on operating standards and fees, identify appropriate locations, and specify the community's service expectations, willingness to pay, and cultural attitudes toward health care services. This component will be activated in during Phase II, to begin in FY '92.

The following are among the activities required to implement Project Component Two:

- The PHO, consisting of a central office responsible for administration and management, will be established to direct the operations of approximately 15 health centers and clinics. A cadre of approximately one hundred health promoters will work through the clinics to provide outreach services and marketing. The PHO will develop a standard basic design for each type of facility, remodel and/or repair and equip facilities as required, and provide assistance to the clinics similar to the concept of a franchise organization.

The PHO management staff will determine whether existing private and/or public sector facilities (clinics, laboratories, pharmacies) can be upgraded and included as part of the network. Under the franchise concept the affiliated clinic will conform to all operational standards of the PHO. In return, the PHO, through the Central Office, will be responsible for all marketing and market research, client referral, accounting and bookkeeping, technical support, medicine and supplies, and other support activities as required. The affiliated clinic will be linked with the PHO network through common advertising, uniforms, and standards of quality. To the extent that existing services can be contracted, franchised, leased, or otherwise absorbed into the network, the overall cost effectiveness of the organization will be increased and start-up costs will be minimized. The franchising approach to clinics, or leasing services from existing laboratories and pharmacies, will be evaluated during the PP design.

- The services of the central office, offered on a franchise basis to member clinics, will:
 - ensure financial management and control, including budgeting, payroll, personnel information, billing, and cost tracking.
 - provide the logistical arrangements pertaining to the procurement, supply, and inventory of drugs, medical devices and equipment.
 - establish standards of quality of care through dialogue with the MOH, define a menu of clinic services, and operational procedures, both administrative and clinical, for all clinics. The services provided will respond to community expectations and the epidemiological profile of the community, and focus on the primary causes of mortality and morbidity, especially acute respiratory illness, diarrhea, malnutrition, vaccines, and family planning.
 - establish and manage a personnel system that includes policies and procedures related to wages, training, supervision, job description and advancement.
 - conduct operations research on key health care issues. Activities will include a baseline survey, pre and post project studies, market studies, cost

determinations, appropriate technology in medicines, service mix, and impact of alternative financing options.

- **develop and implement monitoring systems for managerial, financial and service delivery activities. Systems will also be put in place to analyze health statistics by health centers and type of service.**
- **establish standard approaches to identifying and analyzing the market for health services, locating health clinics, pricing of services and pharmaceuticals.**
- **establish neighborhood volunteer boards, or advisory groups, for each clinic to ensure that feedback is received from community members and that adequate community support is mobilized for the project.**
- **establish links with the MOH and IPSS and other private sector insurance groups (if possible), to facilitate direct payment to the PHO for services provided to persons qualifying for benefits in either public or private sector insurance programs.**
- **establish a working referral and feedback system to a local hospital for more extensive health care needs. To the extent possible, the referral hospital will be a university affiliated teaching hospital. This arrangement will allow medical students and recent graduates to be exposed to efficient and integrated approaches to health service delivery. It will provide the franchise with access to less expensive but more highly motivated providers.**

Each clinic in the network will:

- **provide preventive services to indigent community members consistent with quality standards on subsidized or no charge basis;**
- **provide curative services on a fee-for-service basis, as well as a percentage of free care to indigent patients, for priority primary health care problems;**
- **sell essential medicines to the community;**
- **provide laboratory services;**
- **conduct community support and outreach activities for both marketing and the mobilization of community support. This will be conducted through commercial marketing strategies and health promoters. Community**

commitment and support are considered crucial for maintaining demand for services and enabling the clinics to offer extended service hours and in-patient care.

The PHO's key to expanding coverage on a self-sustaining basis will be to control costs and establish a revenue structure that allows profitable services and programs to subsidize necessary services, that people are either unwilling or unable to pay for. The cross-subsidy idea is based on a recognition that people are more likely to pay for curative rather than preventive care, even though the preventive health care may well be more cost-effective.⁸ It is expected that the PHO will employ cross-subsidies on three levels:

- fees generated by curative care will subsidize low cost or free preventive care;
- surpluses generated in more viable (usually urban) clinics will cover the losses incurred in clinics located in poorer, usually rural and marginal urban areas; and
- higher, market-based fees charged to middle and high income clients will subsidize services provided to low income clients.

For the PHO to be self-sustaining it must achieve a surplus from the network of clinics in different locations, serving different clientele, and offering a different mix of services. For example, it is expected that rural clinics will probably not become self-sustaining due to the relatively low income levels of clients and the logistical problems in providing higher margin specialist services (pediatrics, obstetrics, dentistry). Overall, the PHO must achieve a balance of clinics that generate revenues sufficient to cover all operating costs, as well as a surplus sufficient to meet the expenses of the central office.

It is important to recognize that the PHO will operate as a not-for-profit business entity, with the PHO's managers and community having a strong sense of ownership. The project will provide start-up capital, training and specialized technical expertise. The primary purpose of the PHO is to establish a system that is capable of providing access to high quality primary health services for as many low income clients as possible. This objective is distinct from the purpose of PROSALUD (Bolivia), for example, which provides quality health care to a given target population and for the achievement of a maximum level of cost recovery.

⁸From a societal viewpoint the ideal system provides preventive health care practically free of charge in order to ensure adequate coverage of the population. This approach ultimately reduces the overall economic cost of health care by reducing the incidence and severity of disease and therefore the need for relatively expensive curative care.

A key objective of the PHO is that a significant percentage of clients served will be the working poor or lower-middle income families, living in urban areas and who are unable to pay for health care services. For some of the clients, the PHO will be a replacement for existing sources of medical services -- either the MOH, IPSS, a PVO, or a private practice.⁹ The competitive advantages of the PHO will lie in higher quality, more accessible services (longer and more flexible hours each day, including six or seven days per week, at more convenient locations), an emphasis on preventive care, readily available and affordable supplies of pharmaceuticals, and somewhat lower costs than private sector providers.

The value of providing a new source of health care services to populations who may already be served, rather than addressing the needs of the 30% of the population who currently do not receive any health care services, is a key issue addressed by the design team. The main reasons why the selected approach is considered the most appropriate include: 1) the organization will provide a private sector alternative to public sector health care services. By so doing, the project will encourage the regional MOH to move toward policy development and focus more of the provision of health services to indigent populations; 2) the population served by this new organization, including those who receive the subsidized services, will have continuing access to quality health care, regardless of current constraints including public sector budgets, labor problems, or other economic obstacles;¹⁰ and 3) the PHO approach will enable the health care system to develop on a self-sustaining basis, and allow policy makers to focus more attention on the development of other important areas for improving health care status, such as establishing policy norms and standards, and concentrating more time and resources on the indigent and disenfranchised populations.

In addition, the project emphasizes the importance of the PHO providing a reliable distribution point for essential pharmaceuticals. Despite the proposed structural and policy changes, availability of medicines will continue to be a critical problem. However, the sale of pharmaceuticals in connection with the PHO clinics will have the following beneficial effects:

- (1) a reliable supply of pharmaceuticals available in project areas at a reasonable cost;
- (2) pharmaceutical prices which reflect competitive, market prices; and

⁹The degree to which the PHO will replace existing services is hard to estimate because the official data may overestimate coverage by MOH clinics.

¹⁰It is recognized that this approach cannot meet the needs of the entire population. Provision of services to those unserved will require the definition and implementation of different models.

(3) access to essential medicines serving to strengthen the demand for and delivery of all health care services in the project area, both public and private sector.

The project will also evaluate the role of the central office serving as a wholesale supplier of pharmaceuticals to other clinics, pharmacies, hospitals, and other health care providers in the region as a means of generating increased revenues.

At the end of the project, operations research and evaluation systems will compare the costs of the private sector program to that of providing services by the MOH, IPSS, and through existing private sources. At the end of the project, operations of the PHO will be assessed to determine whether it can be successfully replicated in other parts of Peru as part of an overall response to meeting the country's primary health care needs. The results of project research will be presented to health policy and other health care officials/representatives from the public and private sectors.

Component Three. Operational Studies, Dissemination Activities, and Health Policy Development. The third component of the SHIP will be activated under the first phase of the project, and will focus on assessing the effectiveness of project activities in the North and South, and developing approaches for achieving wider dissemination and application of findings. This component will finance a small number of specific studies directly related to the health service delivery experiences of the North and South. Activities will include exploring feasible alternatives to financing health services. In addition, workshops and publications (newsletters) will be designed to disseminate knowledge gained through the project. Policy seminars will be formed to bring public and private sector professionals together to discuss policy and program implications of the health care delivery approaches/mechanisms developed and implemented under the project.

Dissemination Activities and Health Policy Formulation. In addition to the special studies, the project will conduct policy seminars for participating NGOs to analyze and understand different health policy options. SHIP will also conduct workshops to disseminate the results of project components one and two. Policy seminars and workshops will be held in both the North and South project areas. The appropriateness and feasibility of other dissemination mechanisms, such as newsletters, case studies, lectures, etc., will be discussed in the project paper.

The management and implementation of the above project component will be the primary responsibility of a PSC project manager located in Lima.

III. PROJECT DESIGN ISSUES

The PP design team will address the following and other relevant issues:

A. Social Considerations

The social analysis of the project must determine the types of health services demanded by the communities, the constraints to using existing service delivery mechanisms, and the community attitude toward the proposed menu of services to be offered by the PHO. The study should compare the expressed needs for health care with existing epidemiological data to identify any inconsistencies. The study will also determine the cultural acceptance and willingness to pay for health services in the project areas. Social analyses will be conducted in all potential sites for project activities.

The degree of commitment and participation of the local community for the PHO approach also needs to be assessed. The experience of PROSALUD in Bolivia indicates that community organization, promotion, and participation is critical to the successful establishment and ongoing operation of a health clinic. PROSALUD devoted considerable effort and resources to building linkages with the local community. Neighborhood Boards of Directors/Advisors, consisting of community leaders, were established for each clinic. In addition, a regional board was identified for the planning of a country-wide franchise system.

The social analysis will need to review the range of appropriate and effective mechanisms available to encourage and maintain active community participation in the design, implementation, and operation of the clinics. The analysis should specifically emphasize ways in which women will be included in decision-making roles as advisors and members of the local Boards, as well as ways in which community members can participate in managerial, promotional and outreach activities.

The feasibility of promoting and supporting the implementation of alternative health care delivery systems in the South calls for an assessment of the cultural and institutional dynamics vis a vis NGO health care providers, as well as between the health care providers and local communities. The study will identify common interests and objectives among the NGO providers, and determine the needs, objectives, and attitudes of the beneficiaries of health care services.

B. Financial and Economic Considerations

The majority of the financial and economic issues are related to the implementation of the PHO in the North of Peru. However, two key financial issues for the NGO Health Care Providers component in the South must be addressed. The PP design process will determine the

capability of implementing organizations to administer a sub-grant program. A determination will also be made as to whether support for NGOs is the most cost-effective means to lower costs and increase coverage of health care services in the southern region. These issues will most likely be addressed in the context of the project's institutional analysis.

A preliminary assessment has demonstrated that a market does exist for PHO services, if prices are at a level sufficient to generate a surplus. The northern region, including the cities of Piura and Chiclayo, are well integrated into the cash economy and have a history of paying appropriate fees for health services. The MOH also charges for health services, as does IPSS (through an insurance program) and private health services. However, many of the public sector health programs provide poor quality services and fail to reach a substantial portion of the population.

More detailed information and analysis is required, particularly in the feasibility of generating revenues sufficient to cover all operating and administrative costs, while maintaining a capacity to provide preventive and curative health care services at a subsidized below market cost to indigent populations. The PHO analysis will determine the break even point at which subsidized health care services can be fully supported by the system's surplus revenue generations. The PHO is different from a for-profit commercial venture in that start-up costs and technical assistance financed under the cooperative grant, and through in-kind counterpart support, will most likely not be recovered during the LOP. However, the analysis will identify the amount of financial and human resources (technical assistance) and length of time needed to ensure self-sufficiency of project health care services.

The start-up period required for the provision of health care services must take into account the time and effort necessary to establish a critical mass of clinics in the region. A critical mass is needed to achieve a sufficient market share of patients paying for services in each clinic. The cash flow analysis will determine: (1) the period required for each clinic to reach its maximum level of revenue production (which may not be entirely self-sustaining at the clinic level); and (2) the time required for the organization as a whole to achieve self-sustainability, or the coverage of all costs including the central PHO.

Lastly, the PP design will address the following key questions:

- are the target populations willing and able to pay for health services and drugs at a price that can establish a self-sufficient primary health care system?
- what is the expected percentage of subsidized or free services, and the percentage of revenue producing services within the project areas?

- **what are the relative advantages and limitations of different payment schemes (e.g., fee-for-service, pre-paid insurance, third-party payments) in terms of financial viability and consumer acceptance?**
- **what is the potential for participation in the project by consumers of lower socio-economic levels?**
- **what are the economies of scale and other financial implications for the franchising, contracting, or leasing arrangements for expanding health care services and procuring supplies and pharmaceuticals, vs. the use of more direct, individual mechanisms such as hiring personnel, acquiring new facilities, etc?**

The economic analysis of the PHO will focus on the need for financing start-up costs and subsidizing operating costs until the organization can become self-sustaining. One of the issues to be addressed is the willingness of consumers to pay for services -- as an appropriate indicator of the perceived social value of health care service. The analysis will consider the degree to which the initial investment subsidy is a cost-effective means to achieving the objective of self-sustainability. Both project components, the PHO and the NGO Health Care Providers, will be assessed in terms of cost-effectiveness.

C. Technical Feasibility Considerations

A number of technical issues will be addressed, with most pertaining to the PHO component to be implemented in Phase II. It is of primary importance to determine at the outset that the approaches selected will have the greatest impact in addressing and resolving constraints to improved health care delivery.

Component One. NGO Health Care Providers

Existing Health Service Delivery Structure. The PP technical analysis will focus on the existing structure of health care service delivery in the project area, and the ways of improving efficiency/management, increasing coverage, and coordination and definition of optimum roles between the public and private sectors. Also, the analysis will assess the interest of NGOs in participating in the grant management program in the South.

Pharmaceuticals. What are the existing arrangements pertaining to the purchase and sale of pharmaceuticals? What types and amounts of drugs are needed to meet service demands?

Component Two. Self-sustaining Primary Health Care Organization

Site analysis and selection. The areas to be evaluated for possible location of the PHO include Piura and Chiclayo. The criteria below will be used to choose the most appropriate location(s).

- a. Is the demand for health services sufficient justify the establishment of a PHO? What is the proposed project area's demographic mix and population size, and how adequate this is for supporting the first network of clinics?
- b. What health care facilities are available in the area (e.g. clinics, health posts, reference hospitals)? Are these available in sufficient quantity and quality at the appropriate sites?
- c. Are the existing sites available at a cost that would enable financial self-sufficiency?
- d. What is the position of the MOH and IPSS in terms of leasing or yielding control of facilities or personnel to the PHO within the designated project areas?
- e. What percentage of coverage and market share do existing health care services capture? Who is the competition? What is the existing gap (unmet demand) in service delivery, and for which income groups?

Role of the IPSS. Will IPSS be willing to adjust their payment scheme for third party providers? What procedures would be required to accomplish this?

Availability of Health Care Providers. Are there enough qualified physicians and nurses in the area to fully staff the PHO clinics? Is there enough of a surplus to enable the PHO to hire professional medical personnel at a reasonable salary level?

Availability of Referral Services. Are there enough specialized doctors in the area who are willing to provide specialized services (obstetrics, pediatrics, dentistry) for a fixed-fee on a part-time basis? Are there existing private clinics, laboratories, or pharmacies interested in an affiliation or referral arrangement, if suitable terms could be worked out?

Legal and Regulatory Environment. What are the legal considerations and constraints for the MOH or IPSS to contract out for third parties to provide health services? Are there barriers to the PHO acting a pharmaceutical wholesaler?

Pharmaceuticals. What are the existing arrangements pertaining to the purchase and sale of pharmaceuticals? What types and amounts of drugs are needed to meet the demand for services? How much will it cost to satisfy the pharmaceutical requirements of the PHO? Is

local demand sufficient to justify the PHO as a pharmaceutical wholesaler for other health care providers in the region? What prices will need to be charged for pharmaceuticals to ensure that PHO pharmaceutical operations are self-sustaining?

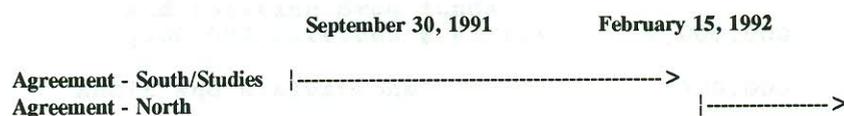
D. Institutional Considerations

The selection of institutions to manage project activities is a key part of the PP design process. The project analysis will identify and define the involvement of project institutions which have the experience and capacity to: (a) manage technical assistance provided to the PHO and the NGOs; (b) carry out studies and in-country training programs; and (c) disseminate information leading to a process of policy dialogue and the eventual formulation of a policy framework between public and private sector agencies.

Since the number of eligible implementing agencies is limited, and the management requirements for the two phases of the project differ, USAID/Peru plans to make a sole source procurement to CARE through a cooperative agreement for Phase I activities in the South, including the studies, during the initial start-up period. Competition and award of Phase II activities will take place during the second quarter of FY92. The delay in Phase II is due to the need to focus project resources initially on start-up activities in the South, and allow slightly more time to better define needs and select the most appropriate institution(s) for participation in the North. Moreover, Phase I grants management activities and studies are tasks with which many USAID/Peru contractors have a high degree of familiarity. On the other hand, supporting the development of a self-sustaining health service delivery franchise will require highly specialized skills which may require a broader search and competitive selection process.

The PP development will review the proposed contracting strategy. Timing of the awarding of project cooperative agreements will most likely follow the timeline below.

Schedule of Selection Process for SHIP Implementing Institutions



In addition, the institutional capacity of existing, qualified USAID/Peru contractors will be thoroughly appraised. Among other elements, this assessment calls for a review of the institutions' organizational autonomy, managerial effectiveness, and relations with beneficiaries and the international donor community.

The NGOs operating in the southern project area which are responsible for the initiation of cost-effective approaches to increasing health service coverage are the second type of institution that needs to be assessed. The institutional capability -- defined in technical, managerial, and financial terms -- of likely grantees will be carefully examined. A review of the in-country experience of the potential grantees is called for, as well as a quantifiable measure of the cost and impact of health care services currently being provided.

E. Estimated Costs and Methods of Financing

Strengthening Health Institutions (SHIP) - PID Budget
Estimated Costs and Methods of Financing **June 1, 1991**

Component	AID	COUNTERPART (*)	TOTAL
1. NGO Health Care Providers	AID	COUNTERPART	TOTAL
---(South)-----			
Technical assistance			
short-term (24*12K) (1)	288,000		288,000
Short-term Training (2)	160,000		160,000
Operating Costs			
Personnel (3)	200,000		200,000
Administrative Support	200,000		200,000
Travel, Per Diem			
Facilities renovation	20,000		20,000
Social marketing (4)	100,000		100,000
Equipment			
Office Furniture	30,000		
Vehicles-2 (5)	100,000		100,000
Block grants for services and rotating drug funds (500,000 services @ \$4) (6)	2,000,000		2,000,000
Audit and evaluations	300,000		300,000
Contingency & inflation 10%	339,800	0	339,800
Total Component 1	3,737,800	0	3,737,800

2. Self-financing PHO (North)	AID	COUNTERPART	TOTAL

Clinics-15 (7)			
construction/transferral (\$30K)		300,000	300,000
rental/remodelling (\$50K)	525,000		525,000
Technical assistance			
long-term (60*12K)(8)	720,000		720,000
short-term (50*12K)(9)	600,000		600,000
Training (short-term)(10)	100,000		100,000
Operating Costs			
Clinics	1,000,000	100,000	1,100,000
Central office	500,000		500,000
Administrative Support	500,000		500,000
Travel, Per Diem			
Facilities renovation(11)	150,000		150,000
Social marketing(12)	500,000		500,000
Research & monitoring	225,000		225,000
Equipment			
Clinical equipment (13)	300,000		300,000
Office Furniture	100,000		100,000
Pharmaceuticals (14)	450,000	22,500	472,500
Vehicles-2 (15)	100,000		100,000
Audits and evaluations	200,000		200,000
Contingency & inflation 10%	597,000	42,250	639,250
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Total Component 2	6,567,000	464,750	7,031,750
3. Operational Studies, Dissemination Activities, Health Policy Development			

Studies	350,000		350,000
-Includes Insurance Study			
Policy Development	250,000		250,000
Dissemination Activities (16)	60,000		60,000
Contingency & inflation 10%	66,000	0	66,000
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Total Component 3	726,000	0	726,000
4. Project support			

Project monitors -3 P.S.C.s (17)	1,500,000		1,500,000
Office support	300,000		300,000
	-----	-----	-----
Total Component 4	1,800,000		1,800,000
5. Buy-ins to Central Projects			

HFS, Healthcom II, HNS, etc.	2,500,000		2,000,000
	=====	=====	=====
GRAND TOTAL	15,330,800	464,750	15,795,550

Notes to the Budget: Principal Assumptions

(*) The counterpart figure does not include revenues from patients paying fees or other costs.

(1) Short-term technical assistance will be called on to meet specific project needs, such as monitoring and evaluation, management, financial systems, MIS applications, child survival and family planning service delivery design, etc.

(2) Peruvian Nationals or other locally-based consultants will conduct five, 40-hour training courses/year, each at U\$200 per hour. This line item also includes the cost for start-up, six-and 18-month workshops, estimated at US \$30,000 each.

(3) Personnel will consist of a technical Director at US \$30,000, a secretary/receptionist at U\$5,000 and a bookkeeper/accountant at US \$5,000 annually.

(4) These marketing funds are designed to create a strong client demand for services and medicines -- a "pull" effect.

(5) This figure includes the cost of purchasing, operating, and maintaining two vehicles during the five-year period of the project.

(6) This amount will be awarded as sub-grants to competing NGOs subject to grant criteria emphasizing improvements in service delivery measured as increases in efficiency, quality, coverage, sustainability, etc.

(7) The majority of the clinics will be existing structures leased by the project. The government may cede a certain number of units. All will need to be remodeled at start-up to conform with franchise specifications.

(8) The long-term consultant will be based at the PHO central office in the North and be largely responsible for facilitating the establishment of the PHO.

(9) Short-term technical assistance will address all clinical and managerial needs.

(10) Peruvian nationals or other locally-based consultants with international experience will be called on to provide short-term training.

(11) In year 4 or 5 of operations the clinics will be renovated, e.g., painted, etc.

(12) This covers the cost of the market surveys needed to identify appropriate clinic locations and determine client expectations, as well as the ongoing expenses of marketing and service promotion.

(13) An average of US \$20,000 will be needed to equip each health center.

(14) An average of US \$30,000 will be needed to stock a clinic pharmacy. Revenues from the sales of pharmaceuticals will permit routine re-stocking.

(15) This figure includes the cost of purchasing, operating, and maintaining two vehicles during the five-year period of the project.

(16) These activities will take place at two conferences in months 36 and 60 of the project. An estimate of US \$30,000 per conference is estimated.

(17) The PSCs will include one expatriate at US \$150,000 annually and two well-qualified nationals at US \$75,000 each annually.

ANNEXES

A. Relevant Experience from Other Projects

NGO Health Care Providers. The PVO Child Survival Network (PROCOSI) in Bolivia is an example of network of NGOs involved in providing child survival health care services. PROCOSI was established in 1988 under a three year OPG from USAID/Bolivia to enhance the institutional capacity of its members in the development, implementation, and evaluation of child survival programs through technical assistance and subgrants. The members of PROCOSI are primarily U.S.-based PVOs, such as CARE, SCF, CRS, Esperanza, and Meals for Millions.

Access to subgrants for project activities was clearly an important incentive for PVO participation in the PROCOSI program. The ability to use PROCOSI as a mechanism to channel grants to PVOs and reduce the USAID mission management burden was a primary justification for the project. The PROCOSI approach, which employs subgrants to strengthen the impact of the operations of the member PVOs, is different from what has been proposed for Peru. In Bolivia, the project emphasized the formal establishment of a network, consisting of PVO members, to carry out child survival activities. Whereas the PVO subgrant activity proposed for a region in the South of Peru will be focused on improving the quality, efficiency, and coverage of health care services of any and all NGO health care providers operating in the project area.

Self-financing Primary Health Care Projects. The best example of a successful cost-recovery system for primary health care may be the PROSALUD project, based in Santa Cruz, Bolivia. Evaluated in 1990, PROSALUD is a group of sixteen health clinics and health posts directed by a Management Support Unit (MSU), which provides administrative and management services as well as training to clinic staff. The PROSALUD system is intended to be self-financing. A fee-for-service payment arrangement allows for cross-subsidies. Preventive services are provided without charge and rural and marginal urban clinics in low income areas are subsidized. The clinics are well managed and provide consistent and high quality health services to the populace served.

The success of the PROSALUD approach is credited to good management, appropriate socio-economic conditions in the Santa Cruz area, careful market analysis for location of clinics, strong community support, and good monitoring and evaluation. To date, PROSALUD clinics are almost self-financing; the organization as a whole, including the MSU, recovers approximately 85% of its costs. However, few if any of the clinics have effectively reached their potential for revenue generation -- with more time needed to increase market share. There is no indication that the rural clinics will ever be self-financing; subsidies will have to continue into the foreseeable future. These rural clinics serve relatively low income clients, and PROSALUD has only a limited ability to offer specialized medical services (obstetrics, pediatrics, dentistry) that generate more income. In addition, for the first several years of project implementation, the pharmaceutical component failed to be self-financing.

B. Proposed Grantee and Implementing Agency

The project will be implemented through two cooperative agreements. The team responsible for preparing the project paper will assess the institutional capability, both managerially and financially, of the likely implementing organization for Phase I. In addition, the Project Paper will address the methods of implementation of the PSCs and centrally funded project buy-ins.

Phase I of the project, including the studies of the third component, will be awarded to the most competitive proposal developed by a private voluntary organization qualified to compete under the 123(e) exemption. Phase II of the project will be competed and awarded during the second quarter of FY92. Should program sanctions be lifted by that time, competition for the selection of a project implementing entity under Phase II will be broadened to include a larger number of PVOs and for-profit companies.

Each implementing organization will be responsible for sub-contracting for technical assistance and training, with technical support provided by USAID/Peru as necessary.

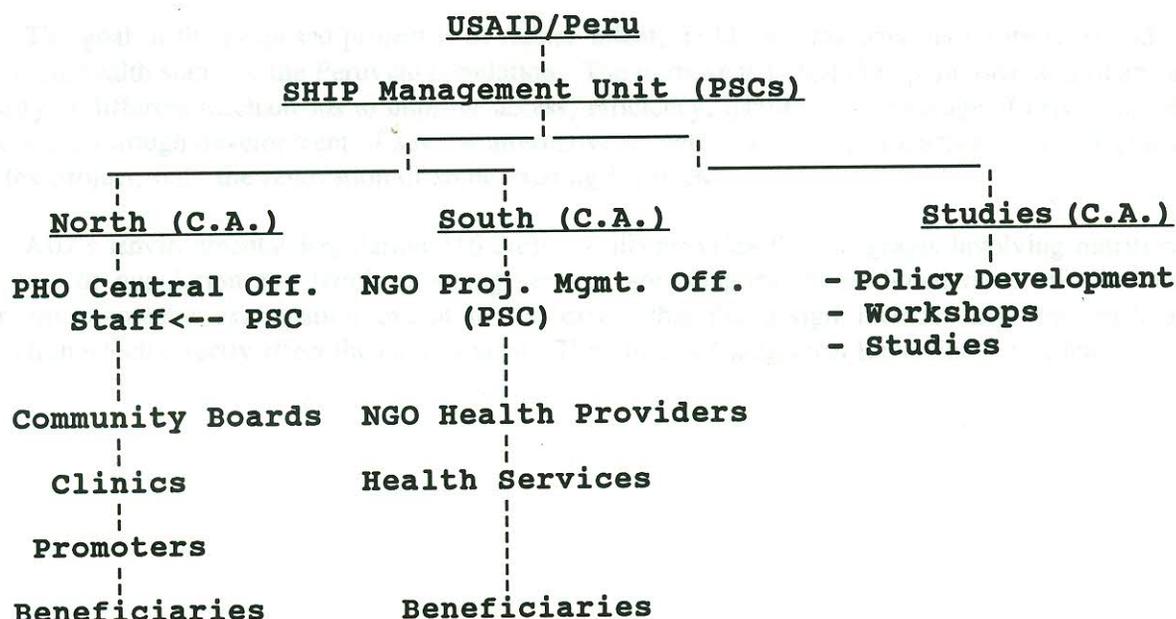
C. Project Development Schedule

Project Paper preparation	July 1991
Limited local competition for Phase I awardee	August 1991
Sign PROAG	September 1991
Compete for technical assistance	October 1991
Begin TA services	January 1992
Phase II competition	February 1992
Phase II Award	March 1992

D. AID Support Requirements

Implementing the SHIP Project does imply some level of increased management burden to USAID/Peru. Contracting for the services of three project-financed PSCs as project monitors will minimize this burden to some extent. One of these positions will be based in Lima; the other two will be based in the project areas - North and South. This level of support is considered necessary given the geographical and managerial dispersion of the project and the need for project oversight. An illustrative, but not definitive, management structure for the project appears below as Chart II.

CHART: Preliminary Structure



To a significant extent, the PSC positions will be used to implement project activities as well as to manage the activities carried out by cooperating agencies. The specific scopes of work for these individuals, the nature of expertise required, and the relationship of the field project managers to the cooperating agencies will be explored in more depth in the project paper. The overall project will be under the direction of the Health, Population, and Nutrition Division of USAID/Peru.

E. Design Strategy

The PP design strategy will include the results of the technical and financial feasibility studies, as well as determine the institutional capability of potential implementing entities both in the South and the North project areas. Other key elements of the strategy will include the degree of community participation and consumer acceptance, and availability of project management and other technical expertise. Selecting the specific project location for the self-sustaining PHO will be among the key design questions. In addition, an assessment of health care providers in both the public and private sectors is needed to determine their level of interest and ability to coordinate activities for the proposed project components.

To resolve these issues, the mission will contract specialized technical services and expertise. The anticipated technical assistance for PP development will include the following areas: USAID project design and design team management; health financing; social soundness analysis; economic analysis; public health (medical expertise); and NGO management. These professionals will begin work in early July. Several local survey workers will also be contracted to complete the market surveys and/or social surveys as necessary during the second half of June. In addition, USAID/Peru will incorporate mission personnel from the Controller's Office and the Division of Health, Population and Nutrition.

F. Recommended Environmental Threshold Decision

The goal of the proposed project is to reduce infant, child, and maternal mortality rates and to improve the health status of the Peruvian population. The purpose is to test the operational and financial feasibility of different mechanisms to improve access, efficiency, quality, and coverage of private health care services through development of several alternative models. No new construction is contemplated under the project, only the renovation of some existing facilities.

AID's Environmental Regulation 216.2(c)[2] (viii) provides that programs involving nutrition, health care or population and family planning services are categorically excluded from the need for further environmental examination except to the extent that the design includes activities such as construction which directly affect the environment. Therefore, a Categorical Exclusion is recommended.

LOGICAL FRAMEWORK
STRENGTHENING HEALTH INSTITUTIONS PROJECT (SHIP)
(527-0319)

NARRATIVE SUMMARY

Program Goal: To improve the health status of Peruvians through access to quality primary health care.

Sub-goal: To adjust the role of public sector health programs toward policy development and oversight and improve the efficiency of service provision to the poorest 30% of the population.

OBJECTIVELY VERIFIABLE INDICATORS

IMR rate reduced from 81/1000 to 65/1000 by the year 1995.

Percentage of target population immunized increases from 65% to 85% by 1995.

Acute child malnutrition rate decreases from 8% to 3% by 1995.

Chronic child malnutrition rates decrease from 60% to 40% by 1995.

Modern contraceptive prevalence increases from 23% to 40% by 1995.

Percentage of MOH budget for preventative services increases from 10% to 40% by 1995.

Private and private voluntary firms replace MOH as primary provider of health services for ---% of population by year 19--.

Third party provision of primary health care for IPSS members increases to cover ---% of population (or population covered)

MOH contracts with private, private voluntary firms to provide services to --- % of population.

Percentage of MOH funds directed to preventative care increases to ---%

MEANS OF VERIFICATION

MOH statistics

IPSS statistics

Census

Program baseline and evaluation studies.

ASSUMPTIONS

No major new causes of mortality occur

Relative level of social and economic stability maintained.

NARRATIVE SUMMARY

Project Purpose: To test the operational and financial feasibility of different mechanisms to improve access, efficiency, quality, and coverage of PHC that can provide models for public-private sector collaboration and cost recovery.

Subpurpose Component 1. To improve collaboration and coordination among primary health care organizations on policy dialogue, efficient provision of high quality PHC services, and cost recovery.

Sub-purpose, Component 2. To develop a self-financing alternative to the public sector that can deliver high quality primary health care services and essential medicines to Peruvians with limited economic resources.

OBJECTIVELY VERIFIABLE INDICATORS

1. Useful alternative mechanisms developed that can resolve key problems of health care financing, efficiency, quality, and coverage.
2. Evaluation data clearly assesses feasibility, factors of success, and tradeoffs of each mechanism.

1. At least XX collaborative activities or project conducted among network members.
2. Regional health policies and procedures reflect concerns and interests of all health care providers and users.
3. Regional health authorities in project and other regions adopt and promote some of ideas developed under project.
4. At least XX examples of more efficient programs, higher quality of care, or greater coverage as a result of collaborative activities.
5. Network members adopt common standards of treatment for priority health problems.

1. Not-for-profit health care system is 100% self-financing by the year ----.
2. PHC services provided to XXXX low income individuals who would otherwise require public subsidy or not receive professional, high quality care.
3. All health care centers in system provide standard level of high quality care.
4. Results of operations research clearly show the parameters of the potential for using cross subsidies to expand coverage to low income populations on a sustainable basis.

MEANS OF VERIFICATION

Project records

Project evaluations

Project evaluation.

Project records.

Project records

Project evaluations

Audit of PVO finances.

ASSUMPTIONS

Project components can identify successful strategies and mechanisms. (Efficiency and cost recovery mechanisms are possible given the social, economic, and political constraints existing in Peru)

Subgrants are successful in creating viable alternative approaches to health care delivery.

Participants from all sectors on policy dialogue participate in good faith.

Decentralization plans proceed on schedule and are effectively realized on the regional level.

It is possible to generate enough revenue in project area to have cross subsidies. Community participation and commitment to the project is high.

MOH regional centers are receptive to this approach and willing to redefine their role in the national health care system. IPSS will adjust payments to third party care providers so that costs are fully covered. Clinics achieve desired market share.

NARRATIVE SUMMARY

Subpurpose Component Three: To broaden the impact of the lessons learned about improving efficiency, cost-recovery, quality and coverage through directed studies and dissemination of results to stimulate and inform the policy dialogue.

OUTPUTS

1. Component 1. PHC service delivery in South region.

1a. Members actively participate in grants program.

1b. Subgrant system established and functioning

1c. NGOs regularly submit grant proposals for increasing the efficiency and coverage of health services and share information on results achieved.

OBJECTIVELY VERIFIABLE INDICATORS

1. Service delivery mechanisms developed in tested under the project are adopted by other private service providers in Peru.

2. Public health services utilize information developed under the project to improve the efficiency, cost-recovery, or management of public health facilities.

1c1. Subgrant management unit channels at least xxx grants of approximately \$xxxx to member organizations

1c2. Clear criteria, format, and objectives of grants are developed and understood by all members.

1c3. Grant system seen as fair and valuable by members

1c4. All grant funded activities have strong monitoring and evaluation system built in to test efficacy of approach.

MEANS OF VERIFICATION

Project evaluation

Project records

Quarterly reports

Project evaluations

ASSUMPTIONS

Policy and resource constraints are not insuperable constraints to adapting and implementing new procedures in public health clinics.

The organizations providing primary health care in the project area have enough interests in common to participate in the network.

The network provides clear benefits to the member community.

NARRATIVE SUMMARY

1d. Training and technical assistance provided to member organizations.

A. Component 2. Self-financing primary health care system. One regional primary health care delivery system established and functioning in the macro-north region.

2a. Central office and clinics established.

2b. Management and control systems established and functioning.

OBJECTIVELY VERIFIABLE INDICATORS

1d1. At least XXX seminars, workshops, and short courses provided on management and technical topics requested by member organizations. At least XXX persons attend the training sessions.

2a. PHC organization consists of one central office for administrative and management and at least XXX health centers and XX health posts.

2b. Central office has following functions established and functioning.

- financial management and controls
- logistics, supply and inventory of drugs and supplies

- standards of quality, procedures, job descriptions, etc. established for all clinics.

- personnel system established with wage scales, training, supervision, etc.

- operations research conducted on systematic basis on key issues

- monitoring system for management, financial and quality control established.

- Standard approach established for market analysis, clinic location, pricing of services and drugs

- operations research conducted on systematic basis on key issues

- monitoring system for management, financial and quality control established.

- Standard approach established for market analysis, clinic location, pricing of services and drugs.

MEANS OF VERIFICATION

Project records

Quarterly reports

Project evaluation

Project Records

Quarterly and annual reports

Midterm evaluation

Final Evaluation

ASSUMPTIONS

Communities or MOH provide physical facilities.

Surplus physicians and specialists are available and willing to serve on part time basis.

Incentive salary payments are adequate to attract capable physicians and staff.

NARRATIVE SUMMARY

2c. Health clinics established and providing high quality health care.

2c. Clinics perform the following functions
-provision of preventative services to community consistent with quality standards
-provision of curative services on a fee for service basis for priority primary health care problems
-sale of essential medicines to clients

2d. Community boards of directors or advisors established for each clinic

2d. At least 80% of clients believe that clinics are more accessible and better quality than alternatives in the community.

Component 3 - Studies, Dissemination, and Policy Dialogue

3a. Feasibility study for private insurance scheme completed.

3b. Results of all studies and evaluations of component activities disseminated through workshops, seminars and publications.

3c. Health policy seminars conducted with participation from all segments of health care providers.

OBJECTIVELY VERIFIABLE INDICATORS

Project monitoring and records,

Quarterly Reports

Project Evaluation

3a. One study completed.

3b. Newsletters(?), conferences, and workshops conducted with broad participation from health care providers in Peru.

3c. At least XXX seminars are conducted on important health policy issues.

3d. Seminar participants formulate policy recommendations.

MEANS OF VERIFICATION

Project Records.

Quarterly reports

Project Evaluation

ASSUMPTIONS

2d. Community support system developed.

2e. Clinics provide improved access to high quality primary health care to target population.

INPUTS

Technical Assistance

Working capital

Equipment, supplies

Vehicles

Buildings suitable for clinics.

	COPY	ORIG	DATE
office	2		
CONT	3		9/2/91
PDP/P	1		✓
PDP	1	1	✓
AID/W	5		✓

MEMORANDUM

TO: The Mission Director
 FROM: Alonzo Wind, HPN
 THRU: Edgar Necochea, A/HPN-HR
 DATE: July 8, 1991
 SUBJECT: PID 527-0319: SHIP



Strengthening Private Sector Health Institutions
 Project (SHIP) 527-0319

PROBLEM: The attached Project Identification Document for the Strengthening Private Sector Health Institutions Project (SHIP) in the amount of US\$ 15.33 million for FY91 - FY96 requires your approval.

DISCUSSION: The attached PID was prepared by the staff of the Health, Population, and Nutrition Division of USAID/Peru, with support from outside consultants and LAC/DR/HPN. This PID was reviewed by the Project Committee and Senior Mission Management on the 7th and 10th of June, and by AID/W on the 27th of June, and recommended for field approval.

RECOMMENDATION: Based on the authorization granted by AID/W for field approval of SHIP project development, we recommend that you approve the SHIP PID by signing the attached facesheet.

Clearances:

PDP:CKassebaum: ck
 CONT:PKramer: pk
 A/DD:ERupprecht: ER