

PD-ABH-313  
10/2/90

**HEALTH FINANCING AND  
SUSTAINABILITY PROJECT**

**TECHNICAL ADVISORY GROUP  
SUMMARY**

**FEBRUARY 2, 1990**

Agency for International Development

Bureau for Science and Technology  
Office of Health  
Health Services Division

*Health Financing and Sustainability (HFS) Project  
Technical Advisory Group Meeting  
Agenda  
February 2, 1990*

Location: SRI International Conference Room  
1611 North Kent Street, 7th Floor  
Rosslyn, Virginia

*Session I – Introduction*

*Chair: Roxann A. Van Dusen*  
Acting Agency Director for Health

10:00-10:05 Welcome

10:05-10:15 Introduction of Attendees

Robert Emrey  
HFS Project Officer  
Health Services Division

10:15-10:30 Overview of the Problem:  
Financing and Sustaining Health Services

Robert Clay  
Acting Chief, Health  
Services Division  
Office of Health

10:30-10:45 Project Concept and Organization

Robert Emrey

10:45-11:15 Discussion

Marty Makinen

11:15-11:30 Break

*Session II – Project Strategy*

*Chair: Robert Clay*

11:30-11:45 Presentation of the HFS Project Strategy

Marty Makinen  
HFS Project Director

11:45-12:45 Discussion

12:45-1:45 Lunch Break

*Session III – Applied Research Plan*

*Chair: Robert Emrey*

1:45-2:00 Presentation of the Applied Research Plan

Maureen Lewis  
HFS Deputy Technical Director

2:00-3:15 Discussion

3:15-3:30 Break

*Session IV – Country Selection and Summary*

*Chair: Robert Clay*

3:30-4:00 Country Selection Process

Richard Roberts  
HFS Deputy Director  
for Operations

4:00-4:25 Summary and Conclusions

Robert Emrey

4:25-4:30 Closing

Roxann A. Van Dusen

**HFS TECHNICAL ADVISORY GROUP MEETING  
FEBRUARY 2, 1990**

**LIST OF ATTENDEES**

NAME	TITLE	AFFILIATION
<u>TAG Members</u>		
John Akin	Professor of Economics	Univ. of NC
Andrew Creese	Health Economist	WHO
Fred Golladay	Principal Economist	World Bank
Philip Musgrove	Advisor in Health Economics	PAHO
David Spencer	Assoc. Medical Director	Kaiser Perm.
Carl Stevens	Professor of Economics	Reed College
<u>A.I.D. Representatives</u>		
Robert Clay	Acting Chief, HSD	A.I.D.
Robert Emrey	CTO, S&T/H	A.I.D.
Sue Gibson	Deputy Chief, ANE/TR/HPN	A.I.D.
Eric Jansen	Economist	A.I.D.
Terri Lukas	Economist, ANE/TR/HPN	A.I.D.
Thomas Morris	Economist/Policy Analyst	A.I.D.
Tricia Moser	Public Health Advisor, LAC	A.I.D.
Nancy Silva	AAAS Fellow, AFR/TR/H	A.I.D.
Ann Van Dusen	Acting Agency Dir., Health	A.I.D.
<u>HFS Project</u>		
John Alden	Management Advisor	M.S.H.
Brad Barker	Technical Associate	M.S.H.
Joanne Bennett	Acting Regional Manager	Abt Associates
Ricardo Bitran	Economist	Abt Associates
Kofi Bota	Vice President	Clark Atlanta Univ.
Roy Brooks	Health Planner	M.S.H.
Harry Cross	Regional Manager	Urban Institute
Paul Fleischacker	Vice President	Tillinghast
Kirsten Frederiksen	Technical Associate	Abt Associates
Stan Hildebrand	Hospital Admin. Expert	Abt Associates
Maureen Lewis	Deputy Technical Director	Urban Institute
Jennifer Lissfelt	Information Specialist	Urban Institute
Marty Makinen	Project Director	Abt Associates
Richard Roberts, Jr.	Dep. Director, Operations	M.S.H.
Holly Wong	Regional Manager	Abt Associates

Other Attendees

Logan Brenzel	Tech. Advisor, HCF REACH II	J.S.I.
Craig Carlson	Project Manager	ASSIST
Carol Carp	Technical Advisor	Mothercare
Stephen Hitchner, Jr.	Sr. Vice President	Urban Institute
Deborah McFarland	Economist	CDC
Jeanne Newman	Deputy Director, PRICOR	URC/CHS
Ron O'Connor	CEO	M.S.H.
Mark Rasmuson	Director, HealthCom Project	A.E.D.
Gerald Rosenthal	Director, Economic Studies	J.S.I.
Riy Struyk	Director, Intl Activities	Urban Institute
Stephanie Wilson	Managing Vice President	Abt Associates

**Summary of Discussion  
of the  
HFS Technical Advisory Group Meeting  
February 2, 1990**

**Introduction:**

**Roxann A. Van Dusen  
Acting Agency Director  
for Health**

Dr. Van Dusen opened the meeting by thanking those who are participating in the Project and in the Technical Advisory Group. She commented that the Health Financing and Sustainability Project is an exciting project with a talented staff which will build upon work initiated by the REACH Project.

She then stated that there are high expectations for the HFS Project. When looking at the problems of the '90's, whether one talks of the lack of health care coverage or the shortage of trained staff, one always comes back to the issue of sustainability. A major task in the design of strategies for this project is identifying what aspect of sustainability is health financing. People often equate the two. In addition to health financing, this project will look at economic, management and staffing issues and design strategies which will carry health care through the 1990's.

**Overview of the Problem:  
Financing and Sustaining  
Health Services**

**Robert Clay  
Acting Chief,  
Health Services Division  
Office of Health**

Mr. Clay stated that many changes in the approach towards health care delivery have taken place. In the last decade, the focus was on expanding weak government-provided health services, making large capital investments, and using extension agents for government health services based on the agricultural model. Health care was centrally planned and supply driven. A lot of effort was spent convincing governments of the importance of health.

Now financial constraints are causing a reassessment of the idea that health is free for all. People have learned that someone needs to pay for health care. There is a growing recognition of the importance of the private sector as a partner with the government in the delivery of health care. Countries are recognizing the importance of private physicians and traditional healers in health delivery. There is a growing acceptance of cost sharing. Now, there is an overall orientation towards the client and meeting the client's needs. The steady focus of donors on child survival (C.S.) activities over the last 10 years has led us through the phases of promotion and expansion. Now we are facing second generation questions concerning the sustainability of successes in C.S.; the institutionalization of C.S. activities; the availability of resources for C.S. activities; and the potential of private sector resources to provide equitable health care.

The health community is becoming increasingly interested in the problems of financing and is seeking the assistance of economists in designing solutions to these problems. Among these problems are the narrow financial base upon which health care delivery is dependent, the often inefficient use of limited resources, the inappropriate mix of services which favors specialized costly care over cost-effective, preventive interventions, the inadequate use of the private sector in offering services and finally, the lack of communication between health care providers and economists.

These problems create opportunities for those of us interested in health care financing. Donors are noticing the importance of health financing issues. Innovative work has already begun which provides useful models for our work. The expertise and resources available in the field are growing. The strong interest in sustainability is evidenced by the large response of missions and host governments to the Project's announcement cable. It is also reflected by the interest of projects involved with C.S. activities such as EPI and ORT in making their own work sustainable.

**Project Concept and Organization:**

**Robert Emrey  
HFS Project Officer**

Mr. Emrey commented that much of the design and concept for HFS is based upon the innovative work of the REACH project. He requested that the TAG consider the following five areas in its discussion:

1. Health sector policy makers can and should play a role in health financing issues. An important contribution of this project will be to strengthen the capacity of health sector officials to communicate, understand and analyze health financing issues.
2. There are some who believe that health financing is an end in itself. This project was designed with the concept that financing is a means to achieving health goals, not an end in itself.
3. There are policies at all levels of governments which need to be changed because they impede the financing process and consequently the availability and use of resources in the health sector. This project will give high priority to policy issues.

4. There is a lack of data. One of the mandates of this project is to collect better data which will help to understand how resources are currently being used and how they can be better used. Also, data will be collected to better understand equity, operational and health systems issues.
5. Another Project mandate is to conduct applied research. We look forward to a good discussion of the topics selected so that the Project's scarce resources for research activities will be used effectively.

Mr. Emrey also drew the TAG's attention to the five technical areas:

1. Resource generation
2. Social financing
3. Private and public sector collaboration
4. Resource allocation
5. Identification of costs and production functions of the health sector.

In addition, there are three aspects of the way the HFS Project will carry out its work which should be considered in today's discussion:

1. There is not yet available a large group of local professionals who can conduct work in this area. Therefore, an important part of our mandate is to involve people at the local level, even from other sectors, who will be able to carry on the work after the Project has ended.
2. There is interest at A.I.D. in looking at US and European models as tools to help in our work in developing countries.
3. There is a great deal of interest in involving the private sector. There is a belief in A.I.D. that the private sector has not been used enough. Should we be tapping into the resources of multi-nationals? Should we be looking at more innovative ways of using the private sector?

## **Discussion:**

### Ends/Means Paradigm

Dr. Carl Stevens began the discussion by emphasizing that health financing is a means to an end rather than an end in itself. He stated that it is important to first define the level of preferred performance for a health system and then determine what is the most effective strategy for achieving that level of performance. Health financing and private sector participation in health care delivery are means to achieving the preferred performance of the health system. Dr. Van Dusen commented that the applied research activities will determine the most effective strategies for improving the health system in the countries in which the Project will work.

### Sustainable with LDC Resources

Dr. David Spencer questioned what was meant by sustainability and asked if there will be sufficient resources in the countries to sustain services or whether additional money will come from external resources. Dr. Van Dusen responded that the goal is to assist countries to reach a point where they will no longer need external assistance. Dr. Makinen added that the focus will be on the sustainability of operations over the long term. Also, the system designed for a country will be compatible with the available resources.

### Incentives for Performance

Dr. Philip Musgrove commented that the design of the Project overemphasizes the private sector. He also noted that there was not enough emphasis placed upon improving the management of publicly provided services. Dr. Stevens responded that many Ministries of Health operate inefficiently because they lack incentives for efficiency. Dr. Musgrove stated that the institutional setting is very important to the effectiveness of incentives. Both agreed that the underlying problem is making facility management accountable for success or failure. The design of incentives and systems of accountability will vary from culture to culture. However, Dr. Stevens suggested that Indonesia could provide a useful model.

### Relevance of U.S. and European Models

Dr. Stevens stated that the US health system model is basically irrelevant to the LDC experience. Knowledge of the US system is useful for work in developing countries because it includes almost every institutional arrangement conceivable. However, the US has yet to master cost containment. He concluded that the US system can be used as a model for institutional arrangements but not for cost containment. Dr. Fred Golladay commented that it would be worthwhile to look at the phases institutions, particularly in Europe, have passed through as health financing has evolved.

**HFS Project Strategy:**

**Dr. Marty Makinen**  
**HFS Project Director**

Dr. Makinen began the discussion of the HFS Project strategy by first presenting background information and highlights of the strategy and then introducing specific issues for consideration by the TAG. He also reminded the TAG that the purpose of the strategy document is to guide the overall project activities.

The HFS Project has developed the following view of the problem of financing health care in developing countries: There are insufficient resources available for the provision of health care in most LDCs and resources which are available are often used inefficiently. Physical and economic access to health care is unequal. Quality of care is often low. Finally, governments are unable to analyze the situation and develop appropriate solutions. The HFS Project will respond to these problems by conducting technical assistance and applied research activities in the five technical areas mentioned by Mr. Emrey. Host country personnel will be used as counterparts as often as possible in order to institutionalize capabilities and help country nationals develop health financing skills. Project findings will be disseminated to appropriate audiences in order to advance knowledge in the field.

The HFS Project has \$16 million to support its activities. One half of these funds come from central A.I.D. funding and the rest from USAID mission buy-ins. The Project staff come from Abt Associates Inc., Management Sciences for Health, The Urban Institute, Clark Atlanta University and Tillinghast.

A.I.D. has set the following objectives for the HFS Project:

- Assist in policy change and implementation in eight to twelve emphasis countries.
- Advance knowledge of health financing by looking at what works and what does not work through applied research activities.
- Improve the capabilities of host country nationals to understand health financing issues.
- Reach target audiences to increase understanding of health financing issues.

The HFS Project is obligated to provide long term technical assistance in eight countries, conduct nine major applied research activities and 30 smaller applied research activities. The Project will also carry out an unspecified amount of short term technical assistance. The Project contract specifies that 61 percent of Project resources go to technical assistance, 22 percent to applied research, 14 percent to dissemination, and 3 percent to training.

The Project has developed the following approach for improving health care financing in LDCs and meeting its objectives: The HFS Project will work where it can have a major impact on policy. The Project will concentrate its efforts in long term technical assistance and applied research in eight to 12 countries.

The technical assistance and applied research activities will overlap and complement one another. Smaller applied research activities will take place where long term technical assistance is being conducted. The Project will be proactive in seeking sites and topics for applied research and will facilitate this by allocating core funds to applied research. The Project will seek buy-ins for all technical assistance. Consequently, technical assistance will be demand driven. The Project will seek a regional balance in long term technical assistance and major applied research. Some applied research work will be comparative, across countries. The Project will also seek a balance among the five technical areas in its long term technical assistance activities. It will include local researchers in most of its activities and local experts in workshops to help them improve their skills.

The selection of countries for major work will be presented by Dr. Richard Roberts this afternoon. Country activities are determined in three ways: bureau and mission requests, Project initiated contacts with USAIDS and follow-on to short term technical assistance. Country activities will be initiated with the following process: an initial assessment visit, follow-up visits to determine the best strategy for working in the country and, finally, implementation of activities.

Dr. Makinen suggested that the TAG consider the following issues in its discussion of the strategy:

1. Policy change versus implementation: The Project has emphasized that decision makers are not completely aware of the depth of financing problems nor are they aware of the array of policies that can be used to address these problems. Another approach assumes that policymakers are aware of policy options but that they have difficulty implementing them. **Has the Project given policy change the proper emphasis?**
2. Technical Approach: Does the sketch of the way the world is and the way it could be as presented in Appendix A capture the state of health financing? **Have we correctly interpreted the technical areas?**
3. The Private Sector: We have not given more emphasis to the private sector than to the other technical areas. What is the appropriate approach to the private sector issue? **Has the Project struck the proper balance between the public and private sectors or should more weight be given to the private sector?**

## Discussion:

### General Comments on Project Strategy

This discussion focused on the objectives of the Project and the allocation of resources. Professor John Akin commented that it was difficult to define the objectives of the Project and that the allocation of resources recommended by A.I.D. seemed arbitrary and made it difficult to determine what A.I.D. really expected. He questioned whether the Project was designed to give more emphasis to applied research or technical assistance. Dr. Musgrove asked how the Project was to have a maximum impact if only three percent of its resources were to be allocated to training. Dr. Stevens commented that it was not possible to say how many resources should go towards training without getting out to the field and assessing the needs. Dr. Andrew Creese questioned the extent of the Project's potential impact on institutional capacity if so few resources were allocated to training. He asked if the Project was realistic in the goals it was setting. Dr. Makinen agreed that three percent was too little to allocate to training.

Ms. Logan Brenzel asked if the Project would collaborate with donors both in and out of country. Dr. Makinen responded that the Project intended to leverage its resources by collaborating with other donors. He cited Project efforts to include donors in the TAG and the promising potential of collaborating with UNICEF on the Bamako Initiative.

The discussion then turned to the question of how to integrate the demand driven technical assistance activities with a proactive approach towards applied research. Ms. Terri Lukas responded that since the Project's funding is so heavily dependent upon buy-ins, the Project needed to develop a very flexible strategy and remain responsive to requests from missions, A.I.D. bureaus and S&T/Health. Dr. Makinen reiterated the Project's approach of allocating core funds to applied research activities which would advance knowledge in the field without being constrained by the need to obtain buy-ins. Mr. Emrey emphasized that the Project was designed to have the freedom to pursue its own research agenda. Mr. Clay clarified the concept of buy-ins and the trend in A.I.D. toward decentralized funding. Dr. Musgrove asked if there was a potential conflict in responding to mission requests for technical assistance and maintaining autonomy for applied research activities while integrating technical assistance and applied research. Dr. Makinen responded that while the Project would respond to demand, criteria for establishing priorities for activities did need to be established.

### Policy Change versus Implementation

Dr. Stevens initiated the discussion of policy change versus implementation by questioning the distinction between the two. Is it simply a matter of discourse versus action? He recommended that the Project identify the best opportunities in the field rather than establish rules for allocating resources which would constrain the Project. Ms. Lukas agreed that there was no need to distinguish between the two but that both should be emphasized. Dr. Musgrove pointed out that the question is difficult because policy can take on so many different sizes and forms. Dr. Golladay suggested that rather than discuss policy change the

TAG should discuss the need for institutional capacity to assess policies and determine if change is necessary. He felt that such an approach would have a better long term impact.

### The Project's Interpretation of Technical Areas

Dr. Creese noted that the five technical areas as outlined by A.I.D. are not technical areas. In fact, resource generation, social financing, private/public collaboration, and resource allocation represented policy options whereas, identification of production functions is a technical area. He also expressed concern that the areas are overlapping. He emphasized the need to set priorities in determining Project activities and to rethink these areas accordingly.

Dr. Musgrove stated that the interpretation of the technical areas, as reflected in the diagrams in Appendix A, was correct given the complexity of health financing issues. Dr. Creese suggested that a discussion of the diagrams was not useful and the remaining TAG members agreed.

### Public versus Private Sector

Ms. Lukas commented that there is an interest in the Asia/Near East Bureau in leveraging resources from the private sector. Dr. Spencer observed that the extent to which the private sector can be tapped depends on the situation. While the Project can respond by preparing itself with the expertise, it should determine how it will handle the issue of privatization. Is the Project going to back away or charge in?

Dr. Musgrove cautioned that there is a danger of becoming too ideological concerning the private sector. It is important to first determine the outcomes one is seeking such as equity, efficiency, and access, and then look at both the private and public interventions which are available to determine the best mix for achieving those objectives. Dr. Creese stated that the Project should take the conventional approach of economic analysis and not promote the private sector more aggressively. He recommended that all decisions be based on economic appraisal. Dr. Musgrove emphasized that the Project should not begin with a bias towards the private sector. Rather it should help missions to assess the situation and determine the appropriate strategy with no particular bias towards a specific approach. Dr. Makinen responded that the approach of the Project will be to define, on the assessment visit, the ends being sought by the government and to determine the context and institutional arrangements in the country. Then the Project will lay out for the government and the mission a set of options grouped in the first four technical areas and including the private sector option. The mission, the government and the Project will choose the appropriate strategy by using standard economic analysis and assessing efficiency, equity, and access.

Professor Akin commented that there is a lot of research of the private sector which can be conducted, particularly concerning efficiency. Dr. Golladay suggested that the Project look carefully at the private sector because it is composed of a lot of different types of organizations and offers a variety of services in the health sector. Dr. Makinen responded that because there are those who advance the private sector ideology, applied research concerning the

private sector should be pursued. The Project can pursue applied research in settings where the government has selected the private sector option. The job of the Project is to explore the costs and benefits of all options included in the spectrum of private public collaboration.

**The Applied Research Plan:**

**Dr. Maureen Lewis**  
**Deputy Technical Director**

The Plan sets forth the parameters for both the technical and managerial aspects of the applied research activities of the Project. The applied research component of the Project will be designed to complement the technical assistance activities and advance the knowledge of the field. Applied research will also provide a good opportunity to help individual countries. Since A.I.D. has not traditionally funded research in health and countries have not emphasized research, this is a welcome component in the Project. In the next few months, the Project will develop an agenda which will be based upon a review of what is known and the general issues which are set forth in this Plan.

The applied research component of the Project includes 30 small research projects and up to nine major studies. The small projects, costing between \$15,000 - \$35,000, will be small, focused activities which are largely country-based and will lead into a large applied research activity or further technical assistance activities. The nine major studies will take place in as many countries and will be funded at much higher levels. Dr. Lewis asked for recommendations from the TAG concerning the allocation of funding for the applied research activities. The topics for applied research are drawn broadly from the five technical areas. However, they will also come from demand at the country level and from areas which need more research. There are an infinite number of topics which can be selected. But, preliminarily, the following broad categories have been selected: insurance, the private sector, and resource generation. One question we would like to be considered is: Should this strategy be more specific or should it remain rather broad?

Three million dollars of central funds, excluding management costs, have been allocated to applied research. Activities will be staffed predominately by the partner institutions. We are proposing that \$0.5 million be allocated to the smaller activities and \$2.5 to the major activities. This allocation is based on the rationale that the smaller activities have narrower focuses and can be conducted by local consultants.

The review of proposals will be largely internal. Research results will be disseminated to a wide audience through reports translated into French and Spanish and policy briefs developed for policy makers. The Project will also have a newsletter. Dissemination will be emphasized both in host countries and in Washington, to A.I.D., and to other donors.

Dr. Lewis suggested that the TAG consider the following issues related to applied research:

**What should be the priorities for applied research? Should the Project be more focused?**

**How comprehensive should the review of the literature be?**

**How should priorities for research topics be established?** What should the mix be between policy and operational level research? And, what should the mix be between generic and country-specific work? Should topics at the policy level or the service delivery level be pursued? And, should generic topics be researched or topics which are integrated into technical assistance activities and which will benefit a specific country?

**How should resources be allocated?**

### General Comments on the Applied Research Plan

Dr. Musgrove asked if the scope of work for conducting applied research is realistic. He also questioned the capacity of the Project to supervise nine major research projects and thirty smaller projects. He emphasized that management and oversight of all these activities will be critical to their success and should be monitored closely.

Ms. Logan Brenzel asked to what extent HFS intended to draw upon the recommendations which have been set forth by the REACH and PRICOR projects. Professor Akin asked for clarification of the role of applied research in the Project. He asked if the intended audience for the applied research activities was the international academic community, the countries themselves, or A.I.D.

### Priorities for Applied Research Activities

Dr. Stevens initiated the discussion of priorities by questioning the need for a list of priority topics and emphasizing the importance of maintaining flexibility. Professor Akin asked how the list would be used. Dr. Lewis responded that the list is to guide the Project in its applied research activities. Dr. Creese commented that a research agenda could deprive the Project of the opportunity to pursue interesting topics which would be encountered during technical assistance activities.

### **What should be the relationship between Technical Assistance and Applied Research?**

Dr. Jeanne Newman pointed out that research conducted in conjunction with technical assistance is small scale and focuses on the particular issue being addressed by the technical assistance. Dr. Gerald Rosenthal added that any short term technical assistance which involves analytical work includes research. He emphasized that the research which will be conducted by the Project is opportunistic in nature. It analyzes specific experiences and draws generalizations from those experiences which can be applied to other settings. Dr. Lewis commented that even priority research should be tied in with technical

assistance because the technical assistance wins the support of the government for the research activity. Dr. Musgrove again questioned the potential conflict of obtaining buy-ins for technical assistance and conducting innovative research when integrating applied research and technical assistance activities. Prof. Akin added that the Project is fortunate to have resources available to use at its own discretion and should use them to pursue innovative research. Concerning the mix and level of research activities, Dr. Musgrove stated that the Project should be very comprehensive and that it should include research at the service delivery level.

### Review of Literature

Dr. Musgrove stated that the review of the literature should focus on gaps in knowledge and should not attempt to assemble a review of all that has been done in the field. Dr. Stevens added that the review should not be limited to literature on health services because there has been very useful work conducted in other areas. Mr. Ricardo Bitran emphasized the need to define the outcome sought from the review, the level of effort which it would require and the time frame in which it should be completed. Mr. Bitran requested that the TAG offer recommendations of the gaps in knowledge which the Project should research. Dr. Stevens suggested the relationship between health status and economic development. Dr. Musgrove cautioned that that topic is very age specific. Dr. Musgrove recommended that the Project research the principal determinants of the ideal allocation of resources and investigate the measurement of public sector inefficiencies and wastage.

Dr. Creese proposed a country-based approach which would research specific problems in a given country and then produce findings which could be used by similar countries. Ms. Patricia Moser supported this idea and commented that A.I.D. has had difficulty integrating research into country strategies. She stated that a country-based approach could resolve that problem. Dr. Spencer commented that the Project should use the experience of A.I.D. to determine what the problems of health care delivery are in different countries and to see if there are common problems which can be studied in the major applied research projects. Dr. Golladay cautioned that it is difficult to know what to ask. The context can often be illusive and provide conflicting findings. He cited the example of contrasting findings regarding the impact of user fees on utilization.

Dr. Stevens concluded by commenting that the best the Project could do is develop criteria for establishing priorities.

### **Country Selection:**

**Dr. Richard Roberts  
Deputy Director of  
Operations**

Dr. Roberts stated that the Project needs the acceptance and agreement of missions and governments to do applied research and it needs the funding from missions to do technical assistance. Consequently, HFS technical assistance is demand driven. A.I.D. sent out an announcement cable in December. The Project has received 24 responses from missions since December.

Dr. Roberts discussed the proposed funding arrangements and regional division of the mission requests. Response has been heaviest from the Asia/Near East region. In considering these requests, the Project needs to be selective because it has had a lot of demand for assistance and must meet its deliverables. Therefore, the Project needs to prioritize which activities will best enable it to meet its goals.

Dr. Roberts discussed the criteria which have been developed for setting priorities. Geographic distribution is important. Distribution among the five technical areas is also important. Distribution among the five technical areas in countries of varying socio-economic levels would be very interesting to the Project. The Project anticipates potential long-term activities in Kenya and possibly Senegal. Nepal has requested an assessment after which the Project will determine if it will work there long-term. Jordan, Morocco, and Egypt have also requested assistance. But, HFS has a budgetary ceiling and cannot afford to get too involved in all of these countries. In the Latin America and Caribbean regions, HFS has had requests from Jamaica, Belize and Bolivia.

Dr. Roberts requested that the TAG assist in deciding where to focus Project activities. It is difficult to rank these opportunities but perhaps the TAG can help the Project strengthen its criteria.

#### General Comments

Mr. Clay emphasized the importance of country selection.

Dr. Stevens suggested that impact is the most important selection criteria. However, he cautioned that it is difficult to measure impact. He recommended that a methodology be developed. Dr. Golladay suggested a matrix of administrative and cultural traditions which could be used to look at impact in not only country terms but also across larger categories. Dr. Musgrove suggested that sustainability and long-term prospects should be used for setting priorities. He said that anything which clearly works better in a few years will continue because people see the benefit. He also asked how much allowance the Project was willing to give itself for failure. Dr. Stevens added that it is important to realize that projects which collapse are not necessarily failures. Dr. Van Dusen interjected that although A.I.D. bureaucracy is cumbersome, it is possible to change course and be flexible.

Dr. Stephanie Wilson asked if any of the countries asked for applied research and, if so, how the requests were distributed across research areas. Dr. Roberts responded that some have requested applied research and, of those, many want it to be paid for with core funds. Burkina Faso is willing to pay for assistance in analyzing data. Senegal requested follow-up on some REACH research studies. However, it is hard to tell from the initial cables exactly what needs to be done. Dr. Makinen added that the initial visits will be critical to defining the scope of activities.

**Summary and Conclusions:**

**Mr. Robert Emrey**  
**HFS Project Officer**

Mr. Emrey concluded by thanking the attendees for their time and thoughtful comments and summarizing the highlights of the discussion:

1. The discussion emphasized the importance of looking at health financing as a means to an end. Incentives and the institutional arrangements needed to make them work were also emphasized. Comments were made concerning the administrative and cultural factors which provide the context for incentives. These factors often determine if the incentives will work.
2. Discussion centered around where HFS will have its impact. Where are the ends to be defined, will they be in health or other factors? Attention should be given to the host government, the mission, the private sector, and to people on the firing line.
3. Concerning policy implementation versus policy change, the Project must realize its limitations in time and money, but not close off any opportunities. HFS should emphasize building capacity for policy analysis in the countries in which it works.
4. In working with resource generation policies and enlarging the role of the private sector, the private sector should remain a high priority. However, the Project will remain evenhanded in developing strategies including both the private and public sectors. The private sector is very complex. Therefore, HFS will need to be careful in how it approaches the private sector to be sure that the institutional arrangements of the private sector are understood.
5. The Project has a lot of work cut out for itself in applied research activities. Applied research is a complex process. Supervision of multinational research activities will be very complex. The Project must develop an approach for the synthesis of the literature. There is consensus that the synthesis is needed but the outcome the Project seeks needs to be clearly defined in order to determine the inputs the synthesis will require.
6. It is important that the Project get on with the research and be sensitive to what it learns in the different countries. The priorities should concentrate on gaps in knowledge. Mr. Emrey requested that the TAG members submit written suggestions of research topics. There was an interesting discussion of national agendas for research put forth by both Ms. Moser and Dr. Creese.
7. The selection of country activities is important and difficult. It is difficult to define the criteria for impact. It is also important that the Project leave room for failure of some of its activities.

The meeting adjourned at the conclusion of Mr. Emrey's remarks.

## APPENDIX A

### Policies to Improve Health Financing in LDCs

The project approaches the technical issues of health financing and sustainability with a model in mind of what the goals are for most health sectors; what financial, economic, and management constraints are faced in attempting to realize those goals; and what solutions are possible. This model, as it is described here, is generic, it will be adapted to the specific country, when used in actual situations. The initial characteristics of the situation and the politically and administratively possible solutions will shape how the model applies in a given situation. Further, a model is by definition a simplification of reality. However, a good model identifies the key elements of reality, to provide a framework to guide analysis and action. This model identifies the key elements of the health financing problem and possible solutions. It shows where specific interventions of the types designated as focus technical areas fit. The model is summarized in Exhibits A.1 and A.2.

Most governments have as goals for their health sectors: economic and physical access to services of an acceptable level of quality, achievement of high levels of coverage of preventive and promotive services, and the accomplishment of public health tasks. Economic access means that no one is denied health services because of an inability to pay. Physical access means that health services are available to all at a reasonable distance from their residence. An acceptable level of quality means that competent personnel equipped with at least basic diagnostic technologies and essential drugs and supplies are available to serve patients, backed by a referral system to provide supervision and more complicated care. Governments take a special interest in preventive and promotive services because they feel that if the population were left on its own, it might under-consume them. Public health activities are those that may only be provided to the population as a whole, not on an individual basis, such as vector or epidemic-disease control.

Developing countries have had difficulty in achieving their goals for the health sector. The sources of those difficulties are a series of constraints, many of which are linked to an over-reliance on the government as the provider and financier of health services. These constraints are: limited resources available to the sector; lack of tools to efficiently allocate resources within the government programs; inefficiency in the provision of services; and over-utilization or inappropriate utilization of services by consumers. An additional constraint has been the inability of governments' policymakers to devise and implement solutions to the constraints.

A stylization of the current situation is shown in Exhibit A.1. Governments, through Ministries of Health and Social Security Institutes, provide health services at little or no charge to consumers. The private sector operates in parallel, charging fees for services. While the private sector may provide more services than the government in many situations, it usually provides less than it might because of restrictive regulations, if not outright bans. Further, rarely have private social financing mechanisms

To complement the introduction of user charges and a greater reliance on private provision of services, systems will be devised to exempt or reduce charges to those with a limited ability to pay in government facilities or subsidize services provided to them by private facilities. In addition, new management systems will need to be devised and implemented to permit the user-charge system to function. This includes fee collection, accounting, safeguarding, and audit.

The use of all of the above tools would produce significant additional resources for the health system. In particular, the government would earn additional revenues through user charges at government facilities and realize savings by allowing a greater private-sector role and by the efficiency gains achieved through allocation and delivery improvements in the government sector. Physical access to services could be improved both by the expanded private sector and by the use of the additional resources available to governments to expand coverage. Further, the additional resources available to governments could be used to increase funding for preventive and promotive services and public health activities. These could be areas of government specialization. Lastly, governments will have tools at their disposal to address new problems as conditions change.

The focus technical areas enter into this picture in several places, as noted in Exhibit A.2. Resource generation through cost recovery is a key part of the strategy for both government (A1) and private providers (A2). Social financing mechanisms facilitate cost recovery for private providers (B1) and, if devised properly, may provide incentives for private provision of preventive and promotive services, through managed care arrangements, in addition to personal curative services.

Private-public collaboration enters in terms of policy and regulatory changes that allow an expansion of private sector provision of services (C1) and the development of private social financing mechanisms (C2). Further, there would be additional collaboration when governments provide subsidies for services provided by private facilities to those with limited ability to pay (C3). Lastly, by explicitly taking the advantages and limitations of the private sector into account in strategic planning, governments will be better able to coordinate the provision of services, thereby decreasing overlaps and closing gaps (C4).

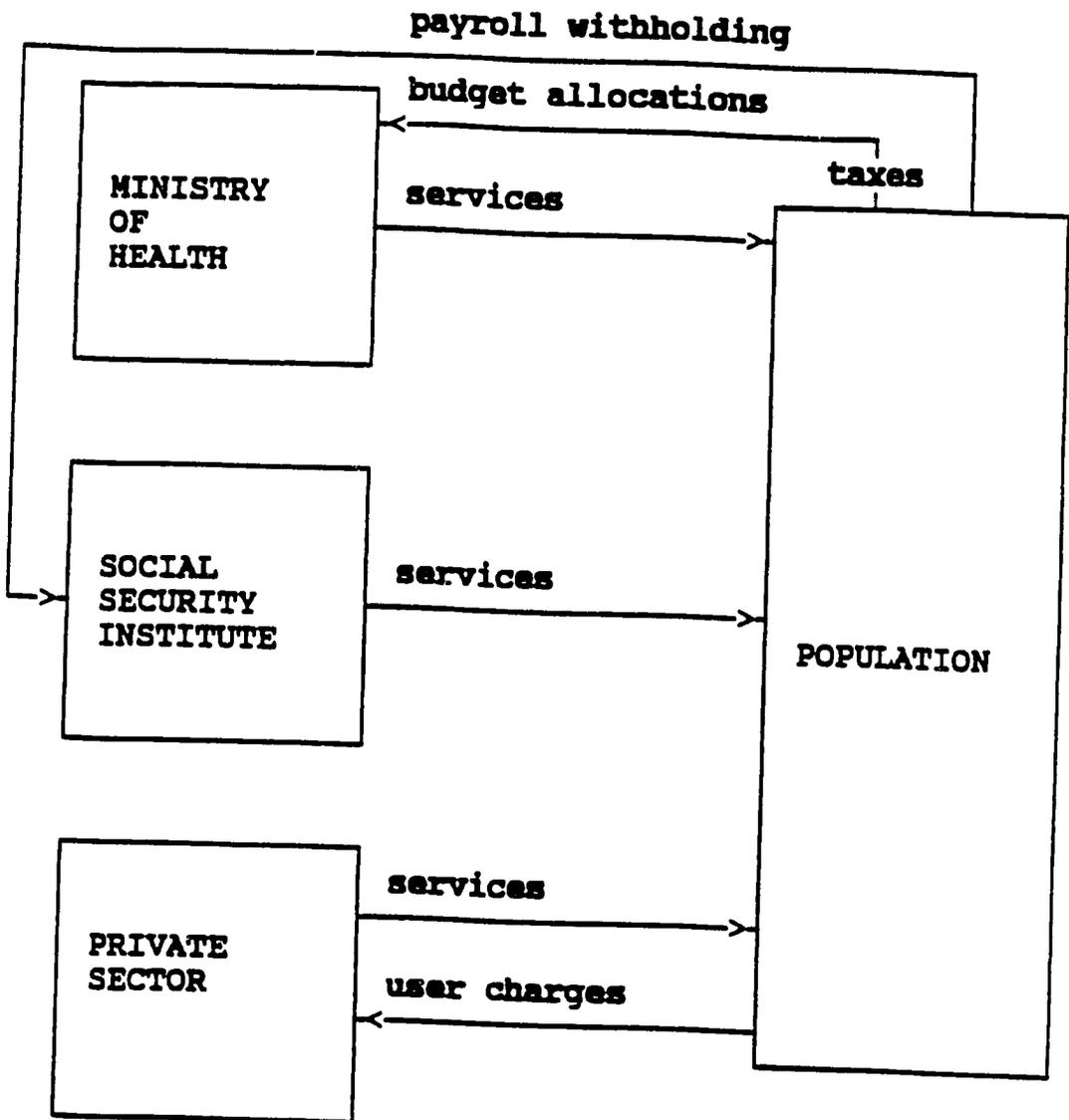
Resource allocation, use, and management enters in three ways: tools in the hands of government policymakers and analysts to decide how to allocate resources among government programs and the extent to which the private sector may be encouraged (D1), in the management and incentive systems put into place to allow government services to be provided more efficiently (D2), and price incentives to consumers to use government services appropriately (D3).

Costing is a tool or technique that would be used in both the resource allocation decisions (E1) and in choosing technologies and managing the delivery of services (E2).

APPENDIX A

Exhibit A.1

Stylization of the Current Health Financing Situation  
in LDCs

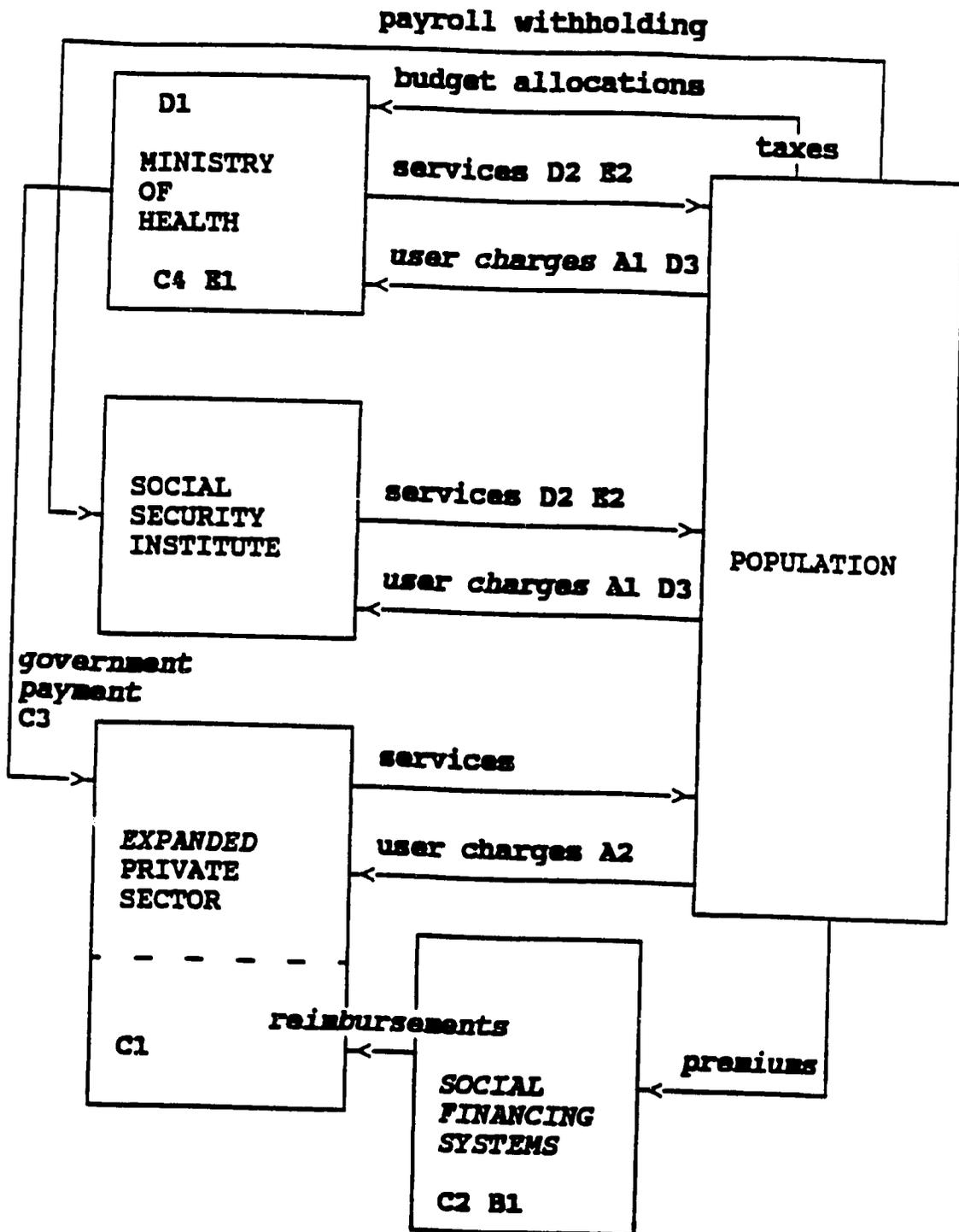


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APPENDIX A

Exhibit A.2

Stylization of How the Health Financing Situation  
Could Look in LDCs



## CRITERIA FOR TASK AND COUNTRY SELECTION

Implementation of the project will be guided by the expected outcome of achieving policy change. Priority will be given to opportunities for major long-term policy change. Further, policy change will be sought in all of the focus technical areas, in a variety of socio-economic settings, and in roughly-equal distribution among A.I.D.'s three regions. Project resources will be leveraged to the extent possible by conducting most AR in countries where long-term TA is provided, collaborating with other donors, and working where local political and technical commitment to policy change exist. Thus, the project will favor opportunities to make major impacts over a longer term over discrete TA assignments. The criteria to set priorities among requests for project assistance include both substantive and practical considerations:

### SUBSTANTIVE CRITERIA

**MAXIMUM IMPACT** The project will consider which interventions are likely to have the greatest impact for the level of project resources required. Another element of this is working in countries where addressing a major constraint would be expected to have an important impact on the provision of health services. Finally, the achievement of impact must be feasible, i. e., the prospects for success in addressing the identified problem must be judged to be good.

**GENERALIZATION TO OTHER COUNTRIES** Issues with solutions that may be applied in other countries will have higher priority. This means that differing social, economic, and political settings will be sought for long-term work to maximize the ability to generalize from results.

**LONG-TERM PROSPECTS (SUSTAINABILITY)** Long-term and sustainable changes are the primary focus of this project. This means that priority will be given to settings where there is political and technical commitment to change. Further, the availability of local analysts and researchers to work with project personnel will develop local capacity to carry on after the project's assistance has ended.

**POTENTIAL FOR MAJOR APPLIED RESEARCH** The project will initiate most major AR, which will address issues of general interest beyond those of the specific country in which the research is conducted. The project will require cooperation and collaboration, however, from the USAID and the host-country institution with the AR.

### PRACTICAL CRITERIA

**AVAILABILITY OF FUNDING** Nearly all of the TA work of the project will be funded by USAID buy-ins. The project thus will focus on countries that already have or are preparing bilateral health projects, since such projects are the major sources of funding for buy-ins.

**SUPPORT BY USAIDS** The project will seek to work in countries where the USAID mission management and health program manager appreciate and support assistance activities to address health financing problems. Appreciation and support is often indicated by attention given to financing issues in sector strategies and commitment of funds in bilateral projects to health financing initiatives.

**OPPORTUNITIES FOR LEVERAGE** Most major and smaller AR will take place in countries where the project is providing long-term TA. This will permit integration of the two forms of activity and facilitate AR with data gathered for the TA effort. This project's technical resources can have greater effect where other donors are able to support complementary costs of policy reform, such as purchase of commodities.

**DISTRIBUTION OF PROJECT ASSISTANCE** Activities are intended to take place in roughly-equal proportion in each of A.I.D.'s regions. They will cover all five focus technical areas. In addition, the project will seek to operate in countries of differing socio-economic levels, to test the replicability of solutions to common issues across levels of development.