

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete) Amendment Number: 896 DOCUMENT CODE: **3**

2. COUNTRY/ENTITY: Caribbean Regional

3. PROJECT NUMBER: 538-0181

4. BUREAU/OFFICE: Latin America & Caribbean 05

5. PROJECT TITLE (maximum 40 characters): Health Care Policy Planning & Management

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY 09 30 98

7. ESTIMATED DATE OF OBLIGATION (Under 'B' below, enter 1, 2, 3, or 4):
 A. Initial FY 92 B. Quarter 4 C. Final FY 97

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY <u>92</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	455	250	705	4235	2265	6500
(Grant) \$000	(455)	(250)	(705)	(4235)	(2265)	(6500)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
Other U.S. 2.						
Host Country	-	-	-	-	811	811
Other Donor(s)						
TOTALS	455	250	705	4235	3076	7311

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	HESD	17		0	0	705	-	6500	-
(2)									
(3)									
(4)									
TOTALS				0	0	705	-	6500	-

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	INS	PBL	PVZ	ROR	SFI	TTE	TWN
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To achieve the more efficient and equitable generation, distribution and use of health sector resources.

BEST AVAILABLE DOCUMENT

14. SCHEDULED EVALUATIONS

Interim	MM YY	MM YY	Final	MM YY
	06 94	01 98		

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

I certify that the Methods of Implementation and Financing and audit plans are in compliance with the Payment Verification Policies.

James B. Sanford 9/20/92
 James Sanford
 Regional Controller

17. APPROVED BY

Signature	<i>Mosina H. Jordan</i>	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
Title	Director, RDO/C	
Date Signed	MM DD YY 09 21 97	MM DD YY

ACTION MEMORANDUM FOR THE REGIONAL MISSION DIRECTOR

FROM: Winston M. McPhie, A/C/PDO

SUBJECT: Health Care Policy Planning and Management Project (538-0181)

DATE: September 16, 1992

Action Requested: You are requested to authorize a grant in the amount of \$6.5 million from Development Assistance funds for the Health Care Policy Planning and Management (HCPPM) project in the Eastern Caribbean. The FY 92 obligation amount is \$705,000.

Discussion:

- A. Grantee: The Organisation of Eastern Caribbean States (OECS).
- B. Implementing Agency: Health Policy Management Unit (HPMU) of the OECS Secretariat.
- C. Description: Eastern Caribbean countries are facing problems which are centered on inefficiencies in the financing, allocation of resources, and management of the health sector. The project proposes to address these problems through the activities outlined below. The goal of the proposed Health Care Policy Planning and Management Project (HCPPM) is to improve and maintain the health status of the people of the Eastern Caribbean. The purpose of HCPPM is to achieve the more efficient and equitable generation, distribution and use of health sector resources.

The planned HCPPM activity, which is to assist both the private and public sectors, will consist of three components:

- (1) Analytic and Diagnostic Studies (\$2.0 million) - the objective of this component is to provide the data necessary for policy formulation and decision-making through a series of analytic and diagnostic studies.
- (2) Applied Research and Organizational Development (\$3.2 million) - this component will include pilot tests and the implementation of policy reforms and new systems, resulting from data gathered during the analytic and diagnostic stage.
- (3) Training and Information Dissemination (\$1.3 million) - the objective of this component is to promote the adoption and acceptance of policy reforms.

D. Financial Summary: The planned US Government contribution to the project, summarized below, is estimated to be US\$6.5 million in grant funds over six years. This

amount will be complemented by an estimated \$811,200 (in LC equivalent) of **in-kind** contributions by the beneficiary governments. The detailed project budget is at Section 4.1 of the attached Project Paper.

<u>Category</u>	<u>LOP Funding Requirements</u> (\$000)
Project Coordination	1,434
Technical Assistance	3,479
Training/Information Dissemination	713
Commodities	97
RDO/C Project Manager	517
Evaluations/Audits & rounding	<u>260</u>
TOTAL	<u>6,500</u>

E. Technical, Economic and Financial, Institutional and Administrative and Social Soundness: The Mission has reviewed the subject analyses carried out for the proposed project (Part 5 and Annexes D-G of the PP). In each case the project was found feasible (or likely to be feasible) and in compliance with AID policy and programming criteria. The project is also found appropriate within the framework of RDO/C's regional strategy.

F. Environmental Determination: Per LAC-IEE-92-00 dated July 16, 1992 Mission request for a categorical exclusion was approved. The exclusion is based on Environmental Procedures 22 CFR Part 216, Section 216.2 (c)(2), Subsections (i), (iii) and (viii) which exclude projects in the following categories:

- (i) Education, technical assistance, or training programs except to the extent such programs include activities directly affecting the environment (such as construction of facilities, etc.)
- (iii) Analyses, studies, academic or research workshops and meetings;
- (viii) Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)

G. Implementation Plan: Implementation arrangements, including plans for monitoring and evaluation detailed in Section 3 of the PP, have been reviewed and revised and determined to be sound by the Executive Committee. Subsequent to authorization and within the initial phase of the project they will have to be adjusted to reflect the findings of the individual country work plans. They may also have to be modified for the last three years of the project based on the experience of the initial years.

H. Procurement and Waivers: The following items are planned to be procured under the project: US and Regional technical assistance, project coordination and management, Regional and US training, commodities, and evaluation and audit services. Until the proposed Implementing Agency (HPMU) has been certified as a contracting agent, all project procurement, other than local cost procurement of HMPU staff and office direct expense items, will be handled by the Mission.

I. Waivers : Waivers of source, origin and nationality for the procurement of technical services in the states of the OECS are proposed and justified respectively in the attached Project Authorization and the Procurement Plan of the Project Paper.

J. Justification to Congress: Mission submitted the Congressional Notification (CN) on July 30, 1992, and per State 281230 dated August 29, 1992, was advised that the waiting period had expired, without objection, on August 21, 1992.

K. Conditions and Covenants: Conditions and covenants to assist in ensuring timely and effective implementation of the project are included in the attached authorization.

Authority: Pursuant to DOA No. 752, Section II. A, you have the authority to authorize a project, if (1) the LOP cost does not exceed \$20 million; (2) there are not significant policy issues; (3) no issuance of waivers by the Administrator or Assistant Administrator are required; and (4) the life of project does not exceed 10 years. All of the above criteria have been met.

Recommendation: That you sign the attached Project Authorization and thereby (a) approve the funding of \$6.5 million in grant funds to the Organization of Eastern Caribbean States for the Health Care Policy Planning and Management Project (538-0181) and (b) approve the requested source/origin waivers.

Approve: _____

Mosina H. Jordan

Disapprove: _____

Mosina H. Jordan

Date: September 21, 1992

Drafted by: PDO:WMcPhie:wmcpr:09/17/92:0021c

CLEARANCE:

C/HPE:RCohn in draft Date 9/16/92 RCO:AEisenberg in draft Date 9/17/92
PRM:EMcPhie in draft Date 9/17/92 CONT:JSanford JS Date 9/19/92
RLA:DLuten in draft Date 9/17/92 A/D/DIR:BBurnett BB Date 9/20/92

PROJECT AUTHORIZATION

Name of Project: Health Care Policy Planning & Management

Project Number: 538-0181

Project Site: OECS Member Countries (Antigua/Barbuda, British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts/Nevis, St. Lucia, and St. Vincent/Grenadines.)

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961 as amended, I hereby authorize the Health Care Policy Planning & Management project for implementation by the Organisation of Eastern Caribbean States (OECS) (the "Grantee") involving planned obligations of not to exceed six million, five hundred thousand United States dollars (US\$ 6,500,000) in grant funds ("Grant") over a six year period, with a PACD of September 30, 1998, subject to the availability of funds. The Grant is to assist in financing the foreign exchange and local currency costs of the project.

2. The project consists of assisting the eight OECS member countries to assess the needs for health sector reform to address the health care needs of their populations more effectively, to undertake and evaluate those reforms, and to improve the management of health sectors to assure that resources are efficiently provided and utilized.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms, conditions precedent and covenants, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source, Origin and Nationality

Except as A.I.D. may otherwise agree in writing, the following source, origin and nationality stipulations shall apply to the use of A.I.D. funds under this project:

(i) **Commodities:** All commodities shall have their source and origin in the United States (Code 000).

(ii) **Technical Assistance Services:** The source, origin and nationality of individuals and firms providing technical assistance services under the project shall be limited to the United States (Code 000) and the Eastern Caribbean. Details on the proposed procurements and rationale for authorizing local procurement are included in the Procurement Plan of the Project Paper.

(iii) **Ocean Shipment:** Financing of Ocean Shipment shall be limited to United States (Code 000) flag vessels.

B. Conditions Precedent to Disbursement

(i) **First Disbursement.** Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) An opinion of the Attorney of the Grantee that this Agreement has been duly authorized and/or ratified by, and executed on behalf of the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(b) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2., and of any additional representatives, together with a specimen signature of each person specified in such statement; and

(c) Evidence that the Grantee has established a separate, interest bearing account for Grant funds.

(ii) **Subsequent Disbursements.** After satisfaction of the conditions precedent to first disbursement, disbursements under the Grant shall be available for project start-up costs, which shall include staff salaries, office expenses, regional travel and any other items to be agreed upon by the Parties through countersigned project implementation letters.

Prior to subsequent disbursements under the Grant, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., a time-phased implementation plan for the first year of the project which includes the time-frame, relevant details and assigned responsibility for the following:

- establishment of a project office,
- hiring of staff for the Health Policy Management Unit,
- scheduling of initial country visits and development of country work plans,
- development of the health financing/management information resource center, and
- establishment of the Health Financing Advisory Committee.

C. Special Covenants

(i) **Organizational Setting and Arrangements.** The Grantee shall, except as A.I.D. may otherwise agree in writing:

- (a) establish the Health Policy Management Unit within its organization, so that the Unit can benefit from existing administrative and policy structures employed by the Eastern Caribbean Drug Service;
- (b) maintain an accounting system for Project funds which meets A.I.D. financial reporting and management standards; and
- (c) maintain the material contributed to the Health Financing/Management Information Resource Center, and continue their availability to Project beneficiaries after the termination of the Project.

(ii) **Project Evaluation.** The Parties shall agree to establish an evaluation program as part of the Project. Except as the Parties may otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

- (a) evaluation of progress toward attainment of the objectives of the Project;
- (b) identification and evaluation of problem areas or constraints which may inhibit such attainment;
- (c) assessment of how such information may be used to help overcome such problems; and
- (d) evaluation, to the degree feasible, of the overall development impact of the Project.

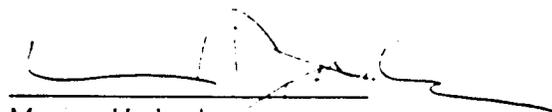
(iii) **Individual Country Work Plans.** Prior to undertaking any Project activities, other than the initial assessments, in any eligible country, the Grantee shall negotiate and agree upon a country work plan with the Government of that country. Agreement between that Grantee and the country shall be evidenced by a Letter of Understanding signed by the parties, to which shall be attached a detailed work plan which outlines at a minimum:

- the desired overall outcome of the Project's assistance to that country;
- the activities to be implemented in pursuit of the outcome;
- a schedule of those activities; and
- assigned responsibilities in the cooperating government and other agencies for realization of the outcome.

(iv) **Annual Project Implementation Plans.** The Grantee shall submit annually to A.I.D. for review and approval, comprehensive, time-phased implementation plans and operational budgets for activities to be carried out under the Project. The implementation plans shall be submitted to A.I.D. by the end of the first month of years 2-6 of the Project. These plans will comprise all the activities to be conducted by the Project during the year ahead, and will consider the optimal utilization of Project and cooperating country resources in implementation of this Project. The Annual Implementation Plans should include:

- a statement of the regional outputs and outcomes to be targeted for the period;
- Project activities grouped by Project component;
- responsible parties for cooperating in and executing each activity;
- resources required from project and cooperating agencies;
- time-phased schedule of activities, and
- assumptions.

(v) **Project Start-up.** The Grantee shall, except as A.I.D. may otherwise agree in writing, provide such personnel and other resources to start up the Project, including hiring permanent Project staff, and account for Project funds advanced by A.I.D.. The Grantee will submit to A.I.D. for review and concurrence, the nominations (supported by recent *curricula vitae* and other relevant data) of candidates for all Project-funded staff positions, following agreed schedules for filling these positions.



Mosina H. Jordan
Director

September 21, 1992

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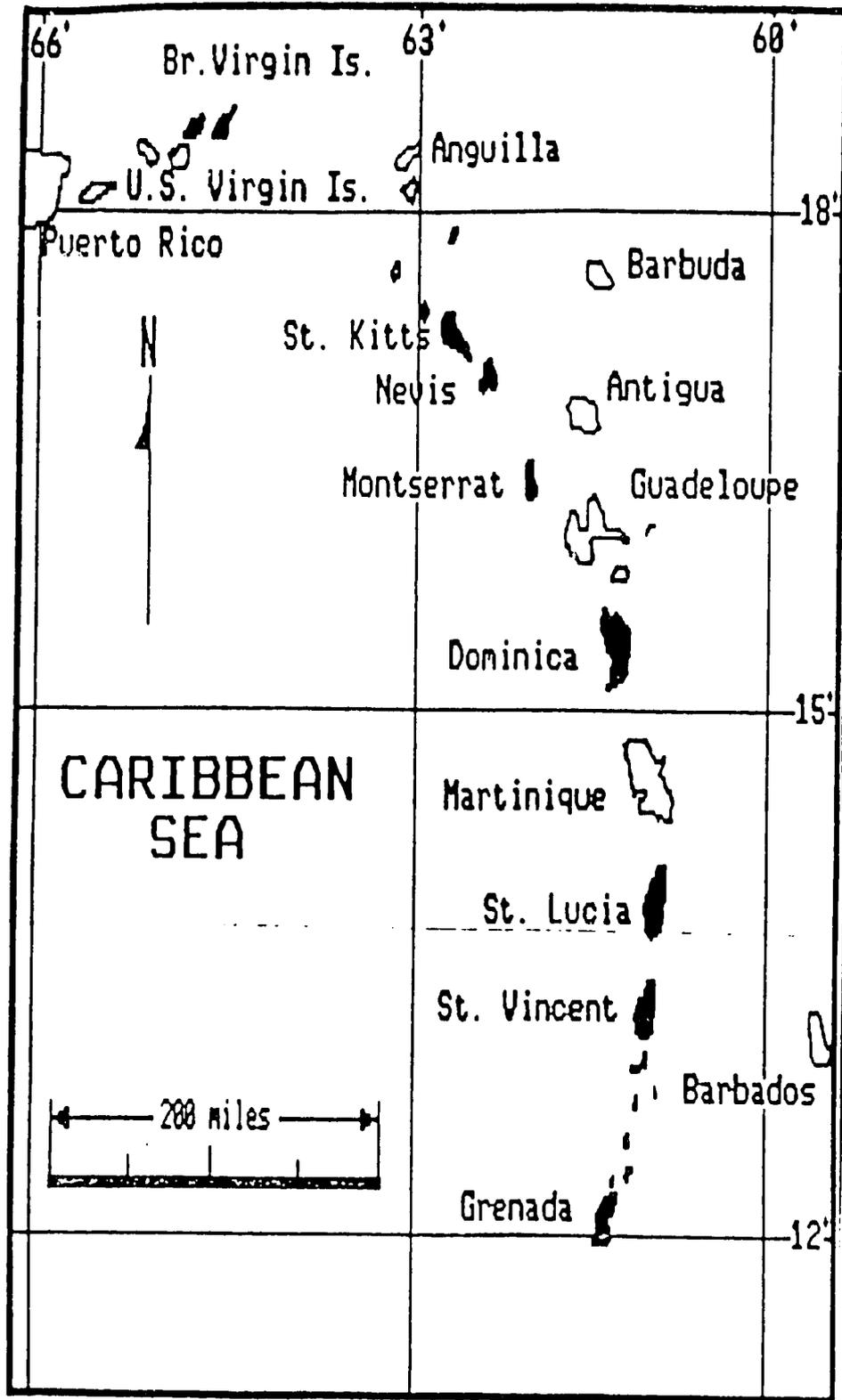
- A. Request for Assistance
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Acronyms and Currency

AID	Agency for International Development
BVI	British Virgin Islands
CARICAD	Caribbean Center for Development Administration
CCH	Caribbean Cooperation in Health
CMO	Chief Medical Officer
CMD	Center for Management Development (UWI)
EC	Eastern Caribbean
ECDS	Eastern Caribbean Drug Service
FY	Fiscal Year
GDP	Gross Domestic Product
HCPPM	Health Care Policy Planning and Management
HFS	Health Financing and Sustainability
HPMU	Health Policy Management Unit
IA	Implementing Agency
IDB	Inter-American Development Bank
IPC	Implementing Policy Change
LAC	Latin America and the Caribbean Bureau (AID)
MBS	Medical Benefits Scheme (Antigua)
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHS	National Health Service
NPA	Non Project Assistance
OECS	Organisation of Eastern Caribbean States
OUS	Office of University Services (UWI)
PAHO	Pan American Health Organization
PID	Project Identification Document
PS	Permanent Secretary
PSC	Personal Services Contractor
R&D	Research and Development Bureau (AID)
RDO/C	Regional Development Office/Caribbean (AID)
RDSS	Regional Development Strategy Statement
RFP	Request for Proposal
SVG	St. Vincent and the Grenadines
UWI	University of the West Indies

Currency: Cost figures in the text are in U.S. dollars.
US\$1.00 = Barbados \$2.00; US\$1.00 = EC\$2.65

Map of the Eastern Caribbean



EXECUTIVE SUMMARY

The Health Care Policy Planning and Management project is a six year, US\$7.31 million effort funded jointly by the U.S. Agency for International Development, Regional Development Office for the Caribbean, and cooperating countries of the English-speaking Eastern Caribbean. Its purpose is to achieve the more efficient and equitable generation, distribution and use of health sector resources.

The project will benefit the eight countries of the Caribbean which are members of the Organisation of Eastern Caribbean States. It will help Governments to make practical decisions on the direction which their health sectors should take in order to deliver health services more efficiently and equitably to the populations served.

Specifically, countries will be assisted to assess the needs for health sector reform to address the health care needs of their populations more effectively, to undertake and evaluate those reforms, and to improve the management of health sectors to assure that resources are efficiently provided and utilized. An important element of the reforms to be considered will be an increase in the role played by the private sector in delivering health care in the Eastern Caribbean. The project will provide technical assistance, training, equipment and material to the beneficiary countries. The technical assistance will generally be directed at developing regional and national capacity to undertake policy research and reform activities.

Project elements will comprise analytic and diagnostic studies, applied research and organizational development, and training and information dissemination. Activities will include development of country work plans, cost, demand and alternative financing studies, user fee and privatization pilot tests, and policy workshops.

The project will be implemented regionally, in order to take advantage of any economies of scale, as well as any regional coordination potential which may emerge during project implementation. A grant will be awarded to the OECS, through which a Health Policy Management Unit (HPMU) will be established to implement the project. The HPMU will provide the coordination of project activities, development of project plans and will serve as the initiator and coordinator of policy dialogue efforts expected to lead to policy reform and management change in the health sectors.

1. Project Background and Rationale

1.1 Regional Setting

1.1.1 Economic and Demographic Background

The eight countries targeted by this project: Antigua and Barbuda, Montserrat, the British Virgin Islands (BVI), St. Kitts and Nevis, Dominica, St. Vincent and the Grenadines, St. Lucia and Grenada are members of the Organisation of Eastern Caribbean States. They are either formerly British colonies, now independent countries or remain British Dependent Territories (Montserrat and BVI). The countries share a common history as British colonies, thus their economies and public sectors are similarly structured.

All eight countries are island nations ranging in size from 291 square miles (Dominica) to 39 square miles (Montserrat). Their populations are similarly small, ranging from 12,000 in Montserrat to 152,000 in St. Lucia. Two major common features of the populations are that they are predominantly under 25, and the proportion over 65 is growing.

Gross Domestic Product per capita for these countries falls within the middle income range; the six independent countries range between US\$1,157 and US\$2,570, with most clustered at the lower end. The two British Dependent Territories have significantly larger per capita incomes: Montserrat - US\$3,600, and BVI - US\$7,040.

All the countries depend largely on tourism as a major source of foreign exchange. Some have traditionally had bananas as a major export crop, but proposed changes in the guaranteed European market for this crop will very likely cause severe dislocation in the agriculture patterns in the region. The small size of the economies, populations, and natural resource bases are limitations which have impeded the countries' development progress, and the changing world economic environment has further increased the difficulties which these countries face.

1.1.2 Health Sector

Health status in the region is considered excellent by developing country standards. The infant mortality rates range from a low of 11 in Antigua and Montserrat to a high of 39 in St. Kitts. Life expectancy data are also impressive. Dominica has the highest life expectancy of 75 years, while Grenada has the lowest of 68 years. However, as the demographic profile changes to reflect these advances in child health, the epidemiological profile is also changing.

The countries are all seeing greater incidence of chronic and degenerative diseases, such as diabetes, cardiovascular illnesses, and cancers. An estimated 25-40% of the population over 40 years old in the region suffers from hypertension. Diabetes also affects a significant 10%

of the adult population. The incidence of these diseases in the Caribbean is similar more to the pattern in developed countries, and signify the transition in development which the countries are undergoing. The problem is compounded by the "graying" of the populations: the percentage of the population represented by the over 65 year old group is growing in each country. Added to the chronic and degenerative diseases, injuries from traffic accidents and the recent advent of AIDS now show greater prominence in the morbidity and mortality data.

These changes in the epidemiological profile, combining diseases commonly associated with both the developed and developing worlds, will all place a much heavier burden on already over-extended curative care services available in the countries, and will expose the inadequacy of the geriatric care services. In addition, the economic transition which each country will undergo is likely to cause declines in public contributions to the social sectors, including health, over the next decade. The issue of quality of care becomes critical in these circumstances, from both the technical and cost-effectiveness perspectives.

1.2 Health Care Policy

Their common history as British colonies has left all the countries a legacy of considering free access to health care as a right, not a privilege. While this is nowhere enshrined as a policy, in practice each country has traditionally recovered less than three percent of their expenditure on health care: testimony to the generally accepted notion that health care should be free.

Perhaps less as an adopted policy and more as a consequence of the colonial history and small sizes of the countries, the health sectors are all highly centralized, with government participation being dominant. Private sector participation in providing health care services has tended to be limited to pharmacies and physician consultancies. Facility based care, as well as other services such as radiology and laboratory, are by and large restricted to public sector delivery.

Decision making in the health sectors of the Caribbean has also tended to be highly centralized. Hospital management is not autonomous, and must respond to public service rules as much as any other civil service activity. Being subject to the same financial limitations as other ministries of government has also restricted the ability of ministries of health to expand the range and improve the quality of care which the hospitals under their control can provide.

As with any other sector or activity in an economy, financing is the linchpin of the health sectors of the Eastern Caribbean. These health sectors are overwhelmingly public sector financed, and heavily subsidized. Governments provide up to 80% of the total expenditure on health care in the region. In recent years, government allocations to health have ranged between 10% to 13%, and on occasion, up to 17% of their annual recurrent budgets. However, in spite of these proportionately high allocations, it is evident that real government contributions to health have either declined or remained constant due to inflation and the slower rate of growth in national budgets. Difficulties have accordingly been experienced in maintaining the quality of services provided through government health facilities, in the face of declining real budgets.

Capital development budgets in the health sector have been seriously under-funded. This has resulted in an inordinate dependence on donor funding and charitable contributions, with the consequence that much of the equipment in hospitals is not standardized, is obsolete and is un-repairable. The quality and appearance of many hospital structures also leave much to be desired, and these have added to the public's low perception of the quality of care offered at public facilities. The operational cost for new technologies acquired for public facilities also tends to exceed the governments' abilities to maintain them.

Caribbean governments have recognized that continuing to provide quality health care to their populations will not be possible under the existing arrangements. As the epidemiological profile changes to encompass both chronic and communicable diseases as major causes of mortality and morbidity, there is considerable pressure for greater investment in both curative and preventive health facilities. It is unlikely that the source of this new investment will be governmental tax revenues and donor funding, as it has been traditionally.

Analyses¹ of health care costs and budgets at several hospitals in the Caribbean have shown that between 70 and 85% of government hospital budgets have been utilized for personnel support. This factor has worked to the detriment of material and other support in the health sector, and equipment and vehicle maintenance have been particularly affected.

Given the current circumstances, it is evident that maintenance of the gains made in the last few decades, and further development in health status of the region will be difficult. The sectors need to attract additional sources of funding, and to improve the efficiency in using the resources made available to the sector. There is a clear and critical need for sectoral reform in the financing and management areas, of which privatization is a potential outcome.

¹ Enright, et al. *Analysis of the Costs and Financing of the Holberton Hospital, Antigua* and Zschock, et al. *Comparative Health Care Financing in St. Lucia, Grenada, and Dominica.*

The A.I.D. RDO/C Program Strategy is outlined in its Program Operations Document (POD) for the 1992-1997 period. The strategy focuses on increasing and diversifying trade, and improving natural resource management. Outputs under the strategy include improving the policy framework affecting trade, and achieving more effective public and private sector management. The over-arching goal of the RDO/C Program Strategy for the region is "broad-based, sustainable economic growth." This goal is important if the Eastern Caribbean economies are to be capable of competing in a new global trade environment.

The A.I.D. Latin America and Caribbean (LAC) Bureau has issued in draft an "Economic Assistance Strategy for the Caribbean, 1992-2000". This strategy emphasizes the stimulation of economic growth in the LAC countries through:

1. increasing and diversifying trade, and expanding opportunities,
2. supporting efforts to improve management of natural resources, and
3. assisting in human resource development.

One of the processes by which the strategy aims to accomplish its goals is to "broaden the economic base by improving access to basic education and health care"²

The HCPPM project is supportive of both RDO/C strategies and is consistent with the LAC Strategy for the Caribbean. The project will assist OECS countries to re-examine policy and financing mechanisms in the health sector, to undertake and evaluate reforms in those areas, and to improve sector management. Among the reforms to be considered will be increasing cost recovery and the role of the private sector in delivering and financing health services. The project has the potential to serve as a model for governmental policy analysis on the provision of public services. Through improved incentive frameworks, it will encourage greater private investment in health care delivery, and thus enhance the availability of important services in the economy. Greater emphasis on environmental health, through the primary and preventive health care programs, will complement the more industry-related environment and natural resource management activities under the strategy.

The maintenance and improved efficiency of public social services are supportive of activities in the productive sectors. The cost recovery and cost-effectiveness outputs of this project are complementary to improved efficiencies in the management of the public and private sectors. HCPPM will also promote the reduction of the over-reliance on the public sector for not only the delivery, but also the financing of health care. This over-reliance translates into a tremendous subsidization of health care costs, to the benefit not only of those who seek care, but also those employers who have assumed no responsibility for ensuring that one of their

² Draft Economic Assistance Strategy for the Caribbean, 1992-2000, page ii, U.S. Agency for International Development, Washington D.C., August 1992

main inputs to production, labor, remains healthy. A healthier workforce would be an immediate consequence of successful health sector reforms. Reduction of subsidies is desirable and consistent with making Eastern Caribbean economies more competitive.

At the national level, high allocations to the health sector crowd out increased funding of the productive sectors, and the sectoral level, curative care funding similarly crowds out funding for preventive care. Accordingly, a potential consequence of this project would be the freeing up of financial resources for the productive sectors, and within the health sector, increased attention to preventive care. As the interrelationships between health and the environment are stressed by preventive health care workers, improvements to immediate housing surroundings, as well as to certain injurious agricultural practices, for instance, abuse of pesticides, may result.

The LAC Strategy stresses that improved access to quality health care is essential to broadening the economic base. That strategy also seeks to maximize the impact of limited USAID resources by complementing other donor flows. This project will directly promote improved and equitable access to health care services, as a complementary effort to the construction and remodelling activities being supported by other donors, particularly the French and Italians. The project will assist with human resource development to stimulate economic growth. A number of individuals will be trained, thus improving their planning and management capabilities. This increased capability to manage and more rationally allocate resources, coupled with more effective policies, will lead eventually to healthier and more productive citizens in the region.

By assisting with the creation and maintenance of efficiencies in the health sector, including promoting the greater devolution of health care responsibilities to the private sector and to the consumers of health care, the project supports the development of a wider role for the private sector in the economic development of the Eastern Caribbean countries. It is expected that, ultimately, governments will carry out health sector planning as an integral part of national development planning, and will recognize and support the expanded role which the private sector could play in the health sector.

2. Project Description

2.1 Project Goal and Purpose

The goal of the Health Care Policy Planning and Management (HCPPM) project is to improve and maintain the health status of the people of the Eastern Caribbean.

The purpose of the project is to achieve the more efficient and equitable generation, distribution, and use of health sector resources.

The goal is consistent with the LAC Bureau objective of improved health and child survival. The project supports the RDO/C strategy through the establishment of policies that promote a more rational allocation of countries' budgets.

2.2 Project Strategy

2.2.1 Problem Statement

Eastern Caribbean countries are grappling with problems rooted in inefficiencies in the financing, allocation of resources, and management of the health sector. These problems may be summarized as over-reliance on the public sector for health financing, poor cost recovery, the high and increasing cost of in-patient health care, and declining real health care budgets. Important consequences of these problems include underfunded capital development, a lack of good, wide ranging data on costs and demand for care, an insufficiency of (and inability to retain) adequately trained personnel to plan, implement and manage policy options, and an inability to assure universal and continuous access to quality health care.

While the region's health indicators (infant mortality rates, life expectancy) are good by developing country standards, the problems outlined above pose significant difficulties for continued improvement to or even maintenance of the gains made in previous decades. These were more fully described at Sections 1.2 and 1.3 of this Project Paper.

The implementation of policy reform has been identified as a necessary precondition to the effective resolution of these problems. With the adoption and sustained implementation of policies which permit health sector financing to be more equitably shared, other health problems, including attention to quality assurance issues, are consequently likely to be more readily addressed.

2.2.2 Project Mode

The HCPPM project will provide technical assistance and training on a regional basis to promote policy and operational changes to the health sectors of participating countries. The total project cost is \$ 7.31 million, of which the AID grant will finance \$6.5 million, and host country contributions, both in-kind and actual expenses, will finance \$ 0.81 million. The project will be carried out over a six year period. The sustainability of this project will be reflected in the policy changes and the developed institutional capabilities of the host governments, rather than in any permanent role for the implementing agency itself. Regional implementation, rather than bilateral agreements, is planned. The countries face common problems in health policy and management. The small sizes of the countries in the region, and the technical assistance nature of this project, would make individual bilateral agreements very difficult to negotiate and administer. Through the regional mechanism, the project can also take advantage of economies of scale which may be presented in implementation of some activities, particularly training. The sharing and transfer of experiences and skills between Eastern Caribbean countries would also be fostered by the regional mechanism, and the annual regional policy workshops planned under the project would be one activity to benefit from this approach.

One consequence of regional importance which the project could affect would flow from the resource allocation and management activities. This consequence would be a recognition that some aspects of care are more economically, and cost-effectively provided on a regional or sub-regional basis, rather than by each country. The project will facilitate discussions and operational research on activities such as these.

The project will be implemented as a development project, without a "non-project assistance" (NPA) component. The NPA option was considered, but given the circumstances existing in the region (described below), NPA was determined to be inappropriate for this project.

Governments in the region fully understand their health sector problems and are eager to undertake reforms. Indeed, the governments have requested the kinds of technical assistance this project will provide, and one, St. Lucia, has benefitted from this technical assistance recently in adopting and implementing, on a pilot basis, reforms to its hospital accounting, admissions and discharges systems. These reforms have resulted in significant improvement to the flow of patients and patient documentation in the hospital, and more importantly to a ten-fold increase in collections.

There is no need to leverage policy change, since governments have demonstrated a willingness to make rational change based on a studied approach. Evidence in the region shows that leaders are willing to commit to changes in traditional approaches when provided with appropriate catalysts for change. In several countries of the region, the reconstruction and refurbishment of hospital facilities at major cost to the governments, has served as such a catalyst for considering higher cost recovery as acceptable.

Country understanding and interest in health care policy, management, and financing was in full evidence at a regional workshop sponsored by RDO/C in May 1992. The three day Health Care Financing Workshop (carried out by the UWI Office Of University Services under its Development Training project with RDO/C) brought together high level representatives of eight governments, other regional resource persons, and RDO/C staff and consultants. The seriousness with which the governments regard health sector issues was reflected by the participation of Permanent Secretaries, senior health planners, and public insurance scheme specialists. The subject areas of alternative financing mechanisms, health care demand analyses, cost recovery and cost containment, and public and private sector collaboration in health care, confirm that this project responds to country interests. Indeed, the Workshop participants' detailed review of the PID confirmed the need for and concurrence with the technical assistance and training proposed.

Analyses of Eastern Caribbean health sector problems show that the lack of hard currency, which NPA would provide, is not an obstacle to policy implementation. The critical need is to translate that desire to make changes into action that impacts positively on the areas targeted.

2.2.3 Eligible Countries and Key Institutions

The project will work with the key institutions involved in health care delivery in the eight Eastern Caribbean countries of St. Lucia, Grenada, Dominica, St. Kitts, St. Vincent and the Grenadines (SVG), Antigua, Montserrat, and the British Virgin Islands (BVI). The key institutions in each country are primarily the Ministries of Health and the major hospitals, but will include as well the Ministries of Finance, Planning, and Establishment, public insurance providers (i.e., national insurance schemes, social security systems) and those involved in the private provision of health services. The latter group includes the commercial insurance companies, non-government organizations (NGOs), private physicians and clinics, and potential support service providers.

While all countries will be eligible for project assistance, the extent to which each will participate in project activities will vary, and will depend on their interest, willingness, capability, and policy and technical readiness to effectively utilize project activities. The "policy readiness" of countries will be a major defining factor of the types of project activities implemented there. For example, the implementation of demand studies presuppose that increased cost recovery through the imposition of user fees or other similar schemes is a policy being actively pursued by the country. Some countries have also benefitted from research and implementation support in the health care financing area within the last six years. These activities, and their relevance to the project's strategy will be considered in the development of country and project work plans. Limitations in country technical capacity will be another factor defining the extent to which certain management initiatives are implemented. The project will consider sustainability of the initiatives implemented as a critical factor in successful implementation. Country interest in the project will, however,

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underline all activities included in the work plans. The project will not attempt to implement activities unless there is strong country commitment to its purpose.

Using the criteria set out above, the likelihood is that the more active participating countries will be self-selected. In addition, as elaborated in the Technical Analysis, some countries have already had varying levels of assistance from A.I.D. and other donors in the health financing area. These activities will be taken into consideration during work plan development and will not be repeated.

Implementation will perforce be phased based on the same criteria outlined above. Successful implementation in the initial participating countries is expected to stimulate greater willingness of other countries to consider and implement policy reform activities.

2.2.4 Policy Focus

A policy focus is essential to directing the type and level of management interventions to be implemented by the project. It must be emphasized, however, that policy reform is considered to be an interim accomplishment of the project. Policy reform is the *means* towards the *end* of improved management and policy analysis in Eastern Caribbean health sectors.

The project will assist the key institutions in the targeted countries to address policy reform and policy implementation in three essential areas:

- a. *Cost Recovery and Cost Containment.* Cost recovery is achieved through the charging of fees to users. The poor record of recovering costs is attributed to consumer expectations of nearly free public medical services and the lack of effective user fee management will be addressed by new user fee policies, updating of fee structures, and public information campaigns which promote fee collection. Cost containment will be addressed by changes in hospital cost systems based on new and effective accounting and financial management methods.

A management action with potential to support the cost recovery and cost containment policy will be increasing management autonomy in public hospitals. The major hospitals on each island currently function as part of an extremely centralized public health care system. Hospital policies, fee structures and staffing decisions may be made at Ministerial and even Cabinet levels, leaving little if any management autonomy to the hospitals themselves. The project will examine the inefficiencies in health care delivery caused by overly centralized public health systems. On the broader level of public finance management, the project will also examine opportunities to increase overall resources available to the health sector (or to individual facilities) through the generation of user fee revenues.

- b. *Risk-coverage Schemes.* Social financing arrangements provide the means whereby the risk of large outlays for medical care is shared among individuals. Risk sharing is the central element of social financing and, at the same time, underlies the broader equity and efficiency issues that dominate health finance policy-making and analysis. The project will address these issues by undertaking insurance feasibility studies and testing proposed pilot efforts to expand health insurance coverage.
- c. *Private Sector Service Provision.* The private sector encompasses both for-profit and not-for-profit providers of health services, and ancillary goods and services that are not directly part of the government-supported system. The private health sector therefore includes fee-for-service providers (e.g., physicians in private practice, clinics, pharmacies), insurers, and firms providing support services, such as food and laundry. In many countries, a significant proportion of the curative care services are provided by private physicians. The project will address the feasibility of the private provision of support services, and health insurance, by identifying the stimuli to the private sector, as well as the government barriers to greater private sector participation.

2.3 End of Project Status

Upon completion of the project, it is expected that a number of achievements will be in place in the countries assisted. However, due to the regional nature of this project, as well as the fact that technical assistance is being provided to lay out specific Work Plans for each country, it is neither possible nor desirable, at this stage, to define exact achievements on an individual country basis. Nevertheless, the following achievements are expected in the most actively participating countries:

- A developed institutional analytic capacity to plan and manage the health system, including the ability to identify, implement and evaluate health policy research, will be in place.
- Improved cost recovery systems will be designed and in place.
- Improved management systems within public sector hospitals will be designed and implemented, with the potential for increased organizational autonomy for the hospitals examined.
- Social and commercial risk coverage schemes to finance health care services will play a significantly increased role in financing the health sector in at least three countries.
- The potential for increasing non-governmental (or private) provision of health services will have been examined, and where feasible, those providers will have been stimulated and strengthened.

2.4

Project Outputs/Activities

The activities to be financed by the project fall into three main categories: analytic and diagnostic studies, applied research and organizational development, and training and information dissemination.

2.4.1 Analytic and Diagnostic Studies

A series of analytic and diagnostic studies will provide data needed for policy formulation and decision-making. These studies will be conducted by a combination of HPMU staff, outside technical assistance, and host country personnel. They will present options for the policy-makers to consider. The following describes an illustrative, but by no means exhaustive, series of studies to be carried out. Moreover, these are examples of the types of studies to be done, although a given study may not be undertaken in any or all countries.

a. Country Work Plans will be developed for each of the eight countries of the region. This process will identify specific project activities appropriate to each country, and will therefore differ by country. In some countries, most notably St. Lucia, a significant amount of work has been completed in recent years in diagnosing the problems of the health sector, particularly in financing and management. In those countries, alternative policies have been formulated. What remains is their implementation: a task requiring *inter alia* policy analysis and evaluation skills of which the region's health sectors have little in-house stock. In other countries, more wide-ranging health sector assessments will need to be undertaken, to identify the policy environment, resources, needs, and problem areas. For example, an assessment will examine current cost recovery rates at hospital facilities, the size of the private health sector, and the existence of legal barriers that may limit the participation of the private sector in providing health care services. An illustrative "Country Assessment Checklist" is provided on the following page, and gives examples of the areas and issues that will be addressed.

The results of these broader assessments will then help to define health financing and management activities through the life of the project. Country Work Plans developed at the outset of the project will define the level of participation expected from individual countries. Work Plans will set the agenda with host governments on health financing and management activities, and establish priorities for project activities. It is expected that PAHO will participate in the assessment process; the project will not only benefit from its extensive experience and relationships in the region, but its participation will assure the maximum coordination and complementarity with its regional projects.

COUNTRY ASSESSMENT CHECKLIST

- Assess government laws and policy regarding alternative delivery and financing arrangements: private sector, charging for services, insurance/prepaid health schemes, and others.
- Evaluate the size and utilization of public and private (for- and not-for-profit) sectors in the delivery of health services (to rural and urban populations; primary, secondary and tertiary services).
- Analyze trends in government expenditures on health services (investment, operating, foreign exchange).
- Analyze resource allocation trends (hospital vs. non-hospital, personnel vs. drugs, supplies, and maintenance).
- Summarize efficiency problems and gaps in knowledge.
- Assess decision-making, resource control, and planning processes.
- Establish extent of social financing arrangements, public or private insurance, PPOs, HMOs, other managed care.
- Collect and review documents, papers, or research on health financing related topics.
- Identify data collection, analysis, and research needs and priorities.
- Assess the opportunity to leverage project resources through cooperation with other donors.
- Assess the potential benefits from possible policy changes
- Assess the willingness of host country to effect change, and to contribute human and logistical resources.

These initial Work Plans will lay out the types of diagnostic and analytic studies to be undertaken. The country work plans will identify not only project actions but will also outline cooperating country contributions and covenants, so that the synergism between project actions and the policies of the recipient government can be clearly assessed. With the development of these plans, a regional or project implementation plan can then be facilitated. This plan will identify areas of commonality and opportunities for regional implementation.

Upon the completion of the diagnostic studies identified in work plans, and subsequent to a series of policy workshops within countries, more detailed Work Plans will be developed to lay plans for specific policy reform implementation activities.

It is estimated that eight country Work Plans will be developed: three of these will be based on brief assessments (based on work completed to date), and five of these will derive from more lengthy assessments. The brief assessments will each be done by HPMU staff, in

collaboration with MOH staff in the cooperating country, and will require a two person team for one week. The in-depth assessments will utilize a two consultant team for 1.5 person months of effort.

The individual country Work Plans will be developed by the HPMU and concurred with via a Letter of Understanding by the cooperating governments. These country work plans will form the basis for the project annual implementation plans which will be approved by RDO/C.

b. Cost Studies will be conducted to examine the operations of hospital facilities. The purpose of these studies will be to provide input for a reexamination of hospital fee structures, as well as to provide hospital staff with information regarding internal management and operating efficiencies. Information from cost studies is instrumental in considering changes in user charges, and will help in examining possible cross-subsidies. At the same time, because most hospitals do not currently identify cost centers within their operations, it is impossible to track costs effectively for planning and management purposes. These studies will help in that effort and subsequently with the implementation of cost accounting systems.

It is projected that four hospital cost studies will be carried out, each utilizing 3 person months of consultant effort.

c. Demand Studies will be conducted to examine the determinants of demand for health care services, both public and private. Results from these studies will be critical for laying out options for reforming the cost recovery system, as the data will enable simulations to be carried out on the possible effects of policy changes. The information derived from demand studies also allow the more accurate targeting of cross-subsidies in pricing health care outputs. These data could also be used to sharply define the health care output: for instance, should charges for hospital care be assessed on the basis of person bed-days, or good health outcomes. The demand studies will require both outside technical assistance and the hiring of local enumerators (and other resources).

It is projected that two demand studies will be undertaken, each requiring 6 person months of consultant effort in design, implementation and analysis of the studies. The team of three consultants will be supplemented by survey personnel recruited locally.

d. Focus Groups will be conducted to analyze consumers' perceptions of quality of care. These will serve as important complements to the demand studies, which will concentrate on quantitative data. The focus group studies will collect qualitative information about patients' willingness to pay fees (or increased fees) for services in public facilities, their attitudes about private providers, and about the types of quality improvements that may be required to attract patients.

Four focus group studies will be done, each requiring .5 person months of consultant time, supplemented by local facilitators.

e. Insurance Feasibility Studies will be undertaken to examine the prospects for expanding the coverage of insurance mechanisms. Such studies will address the prospects for both commercial and social insurance programs, including expanding existing programs such as social security to include health care benefits. Issues to be addressed will include the actuarial soundness of expanding existing programs, legal barriers to broadening coverage or to starting commercial ventures, and the institutional feasibility of increasing coverage.

The three insurance feasibility studies contemplated will each utilize three consultants for a total level of effort of 2 person months.

f. Hospital Management Studies will be carried out to examine a broad range of hospital operations, with a focus on financial and management problems. These studies will analyze systems such as admissions, fee collection, inventory, personnel, and ancillary services. One aspect of these studies will be to consider the feasibility of contracting out some of hospital operations (e.g., ancillary services or housekeeping services). Another aspect will be the consideration of alternative forms of organizational structure for public hospitals, which would allow them increased autonomy in financing and management.

Each of the three hospital management studies carried out will require three consultants providing a total of 6 person months of effort.

g. Resource Allocation Studies will be conducted to provide information about the allocation of resources within the health sector. These studies will examine the breakdown of costs by input (e.g., personnel, drugs, travel) and by level of service (e.g., preventive, primary, secondary, and tertiary care). These data will then provide a baseline from which the health sector can establish objectives and measure progress.

It is estimated that two resource allocation studies will be prepared. Each study will consume 1.5 person months of effort by a two person team.

2.4.2 Applied Research and Organizational Development

Applied research activities under this project will include pilot tests and implementation of policy reforms and new systems, based on information gathered during the analytic and diagnostic stage. These activities will result from the policy workshops conducted in the first phase of project activities, in which specific actions will be decided upon. These activities will contribute to the restructuring of decision making and planning systems, and will thus encourage organizational development within both the public and private sectors of host countries. As in the case of analytic studies, the following is an illustrative list of activities. Specific activities will vary by country and be based on the types of diagnostic studies carried

out. *[Note: The specified time periods refer to the period during which technical assistance is required; the pilot tests themselves will be in place for longer periods.]*

a. User Fee Pilot Tests will involve the implementation of newly designed user fees systems. These will be done on a "pilot test" basis in order to measure the impact of the implementation of new or higher fees on utilization, demand, revenues, and the quality of services. Particular attention will be given to the implementation of appropriate means testing systems, to ensure that access to health care services by the poor is not compromised. Alternatively, a series of pilot tests could be undertaken to compare a fee-for-service system to a fee-for-coverage system.

Two user fee pilot tests are planned; each expected to utilize a three person consulting team over 5 person months.

b. Implementation of Hospital Reforms will take place in public hospitals based on results from the formative research on hospital management. The types of reforms to be implemented will include activities such as revising fee collection systems, improving record keeping systems, or establishing quality standards for hospital operations.

It is estimated that three pilot tests will be undertaken to implement hospital reforms. Each pilot test will be done by a three consultant team over 5 person months.

c. Health Planning and Resource Reallocation Reforms will be implemented by defining specific objectives for the health care system. These will involve indicators such as the percentage of resources to be devoted to preventive, primary, secondary, and tertiary care, or the breakdown of costs by line item. These indicators will be decided upon after baseline studies conducted during the formative research phase, and implementation will involve monitoring the given ministry's ability to meet its targets.

Two health planning and resource reallocation reform pilot tests will be undertaken. Each will require two consultants over 2 person months.

d. Privatization Pilot Tests will include a variety of activities to increase private sector participation in the health sector. An example would be experiments conducted at the hospital level to examine the feasibility of privatizing some portion of health care services. These tests may include contracting out some services such as management, housekeeping or catering, or privatizing a wing of the hospital. Alternatively, a pilot test might involve means to stimulate commercial endeavors, such as decreasing tariff rates on pharmaceuticals, or giving private practitioners admitting rights at public hospitals.

One privatization pilot test will be carried out, utilizing 6 person months by a team of three consultants.

e. Insurance Pilot Tests will be conducted to expand the coverage of current risk-pooling schemes. Depending on individual country circumstances, these pilot tests will involve broadening the role of public sector agencies to include the financing of health care services (e.g., a National Insurance Scheme or a Social Security Board), or creating or strengthening the commercial insurance industry.

Two insurance pilot tests are planned, utilizing four person months of consultant time each.

2.4.3 Training and Information Dissemination

The project's training and information dissemination activities will seek to promote the adoption and acceptance of policy reforms. Training will be carried out by both formal and informal means, through training courses in the region and in the U.S., policy workshops at which specific health financing and management policies are considered, and through on-the-job training, whereby health sector personnel (from both public and private sectors) of host countries work in conjunction with externally provided specialists to conduct diagnostic studies and applied research. Through these means, it is anticipated that a transfer of knowledge will occur, and that in the later years of HCPPM, host country personnel will be able to take on greater responsibilities for project activities.

Public awareness, understanding, and acceptance are necessary for change, particularly in the issues of public health. Information dissemination activities will include public education campaigns on specific issues (e.g., a new cost recovery system, improving quality at public facilities) as well as on more general operations of the health care system.

The following is an illustrative list of training and information dissemination activities to be carried out as part of HCPPM.

a. MOH Policy Workshops will be held to consider the various policy alternatives emanating from the above analytic studies. These workshops will involve senior and mid-level Ministry of Health (MOH) personnel who are likely to be affected by policy changes, e.g., hospital administrators, hospital accountants, and health planners. The workshops will produce strategies for adopting policy changes and improving the effectiveness of health care services.

It is estimated that eight MOH policy workshops will be held. Each of these workshops will involve a team comprising key HPMU staff, facilitators, and selected consultants, as well as the Ministry of Health participants. MOH policy workshops will be held in country for a period of approximately three days.

b. Consensus Building Policy Workshops will be held to reach a broad consensus on the types of reforms to be considered or undertaken by the Ministry of Health. These

workshops will follow the MOH policy workshops, and will include participants from other relevant ministries (Finance, Planning, Establishment), the private sector (health care providers, ancillary services, insurance companies), and other agencies (e.g., Social Security Boards). These Consensus Building Workshops will seek to gain support for MOH policy alternatives and to lay the groundwork for the formal implementation of policy changes.

Eight Consensus Building Policy Workshops will be held, each over three days.

c. Regional Policy Workshops will be held every year to enable participant countries to share their experiences with their neighbors. These workshops will provide a forum in which progress, successes and failures can be discussed, with a view toward designing more effective strategies to improve health sector efficiencies and operations. Representatives from non-OECS country, particularly those with more experience in addressing health financing issues, will also be invited to participate in these workshops

Each of the six Regional Policy Workshops will involve a team comprising HPMU staff, consultants and facilitators, in addition to country participants. Members of the Health Care Finance Advisory Committee will also be present at the regional workshops, which will last approximately three days.

d. Public Education Campaigns on User Fees will be undertaken in conjunction with the implementation of fees, in order to promote a greater understanding and acceptance of charges for public health care services. These campaigns will take advantage of a wide range of media (newspaper, television, radio) and will be directed beyond the immediate health care facilities themselves. They will focus on both the general public as well as on policy makers, and will promote changes in perceptions and behavior.

These public education campaigns on user fees, of which two are planned, will each require consultants to assist with planning and implementation. 2 person months of consultant time is estimated for each campaign.

e. A Health Financing/Management Resource Center for the Caribbean will be developed as part of HCPPM. The Center will collect and disseminate information on the broad range of health financing and management issues appropriate for the region. It will maintain a library, document project results, provide guidelines for analyses (e.g., cost study methodologies, survey questionnaires). The Resource Center will be located in the HPMU, and will be available for use by all project personnel from host countries, RDO/C, and by consultants providing technical assistance. The Resource Center will be integrated with the Library facilities currently maintained at the OECS Secretariat.

f. Short-term Training Courses will enable analysts as well as policy-makers in host country health sectors to improve their functioning in the planning and implementation of health sector policies. Courses in financial management, health financing, health

administration, and health economics would be appropriate under this project. These courses may be available in host countries, in the region, or in the U.S.

An estimated 48 participants will attend training courses lasting from one week to three months, both regionally and in the U.S.

2.5 Inputs

The inputs provided under the project in order to achieve the project outputs will comprise technical assistance, training, and limited commodity support (i.e., computer equipment and software, and books and materials). The inputs will also include policy dialogue and project coordination services to be provided by the HPMU. These inputs are discussed in greater detail below.

2.5.1 Project Coordination

The establishment of the HPMU will realize this input. The HPMU will be the central coordinating point for the project and will comprise four staff members initially. These staff will provide project management and coordinating functions, as well as some technical assistance services through collaboration with the short and long term TA resources obtained through the institutional contracts. The HPMU will also be the focal point for policy dialogue with governments of the recipient countries.

The staff will initially comprise:

1. a Project Director,
2. a Health Economist
3. an Administrative Officer, and
4. a Secretary.

These staff will be drawn from the Caribbean, particularly the OECS countries. The Project Director who should possess expertise in policy analysis and policy management, and along with the Health Economist will play a leading role in planning and implementing country activities, in close collaboration with the technical assistance resources. In addition to being part of teams undertaking diagnostic studies, these professionals will participate in the implementation of management and financing reforms, and will guide the policy dialogue efforts in individual countries and in the region as a whole.

The Administrative Officer will be responsible for handling project financial record-keeping, including contracting, travel, budgetary reports for RDO/C and other project documentation. A Secretary will support the staff of the Health Policy Management Unit.

During the final nine months of the tenure of the long term advisor in health management, the HPMU will recruit a regional specialist in the same technical area. This specialist will work closely with the advisor, and will take over some of the advisor's functions upon his/her departure.

2.5.2 Technical Assistance

Technical assistance will be an important component of this project due to the nature of diagnostic studies and policy implementation. There is currently limited capacity within the ministries of health in the region to carry out these activities themselves, requiring that outside assistance be provided. Both long-term and short-term technical assistance, accessed from both U.S. and regional sources, will be utilized.

a. Long-Term Technical Assistance. Long-term technical assistance will be provided as an advisory and institution building function to the Health Policy Management Unit (HPMU). The long term TA will also work directly with countries to assist with identification, planning and where appropriate implementation of management and training interventions. Long-term technical assistance will be limited to one advisor in Health Management and Administration, who will be resident in the region for thirty months.

b. Short-Term Technical Assistance. Short-term technical assistance will be provided to the cooperating agencies, also through the HPMU. An estimated 134 person-months of short-term technical assistance will be required in the areas listed below. This list does not preclude other technical areas which may subsequently be determined to be required for project activities:

- health economics
- hospital management
- cost accounting/financial management
- actuarial sciences
- health insurance
- legal and regulatory analysis
- health planning
- health education and communications

Technical assistance in these areas will be accessed through the HPMU, and will include U.S.-based consultants as well as regional and local experts. The provision of short-term assistance will in all cases be preceded by team planning meetings conducted by the HPMU to ensure that the activity is well-understood and carried out. Moreover, all short-term technical assistance activities will involve the active participation of host country personnel serving as counterparts to the consultants, in addition to the HPMU staff, ensuring that on-the-job training occurs.

It is envisioned that heavier use of external technical assistance will be required in the earlier years of the project. As greater experience is obtained by regional resources in all aspects of health financing research and programs, HPMU staff and host country personnel will take on increasingly more demanding tasks, thereby diminishing the need for outside assistance.

2.5.3 Training

a. Short-Term Training Courses. The programmed training will take place in the host countries, throughout the region, and in the U.S. Participants will attend courses ranging in length from one week to three months, depending on their qualifications and requirements. In accordance with the focus of the project, the following types of training programs will be undertaken:

- Financial management for health
- Health financing in developing countries
- Management methods for health programs
- Management Information System (MIS) development and design for health systems
- Hospital management (including personnel, inventory, and medical records)
- Planning and budgeting

Forty eight participants will attend such training programs. The host country contributions to this project will include covering airfares for participants travelling abroad for training (from their country to Miami), as well as the cost of continuing salaries for personnel while attending training programs.

b. Workshops. A number of policy workshops will be held in individual countries and on a regional basis in order to provide training to decision makers in the planning and implementation of effective health sector policies. Six regional workshops will be held in order for policy-makers in each of the eight countries to share experiences and lessons with neighboring countries.

In each country anticipating significant policy reforms, it is expected that an MOH Policy Workshop will be conducted subsequent to the completion of a series of analytic and diagnostic studies. This workshop will be followed by a Consensus Building Workshop for a broader audience, including both public and private sector entities likely to be affected by envisioned policy changes. These workshops will provide opportunities for policy discussions at the highest levels, encompassing not only MOH officials but officials from other sectors (e.g., Finance, Planning, Establishment) as well as representatives from the private sector. These workshops will culminate in development of a country work plan which expresses the commitment of the project and the country to collaborate on specific health policy activities.

It is anticipated that a minimum of fifty individuals will participate in policy workshops at the national or regional levels.

2.5.4 Commodities

A limited amount of commodities will be provided as part of project activities, with the primary focus on the Health Policy Management Unit. This will include three desktop computers, two laptop computers (for field use), a printer, and appropriate software. In addition, the project will finance the purchase by HPMU of office supplies, as required.

A computer system may also be provided to host governments in order to implement improvements in management capabilities. If needed as part of a broader management information system, this will include a computer, printer, and software.

Over the life of the project, the HPMU will also acquire materials for a health financing/management resource center for the Eastern Caribbean region. These materials will include journals, books, publications on health financing and management topics from AID and other donor activities in the region and around the world. Copies of materials may be distributed to participating countries, as appropriate.

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3. Implementation Plan

3.1 Institutional Arrangements

Based on the Institutional and Administrative analysis, the following plan is proposed for the effective implementation of the project. In summary, the implementing agency will be a Health Policy Management Unit (HPMU) to be established by the Organization of Eastern Caribbean States (OECS), which will employ a Project Director and support staff, and will also be supplemented by contracted U.S.-based and regional consultants providing short and long term technical assistance.

A Health Care Financing Advisory Committee will be established by the project to provide a forum for policy analysis, as well as to explore health financing options and mobilize the commitment to changes in health care financing. It will also assist with focussing the project's direction and facilitate country coordination.

Each country will designate a National Coordinator, who will serve as the principal contact with the Project Director from the HPMU. An AID Project Manager at RDO/C will provide project direction, oversight, and monitoring, and will work closely with the HPMU and host country governments.

3.1.1 Project Implementation Agency

The project will be implemented by a Health Policy Management Unit (HPMU) within the Secretariat of the Organization of Eastern Caribbean States (OECS) located in St. Lucia.

Within the OECS structure, the HPMU will utilize the established framework of the Eastern Caribbean Drug Service (ECDS), but will be a separate unit in the OECS health portfolio, benefiting from ECDS experience, network, and policy orientation, as described more fully in Annex G. The HPMU will plan, design, and implement of all activities under the project. The HPMU will be responsible for the technical inputs into (i) the development of policy analyses studies; (ii) the strengthening of management systems; and (iii) the development and implementation of training. This unit will comprise the following full time staff whose costs will be met from project funds.

A Project Director will be contracted by HPMU with RDO/C concurrence. The person appointed to this post should have an outstanding record of effective service public policy, management, or health management and policy. The Project Director will be responsible for coordinating all project activities including research studies, symposia, organization development interventions, seminars, conferences and inputs aimed at strengthening the policy analysis and implementation capability of MOHs in participating countries. In addition, he/she will liaise with several regional institutions (OUS/UWI, CARICAD,

CARICOM, PAHO, and CMD of UWI, Cave Hill) for their professional input as necessary in the planning, design and implementation of project activities. He/she will be responsible for approving the expenditure of project funds and will be accountable to the OECS Director General (Grantee's Principal Representative) in the performance of his/her duties. The Project Director will also be responsible for coordinating inputs from the project resources. He/she will seek to ensure that inputs from these sources are made in a timely, efficient, and effective manner in order to maximize their benefits to the project.

The HPMU will also recruit and hire Caribbean nationals to serve as Health Economist, Health Management Specialist and Administrative Officer. The Health Economist and Health Management Specialist will serve primarily in technical roles, working closely with the Project Director, and the long and short term consultants to plan and implement policy and management interventions. The Administrative Officer will provide general accounting, logistical and administrative support to the HPMU, and will need to be familiar with USAID financial and programmatic reporting systems.

A Secretary appointed by HPMU will work under the guidance and supervision of the Administrative Assistant and will provide the general typing, secretarial and clerical support required by the Health Policy Management Unit.

The Grantee's Principal Representative will be the Director General of the OECS who will provide policy guidance and, in consultation with RDO/C, will make major policy decisions regarding project implementation.

3.1.2 Institutional Contract

The Health Policy Management Unit will obtain technical assistance through institutional contractual arrangements. There are several options for these arrangements, and these include:

- a. a single consolidated contract with a U.S. firm to provide both long and short term consultants; both U.S. and Caribbean regional expertise.
- b. a single contract, with a prime and sub-contractor, bid by U.S. and Caribbean regional firms, with either party being prime contractor. Both regional and U.S. expertise will be accessed through this mechanism.
- c. separate contracts with U.S and Caribbean institutional contractors to provide the respective expertise, as needed. This option may be limited to two contracts, or alternatively may include multi-contractual arrangements, especially with the various regional institutions (eg. CARICAD, UWI, private institutions) which have

in-house expertise in research, training, and implementation of administrative reform programs.

Final determination of the configuration of the contractual arrangements for obtaining technical assistance will be made by USAID, in concert with the OECS. This determination will consider the technical merits of each option, as well as the contractual burden which each will place on the project. As indicated in the Procurement Plan, contracts will be executed directly by USAID, pending the RDO/C Director's certification of the acceptability to USAID of the procurement rules, procedures and capabilities of the OECS, based on the advice of the Regional Contracting Officer.

Technical assistance contracts will include technical assistance only. Facilitation of training of participants in the U.S will be executed under separate contractual arrangements, although technical assistance resources may certainly be used to implement regional and in-country training programs.

Evaluations and audits will also remain outside the scope of the contractual arrangements outlined above. Audits will be arranged by the HPMU, under the Recipient Contracted Audit program, with RDO/C concurrence and approval. Contracting of resources for conducting evaluations will be done by USAID, either through "buy-ins" to A.I.D. centrally-funded contracts, or independent arrangements.

3.1.3 RDO/C Project Management

RDO/C will provide project direction, oversight, and monitoring through a Project Manager. This officer will serve to facilitate project implementation by providing guidance and assistance to the HPMU, working closely with it and with country governments to ensure the development and implementation of work plans. The RDO/C Project Manager will assist the HPMU to develop terms of reference and coordinate the contracting for evaluations and audits.

3.1.4 Health Care Financing Advisory Committee

Given the significant changes which the project will promote with respect to policy, management systems, and management capabilities, it is crucial that the key actors in the health and management and policy areas be involved. A Health Finance Advisory Committee including representatives of RDO/C, PAHO, CARICOM, and OECS, will be empanelled at least twice annually to review project progress, provide focused direction of project efforts (especially in light of other donor support to this sector), give leverage to policy direction, and to help influence the policy environment and strengthen the "change ethos" in the participating countries.

3.1.5 National Coordinators

Each participating country will appoint a National Coordinator who will be responsible for channelling requests from that country to the Health Policy Management Unit and who will in turn be the contact point for arranging and facilitating project activities in that particular country. The coordinator will also be charged with maintaining close contact with other complementary programs and projects including administrative reform projects to avoid duplication and ensure coordination.

3.1.6 Collaborating Agencies

It is expected that the HPMU will collaborate where appropriate, with a number of regional organizations e.g., PAHO, OUS/UWI, CARICAD, CMD, etc. The Project Director will ensure such collaboration and will make the necessary arrangements in this regard. Collaboration will be in the areas of technical expertise for diagnostic studies, applied research, training of managers, and policy dialogue.

3.2 Schedule

Upon approval of the Project, RDO/C will negotiate and enter into a HB 3 Grant Agreement with OECS for the operations of the HPMU. The OECS will establish an office for the HPMU and recruit and hire the Project Director and support staff. The HPMU Project Director will prepare a Year One Work Plan to be approved by RDO/C. This Project Work Plan will detail activities such as contracting and preparation of country assessments, and the development of individual country Work Plans. Open competition for long and short term assistance will be conducted by the A.I.D. Contracting Officer.

The project actions outlined below are indicative of the process to be followed in each of the participating countries. The process will proceed at a different pace for each individual country, and will therefore result in a slightly modified timeline for overall project activities.

- HPMU conducts initial assessment visits (with PAHO participation) to meet with decision-makers, establish priorities, and define study areas.
- If necessary, more in-depth assessment undertaken.
- HPMU and MOH establish Work Plan (expressing project and country commitments to activities, not policies).
- Analytical studies undertaken.
- Results of analytical studies reviewed by HPMU and MOH.
- Regional workshop held to review progress and activities of project.
- MOH policy workshop held to evaluate policy options, assess next steps, set priority areas.
- Work Plan approved by government officials (e.g., MOF, Attorney General, MOH).

- MOH begins plans for implementing some policy changes and plans for consensus building workshop.
- Consensus building workshop held with broader audience (other ministries, private entities).
- Pilot tests/policy changes planned to address objectives agreed upon.
- Pilot tests/organizational development activities begin.
- HPMU and MOH review results of implemented management reforms and pilot tests.
- Recommendations made regarding broader (or different) implementation of policy reforms.
- National workshop held on health financing and management policy reforms.
- Regional workshop held to assess project results.

An illustrative project implementation schedule is shown below.

ACTIVITY	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6
PROJECT MANAGEMENT & ADMINISTRATION						
1. Implementing Agency establishes office and hires staff, procures commodities	Q1-2					
2. Technical assistance contracted	Q3					
3. HPMU develops annual project work plan	Q2	Q1	Q1	Q1	Q1	Q1
4. HPMU develops memoranda of understanding with participating countries, with designation of National Coordinators, and country work plans	Q1-4					
5. HCF Advisory Committee meets	Q3	Q1.3	Q1.3	Q1.3	Q1.3	Q1.3
6. Project Monitoring and Reports	Q1-4	Q1-4	Q1-4	Q1-4	Q1-4	Q1-4
7. Audits		Q2	Q2	Q2	Q2	Q2
8. Evaluations		Q3		Q1		Q2
TECHNICAL ASSISTANCE ACTIVITIES						
1. HPMU conducts initial assessments to develop country work plans	Q1-4					
2. Analytic and diagnostic studies undertaken	Q3.4	Q1-4	Q1-4	Q1-4	Q1.2	
3. Study results reviewed by HPMU and MOHs, policy options laid out, detailed country work plans to implement policy or management reforms	Q4	Q1-4	Q1-4	Q1-4	Q1-4	
4. Applied research (pilot tests) and organizational development activities undertaken	Q3.4	Q1-4	Q1-4	Q1-4	Q1-4	Q1.2
5. Results of pilot tests evaluated		Q4	Q1-4	Q1-4	Q1-4	Q1-4
6. Recommendations for broader policy reform or changes reviewed			Q2-4	Q1-4	Q1-4	Q1-4
7. Implementation of accepted reform activities			Q3.4	Q1-4	Q1-4	Q1-4
TRAINING AND INFORMATION DISSEMINATION						
1. HPMU assembles resource materials on health financing and management issues	Q1-4	Q1-4	Q1-4	Q1-4	Q1-4	Q1-4
2. Regional Health Policy Seminar		Q1	Q1	Q1	Q1	Q1.4
3. MOH Policy workshops		Q1-4	Q1-4	Q1-4	Q1-4	Q1-2
4. Consensus-building policy workshops		Q2-4	Q1-4	Q1-4	Q1-4	Q1-2
5. Short-term training (U.S. or regional)	Q3.4	Q1-4	Q1-4	Q1-4	Q1-4	Q1-2
6. Public Education campaigns to promote support for policy change		Q1-4	Q1-4	Q1-4	Q1-4	Q1-3

3.3

Procurement Plan

The project is appropriate for participation by minority and/or Gray Amendment institutions, including historically black colleges and universities. The Grantee, commodities suppliers and the TA contractor, if they are not Gray Amendment organizations, will be encouraged to employ Gray Amendment individuals or sub-contract with such firms where appropriate. Guidance will be provided by RDO/C to those organizations on how to identify and access the services of Gray Amendment firms and individuals.

The types of resources to be procured under the project will comprise U.S technical assistance, regional technical assistance, HPMU staff, the RDO/C project manager, evaluation and audit services, computer equipment, technical literature, and training resources. The mechanisms and schedules for obtaining each of these types of resource are outlined below.

3.3.1

U.S. and Regional Technical Assistance

The institutional contract(s) will be let based on full and competitive bidding open to U.S. and regional institutions. Pending certification of the OECS procurement procedures, RDO/C will contract for the technical assistance directly. When OECS procurement procedures have been certified, RDO/C will assist the HPMU to prepare requests for proposals (RFPs), advertise in appropriate publications, establish selection criteria, and select the contractor. The contract(s) are expected to be let within the first six months of the project.

A nationality waiver is proposed to permit the accessing of non-U.S. nationality technical resources. This waiver would authorize local procurement, specifically the use of technical resources from the countries of the OECS, and it is justified on the grounds that complementing U.S. nationality technical resources with regional technical resources is critical to the project's success, and would best promote the objectives of the Foreign Assistance program, in accordance with A.I.D. Handbook 1B, Chapter 5, Section 5B4.a. This mode of providing technical assistance will have the following advantages:

- teams comprising both U.S. and regional consultants are likely to accomplish project activities more efficiently than teams of only U.S. consultants, because of the greater familiarity with the systems, people and customs of the region which the regional consultant will bring to the project;
- sustainability of the project's objectives is enhanced by raising the capability of regional resources to deliver services in the technical areas which the project will assist. The experience to be gained by regional resources from the close collaboration with U.S. consultants is expected to be of lasting benefit to the region;
- regional technical resources are more likely to remain in the region, thus their services will remain at the disposal of regional institutions, including Ministries of Health and the private health sector, beyond the life of this project.

It is estimated that the value of regional procurement under the project will be \$0.77 million for technical services, \$1.43 million for project coordination, including staff salaries, regional travel and per diem, and office expenses, and \$0.47 million for regional workshops and training.

3.3.2 HPMU Staff

The OECS will follow usual recruitment procedures in hiring the staff of the HPMU. The job descriptions, including desired qualifications and salary and benefits packages, will be approved by A.I.D. in advance of recruitment procedures being initiated. The concurrence of A.I.D. will also be sought for the appointment of the selected candidates for the three senior positions (Project Director, Health Economist and Health Management Specialist). The first two named positions are expected to be filled by the OECS within the first six months of the project, and the latter during the third year of project implementation.

A nationality waiver for these staff is also proposed on the grounds that the objectives of the Foreign Assistance program would best be promoted by the employment of Eastern caribbean nationals in the above positions. This waiver would allow the accessing of OECS staff resources from the cooperating countries. These staff would also be paid under local cost provisions.

3.3.3 RDO/C Project Manager

RDO/C will follow usual competitive contracting procedures in selecting its project manager.

3.3.4 Computer Equipment, Software and Other Commodities

Computer equipment, software and other commodities needed for the project will be procured by A.I.D. direct procurement, using PIO/Cs, until OECS procurement procedures have been certified by the RDO/C Director. Open competitive bidding procedures will be used to the fullest extent, except when standardization or other factors justify waivers. The availability of service contracts in the region for the equipment to be purchased may assist in defining equipment specifications.

The total expected cost of the computer equipment, software and peripherals is less than \$100,000 thus A.I.D. Information Resources Management (IRM) approval for procurement is not required.

3.3.5 Training Resources

The project will access its training resources from several sources. PIO/Ps will be used to process training for U.S. participants. The training contractors hired by A.I.D./Washington

for managing U.S.-based training will be used. For regional training, the HPMU will use a combination of established programs at regional institutions, and specially organized training using training expertise from both U.S and regional sources. The HPMU will contract these training resources separately, when necessary.

The blanket nationality waiver for technical resources will also cover the use of regional resources to undertake the training discussed above. Use of regional resources in these instances would be justified on the grounds that the objectives of the Foreign Assistance program are best promoted by this method of training under selected circumstances.

3.3.6 Evaluations and Audit Services

External evaluations and audits will be contracted as needed by the project. Audits will be contracted and managed by the OECS in accordance with the Guidelines of the Recipient Contracted Audit Program. For the external evaluations, A.I.D. direct contracts will be used to secure technical assistance through buying in to existing AID/Washington centrally funded contracts with the required technical capacity, or through open competitive bidding.

3.4 Training Plan

The HPMU will provide training and its attendant support services for the project. Training includes seminars and workshops, short and long courses, and on-the-job training. Long-term, academic, degree-granting programs are not anticipated under this project. Training will be provided on both a country-specific and regional basis, and will be provided in the region and in the U.S. With the assistance of the RDO/C where necessary, and in concert with needs identified during country work plan development, the HPMU will develop a training plan that includes the substance of the training event (e.g., objective, design, content, target audience) as well as the logistics required (e.g., programming, venue, timing, participant selection and invitation, trainer use and contracting, monitoring, support).

Training in the U.S. will be implemented under the provisions of the Participant Training Handbook. Project Implementation Orders/Participants (PIO/Ps) will be prepared and channelled through the RDO/C Training Office. Other training in the region and in-country will be planned and conducted separately by the HPMU.

Training will encompass such technical and skill subject areas as financial analysis, hospital financial management, hospital administration (e.g., admissions, transfers, discharges, collections, logistics, personnel supervision), health economics, application of management information systems (including the use of micro-computers), and policy analysis.

Trainee selection will be based on the nature of the identified need, and will include senior and mid-level personnel from the Ministries of Health, Finance, Planning, and

Establishment, hospital management personnel, Chief Medical Officers, and others from national insurance and social security offices, and private health insurance providers and potential vendors of health care and support services.

The HPMU will designate a staff member with primary responsibility for planning and management of training. The HPMU administrative officer and secretary will provide necessary support services. These persons will work closely with the RDO/C Participant Training Office to assure full compliance with AID training requirements and full utilization of AID regional training experience. As appropriate, training activities under this project may be carried out in association with the UWI Office of University Services.

3.5 Monitoring and Evaluation Plan

Project monitoring will be carried out by the RDO/C Project Manager, who will also assist HPMU in the formal, scheduled process of evaluating the progress and impact of the Project. RDO/C has the capability to monitor the project by the Health, Population, and Education Office where the Project Manager will be housed.

Project monitoring will ensure that the project is on track and that necessary reviews are undertaken to evaluate and measure impact. Progress will be monitored through biweekly meetings between the Project Director of the Health Policy Management Unit and the Project Manager of RDO/C. Training will be monitored by attendance and the feedback received from participants, as well as direct reporting from U.S. or local training institutions.

In addition, the implementing agency will submit to RDO/C annual reports which summarize activities undertaken in relation to the plan, policy and technical achievements, problems encountered, and planned activities for the coming year.

The HPMU will prepare an annual Project Work Plan which includes activities from each country Work Plan, so that staff time can be properly scheduled and allocated.

An external and independent evaluation will be financed by the project and conducted during year three. This evaluation will examine whether the approach to promoting health financing policy and implementation change is sound. This evaluation will determine the extent to which the project is meeting its overall purpose, if inputs are being provided in a timely manner and planned outputs are being achieved, and provide recommendations on timely corrective actions needed. The evaluation will examine the extent to which policy analyses are being translated into management, administrative and financial reforms in the health sectors of participating countries. If the project is not achieving or will not likely achieve its policy implementation objectives, RDO/C will consider whether a reorientation of the project or other management action is required.

If warranted, a final evaluation may be conducted during year six. This evaluation will judge the impact the project has had on health care financing and management reforms in the region, and in individual countries, and will synthesize the lessons learned for dissemination to AID/W and other countries which are addressing similar health care financing and management concerns. The evaluation may not be warranted if follow-on activity by USAID is not planned, and if progress and technical reports can suffice to indicate lessons learned.

Monitoring and evaluation will be based on progress against established indicators of success. At the project level, progress will be measured by the number of activities taking place, e.g., research and training. At the country level, evaluations will measure changes in indicators established in each country Work Plan. The following indicators are illustrative of the kinds that can be qualitatively and quantitatively judged in project evaluations. They are based on current RDO/C understanding of the situation and realities in the region. The ultimate and most effective use of these indicators and others, of course, will depend on the initial country analyses, verified over time with the results of carrying out the studies programmed in the Work Plans.

Cost Recovery Indicators

- . Objectives of cost recovery system defined; targets established for the short, medium, and long term, and met in the short term in four countries. Options:
 - . cost recovery rates of 10 percent in each country undertaking cost recovery reform (or for the region as a whole).
 - . increase cost recovery rate by 100 percent (for example, three percent recovery rate in a country increases to six percent recovery).
 - . increase in cost recovery revenues of 300 percent (for example, the collection of \$10,000 increases to \$40,000).
- . In two countries, rational fee structure defined, agreed to, and tested or implemented based on demand and cost study results.
- . In two countries, criteria and mechanisms established and followed for retention of a gradually increasing proportion of cost recovery revenues within the health sector.
- . In two countries, means testing systems in place to promote equity and protect the poor.

Other Health Financing Options Indicators

- . In two countries, feasibility studies of social financing systems undertaken and recommendations under consideration (or implemented) by MOH (and the private sector).
- . In two countries, analysis of non fee-for-service systems (e.g., fee for coverage, earmarked taxes) completed, and recommendations considered or implemented by MOH and host government.

Hospital Operations/Management Indicators

- . In three countries, established or improved hospital administrative procedures (e.g., admissions, fee collection, financial management and planning).
- . In two countries, analysis of potential for restructuring hospital relationship with MOH completed, and recommendations considered or implemented by MOH and host government.

Resource Allocation Indicators

- . Maintain, or increase by five percentage points, the percentage of government health expenditures devoted to primary, preventive, and promotive care.
- . Government role in overall financing of the health sector gradually decreased by ten percent; for example, if the government's current responsibility for 90 percent of financing is reduced to 81 percent.

Institutional Strengthening Indicators

- . In four countries, MOH developed and implemented national health policy planning framework.
- . In four countries, MOH capability to identify, conduct, and evaluate health policy reform or research.
- . At least 65 participants trained (formal short courses and workshops and seminars) in areas of management, finance, economics, policy analysis.

RDO/C currently finances several other projects in which the OECS is the implementing agency, and through which it is subject to annual audits. The OECS has recently implemented a new uniform accounting system which will allow for consolidation of its financial statements. Accordingly, audits of the OECS as a whole, by independent public accounting firms, would be the preferred *modus operandi*. In these circumstances, the scopes of work for the annual audits will be extended to address particular A.I.D. requirements and concerns, whether functional or project specific.

Annual disbursements for the HCPPM project will be in the region of US\$ 1 million, and much of this amount will flow through the HPMU, thus annual audits are a requirement. Since the HPMU will never have been the subject of an A.I.D. audit, a separate one may be conducted at the end of year one. Project funds have been budgeted for a separate audit after year one, and for audits based on extended scopes of work for the subsequent years.

Since the U.S. and regional institutional contracts will each exceed U.S. \$25,000 annually, they will also be subject to annual audits. The project budget includes an allocation for these audits.

Audits of Caribbean-based recipients of Grant funds may be contracted directly by the OECS, and will follow the guidelines set forth in A.I.D.'s Recipient Contracted Audit Program. The A.I.D. Inspector General's Office (IG/FA) will be responsible for the audit of U.S.-based organizations which receive Grant funds.

4. Cost Estimate and Financial Plan

4.1 Project Costs

A.I.D. contributions to the project will amount to U.S.\$6.5 million, and will be used to finance both local cost and foreign exchange costs of implementing the project. Major cost items will be the technical assistance and project coordination items. Implementation of the Applied Research and Organizational Development component will utilize the largest part of the A.I.D. budget.

Cooperating countries' contributions to the project will be solely in-kind, and will be provided through their support for personnel who collaborate in studies, program implementation and training, as well as local materials associated with health education campaigns, and the cost of airfares for personnel who attend training programs in the U.S. The airfare required will be from point of origin to the closest gateway airport to the mainland U.S. (Miami, in the case of the Caribbean).

The total estimated in-kind contribution from cooperating governments is anticipated to be U.S \$0.81 million. Details of how this amount was estimated are provided in Annex I, Table I2. These estimates have been determined for the purpose of assessing a comparative relationship between the A.I.D. and cooperating country contributions, and for suggesting an indicative value of their contributions to the respective cooperating governments. RDO/C considers that the provision of the counterpart services is of greater significance to project accomplishments, than whether the actual value of the contribution either exceeds or is less than the estimates provided herein. Accordingly, RDO/C will more actively monitor whether countries are contributing the personnel and other resources on the agreed schedules, than it would the value of those personnel and resources, which will be reported quarterly, as an aggregated estimate, by the OECS.

Inclusive of the estimated cooperating countries' contributions, total project cost is expected to be U.S. \$7.31 million, of which 89% will be contributed by A.I.D., and 11% will be borne by the cooperating countries on an in-kind basis. Table 1 presents a summary of the project cost estimates, reflecting both A.I.D. and cooperating countries' expected contributions to the project.

Table 1. SUMMARY COST ESTIMATE AND FINANCIAL PLAN (US\$ 000)
(including inflation and contingencies factors in each line item)

Element	Source		
	AID	Coop. Govts	Total
1. Project Coordination (including Operational Expenses)	1434	375	1809
2. Technical Assistance	3479	133	3612
3. Commodities	97	0	97
4. Training/Info. Dissemination	713	303	1016
5. Management Support (A.I.D.)	517	0	517
6. Evaluation/Audit	260	0	260
TOTALS	6,500	811	7311

Table 2 presents the costs of the three types of project outputs: analytic and diagnostic studies, applied research and organizational development, and training and information dissemination.

Table 2.1 ESTIMATED COST OF PROJECT OUTPUTS BY DONOR/HOST GOVERNMENT
(US\$ 000)

Inputs	Outputs			
	Analytic and Diagnostic Studies	Applied Research/ Organiz. Development	Training/InfoDissem.	Total
AID	\$2,005	\$3,157	\$1,338	\$6,500
Host Governments	\$177	\$507	\$127	\$811
Total	\$2,182	\$3,664	\$1,465	\$7,311

Table 3 presents the project costs by fiscal year, over the six year life of the project.

Table 3. ESTIMATED PROJECT COSTS BY FISCAL YEAR
(US\$ 000)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
AID	\$ 875	\$1,290	\$1,424	\$1,119	\$ 987	\$ 805	\$6,500
Host Governments	\$71	\$135	\$200	\$135	\$135	\$135	\$811
Total	\$ 946	\$1,425	\$1,624	\$1,254	\$1,122	\$ 940	\$7,311

Further detail on project costs is shown in Annex I. Tables in Annex I present project costs by line item: project implementation and policy dialogue, technical assistance, commodity support, travel and per diem costs, training, A.I.D. project management, and evaluations and auditing. Inflation and contingency factors are included, and the assumptions upon which the costs have been estimated are identified.

4.2 Methods of Implementation and Financing

The project will be a Grant, funded from the A.I.D. Health Account. Two methods of financing will be utilized. Direct payments will be made to contracts executed by A.I.D (for technical assistance, project management, and evaluations), and to U.S. training institutions on behalf of the Implementing Agency for training costs reserved by funded PIO/Ps. Direct Reimbursements will be made for all other methods of implementation. These are summarized in Table 4.

The implementing and financing methods outlined in Table 4 are in accordance with AID's payment verification guidelines. The Health Policy Management Unit will be the implementing agency and will be responsible for accounting and financial reporting to A.I.D. Funds will be disbursed by RDO/C to the HPMU on a reimbursement basis. A Financial Analyst from RDO/C will assist the HPMU to establish and maintain accounting and reporting systems, consistent with the OECS accounting system, and satisfactory to RDO/C requirements.

Table 4. METHODS OF IMPLEMENTATION AND FINANCING

INPUT	METHOD OF		AMOUNT (000s)
	IMPLEMENTATION	FINANCING	
Project Coordination	HC Contracts	Direct Reimbursement	\$ 1,434
U.S. Technical Asstce	A.I.D. Contract	Direct Payment	2,649
Regnl. TA	A.I.D. Contract	Direct Payment	830
Country Workshops	HC Contracts	Direct Reimbursement	403
Seminars	HC Contracts	Direct Reimbursement	103
U.S. Courses	PIO/Ps	Direct Payment	207
Computers/Software	HC Contract	Direct Reimbursement	84
Reference Materials	HC Contract	Direct Reimbursement	13
A.I.D. Management	AID PSC	Direct Payment	517
Evaluations	AID Contract	Direct Payment	162
Audits	HC Contract	Direct Reimbursement	98
TOTAL			\$ 6,500

5. Summaries of Analyses

5.1 Technical

The HCPPM project is technically sound, appropriate for the regional environment and timely. It takes a thorough, comprehensive and flexible approach to achieving some level of progress in each of the eight countries eligible for participation. The proposed activities or elements are sufficient to meet project objectives and goals. Project design is consistent with the body of knowledge in health care policy, planning, financing, and management. Representatives from the eight target countries have had input into project design and the overall approach conforms to regional development strategies of RDO/C and the Caribbean Cooperation on Health (CCH). This analysis presents an up-to-date regional health sector analysis and identifies how the HCPPM project plans to approach issues of concern.

5.1.1 Problem Analysis

As discussed in Annex D, and summarized at Section 2.2 of this Paper, the major problems facing the health care services system in the Eastern Caribbean region are related to inadequate financing, poor allocation of resources, and inefficient management structures. Human resources present another dilemma, that is, attracting, developing and maintaining an adequate number and mix of health professionals. Consistent with global trends, the cost and demand for quality health services are growing at a disproportionately high rate compared to other sectors of national economies. Given competing priorities and current economic conditions, the target countries will not be able to fund and sustain quality services without significant reforms in health policy, financing, and management.

Although each country is unique in many respects, significant similarities do exist in the region with regard to the history, general philosophy, level of development and management of health services. The systems are largely publicly funded and managed, and are originally based on the British National Health Service (NHS) model. Recent exposure to the U.S. health care system by providers and consumers has had an impact on their demands and expectations. However, health care in the region has traditionally been viewed as an entitlement by government and the population. Various government policies exempt between 60 to 90 percent of the population from fees, usually those individuals under 16 years and over 60 years of age. Moreover, all fees collected go directly to the governments' consolidated funds. As a result, cost recovery and efficient management has not been a priority. Nor has the promotion of a private health sector and alternative models of care delivery received much encouragement. Management authority is highly centralized, residing largely with the Ministries of Health and Finance. Ostensibly, primary health care is the focus of these systems; hospitals, however, represent the largest single component of the national health budgets and the primary source of care.

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While the similarities are substantial, the differences between countries cannot be overlooked. The status of their economies vary. Governments diverge in their access to resources, i.e., trained manpower, finances and facilities. Current health policies, approaches to system enhancement and political commitment to policy reform differ. Another island specific characteristic is the availability and utilization of health insurance, both public and privately funded. The nature and capabilities of the private health sector, in medical care and related services, are also unique to each country.

The HCPPM implementation plan calls for a regional approach with sufficient flexibility to account for varying capabilities and commitment among eligible countries. Moreover, it is proposed that an existing regional institution fill the role as implementing agency, with support from RDO/C and a project advisory committee that reflects a cross-section of government and regional organization officials. It is noteworthy that representatives from the eligible countries have had input into the project design.

The lack of focus on cost recovery is a major disadvantage which results in minimal revenue that could be used to support health services. Fee schedules are obsolete and bear no relation to actual costs. Moreover, there is a lack of information on operating costs, and collection procedures are inadequate.

Management capabilities throughout the health sector are in need of strengthening, from the Ministry of Health to departments within health facilities. The need for competent, decentralized management authority is most critical in the areas of financial and personnel control. Accurate, timely data collection and analysis with regard to service utilization and costs is a problem.

For capital improvements and equipment, the countries are highly dependent on the contributions of donor agencies. While health indicators are relatively high by developing country standards, the growing elderly population is leading to a greater incidence of chronic disease. The demand for other high cost services such as mental health, trauma, substance abuse, and HIV treatment is on the increase.

HCPPM's approach to management and financing issues fall into three main categories: analytical and diagnostic studies, applied research and organizational development, and training. The first two categories are often referred to as technical assistance. Under each category are several specific activities. Analytical and diagnostic studies include individualized country work plans, cost studies, demand studies, focus groups, insurance feasibility studies, hospital management studies, and resource allocation studies. Applied research and organizational development activities include user fee pilot tests, implementation of hospital reforms, health planning and resource allocation reforms, and privatization and insurance pilot tests. A variety of workshops, public education and behavior modification campaigns, and short-term training courses are activities that fall under the training component. Thus HCPPM takes a comprehensive approach to achieving project outputs.

5.1.2

Financing

The health care systems are funded almost entirely by government funds and most care is free or highly subsidized. Governments devote at least 11 percent of annual recurrent expenditures on health care through the MOH, second only to education. Hospitals represent the single largest component of MOH operating budgets, in several cases consuming about 50 percent of the total MOH budget. Zschock estimates that the public share of total national health expenditures in St. Lucia, Dominica and Grenada averages 85 percent. These data are in marked contrast to developed countries expenditure on health which are closer to 5% to 6% of annual recurrent costs, and highlight the need for better allocation of resources, and additional sources of financing, if improved quality and range of health services are to be accomplished.

Policies and procedures for cost recovery are antiquated with virtually all hospitals reporting revenues of less than four percent of annual operating expenses. This is the result of inadequate management practices, low fees that bear no relation to actual costs, and policies that exempt the majority of the population from paying for goods and services for which fees exist. Management information systems, essential for financial efficiency and operational productivity, are also in need of updating.

5.1.3

Hospitals

Public general hospitals are the primary source of ambulatory and inpatient care. Each country has one primary public hospital which provides secondary care. Most islands have at least one other auxiliary hospital which is usually poorly equipped and underutilized. For the principal hospitals, occupancy rates average 75 percent and average length of stay is in the range of eight days. There is considerable variation among the hospitals with regard to the availability, age and condition of their physical resources. In most islands, accident and trauma services are in need of improvement. Arrangements for tertiary care and other specialized services are discussed in the section entitled regional and overseas referrals.

Hospital directors have little autonomy. There have been a few experiments with hospital boards that have ended with mixed results. Financial and personnel authority is highly centralized. Hiring, training, and retaining qualified personnel of all categories is difficult. Following personnel costs, which average 75 percent of hospital operating budgets, technology and pharmaceutical products are the most expensive categories. Inadequate funds remain for supplies. Materials management, plant and equipment maintenance are problematic. Skilled technicians and other resources needed for routine maintenance and repair are scarce. Yet the hospital represents a major source of employment and is a significant source of the little revenue government receives from the health sector.

Widening the burden of financing the national health care systems and increasing user fees are two significant project outputs, as are improved management efficiency and

policy/planning capabilities. It is expected that the consequences of these outputs will converge to have a positive impact on access to better quality care and health status.

5.1.4 Private Sector

The private health care sector is relatively small in the Eastern Caribbean, and its potential for significant growth may be limited. A priority of the HCPPM project is the stimulation of private sector alternatives to the provision of health care and related services. Certain target groups would include physicians and allied health personnel. Pharmacies, laboratory services and radiology are ancillary services that often have the potential for privatization. Facility support services, such as housekeeping, dietary services, laundry, security and maintenance are other common candidates. The project proposes to examine the policy, legislative, economic and management constraints that limit private sector growth at the present time. Incentives to private sector development will be identified and promoted with the active participation and support of collaborating governments. Pilot test studies are planned, information from which will be shared with other countries as lessons to guide their future actions.

5.1.5 Human Resource Development

The availability of physicians, nurses, dentists, health administrators and allied health professionals has been a chronic problem, although recent improvements are notable. Most health care workers are employed by the public sector, while many physicians work in both the public and private sectors. As the absolute numbers are relatively small, a minor change in personnel can create a significant difference in service availability. This project is highly dependent upon the availability of a few key professionals in each country.

HCPPM proposes to provide a wide variety of training and information sharing activities to assist in the development of a cadre of professional health policy analysts, planners and managers. Training opportunities will not be limited to public sector personnel, but will be extended to identified eligible private sector personnel whose greater role and efficiency in delivering health care would promote project success.

5.1.6 Insurance Programs

Most countries have no publicly sponsored health insurance programs. They have National Insurance Schemes (NIS) or Social Security which are primarily for retirement benefits and income supplementation support, although in some cases contributions are made to the health system via the Consolidated Fund. Dominica, Antigua and St. Lucia are three examples of countries whose social security programs make monetary contributions or purchase equipment for their health systems.

Some insurance programs pay maternity and workman's compensation benefits, which are designed to pay for lost wages as opposed to health fees. Only Antigua has a form of public health insurance, known there as the Medical Benefits Scheme (MBS), which is funded by employee and employer contributions. The public hospital documents the charges for MBS participants and the MBS transfers money directly to the Consolidated Fund.

Private health insurance coverage is reported to be very low in Eastern Caribbean countries, with coverage ranging from 15 to 20 percent of the populations. The degree of coverage and utilization varies by country.

The project proposes to examine insurance options in both the public and private sectors. Insurance pilot tests are planned in an effort to expand risk-pooling schemes. Many characteristics of the current health systems discourage the pursuit and use of insurance, e.g., no or low fees, ineffective patient accounts procedures. A critical element in this area will be identifying and resolving barriers to higher levels of insurance coverage, testing consumer demand and analyzing the affordability of insurance.

5.1.7 Other Donor Activity

There are several significant development activities being conducted in the region under the sponsorship of other donors. Important research and technical assistance has been provided in the region under the auspices of RDO/C, PAHO and others. Many of these activities reinforce the need for the health policy project. It is timely and complementary that health policy and management skills are being targeted by this project when other donors are supporting largely facility construction and equipment acquisition.

The Eastern Caribbean Drug Service (ECDS) may be the best example of a successful health care development program in the region. Initially funded by RDO/C and managed by the OECS Secretariat in St. Lucia, the ECDS facilitates the group purchasing and distribution of pharmaceutical products among the eight member countries. After manpower, drugs represent the second most costly resource for regional health care systems.

The Pan American Health Organization/World Health Organization (PAHO/WHO) is the predominant international agency specializing in the area of health in the region. The organization has a history of funding scholarships for professionals from the region to obtain degrees in public health and management. Currently, PAHO has three regional programs that relate to this project: a Management Information System (MIS) development and implementation project funded jointly with the Inter-American Development Bank (IDB); Health Desk, a program to coordinate and integrate health resources in the OECS; and the development of quality assurance and accreditation standards for the Caribbean and Latin America. The MIS project will be most complementary to the HCPPM project. This project will be implemented over a thirty month period, and has as its objectives the development and implementation of a MIS in the Community Health Services, and strengthening

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institutional mechanisms needed to manage and make full use of the database system in the Ministries of Health. The MIS will particularly target improvement of supplies planning and management, maintenance of plant and equipment, and will costs of these inputs.

The British Overseas Development Administration (ODA) is also active in the health financing area. ODA is currently negotiating a grant to the Caribbean Epidemiology Centre for training and research in health economics. In addition, ODA assistance directly to the British Dependent Territories (Montserrat and BVI included) in restructuring the health sectors, particularly the financial arrangements, will be of immense interest to the main countries which the HCPPM will target, since the complementarities between the ODA plans and HCPPM abound.

In general, the HCPPM project is complementary to many of the activities being sponsored by other donor agencies in the region. It builds upon previous technical assistance. Moreover, provisions have been made in the HCPPM project to communicate and collaborate with other regional agencies and donors.

5.2 Economic and Financial

The project design is recommended as economically sound. The benefits appear to be greater than costs, and the approaches to be taken are cost-effective.

The choice of overall design for HCPPM, its components, and the types of activities to be carried out, appear to be cost-effective approaches. The design as a regional project is cost-effective, as are the technical assistance, training and information dissemination components which will address health financing and management issues in individual country contexts.

The benefits to be produced by the project include:

- Decreased morbidity and mortality due to more effective provision of health care services.
- More rational allocations of resources, with primary and preventive health care targeted, and with women and children as the prime beneficiaries.
- Improved quality of health care services.
- Strengthening of local capacity to manage health systems.
- Increased levels of resources available within the health sector.
- Strengthened private sector role in providing and financing health care services.

- Protected access of the poor to health care services.
- Increased consumer knowledge of health care and operations of the health system.

The marginal recurrent cost implications of this project for ministries of health are minimal. Moreover, this project will provide significant opportunities to decrease or rationalize recurrent expenditures on the part of the public health sector.

Studies in three particular areas are recommended. It is recommended that pilot tests of alternative means testing systems be conducted, which will provide important knowledge worldwide. Examining the prospects for sharing resources on a regional basis would be useful for the individual countries, and could provide lessons for other regions as well. Lastly, baseline studies, monitoring studies, and follow-up studies should be conducted to assess the effectiveness of individual project activities as well as the broader implications of policy reforms.

5.3 Institutional and Administrative

5.3.1 Implementing Agency

An institution and administrative analysis was undertaken of three main institutions considered for implementing this project: the Office of University Services of UWI (OUS/UWI); the Caribbean Centre for Development Administration (CARICAD); and the Secretariat of the Organisation of Eastern Caribbean States. Brief descriptions of each are provided in Annex G.

Both process and content are important in this project. In this regard, an effective implementing agency should have strong mechanisms of influence in the Eastern Caribbean, especially in the health sector. For several reasons, the institutional analysis concludes that the appropriate implementing agency should be the OECS, through a Health Policy Management Unit.

First, the OECS already has a mechanism for coordinating and rationalizing health related programs through its Eastern Caribbean Drug Service (ECDS), hence minimizing duplications and possible conflicts. Second, the OECS mission is consistent with the objectives of the project. A third point in the OECS favor is that it has a network of institutions and influence mechanisms second to none in the region, and hence is well equipped to promote the policy agenda.

The OECS Policy Board allows direct access to the OECS health Ministries for policy dialogue and inputs to the project. A fifth supportive factor is that the OECS has wide and long experience in managing donor funds and consultants, and on balance has done well. Its experience with RDO/C projects is positive, and, at the inception of the ECDS, successfully

managed the procurement and use of a long-term, U.S.-based institutional contractor. Sixth, its modus operandi is consistent with the needs of a project which promotes change as significantly as the HCPPM intends.

Based on a recent financial management capability assessment of the OECS, the RDO/C Controller Office noted significant improvements in the organization's accounting and internal control systems over the last two years, and concluded the organization's accounting and funds control procedures are adequate for USAID's purposes. The procurement and contracting systems in the OECS were, however, judged to be weak, and will require guidance and support from RDO/C for improvement.

Finally and importantly, there is a strong preference for OECS as the implementing agency among health professionals and MOF officials in the region.

5.3.2 Collaborating Institutions

The following organizations will be invited to participate in varying degrees in the project (i) on the Health Financing Advisory Committee, and/or (ii) in assisting in the planning, design, or implementation of aspects of the project: PAHO, the Centre for Management Development (CMD), Caribbean Cooperation in Health (CCH in the CARICOM Secretariat), the Caribbean Development Bank, the Caribbean Centre for Development Administration (CARICAD), and Office of University Services of UWI.

5.3.3 The Public Service Environment in the Eastern Caribbean

An analysis of the institutional framework at the level of public services in general and the Ministries of Health in particular point to generally inflexible rules-bound, centralized public sectors which are unable to respond to the turbulent environment they face. The public services and the MOHs have weak planning, information, and human resource management systems. With its focus on health policy and management, this project will address some of these issues, most notably policy research and diagnosis; applied research and organizational development; policy symposia and management training; and documentation and dissemination.

5.3.4 Choice of Countries for Project Actions

Project activities will be carried out in countries depending on their expressed interest and commitment to the project, their willingness and capability to participate, and their policy and technical readiness to effectively utilize project activities. As elaborated in Section 2.2, while all countries will be eligible to participate, the criteria outlined above will see a few countries being more active than others, and therefore obtaining greater proportions of the assistance available under the project.

Social Soundness. The project is largely compatible with the socio-cultural environment of the Eastern Caribbean region. The proposed implementation framework is appropriate and designed to broaden support of the enhanced health systems, financially and managerially. Greater collaboration among government agencies, the private sector, and health consumers should result from the project.

Health policy reform is a complicated, long-term process and represents a significant change in any society. Caribbean health consumers and providers have rising expectations and demands for health care services in terms of quality and sophistication. It is clear that current financing and management systems are inadequate to develop and sustain a contemporary health care system. Technical assistance, training and information dissemination in the area of health care financing and management are not new to the region. Governments, the health care community and the public are aware of the need for change. However, it is envisioned that the mechanisms introduced by this project will assist the countries in making the difficult decisions and implementing policy reforms.

The selection of a regional institution as the implementation agency will foster greater credibility with area governments and facilitate the creation of a regional capacity to develop human resources and better manage health resources.

Beneficiaries. Governments will be the initial beneficiaries of the project. An efficiently managed health system that is less reliant on government financing will have a spread effect beyond health care and the government budget. Given the inefficiencies in the current system, the potential for cost savings and increased productivity are vast. Improved health services may be a boon to the tourist industry, (which is a major earner of foreign exchange), by creating an additional selling point for visiting the region.

The average health care worker should also benefit from the project. The hospital is a major source of employment; relatively large numbers of people will be exposed to up-to-date management techniques. Perhaps over time management innovations introduced in health will spread to other sectors as people change jobs. In general, the work atmosphere should improve with greater delegation of authority and opportunities for career development. A successful experience with public administration reform may encourage similar steps in other areas of government.

The establishment and development, i.e., training, of hospital management or advisory boards may create the opportunity for community involvement in the health care system. Education of the public will be an important factor in the success of the project. Informing citizens how to best utilize their health resources is an important component of the project.

Existing businesses and entrepreneurs can benefit from opportunities created by the search for greater private sector involvement in the health sector, whether it be direct health care services or support services. Barriers to private sector development will be identified and incentives for such development promoted. Pilot tests will be performed to examine the feasibility of a greater private sector role in providing or financing health care services. To the extent that specific services currently provided in public facilities can be contracted out to the private sector is feasible, the private sector will benefit. Support ("hotel") services and particular ancillary services are the most likely opportunities.

Research indicates that people are willing to pay for what they perceive to be quality services. Higher service fees, bearing a closer relation to actual costs, will create greater demand for private sources of care and insurance. Private practices may become more profitable, stimulating growth in that aspect of the health care delivery system. People will want to obtain insurance coverage to help pay higher fees, thereby creating more favorable opportunities for private insurance carriers. Cross subsidies in service charges will have a positive impact; the medically indigent will have greater access to better quality public facilities as a result of the system having a more sustainable financial base.

Disadvantaged populations such as women, children, the elderly, and the indigent will benefit from the project by having greater access to improved health services. Research indicates women use health services more often than men and are more likely to pay for private care. Moreover, women represent a relatively large part of the health care work force and will benefit from a better work environment and training opportunities.

Training and development of health care policy makers, planners, and managers will have a major effect on the future capabilities of the health sector. Countries will be less reliant on donor sponsored research and technical assistance.

Equity of access to the full range of available health services is an objective of the project. Enhancement of management capabilities, across the spectrum of health care facilities, will yield greater efficiency, effectiveness and access to basic services.

Potential Areas of Difficulty. Perhaps the area of incompatibility or conflict with the socio-cultural environment most common to all countries in the region is bureaucratic inertia. Other challenges will vary with the political and economic atmosphere in the individual countries, e.g., the willingness of political leaders to make potentially unpopular decisions and the capabilities of the private sector. Studies, consensus building workshops, public education and training are the kinds of activities designed to overcome resistance to change.

The absence of a sizeable number of skilled managers to facilitate change is another significant circumstance to overcome. The project approaches this obstacle directly by providing regional and overseas training opportunities. The experience of external and

regional staff working with host country counterparts will serve as another source of learning.

Delegation of management authority and greater financial autonomy of facilities are project objectives for which considerable resistance are anticipated. Political decisions and consumer reaction are more difficult to predict. While the need to increase hospital fees is clear to all parties, any increase in charges to the public is still a difficult decision. The middle class may feel disadvantaged because they may have to pay more for services or insurance, although they should be receiving the benefits of enhanced services. Some physicians will see more opportunities for developing a private practice; while others who are comfortable and benefiting from the current public-private sector mix will most likely have an unfavorable reaction. The project's public education campaigns and consensus building workshops are part of the overall strategy to address unfavorable reactions.

Spread of Benefits. Governments will benefit from the project in numerous ways: the broadening of responsibility for financing health services to other segments of society; improved resource allocation; increased productivity in the public sector; improved management capacity within facilities; greater productivity of resources; and, growth of the private sector. These outputs have benefits in their own right, for example, increased private sector development may lead to higher tax revenues for government. Perhaps other aspects or branches of government will observe the progress achieved in health and adopt the enhanced public administration practices for their institutions.

Similarly, other sectors of the economy or business community in general may benefit from the example being established in health and become motivated to adopt updated management practices. In the long-term, the natural movement of former health sector employees to other areas may help to spread the benefits of modern management principles and practices.

Health care workers will benefit from improvements in management efficiency and the financial viability of the public sector. Training and career development is another important output.

The ultimate beneficiaries will be the health care consumers who will have greater access to better quality services.

5.5 Environmental

The HCPPM project qualifies for, and AID/W has approved, a Categorical Exclusion under the terms of 22 CFR Section 216.2 (c) 2., Subsections (i), (iii) and (viii) which specifically exclude projects which are:

- (i) Education, technical assistance, or training programs except to the extent such programs include activities directly affecting the environment (such as construction of facilities etc.);
- (iii) Analyses, studies, academic or research workshops and meetings;
- (viii) Programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)

A copy of the AID/W approval of Categorical Exclusion is included at Annex J.

As described in detail elsewhere in this Project Paper, the HCPPM project will be limited to technical assistance, training, analyses, and limited procurement of computer equipment. None of these inputs and outputs will have a negative effect on the environment.

One of the potential consequences of the improved planning and resource allocation which the project aims for is more and better attention to environmental health. The environmental health programs are usually part of the primary health care service offered by Governments. Primary health care has tended to be underfunded at the expense of curative, facility-based services. Adoption of alternative approaches to health financing, and improved planning may see greater allocations of government resources being devoted to primary health care, including environmental health.

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Central Secretariat,
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Our Ref:

Your Ref:

21 September 1992

Ms Mosina Jordan
Mission Director
Regional Development Office for the Caribbean
United States Agency for International
Development
P O Box 302
Bridgetown
BARBADOS

Dear Ms Jordan

Health Care Policy Planning and Management Project

I write on behalf of the member governments of the Organisation of Eastern Caribbean States [OECS] to request a grant of \$6.5 million United States dollars to finance and implement the subject project. I have in my possession letters of approval from the Ministers of Health of Antigua and Barbuda, British Virgin Islands, Montserrat, St Kitts and Nevis, the Commonwealth of Dominica, St Lucia, St Vincent and The Grenadines and Grenada. These letters, in addition to approving the project for their countries' participation, also designate the OECS as implementing agency for the project.

The project will assist the eight countries of the OECS to assess the needs for health sector reform to address the health care needs of their populations more effectively, to undertake and evaluate those reforms, and to improve the management of health sectors to assure that resources are efficiently provided and utilized. Its purpose is to achieve the more efficient and equitable generation, distribution and use of health sector resources.

The OECS will establish a Policy Management Unit in the Secretariat to manage the project, and coordinate implementation within member countries. In addition to the A.I.D. Grant, the member countries will contribute to the project with in-kind resources of staff, facilities, participant travel to the United States, and other direct costs for facility maintenance.

Ms Mosina Jordan
21 September 1992
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This project has been discussed extensively, both jointly and severally, with the managers of the health sectors of the member countries. As evidenced by the letters of approval from the Ministers of Health, it enjoys support at the highest levels of policy-making in the health sector. The OECS looks forward to continuing and building upon this level of co-operation with U.S.A.I.D. to the ultimate benefit of the health of the people of the Eastern Caribbean.

Yours sincerely


Vaughan A Lewis
Director-General

Annex B

PROJECT DESIGN SUMMARY LOGICAL FRAMEWORK

LIFE OF PROJECT
FROM FY 92 TO FY 98
TOTAL U.S. FUNDING: \$6.5M

PROJECT TITLE & NUMBER: Health Care Policy Planning and Management Project (538-0181)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>Project Goal To improve and maintain the health status of the people of the Eastern Caribbean.</p>	<ul style="list-style-type: none"> - Life expectancy and infant mortality rates remain stable or improve. - Increased access by general population to wider range of health care services 	<ul style="list-style-type: none"> - Vital and health statistics reports. - Review of utilization and epidemiological statistics 	<ul style="list-style-type: none"> - Government policies and programs will be supportive of project objectives. - Policy improvements will lead to improved access to better quality health services. - Policy improvements will be implemented by Caribbean governments
<p>Project Purpose To achieve the more efficient and equitable generation, distribution, and use of health sector resources</p>	<ul style="list-style-type: none"> - Increase cost recovery revenues by 300% - Maintain, or increase by five percentage points, the percentage of government health expenditures devoted to primary, preventive and promotive care - Decrease government role in overall financing of the health sector by 10% - Establish MOH capability to identify, conduct and evaluate health policy research in four countries. - Develop and implement national health policy planning framework in four countries - Improve management systems in three hospitals - Increased role of social and commercial risk coverage schemes in health care financing in 3 countries 	<ul style="list-style-type: none"> - Review of work plans and reports developed by HPMU and participating countries - Review of hospital financial and utilization records - Review of policy changes made by governments. - Review of social and commercial insurance schemes 	<ul style="list-style-type: none"> - Outputs are sufficient to promote accomplishment of purpose.
<p>Outputs 4 cost studies 2 demand studies 4 focus group studies 3 insurance feasibility studies 4 hospital management studies 2 resource reallocation studies 2 user fee pilot test 3 hospital reforms implemented 2 resource reallocation reforms 2 privatization pilot tests 2 insurance pilot tests 8 MOH policy workshops 8 consensus building workshops 6 regional policy workshops 2 public education campaigns 1 resource center 48 short-term participants</p>	<ul style="list-style-type: none"> - Work Plan documents - Completed reports - Pilot test evaluation reports completed - Workshop reports completed - Promotional materials produced and distributed - Participant training reports completed 	<ul style="list-style-type: none"> - Mid-term and subsequent evaluations - RDO/C monitoring of HPMU 	<ul style="list-style-type: none"> - Inputs are sufficient to achieve outputs
<p>Inputs Technical Assistance - Long term advisor - Short term specialists Training - Workshops - Seminars - Short courses - On-the-job Commodities - Computers - Software - Books - Technical documents</p>	<ul style="list-style-type: none"> (a) Material change in policies of health sector (b) 48 Trained HC personnel (c) Equipment in place, material delivered and in use (d) 164 PM long/short term TA provided 	<p>Project records Training evaluations Site visits</p>	<p>Inputs are available on a timely basis.</p>

BEST AVAILABLE DOCUMENT

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Annex C

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

Yes.

The purpose of the project is to achieve the more efficient and equitable generation, distribution and use of health sector resources, through the identification and implementation of needed financing and management reforms. The project will not directly affect (a) - (f).

The project is consistent, however, with RDO/C's emphasis on trade and investment policy reform, because controlling governmental costs will support efforts to reduce tariffs, a major source of governmental revenue.

U.S. trade and investment will not be directly supported. Private U.S. participation will result from utilization of U.S. technical assistance.

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign private programs (including use of private trade channels and the services of U.S. private enterprise).

3. Congressional Notification

a. **General requirement** (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

Yes.

b. **Notice of new account obligation** (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. **Cash transfers and nonproject sector assistance** (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic poolicy reforms to be promoted?

N/A

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes.
Yes.

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action

N/a

will be completed in time to permit orderly accomplishment of the purpose of the assistance?

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A

7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N/A

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. See A.1 above.

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

See A.2 above.

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

No U.S.-owned local currencies will be used. The OECS countries will contribute to the project costs in cash and in kind.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No.

c. **Separate Account** (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. Trade Restrictions

a. **Surplus Commodities** (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of

No.

textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)):** Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No.

No.

14. **PVO Assistance**

a. **Auditing and registration (FY 1991 Appropriations Act Sec. 537):** If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A. It is not anticipated that assistance will be provided to a PVO. If provided, applicable requirements will be complied with

b. **Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"):** If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A.

15. **Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)):** Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

The applicable notification/ submission requirements will be complied with after signature.

16. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy):

Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes.

Bulk purchases are not planned under the project.

17. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes.

18. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

The project will be implemented through the OECS, a regional organization.

19. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No.

b. Will any funds be used to lobby for abortion? No.

20. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? No.

21. U.S.-Owned Foreign Currencies

a. **Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509):** Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. No U.S.-owned foreign currencies will be used for this project.

b. **Release of currencies (FAA Sec. 612(d)):** Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

22. Procurement

a. **Small business (FAA Sec. 602(a)):** Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

b. **U.S. procurement (FAA Sec. 604(a)):** Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him? Yes.

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Yes.

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) N/A

f. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No.

g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the Yes.

facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes, if appropriate.

h. U.S. air carriers
(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes.

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes.

j. Consulting services
(FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes, if applicable.

k. Metric conversion
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest

See A.16 above.

documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

23. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A. the project will not involve construction.

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

N/A

24. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A

25. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

Yes.

26. Narcotics

a. **Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes.

b. **Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes.

27. **Expropriation and Land Reform (FAA Sec. 620(g)):** Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes.

28. **Police and Prisons (FAA Sec. 660):** Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

29. **CIA Activities (FAA Sec. 662):** Will assistance preclude use of financing for CIA activities? Yes.

30. **Motor Vehicles (FAA Sec. 636(i)):** Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.

31. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes.

32. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes.

33. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes.

34. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes.

35. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.

36. **Publicity or Propoganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propoganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propoganda purposes not authorized by Congress? No.

37. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?

Yes, if applicable.

38. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

No.

B. **CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY**

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

The project is not specifically intended to support agricultural development activities.

No.

No.

2. **Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"):** Will DA funds be used for tied aid credits?

No.

3. **Appropriate Technology (FAA Sec. 107):** Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Not directly assisted by this project.

4. **Indigenous Needs and Resources (FAA Sec. 281(b)):** Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The project seeks to encourage health sector policy reform through public and private dialogue and consensus-building. Local input and expertise will be relied upon significantly.

5. **Economic Development (FAA Sec. 101(a)):** Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes.

6. **Special Development Emphases (FAA Secs. 102(b), 113, 281(a)):** Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries

(a) (d). By improving health sector financing policies, maintenance and/or improvement of available health services will be supported, and both the poor and women will benefit.

(b) (c) - See B.4 above. The project seeks to encourage policy reform decisions by beneficiary governments, with input from a variety of public and private sources.

and the improvement of women's status; and
(e) utilize and encourage regional
cooperation by developing countries.

7. Recipient Country Contribution
(FAA Secs. 110, 124(d)): Will the
recipient country provide at least 25
percent of the costs of the program,
project, or activity with respect to which
the assistance is to be furnished (or is
the latter cost-sharing requirement being
waived for a "relatively least developed"
country)?

This is a regional project exempt
from the 25% requirement.

Recipient countries and
institutions will make cash and
in-kind contributions, determined
on a activity-by-activity basis.

8. Benefit to Poor Majority (FAA
Sec. 128(b)): If the activity attempts to
increase the institutional capabilities of
private organizations or the government of
the country, or if it attempts to
stimulate scientific and technological
research, has it been designed and will it
be monitored to ensure that the ultimate
beneficiaries are the poor majority?

Yes. The project seeks to encourage
sustainable and equitable health
sector financing and operations.

9. Abortions (FAA Sec. 104(f); FY
1991 Appropriations Act, Title II, under
heading "Population, DA," and Sec. 535):

The project does not involve
population or family planning
activities.

a. Are any of the funds to be
used for the performance of abortions as a
method of family planning or to motivate
or coerce any person to practice
abortions? No.

b. Are any of the funds to be
used to pay for the performance of
involuntary sterilization as a method of
family planning or to coerce or provide
any financial incentive to any person to
undergo sterilizations? No.

c. Are any of the funds to be
made available to any organization or
program which, as determined by the
President, supports or participates in the
management of a program of coercive
abortion or involuntary sterilization? No.

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? N/A

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? N/A

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No.

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes.

11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? No amount has been specified for TA services and for goods, 8(a) firms will be encouraged to compete.

12. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

N/A

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes.

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions

N/A

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which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded

No.

forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? N/A

14. **Energy (FY 1991 Appropriations Act Sec. 533(c)):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? N/A

15. **Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)):** If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage N/A

private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) to be provided in a manner that takes into account, during the planning process, the local-level perspectives of the rural and urban poor, including women, through close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) to be implemented in a manner that requires local people, including women, to be closely consulted and involved, if the assistance has a local focus; (e) being used primarily to promote reform of critical sectoral economic policies, or to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities; and (f) to be provided in a manner that, if policy reforms are to be effected, contains provisions to protect vulnerable groups and the environment from possible negative consequences of the reforms?

16. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. Deobligation/Reobligation
(FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

Applicable regulations will be followed if deob/reob authority is used.

18. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from

See B.4, B.6 and B.8 above.

cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made. N/A

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people. N/A

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

The project seeks to improve health sector financing policies. If successful, it will directly benefit continued and improved delivery of health services.

22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

Annex D: Technical Analysis

This analysis finds the technical strategy proposed by the HCPPM project to be sound, appropriate for the environment and timely. The variety of activities designed to accomplish greater management efficiency, increased access to better quality care and increased private sector participation in the health sector are essential and sufficient to achieve program goals. The project design is consistent with the body of knowledge in health care policy, planning, financing, and management.

HCPPM's implementation plan is appropriate for the environment given geographic, political, economic and other technical factors. A regional approach is taken with sufficient flexibility to allow individual countries to participate on a level commensurate with their capabilities and commitment to health policy reform. Existing regional organizations are candidates for the role of implementing agency. Representatives from the eight countries eligible for participation have had input into project design. Participating governments will be committing resources to the project. Moreover, the focus on the development of human resources and private sector involvement is consistent with RDO/C regional development strategy.

This analysis presents an up-to-date situational analysis of the health sector. How the HCPPM project goals, objectives, strategies and outputs relate to current health sector issues is addressed in each section. The 10 sections are as follows: overview; current situation; financing; hospitals; primary health care; regional and overseas referrals; personnel; insurance; private sector development; and other donor activities.

1. Overview

The major problems facing the health care systems in the Eastern Caribbean region can be summarized as inadequate financing, poorly allocated resources, and inefficient management. Human resources is another dilemma, that is, attracting, developing and maintaining an adequate number and mix of health professionals. Consistent with global trends, the costs of and demand for quality health services are growing at a disproportionately high rate compared to other sectors of national economies. Given competing priorities and current economic conditions, the target countries will not be able to fund and sustain quality services without significant reforms in health financing policies and management systems.

2. Current Situation

Although each country is unique in many respects, significant similarities do exist in the region with regard to the history, general philosophy, level of development and management

of health services. The systems are largely publicly funded and managed, and are originally based on the British National Health Service (NHS) model. Recent exposure to the U.S. health care system by providers and consumers has had an impact on their demands and expectations. However, health care in the region has traditionally been viewed as an entitlement by government and the population. Where there are fees on the books, government policies exempt between 60 to 90 percent of the population from fees, usually those individuals under 16 years and over 60 years of age. Moreover, all fees collected go directly to the governments' consolidated funds. As a result, cost recovery and efficient management have not been a priority. Nor has the promotion of a private health sector received much encouragement. Management authority is highly centralized, residing largely with the Ministries of Health and Finance. Ostensibly, primary health care is the focus of these systems; hospitals, however, represent the largest single component of the national health budgets and the primary source of care.

While the similarities are substantial, the differences among countries cannot be overlooked. The status of their economies vary. Governments diverge in their access to resources, i.e., trained manpower, finances and facilities. Current health policies, approaches to system enhancement and political commitment to policy reform differ. Another difference is the availability and utilization of health insurance, both public and privately funded. The nature and capabilities of the private health sector, in medical care and related services, are also unique to each country.

The project implementation plan allows for different levels of participation from the individual countries without losing its regional perspective. Many joint country activities such as training, workshops, and information sharing, are planned to facilitate the exchange experience with different components of the project.

The lack of focus on cost recovery is a major disadvantage which results in minimal revenue that could be used to support health services. Fee schedules are several years old, fees are low and bear no relation to actual costs. Moreover, there is a lack of information on operating costs, and collection procedures are inadequate.

Management capabilities throughout the health sector are in need of strengthening, from the Ministry of Health to departments within health facilities. The need for competent and decentralized management authority is most critical in the areas of financial and personnel control. Accurate, timely data collection and analysis with regard to service utilization and costs is a problem. Technical assistance and training activities have been proposed to correct these problems.

Capital programs are often underfunded and lack long-term vision. Countries are highly dependent on the contributions of donor agencies for capital improvements and equipment. These factors lead to problems with equipment standardization, maintenance, planning for obsolescence, and quality control. Staff training and technical assistance will be a key ingredient in resolving the problems associated with capital budgeting and planning. Some

services will prove to be best provided on a regional basis, while others will lack sufficient cost effectiveness to be acquired for the region as a whole.

Technical assistance in the forms of diagnostic and applied research will be directed at the above issues. Training, information dissemination and pilot tests are other key elements that will be applied to promote system improvements.

While health indicators are relatively high by developing country standards, the growing elderly population is leading to a greater incidence of chronic disease. The demand for other high cost services such as mental health, trauma, substance abuse, and HIV treatment is on the increase. The current system of planning allows the hospitals and expensive forms of inpatient treatment to divert limited resources from more cost effective forms of care, such as preventive and primary health care. HCPPM addresses these issues by introducing information, skills and techniques that will facilitate health systems planning in ways that are more appropriate for meeting changing demographic and epidemiological needs.

Table 1 presents socioeconomic data such as per capita income and rudimentary health indices. Clearly, the Eastern Caribbean is relatively well off compared to many developing countries.

Table 1. BASIC SOCIOECONOMIC INDICATORS

COUNTRY	Population 1990	Average per Capita Income (US\$)	Life Expectancy at Birth	Infant Mortality Rate (per 1000)
1. Antigua	90,000	\$ 2,570	73 yrs	11
2. BVI	12,500	\$ 7,040	NA	NA
3. Dominica	83,000	\$ 1,184	75 yrs	14
4. Grenada	95,000	\$ 1,340	68 yrs	30
5. Montserrat	12,000	\$ 3,600	69 yrs	11
6. St Kitts	44,000	\$ 1,700	70 yrs	39
7. St Lucia	152,000	\$ 1,540	72 yrs	21
8. SVG	128,000	\$ 1,157	69 yrs	24

Source: Banoub, Samir. Integrating Health Care: Study of Coordinating Health Services and Establishing Referral Centers in the Eastern Caribbean. St. John's: PAHO/WHO/CPC, 1990.

Table 2 presents basic data about each country's health care system -- the size of the principal hospital, the physician to population ratio and the number of other health facilities on each island. Most physicians work as public medical consultants and have their own private practices. Auxiliary facilities refer to geriatric, psychiatric and small district general hospitals, which most of the countries possess. Several islands have small private hospitals, averaging 12 beds, usually owned by physician specialists. There is considerable variation

among the polyclinics and health centers, which are intended to provide different levels of health care. Usually, it is the district health center that has a complete health care team on staff and the most regular hours. The current primary care system of clinics is underutilized and results in high use of hospital outpatient clinics.

Table 2. BASIC HEALTH SYSTEM CHARACTERISTICS

COUNTRY	Principal Hospital Number of Beds	Auxiliary Facilities	Number of Polyclinics	Population per Physician
1. Antigua	180	5	17	2,143
2. BVI	50	2	9	NA
3. Dominica	189	4	53	1,976
4. Grenada	220	8	33	1,827
5. Montserrat	67	1	12	1,200
6. St Kitts	177	4	17	1,073
7. St Lucia	211	4	32	2,171
8. SVG	207	4	35	1,322

Source: Huff-Rousselle, Maggie. Eastern Caribbean Health Sector Assessment and Strategic Alternatives. CIDA 1989.

3. Financing.

The health care systems are funded almost entirely by government funds and most care is free or highly subsidized. Governments, on average, allocate over 11 percent of annual recurrent expenditures to their Ministry of Health budget. The principal public hospital represents the largest single component of the MOH operating budget with the total hospital share averaging 50 percent in Grenada, St. Lucia and Dominica.

Policies and procedures for cost recovery are inadequate with virtually all hospitals reporting revenue of less than four percent of annual operating expenses. This is the result of inadequate management practices, low fees that bear no relation to actual costs, and policies that exempt the majority of the population from paying for goods and services for which fees exist. Management information systems, essential for financial efficiency and operational productivity, are also in need of updating.

Insurance currently plays a relatively minor role in the health care systems. Private insurance coverage in Dominica, Grenada and St. Lucia has been estimated to be about 15 to 20 percent. Government expenditures account for an average of 85 percent of total health expenses in these three countries. Private health insurance is said to account for three

percent of total health care financing in St. Lucia, nine percent in Dominica and four percent in Grenada.

An objective of HCPPM is to spread the burden of financing the health care system. User fees, insurance, cross-subsidizations, and increased private sector involvement are some of the activities proposed to create a more balanced system.

4. Hospitals. Public general hospitals are the primary source of both ambulatory and inpatient care. Each country has one primary public hospital which provides secondary care. Most islands have at least one other auxiliary hospital which is usually poorly equipped and underutilized. For the principal hospitals, occupancy rates average 65 percent and average length of stay is in the range of eight days. There is considerable variation among the hospitals with regard to the availability, age and condition of their physical resources. In most islands, accident and trauma services are in need of improvement. Arrangements for tertiary care and other specialized services are discussed in the section entitled regional and overseas referrals.

The principal public hospital on each island represents the primary source of inpatient and outpatient medical care. Table 3 summarizes fundamental operating statistics such as occupancy rate, the number of admissions and average length of stay.

Table 3. HOSPITAL CHARACTERISTICS

Principal Hospitals

COUNTRY	Hospital Name	Occupancy Rate	Admissions	Average Length of Stay (Days)
1. Antigua	Holberton	50%	NA	9.0
2. BVI	Peebles	60%	NA	NA
3. Dominica	Princess Margaret	86%	7,284	6.2
4. Grenada	General	60%	6,318	7.8
5. Montserrat	Glendon	50%	NA	NA
6. St. Kitts	JN France	70%	NA	9.5
7. St. Lucia	Victoria	70%	8,206	6.8
8. SVG	General	70%	NA	6.8

Hospital directors have little autonomy. There have been a few experiments with hospital boards that have ended with mixed results. Financial and personnel authority is highly centralized. Hiring, training, and retaining qualified personnel of all categories is difficult. Following personnel costs, which average 75 percent of hospital operating budgets, technology and pharmaceutical products are the most expensive categories. Inadequate funds

remain for supplies. Materials management, plant and equipment maintenance are problematic. Skilled technicians and other resources needed for routine maintenance and repair are scarce. Yet the hospital represents a major source of employment and is a significant source of government revenue from the health sector.

Key financial indicators such as ministry of health operating budgets are presented in Table 4. Health is often the second highest component of government expenditure, following education.

Table 4. FINANCIAL INDICATORS
Ministry of Health Recurrent Expenditures

COUNTRY	1990 MOH Recurrent Expenses (US \$ millions)	Ministry of Health Budget as Percent of GDP	MOH Budget as Percent of Gov't. Expenses	Principal Hospital Budget as Percentage of MOH Expenses
1. Antigua	5.85	6.2%	10.1%	35%
2. BVI	NA	NA	NA	NA
3. Dominica	7.9	4.3	13	33
4. Grenada	8.8	6.2	14.3	40
5. Montserrat	1.4	NA	12	NA
6. St Kitts	4.3	NA	8	65
7. St Lucia	8.5	4.3	11.4	36
8. SVG	5.8	5.3	13.6	50

Table 5. HOSPITAL FINANCIAL CHARACTERISTICS
Principal Hospitals

COUNTRY	Hospital	Operating Budget (US\$ million)	Percentage of Budget for Personnel	Revenue as %age of Operating Expenses
1. Antigua	Holberton	3.2	80%	1.2%
2. BVI	Peebles	NA	NA	NA
3. Dominica	Princess Margaret	NA	79%	NA
4. Grenada	General	3.3	82%	2.0%
5. Montserrat	Glendon	NA	NA	NA
6. St Kitts	J.N. France	3.1	57%	3.0%
7. St Lucia	Victoria	1.9	79%	4.0%
8. SVG	General	\$2.9	69%	2.4%

Table 5 contains basic indicators of the hospitals' financial status and performance. The table illustrates two significant problems common to all hospitals in the region, high personnel expenses and low revenue. The impact of high personnel costs is compounded by management inefficiency.

5. Primary Care

The characteristics of the primary care network vary with each island. In terms of number and location, the availability of primary care facilities is favorable in each country. Clinic services are free to encourage preventive health care and early intervention of illnesses. In general, the health centers are underutilized. The primary care systems may require study and technical assistance to identify ways to increase their utilization and encourage less hospital-based, outpatient care.

It is expected that improvements in analytical and planning capabilities of MOH personnel will result in a more rational allocation of resources. While hospitals may appear to be a major focus, PHC will not be neglected and is expected to be strengthened.

6. Regional and Overseas Referrals.

Tertiary care, unavailable in the OECS countries, is often obtained in several nearby islands. The most common sources are Barbados, the French territories of Martinique and Guadeloupe, and Puerto Rico. Jamaica, Trinidad/Tobago, the U.S. and Great Britain are used also as sources of tertiary care. Most referrals are handled independently, by the client and his or her physician. Governments do have policies to assist citizens in obtaining specialized services, but the equity of access to such assistance is questionable. Little information exists on inter-island and overseas cases, publicly or privately funded, in terms of their number, diagnosis and treatment, source of care, and costs.

In this area HCPPM will coordinate activities with PAHO which has a major long term initiative in this area. For example, HCPPM can collaborate by addressing the financial aspects of regionalization and overseas referrals, an issue which PAHO has not evaluated.

7. Health Personnel

The availability of physicians, nurses, dentists, health administrator and allied health professionals has been a chronic problem, although recent improvements are notable. Most physicians work in both the public and private sectors. Private physicians are seen for

curative care, while most preventive care is given in the public setting. As the absolute numbers are relatively small, a minor change in personnel can create a significant difference in service availability.

A concern for the initial stages of the project is the small number of professional policy makers, planners, financial specialists and managers available. HCPPM plans to improve the skills of health personnel by employing a combination of regional and overseas training programs, workshops, information dissemination, and experience working with technical assistance professionals.

8. Private Sector Development

Hospital support services, also known as hotel services, are prime candidates for private sector management. Housekeeping, laundry, dietary services and maintenance are sometimes contracted out to private firms as a means of cost savings. Certain ancillary services have the potential to be operated independent of the hospital or in a private capacity, such as radiology, laboratory and pharmacy.

This potential for private sector involvement in this area will be considered by HCPPM. The AID Health Sector Initiatives project in Jamaica illustrates the complexities of stimulating private sector involvement in providing ancillary and support services in health. This project experimented with contracting out some ancillary services to the private sector. The experiments met with limited success: it appears that the janitorial services have been the best sustained area since the privatization experiments.

A possible signal of private sector interest and potential in the region is that a group of physicians in St. Lucia plans to open a radiology center which will include CAT (computerized axial tomography) scan capability. It remains to be seen whether this venture will be economically successful - the basis on which private sector initiatives fail or succeed. The potential for existing businesses and entrepreneurs to develop varies in individual countries and will receive careful analysis. An important question is what incentives government can provide to encourage private sector growth and what obstacles currently exist.

9. Insurance Programs

Most countries have no publicly sponsored health insurance programs. They have National Insurance Schemes (NIS) or Social Security which are primarily for retirement benefits and replacement or supplementation of lost income due to injury or illness. In some cases contributions are made, usually for capital acquisition, to the health system via the Consolidated Fund. The social security programs in Dominica and St. Lucia make monetary contributions or purchase equipment for their health systems. Antigua's Medical Benefits

Scheme (MBS) also makes similar contributions to the health sector in that country. Some insurance programs also pay benefits for maternity and temporary occupational disability.

Only Antigua's MBS, which covers 85 percent of employed persons, can be described as a form of public health insurance. It is funded by employee and employer contributions. The public hospital documents the charges for MBS participants and the MBS transfers money directly to the consolidated fund. Like user fees collected by the hospital, MBS payments are made directly to the Consolidated Fund and have no impact on budget appropriations for health.

In St. Lucia and Dominica (the NIS and SS respectively), the insurance programs make annual contributions to the health system through the Treasury. Social Insurance is said to account for 4 percent of annual health expenditure in St. Lucia and 6 percent in Dominica. On occasion the SS and NIS contributions have been used to purchase medical equipment.

Private health insurance coverage is reported to be in the range of 15 to 20 percent of the populations, but this may be overstated. However, the potential for developing private insurance sources clearly deserves attention. Many characteristics of the current health systems within countries discourage the pursuit and use of insurance, e.g., no or low fees, ineffective patient accounts procedures. Private health insurance is nevertheless attractive for some, especially the professional class, who mainly use the insurance for medical care obtained outside of their countries.

A project activity connected with this issue will be testing consumer demand for and affordability of insurance. Health insurance coverage for regional and overseas care is another possible area for investigation.

10. Other Donor Activity

There are several significant development activities being conducted in the region under the sponsorship of other donors. Important research and technical assistance has been provided in the region under the auspices of RDO/C, PAHO/WHO, The Canadian Development Agency (CIDA) and others. Many of these activities reinforce the need for HCPPM. It is timely and complementary to target the development of health policy and management skills as other donors are largely supporting facility construction and equipment acquisition.

There is a consistent history of research and technical assistance in the region, including the REACH and LAC Projects of AID. The British government has placed nursing administrators in hospitals to introduce contemporary ward management techniques. In 1989, CIDA commissioned a health sector assessment and strategic plan for the region.

The strategic plan identified three main issues for CIDA's regional strategy:

1. Regional governments' inability to meet growing public demands for a better quality and wider range of health care services;
2. Rationalization of governments' (the public sectors') already high contributions to the health sector; and
3. The need for greater collaboration between countries to achieve more cost-efficiencies and effectiveness in health care delivery.

CIDA is in the process of updating the research done in 1989, and developing an amended plan for region. However, it is clear that the issues identified in 1989 remain as significant in 1992, and demand attention.

The Eastern Caribbean Drug Service (ECDS) may be the best example of a successful health care development program in the region. Initially funded by RDO/C and managed by the OECS Secretariat in St. Lucia, the ECDS facilitates the group purchasing and distribution of pharmaceutical products among the eight member countries. After personnel, drugs represent the most costly resource for regional health care systems.

The Pan American Health Organization/World Health Organization (PAHO/WHO) is the predominant international agency specializing in the area of health in the region. The organization has a history of funding scholarships for professionals from the region to obtain degrees in public health and management. Currently, PAHO has three regional programs that relate to this Health Care Policy Planning and Management project: a Management Information System (MIS) development and implementation project funded by the Inter-American Development Bank (IDB); Health Desk, a program to coordinate and integrate health resources in the OECS; and the development of quality assurance and accreditation standards for the Caribbean and Latin America. The MIS project will be most complementary to the HCPPM project. This project will be implemented over a thirty month period, and has as its objectives the development and implementation of a MIS in the Community Health Services, and strengthening institutional mechanisms needed to manage and make full use of the database system in the Ministries of Health. The MIS will particularly target improvement of supplies planning and management, maintenance of plant and equipment, and will costs of these inputs.

A significant amount of facility construction and renovation is planned or in progress. The French Health Cooperation Program is providing funding and technical assistance, particularly in Dominica and St. Lucia. St. Lucia's Victoria Hospital has recently opened a new maternity block, the first of a three-phase construction plan. In 1990, Dominica opened the Pasteur Polyclinic, an ambulatory and surgical care center attached to Princess Margaret Hospital. Further renovation of the physical plant is planned. The British government is supporting the construction of a new 65 bed hospital in Montserrat and St. Kitts has secured the Italian government's support for hospital renovations.

The Commonwealth Fund for Technical Cooperation (CFTC) recently completed sponsorship of a two year scholarship in hospital management for an Antiguan administrator whose position was temporarily filled by an administrator from Australia. Antigua has been successful in obtaining the support of local private foundations, which have supported significant enhancements of Radiology, Pathology and Pediatrics facilities, all capable of serving as regional resources. Antigua currently is the only one of the eight target countries with a CAT scan, which is underutilized and not financially sustainable with local demand.

The British Overseas Development Administration (ODA) is also active in the health financing area. ODA is currently negotiating a grant to the Caribbean Epidemiology Centre for training and research in health economics. In addition, ODA assistance directly to the British Dependent Territories (Montserrat and BVI included) in restructuring the health sectors, particularly the financial arrangements, will be of immense interest to the main countries which the HCPPM will target, since the complementarities between the ODA plans and HCPPM abound.

HCPPM conforms with regional strategies and programs, for example the Caribbean Cooperation in Health (CCH). Project activities complement other donor programs in progress and will build upon past technical assistance in the region. There is no evidence of conflict or duplication. Moreover, the project strategy calls for the inclusion of agencies such as PAHO in various activities, such as the HCPPM Advisory Committee.

11. Conclusions

The conclusion of this analysis is that the technical aspects of the project are sound, appropriate and timely. The project design has a flexible, thorough and comprehensive action plan. It reflects the input of a diverse group of representatives from all eight countries eligible for program participation. Moreover, the proposed activities are sufficient to meet project objectives.

Annex E: Economic and Financial Analysis

I. INTRODUCTION

A. Objectives and Methods for the Economic and Financial Analysis of HCPPM

The objectives of this economic and financial analysis are to:

- Identify and describe the costs and benefits of the design of the Health Care Policy Planning and Management Project (HCPPM)
- Analyze the cost-effectiveness of the project design and components
- Examine the economic impact of the project activities and anticipated policy changes on consumers (i.e. the ability to pay for health services), and
- Analyze the project's recurrent costs and the impact on host government's health budgets

Cost-benefit analysis, the traditional tool of economic analysis, is not entirely applicable to social sector projects, such as HCPPM. This type of analysis requires the quantification of project costs and benefits, and the latter is frequently difficult if not impossible in health sector projects. For example, it is problematic to reduce outputs such as morbidity and mortality averted, or an increased quality of life, to monetary values. Therefore, one cannot compare benefits to costs and determine an internal rate of return. Rather, a subjective appreciation of the value of project benefits compared to costs will determine whether or not to pursue the project. This analysis thus attempts to identify and describe the anticipated benefits from the project.

Given the shortcomings of cost-benefit analysis for health projects, A.I.D. encourages the use of cost-effectiveness analysis, which utilizes the comparison of various methods of achieving given objectives. This method requires that an economic analysis demonstrate that the chosen project design is the least cost method for achieving a specified level of outputs. This analysis thus examines the cost effectiveness of the project design, and compares it to other possible configurations of project activities.

This analysis also examines the affordability and sustainability of the project from a couple perspectives. It looks briefly at the expected impact of the project on consumers, since the project is largely directed at increasing health sector revenues from non-government sources. Secondly, this analysis analyzes the project's recurrent cost implications for host country governments.

The analysis also indicates the potential costs of foregoing the project, or not implementing the project.

B. Summary of Results and Recommendations

The project design is recommended as economically sound. The benefits appear to be greater than costs, and the approaches to be taken are cost-effective.

The choice of overall design for HCPPM as a regional project is cost-effective. Similarly, the input components of technical assistance, training and information dissemination, which will address health financing and management issues in individual country contexts, have been designed to be provided in a cost-effective way.

The benefits to be produced by the project include:

- Decreased morbidity and mortality due to more effective provision of health care services
- More rational allocations of resources, with primary and preventive health care targeted, and with women and children as the prime beneficiaries
- Improved quality of health care services in the public sector
- Strengthening of local capacity to manage health systems
- Increased levels of resources available within the health sector
- Strengthened private sector role in providing and financing health care services
- Protected access of the poor to health care services
- Increased consumer knowledge of health care and operations of the health system

The recurrent cost implications of this project for ministries of health are minimal. Moreover, this project will provide significant opportunities to decrease or rationalize recurrent expenditures on the part of the public health sector.

Studies in three particular areas are recommended. It is recommended that pilot tests of alternative means testing systems be conducted, which will provide important knowledge worldwide. Examining the prospects for sharing resources on a regional basis would be useful for the individual countries, and could provide lessons for other regions as well. Lastly, baseline studies, monitoring studies, and follow-up studies should be conducted to

assess the effectiveness of individual project activities as well as the broader implications of policy reforms.

C. Organization of Analysis

This economic and financial analysis is organized as follows: Section II covers the cost-effectiveness of the project design and components. Section III identifies and describes the benefits that are expected to flow from the project. Section IV evaluates the economic impact on health care consumers and the overall economy. Section V examines recurrent costs and the budgetary impact of project activities. Section VI evaluates the costs of foregoing the implementation of this project. Section VII presents conclusions and recommendations.

II. COST-EFFECTIVENESS ANALYSIS

A. Project versus Alternative Designs

The present design of HCPPM (see section 2, Project Description) comprises a six-year regional project with the objective of effecting the efficient and equitable generation, distribution, and use of public and private health sector resources. The project will be implemented through a regional implementing agency, in which a Health Policy Management Unit (HPMU) will be created, to be staffed by a Project Director, Technical Staff (including a health economist and a health management specialist), and Support Staff. Project inputs will include (*how many person-months of) technical assistance, short-term participant training, and limited commodities. Project activities will include a series of analytic and diagnostic studies, applied research (pilot tests) and organizational development activities to implement policy reforms, numerous workshops and seminars supplemented by regional and U.S.-based training programs, and information dissemination efforts.

Two alternative project configurations were considered, and both were rejected on the grounds of cost and effectiveness. The alternatives were:

- a series of bilateral projects with individual governments, and
- incorporating HCPPM into a broader program of non-project assistance (NPA)

A bilateral approach would entail individual agreements with the eight countries in the Eastern Caribbean, or some portion thereof. Assuming that HCPPM (as designed to be a regional project) focuses its activities on four countries, a comparable bilateral approach would involve four separate projects. The management requirements on the part of A.I.D.'s Regional Development Office for the Caribbean (RDO/C) would quadruple in terms of monitoring, evaluation, and auditing efforts. Four separate implementing agencies would be

required, as well as four separate technical assistance contracts. Although the personnel requirements for a project management unit in a given bilateral project may be smaller than those for a regional project, the increase in resource demands for bilateral projects would be significant. Moreover, technical assistance would be provided to individual countries sequentially, rather than allowing for the replication of methodologies and analyses. The following table demonstrates some of the cost savings resulting from a regional approach:

Comparison of Regional vs. Bilateral Project Design		
Cost Element	Regional Project	Bilateral Projects (4)
AID Management	\$480,000	\$960,000
Evaluation/Audit	\$260,000	\$1,040,000
Long-Term TA	\$2,347,500	\$5,415,000
Assumptions: <ol style="list-style-type: none"> 1. Long-term TA in regional project includes one project director, one health economist, one health management specialist, one financial analyst, and one secretary. 2. Long-term TA in each bilateral project includes one project director, one health economist, one half-time financial analyst, and one half-time secretary 3. A regional project will require a full-time AID Project Manager. 4. Each bilateral project would require a half-time AID Project Manager. 5. Each project (bilateral or regional) would require two evaluations and two audits. 		

Based on the above information, a bilateral approach would cost a minimum of an additional \$4.3 million to the current regional approach.

Another approach considered was to incorporate the regional project's activities into a broader program of non-project assistance. This method would entail a more generalized assistance program to the health sectors of countries in the region. There are both financial and logistical drawbacks to this approach.

First, one reason for using sectoral grants is to provide badly-needed hard currency to governments contemplating policy reforms. In such instances, disbursing tranches of unprogrammed funds allows host country governments to pay for goods and services (e.g. drugs, equipments) that are essential to the successful implementation of reform programs. In the case of the Eastern Caribbean countries, this does not seem to be a critical factor.

Second, due to the regional rather than bilateral nature of this project, it would be difficult to include conditions precedent to disbursing funds. This would require the agreement on the part of all participating countries to a common set of benchmarks, as well as the ability of individual countries to elicit the cooperation of others. In other words, NPA funds would only be disbursed to the regional implementing agency upon meeting a set of benchmarks which require action on the part of all host governments. One's recalcitrance or

failure to meet benchmarks would deny benefits to all others. On logistical grounds, then, conditions precedent would be difficult to establish for a regional project.

Third, another primary reason for utilizing NPA is to provide clear financial incentives to countries to undertake policy reforms. In many of the Eastern Caribbean countries, there is already a demonstrated willingness to implement policy reforms in the areas of health financing and management. These countries do not require additional incentives so much as they require assistance in setting policy reform agendas and implementing them. This fact was underscored by participants at the Health Financing Workshop held in St. Lucia in May 1992. One purpose of this workshop was to review the Project Identification Document (PID) for HCPPM, and to review strategies for meeting regional and national health needs. A questionnaire distributed to participants at the end of the workshop solicited their viewpoints on the major requirements needed to undertake policy reforms. Two of the possible answers included "technical assistance" and "financial assistance". The first was chosen almost unanimously by respondents, whereas the second was rarely selected.

Thus, non-project assistance would not seem to add significantly to the design of HCPPM. Such an element would either entail significant additional cost, or would detract substantially from the resources devoted to technical assistance, and thus jeopardize the likelihood of project success.

B. Effectiveness of the Regional Approach

Aside from ruling out the above two alternative approaches, there are other clear advantages to the regional approach used in the project design. First, in the early years of the project, U.S.-based TA may be required to carry out analytic studies. These consultants will work in conjunction with local consultants and host country staff, particularly the National Coordinators. The locally-based personnel, including the HPMU staff in the latter years of the project, will then be able to take on the responsibilities of the expatriate staff in similar studies in neighboring countries. This results in a decreasing need for external technical assistance, and an increased regional capacity to carry out health financing and management work.

Second, there will be regional dissemination and sharing of ideas, and successes and failures. Thus, those countries participating in project activities in the earlier stages will provide tangible and (hopefully) replicable case studies for their neighbors. In addition, there will be spill-over effects for all countries in the region, even those which are less active participants in HCPPM. Individual countries will benefit from similar studies undertaken in other countries at an earlier stage (and thus be able to take advantage of already-developed questionnaires or costing shells), from regional workshops, and from the training and information dissemination components of the project.

Third, HCPPM activities may help to promote the regionalization of services or resources, although that is not an explicit objective or activity of the project. Due to the small size of most of these countries, there are few economies of scale of which to take advantage. There has been much discussion of an explicit program of sharing resources among countries in the region, for example, by establishing individual islands of "centers of excellence" for certain medical specialties, or by pooling resources to obtain better purchasing power (in the case of the successful Eastern Caribbean Drug Service). The Pan American Health Organization (PAHO) is spearheading this effort, which currently involves the collection of data on a regional basis. HCPPM activities (e.g. the diagnostic and analytic studies) may help provide insight into the efficacy or feasibility of such an undertaking.

C. Cost-Effectiveness of Project Components

In addition to the cost-effectiveness of the regional approach, the individual project components themselves are based on a least-cost approach to achieving improvements in the financing and management of the health sector. First, the current design calls for use of U.S.-based technical assistance throughout the life of the project. However, this TA, both long- and short-term, is much more intensive during the early years of the project. Two of the positions within the HPMU will be expatriate staff, during years one through three of the project. These positions, however, will evolve into local hires at the midpoint of the project, allowing for significant overlap with expatriate TA. This design is both cost-effective and heavily oriented toward the development of local capacity.

This approach is also replicated in the conduct of country-specific technical assistance activities as well, as described above. By developing and then relying upon regional capability to address health financing and management issues, the project will meet its objectives and ensure the sustainability of project accomplishments.

Second, bringing in technical assistance from outside the region (either through a contract or buy-ins from centrally-funded projects) allows HCPPM to take advantage of an already-established body of knowledge. HCPPM will be able to capitalize on knowledge and experience from health financing and management activities around the world.

Third, the training component of the project is dedicated to developing institutional capabilities to effectively plan, manage, and evaluate health sector initiatives. The cost-effectiveness of this approach is clear: rather than simply having external consultants come in and produce studies time and time again, local personnel are trained (formally in the classroom, and informally through on-the-job training) to conduct such activities themselves.

Fourth, the anticipated activities to be carried out under HCPPM provide an integrated approach to addressing health financing and management issues. For example, the diagnostic studies envisioned include efforts in the areas of cost recovery, privatization, and social

financing mechanisms. It is critical that health sector financing be examined globally, rather than efforts in one area (e.g. increasing user fees) being undertaken independently of others (e.g. the availability of health insurance programs). Taken as a whole, the envisioned activities (ranging from problem diagnosis, analytic study, presentation of reform options, pilot test of policy reform, evaluation of policy reform, to recommendation of broader or different policy change) will allow host governments to effectively address financing and management problems in their health sectors.

III. BENEFITS

As explained above, many of the benefits from a health sector project are difficult or impossible to quantify in monetary terms. Moreover, given the nature of this project (provision of technical assistance and training), the links to "health outputs" such as improved life expectancy or reduced infant mortality are tenuous at best. However, this section attempts to delineate the expected benefits from project activities.

For purposes of this analysis, it is assumed that the results from the analytic and diagnostic studies, and from the pilot tests, will be effectively utilized by policy makers to select and implement policy reforms (as appropriate). This project alone, of course, cannot guarantee that, and failure to do so will call into the question the realization of project benefits.

A. Value of Averted Morbidity and Mortality

The ultimate aim of efforts to improve health care services is to reduce morbidity and mortality. Health indicators in the Eastern Caribbean are quite good, with low levels of infant mortality and high life expectancy. It is neither anticipated that HCPPM will directly contribute to improving those indicators, nor that changes in those indicators will be seen during the life of the project. However, it is likely that project activities will have an effect on health indicators, particularly in the long-run. A current problem in the region is the lack of planning capacity within health systems, such that resources are not directed in cost-effective ways, and such that changes in epidemiology (e.g. increasing chronic diseases, "new" problems such as AIDS) cannot be effectively addressed. By enhancing the regional and national capacity to plan and program the use of scarce resources, as well as to generate additional resources, it is anticipated that HCPPM will contribute to reductions in both morbidity and mortality. The value of these, however, is not quantifiable in monetary terms, except as it might effect national productivity.

B. Changes in Allocation of Resources and Likely Beneficiaries

One often-cited characteristic of health systems in the region is the domination of curative services, particularly hospitals. A consequence of this may be that resources are not being used in the most rational means possible, particularly given the acknowledged cost-effectiveness of preventive and primary health care services.

A likely activity to be carried out as part of HCPPM is an analysis of the current allocation of health sector resources (urban vs. rural, curative vs. preventive). This activity will provide health policy makers with concrete data on current resource allocations, and to consider different targets in appropriating funds. In such cases, actual allocations are rarely in line with stated objectives. If such problems are found, and if policy makers are willing to undertake reallocations, there are likely to be benefits in increased resources for preventive and primary health care. This will have important ramifications for all health consumers, but particularly for women and children who are the heaviest consumers of preventive and primary services.

C. Quality Improvements in Public Health Care Services

One area to be addressed by HCPPM is the provision of health services in public facilities. A likely policy reform to be undertaken there is to increase user fees to generate additional revenues. A by-product of such a reform may be improved quality of services, which can be achieved by "recycling" the increased revenues within the facilities to obtain amenities (e.g. an air conditioner for the waiting room) or to provide training to personnel.

Thus, a benefit from HCPPM activities may be improved quality of services, which has value in and of itself. Besides that, however, may be financial savings for consumers. Based on the current quality of care received in public health facilities, many consumers opt for private facilities, for example, to avoid long waits. If public services are improved so as to attract patients currently going to private services, and if prices in the public sector remain below those in the private sector, an added benefit will be reduced out-of-pocket payments on the part of patients.

D. Long Term Capacity to Plan for the Health Sector

Training as part of HCPPM, both in formal and informal ways, will result in an established long-term capacity to plan for the health sector. This will include the capacity to identify, implement, and evaluate health policy research, as well as the broader capacity to manage health systems.

This benefit will occur during the life of the project, but will extend far into the future. It will result in a decreased need for external technical assistance in the long-run, and thus provide savings for the host government (and donors) beyond a more efficiently-run health system.

E. Improved Management of Hospital Services

Parallel to an improved capacity to plan for and manage the health sector as whole is increased capacity to manage hospital services specifically. This is a critical benefit given the large proportion of resources devoted to hospital care.

Project benefits will include improved management and information systems within hospitals, such as admissions policies, fee collection systems, and planning and decision making processes. These translate into more efficient use of existing resources, as well as the potential for increased resource generation.

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F. Increased Levels of Resources for the Health Sector

An anticipated benefit of HCPPM is an increase in the overall level of resources available for the health sector, as well as a broadened base for those resources. Governments currently provide the vast majority of resources for health expenditures, with out-of-pocket payments, insurance programs, donors, accounting for less than ten percent of health sector expenditures overall. Although government allocations to health sectors in this region are relatively high by international standards (8 to 16 %), public resources are still inadequate.

A likely benefit of HCPPM activities is an increase in resources for health. This will result from (a) new or increased user charges in public facilities, implemented effectively, (b) heavier reliance on social financing mechanisms, and (c) an increased role for the private sector in providing health care services. Increased resources will translate into either improved quality care or a wider range of services becoming available.

G. Ensuring Access for the Poor

One anticipated area of activity for HCPPM is cost recovery, and implementing fee systems that more closely reflect the costs of providing services. Naturally, there is concern that raising or instituting fees in public facilities will deny access to the poor. However, if designed and implemented effectively, cost recovery systems can continue to ensure, or perhaps increase, the access of the poor to health care services.

Systems of user charges can be established whereby health care services for the indigent are subsidized by those able to pay. In such a way, charging increased fees will raise revenues, and can increase the amount of services that are delivered to the indigent. Alternatively, a health sector analysis may determine that an appropriate role for the government is to provide basic health care services, and to leave specialized treatment to the private sector. In this case, public sector facilities would concentrate their resources on a more limited range of services; these facilities would probably treat lower income populations (as those with higher incomes would seek private sector care), and could improve the services that they provide.

Thus, a benefit of HCPPM is likely to be ensuring access of the poor to health care services, and improving those services beyond what currently exists.

H. Increased Consumer Knowledge

Through its Information Dissemination component, HCPPM will increase consumer knowledge and understanding of a range of health sector issues. These include knowledge of specific activities targeted by the project (e.g., the need to increase fees, available insurance programs, how privatization may improve the provision of health care services), as well as

more general knowledge about the provision of health care services (e.g. the need to rely more heavily on preventive and promotive rather than curative care).

Increased consumer knowledge will transfer into (a) greater potential for successful policy changes, (b) more rational use of health care services (e.g. use of preventive and primary care rather than secondary services), and (c) improved levels of health.

I. Strengthened Private Sector

In addition to benefits accruing to the public health sector, HCPPM will result in benefits to the private sector. These benefits may result from specific activities aimed at strengthening the ability of private sector entities to provide health care services (e.g. removing legal or regulatory barriers), or from a recognition that the government cannot effectively provide all services, with a clear decision that certain services are best provided by the private sector.

These benefits would therefore accrue to private health practitioners (e.g. physicians, diagnostic facilities, pharmacies) and to those providing services to the public health sector (e.g. catering and janitorial services). In addition, there may be broader ramifications for the private sector. HCPPM activities may lead to increased recognition or acceptance of the role the private sector can play in collaboration with the public sector. This recognition can extend beyond the health sector, and may improve the prospects for private investment in a variety of endeavors.

J. Broader Economic Impact

Funding health sector programs is often considered to be a purely "consumption" activity, since health is not considered to be a productive sector. However, in a very real sense, funding health programs is a long-term investment, with significant returns in the guise of healthier populations. Because it is impossible to quantify this "return" on investment, the link is considered a tenuous one at best. Nevertheless, the activities of HCPPM can be expected to have an impact on the broader economies of the participating countries.

First, health sectors currently account for significant shares of government expenditures. By generating additional revenues through user charges, and by implementing improvements in cost containment and efficiency, the health sector may be able to reduce its burden on government budgets, thus freeing up some funds that can be redirected to other sectors.

Second, there has been a general trend over the past several years of emigration from the region. This is reflected in a less-skilled labor force, particularly among the well-educated (including physicians and nurses) who seek better opportunities abroad. Strengthening health systems in the region may contribute to retaining skilled professionals. This does not suggest that better health systems alone will stem migration; however, they may provide

opportunities for health professionals, and may provide one less reason for others in the work force to leave.

Third, there are currently significant numbers of patients seeking care outside of their own countries, and outside of the region. This represents a financial loss to the governments, when they are directly paying for this care abroad, as well as when patients are paying out of pocket to overseas facilities. Strengthening facilities in the region may help to keep some of those financial resources at home.

Fourth, tourism is one of the biggest industries for the region. Improved health care systems can contribute to attracting tourists, who might otherwise be concerned about the availability of health care services when abroad.

IV. ECONOMIC IMPACT OF POTENTIAL POLICY CHANGES

Given the nature of activities to be undertaken by HCPPM and the policy reforms that may result, there is likely to be a significant change in the way in which health care services are financed and provided. This will have an important impact on both individual consumers of health care services, and on the private sector.

A. Economic Impact on Consumers

One area of focus of HCPPM is likely to be increasing user charges in public hospitals. This will require increased out of pocket payments for consumers unless they are covered by social financing mechanisms. Critics may argue that these populations cannot afford to pay for services, and that the government has a responsibility to provide them for free.

On the question of ability to pay, it is clear that large segments of the populations in this region are already paying for health care services, whether to private practitioners or in obtaining needed pharmaceuticals. This can be confirmed by demand studies planned under HCPPM, which will also provide information from which realistic and effective fee schedules can be established.

If fees are increased at public facilities without complementary adjustment to the financing mechanisms, such as social and commercial risk-sharing, it will be necessary to institute means testing systems to protect those who truly cannot afford even nominal sums.

On the question of willingness to pay, it is likely that many patients are not inclined to pay for public health care services such as they are currently provided. It will be important to adjust the level of quality of services in public hospitals to accompany increases in fees, in order to continue to attract patients. As a result, there are planned activities in the area of focus groups to ascertain consumers' perceptions of quality of care.

An important component of HCPPM is public education campaigns. It is likely that by demonstrating to the general public, as well as to policy makers, the actual costs of providing services, greater acceptance of increased fees can be obtained.

B. Economic Impact on the Private Sector

Another area of HCPPM's focus will be on an increased role for the private sector to play in financing or providing health care services. An important question is thus whether the private sector has the capacity to take on these roles.

Given the small size of the economies in the region, as well as a traditional reliance on the public sector to provide services, there may not be developed or readily available capacity within existing private sectors to take over public health care services. However, this remains to be analyzed in more depth by the diagnostic studies envisioned as part of project activities. Moreover, it would not be realistic to expect a complete turning over of responsibility to the private sector. It is more likely to happen in discrete and limited ways, including adopting "private sector-like" management approaches in public health facilities, such as competitive bidding for procurement.

The diagnostic studies will examine whether or not there are currently barriers which restrict the ability of the private sector to provide or finance health services. If there are, and if HCPPM results in efforts to revise those policies, there may be significant potential to enable the private sector to take on a greater role.

V. PROJECT RECURRENT COSTS AND BUDGETARY IMPACT

A. Project Impact on MOH Budgets

The existing budgetary situation for ministries of health in the region is described in the Technical Analysis section of this project paper. Suffice to say that it would be difficult for any of those budgets to sustain large increases in recurrent costs over the long-term.

The recurrent cost implications of HCPPM activities are minimal. The focus of the project is on improving the ability of the MOHs to carry out current activities, rather than adding new ones. For the most part, personnel requirements will involve training, not hiring. There may be some additional need for personnel to handle fee collection systems at hospitals, or to monitor the means testing system to protect the poor. However, it is anticipated that additional hires would be minimal, as those activities should be able to be incorporated into the responsibilities of existing staff.

If a significant amount of privatization is carried out, MOHs may be required to shift rather than increase personnel. For example, if a hospital contracts out some portion of

services, workers currently providing those services may become redundant within that facility. On the other hand, there will be a need to monitor the contractor, thus shifting an administrative burden. If the number or types of services provided by the private sector increases or changes significantly, the MOH may be required to establish quality standards and a review system to monitor those services.

Because one aspect of project activities will be to better plan and manage the health sector, it is likely that the MOHs will undertake shifts in recurrent costs. Rather than opening new health facilities, existing ones may be consolidated to make more effective use of resources (including personnel). One area in which inadequate attention has been focused is that of equipment maintenance; HCPPM activities are likely to result in a more rational use of resources to ensure that the recurrent cost aspects of equipment are not ignored.

HCPPM activities will have some recurrent cost implications through the addition of computer systems to improve management and decision-making systems within the MOHs. MOHs will have additional costs of electricity and other support for computer maintenance and use. However, these should not pose an excessive burden on ministry budgets.

Ministries of health will be obligated to cover the cost of airfares to the U.S. for trainees. This is estimated to cost an average of \$1,000 per country. This is not, however, a recurrent cost, as these are one-time investment expenditures that should have long-term benefits to the host countries.

Ministries will also be responsible for payment of some local costs of HCPPM activities, such as printing materials for public education campaigns. These costs are estimated to be on the order of \$3,500 per country, and are not expected to be recurrent costs either.

B. Longer Term Implications for MOH Budgets

While HCPPM activities would appear to impose minimal additional burden on MOH recurrent budgets, they will also have very beneficial longer term implications. Due to the nature of project activities, and the types of policy reforms that may be undertaken, any or all of the following may take place:

- more resources are generated (through user fees) to cover MOH recurrent costs
- existing resources are reallocated in such a way so as to decrease recurrent costs (e.g. from tertiary care to preventive care)
- cross-subsidies are provided from some facilities to others (e.g. from one hospital to another) or from one level of care to another (e.g. from a hospital to a clinic), thus helping to address individual recurrent cost situations

- improved management capabilities allow for the appropriate planning of capital improvements, and correctly account for applicable recurrent cost needs

VI. POTENTIAL COSTS OF FOREGOING IMPLEMENTATION OF THE PROJECT

The question may be asked, "What will happen if USAID does not implement the proposed HCPPM Project?" The explicit dollar costs cannot be specified concerning potential negative developments in the economies of Eastern Caribbean countries if the project is not implemented. The general direction and character of these potential negative developments can be discussed based on some of the disturbing trends and data presented in the "Rationale" section of the PP. This is in effect the focus of the brief discussion that follows.

In short, the economic costs of foregoing the project stem primarily from the reduced rates of productivity in the economy that would likely occur if an intervention like the one proposed in this PP is not implemented. A population with overall declining health would be less productive in terms of the hours of availability and the quality of work it is able to perform. The declining health status is indicated by the fact that there is a growing incidence of chronic and degenerative diseases and also injuries, a population where the proportion of people over 65 is increasing (increasing incidence of geriatric problems), increased incidence of AIDS, and a health care system that has not been able to keep up with all of the needs that these trends represent for curative care, nor keep up with the needs in primary care. Also, unless national resources are allocated efficiently, productivity will decline or be less than optimally possible. Inefficient allocation of resources combined with increased demand on these resources that surpasses available capacity, means increased economic and social stress. If the national government inefficiently allocates resources to the health sector, that means that other expenditures for important investments are "crowded out". It means that a road or a port might not get built or improved, which would allow producers to move their goods and earn income. It may mean that a school might not get built or a scholarship for technical training not created, such that human capital development in the economy is stymied. Also, within the health sector, if funds are spent inefficiently, the country experiences opportunity costs and the population experiences welfare and social costs.

Further, some additional costs of not doing the project can be discerned by referring to the benefits of doing the project discussed in Section III of the Economic and Financial Analysis, and to ascertaining the opportunity costs of deferring these benefits.

VII. CONCLUSIONS

A. Cost-Effectiveness Results

The choice of overall design for HCPPM, its components, and the types of activities to be carried out, appear to be cost-effective approaches. The design as a regional project is cost-effective, as are the technical assistance, training and information dissemination components which will address health financing and management issues in individual country contexts. This means that of the multiple design options identified as viable for achieving the project objectives, the design elaborated in this PP is the least expensive of all those considered. Likewise, of all the viable design options considered for achieving the technical assistance, training and information dissemination objectives, the designs elaborated in this PP for each of these specific components, cost less than all of the other design options considered.

B. Summary of Benefits

The benefits to be produced by the project include:

- Decreased morbidity and mortality due to more effective provision of health care services
- More rational allocations of resources, with primary and preventive health care targeted, and with women and children as the prime beneficiaries
- Improved quality of health care services in the public sector
- Strengthening of local capacity to manage health systems
- Increased levels of resources available within the health sector
- Strengthened private sector role in providing and financing health care services
- Protected access of the poor to health care services
- Increased consumer knowledge of health care and operations of the health system

Although these benefits cannot be quantified, the benefits would appear to merit the anticipated expenditures of this project.

C. Economic Impact of Project Activities

The primary impact of project activities will be on individual consumers of health care services, and on the private sector. While concerns about the ability of populations to pay

for health care services are not unjustified, it would appear that there is substantial capacity to pay at least nominal fees for use of public health care facilities.

At this time, the extent to which a greater role for the private sector in providing health care services is feasible. There is, however, strong interest in examining that as an option for policymakers to consider.

D. Recurrent Costs and Budgetary Impacts

The recurrent cost implications of this project for ministries of health are minimal. Moreover, this project will provide significant opportunities to decrease or rationalize recurrent expenditures on the part of the public health sector.

E. Recommendations

1. Economic Soundness

The project design is recommended as economically sound. The benefits appear to be greater than costs, and the approaches to be taken are cost-effective.

2. Recommendations for Specific Activities/Studies

Although the specific activities to be carried out in a particular country context will be determined in collaboration with the host government and the HPMU at the start of the project, there are a couple of areas in which studies or activities are highly recommended.

As indicated above, it is critical that means testing systems be implemented concurrently with increases in user charges, to ensure that the poor are not denied access to health care services. Therefore, it is recommended that pilot tests of alternative monitoring systems be conducted. Results in this area will provide important knowledge for the region as well as worldwide.

An area which is not directly within the scope of the project, but to which HCPPM can contribute significantly, is that of the feasibility of regionalizing services. As stated previously, due to the small size of the various countries, there are few economies of scale to be gained. There may be strong benefits to regionalizing services and sharing resources, much as has already been done in the area of pharmaceutical procurement. Examining the prospects for sharing resources would be useful for the individual countries, and could provide lessons for other regions as well.

Lastly, it is anticipated that initial assessment visits will be conducted in each country in the region in order to establish workplans for project activities. As part of that undertaking, baseline studies will be done, examining, among other things, utilization of services, market size and share, expenditures and revenues. One would hope that these same indicators would

be revisited as part of monitoring during the life of the project, to identify problems and make adjustments during the project. Similarly, at the end of the project, follow-up studies should be done to assess the effectiveness of project activities as well as to provide broader recommendations regarding policy reforms.

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BEST AVAILABLE DOCUMENT

Annex F: Social Soundness Analysis

The project is largely compatible with the sociocultural environment of the Eastern Caribbean. Its impact and benefits are consistent with development goals and objectives of RDO/C and other regional organizations such as the Caribbean Cooperation in Health (CCH). The proposed implementation framework is appropriate and designed to broaden support of the enhanced health systems, financially and managerially. Greater collaboration among government agencies, the private sector, and health consumers should result from the project.

Sociocultural Feasibility

Health policy reform is a complicated, long-term process and represents a significant change in any society. Caribbean health consumers and providers have rising expectations and demands for health care services in terms of quality and sophistication. It is clear that current financing and management systems are inadequate to develop and sustain a contemporary health care system. Technical assistance and training in areas of health care financing and management are not new to the region. Governments, the health care community and the public are aware of the need for change. However, the HCPPM project can provide mechanisms to facilitate the making of difficult decisions, like raising fees. Public education and information dissemination, with the goal of changing behavior and utilization patterns, is a key strategy to be employed by the project to overcome unfavorable reactions to policy reform. Although the majority of services are currently free, and traditional approaches have left financing exclusively in the realm of government responsibility, it is anticipated that consumers will accept policy reforms. Research (Zschock, et al) and empirical evidence (e.g., Victoria Hospital, St. Lucia) suggest that patients are willing to pay for what they perceive to be quality care, and that there is a demand for curative services in the private sector.

A diverse group of representatives from each of the eight participating countries have had input into the development of project goals, objectives, strategies, inputs and outputs. The selection of a regional institution as the implementation agency will foster greater credibility with area governments and facilitate the creation of a regional capacity to develop human resources in a variety of areas of including health policy, planning, finance and management.

The project design has taken into account other health sector development programs planned and in progress to avoid conflict and duplication. In several instances, project outputs will complement progress being made in related areas by other donors. The project builds upon past technical assistance, all of which identifies the need for improved financing and management.

Beneficiaries

The goal of the HCPPM project is to improve and maintain the health status of the people of the Eastern Caribbean, by achieving a more efficient and equitable generation, distribution and use of public and private resources.

Governments will be major beneficiaries of the project. An efficiently managed health system that is less reliant on government financing will have a spread effect beyond health care and the government budget. Given the inefficiencies in the current system, the potential for cost savings and increased productivity are vast. Broadening the burden of paying for health care may free limited government finances for other priorities and sectors in the economy. Improved health services may be a boon to the tourist industry, a major earner of foreign exchange, by creating an additional selling point for visiting the region.

The average health care worker should benefit from the project. The hospital is a major source of employment; relatively large numbers of people will be exposed to up-to-date management techniques. Perhaps over time management innovations introduced in health will spread to other sectors as people change jobs. In general, the work atmosphere should improve with a greater delegation of authority and opportunities for career development. A successful experience with administrative reforms in decision making may encourage similar steps in other areas of government.

The establishment of hospital management or advisory boards may create the opportunity for community involvement in the health care system, and thus encourage the more active participation of consumers in the health care system.

Existing businesses and entrepreneurs may benefit from opportunities created by the search for greater private sector involvement in the health. Research indicates that people are willing to pay for what they perceive to be quality services. Private practices may become more profitable, stimulating growth in that aspect of the health care delivery system. People will want to obtain insurance coverage to help pay higher fees, thereby creating a more favorable climate for private insurance carriers.

An informal survey of Health Financing Policy Workshop participants in St. Lucia revealed that several respondents believe contracting out specific services to the private sector to be feasible. Support ("hotel") services and some ancillary services were mentioned as candidates. Hotel services include housekeeping, dietary, laundry, maintenance and security. The ancillary services most frequently cited as being feasible were pharmacy, laboratory and radiology. USAID's Health Sector Initiatives project in Jamaica illustrates the complexities and potential for private sector development via contracting out support services. Another indicator of private sector potential is the sophisticated radiology center in St. Lucia being developed by a private physicians group.

Disadvantaged populations such as women, children, the elderly, and the indigent will benefit from the project by having greater access to improved health services. Research indicates women use health services more often than men and are more likely to pay for private care. Mothers tend to take their children to private physicians for curative services. Moreover, women represent a relatively large part of the health care work force and will benefit from a better work environment and training opportunities.

Training and development of health care policy makers, planners, and managers will have a major effect on the future capabilities of the regional health sector. The development of a cadre of health professionals with a variety of skills should be a direct result of the training programs. Consequently, the Eastern Caribbean will be less reliant on donor sponsored research and technical assistance. Opportunities for non-government managers to participate in project training activities will stimulate the introduction of sound management techniques to the private sector.

Equity of access to the full range of available health services programs is an objective of the project. Enhancement of management capabilities, across the spectrum of health care facilities, will yield greater efficiency, effectiveness and access to basic services.

Potential Areas of Difficulty

Perhaps the area of incompatibility or conflict with the sociocultural environment most common to all countries in the region is bureaucratic inertia. Other challenges will vary with the political and economic atmosphere in the individual countries, e.g., the willingness of political leaders to make potentially unpopular decisions and the capabilities of the private sector.

The absence of a sizeable number of skilled managers to facilitate policy reform is another significant circumstance to overcome. The project approaches this obstacle directly by providing regional and overseas training opportunities. In addition, on-the-job training will be provided by having technical experts work closely with host country counterparts during the analytic studies and applied research activities.

The delegation of management and financial authority are controversial issues. Country representatives surveyed thought the delegation of management authority was feasible. Only one respondent thought financial autonomy for hospitals was feasible. Consensus building workshops for policy makers, information dissemination and training activities have been designed to encourage reform of public administration practices.

Increased productivity and improved resource allocation may lead to the identification of excess workers in some areas, whose handling may be a sensitive and controversial issue. The introduction of updated management policies and procedures will create new roles and functions, but the potential for layoffs or transfers should be anticipated.

Initial consumer reaction to policy reform will vary with how a particular change directly affects the person. While the need to increase hospital fees is clear to all parties, any increase in charges to the public is a difficult decision. The middle class may feel disadvantaged because they may have to pay more for services or insurance, although they should be receiving the benefits of enhanced services. Public education campaigns are planned to inform the consumer and facilitate behavior modification.

The response of the physician community is difficult to gauge. Some will see more opportunities for developing private practices. Others who are comfortable and benefit from the current public-private sector mix will most likely have an unfavorable reaction. Consider the case of hospitals where physicians receive a disproportionate share of fees for hospital services. A common example would be lab tests, where the physician receives the majority of the fee although hospital resources are used. Management enhancement activities will require an examination of the financial and practice arrangements between facilities and medical consultants.

Spread of Benefits

Governments will benefit from the project in numerous ways: the broadening of responsibility for financing health services to other segments of society; improved resource allocation; increased productivity in the public sector; improved management capacity within facilities; greater productivity of resources; and, growth of the private sector. Positive experiences or lessons from management reform in the health sector may be transferred to or adopted by other public agencies, and perhaps by elements of the private sector.

Health care workers will benefit from improvements in management efficiency and financial viability of the public sector. They will also receive training and career development, another important output of the project.

The ultimate beneficiaries will be the health care consumers who will have greater access to better quality services.

Annex G: Institutional and Administrative Analysis

This analysis is aimed at ensuring that there is a careful examination of the strengths and weaknesses and appropriate roles of the several organizations that have to act to assure successful implementation of the project.

The analysis reflects on (a) the regional organizations considered for implementing the project; (b) the organizations (regional and international) being considered as major collaborators; and (c) the national organizations at the three levels of the Public Service (Ministries of Finance, Planning, Establishment), the Ministries of Health, and the Hospital.

In the case of (a) and (b), the capability of the organizations to successfully implement or support the project are considered, and in the case of (c), the institutional readiness and constraints and opportunities to project success are considered, in addition to refining areas of potential project contribution.

1. Implementing Agency Approach

The project is fundamentally a "change" project aimed at health policy reform, improved cost recovery, improved management practices, improved resource allocation, and changed relations between private and public sectors. In this regard it will call for a number of actors operating in concert if it is to be successful. The choice of an implementing agency was therefore made on the basis of the project going beyond the technical dimension of Health and encompassing the mobilization of commitment to new policy options, research into new, more effective management and financing systems, and training to implement such systems.

Against the backdrop of the nature of the project are these criteria for choice of implementing agency:

- . The strategic coherence of its Mission and its programs.
- . The fit between the Mission and the Project.
- . The appropriate organizational structure able to achieve the goals both of the organization and the project.
- . The presence of competent and committed staff (with reasonable periods of continuous service).
- . The access to a network of appropriate consultants and national and regional institutions.

- . The respect and confidence of regional governments and public sector organizations.
- . The respect and confidence of RDO/C and other donors.
- . The respect and confidence of other regional institutions (possible collaborators).
- . Good financial accounting records and reporting systems.
- . Credibility of leadership of the organization.

2. Implementation Agency Review

Three agencies were considered as possible implementing agencies: a Health Policy Management Unit in the Secretariat of the Organisation of Eastern Caribbean States; the Caribbean Centre for Development Administration (CARICAD); and the Office of University Services (OUS/UWI) of UWI, Cave Hill.

THE OECS/ECDS SECRETARIAT

The Organisation of Eastern Caribbean States (OECS) was established in 1981 to promote the social, economic and political developments of the peoples and countries of the Eastern Caribbean through joint action effectively utilizes their limited resources to protect and advance the common interest.

The treaty was signed by the governments of Antigua, Dominica, Grenada, Monsterrat, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines. Later the British Virgin Islands became an Associate Member of the body.

The OECS is coordinated and managed by an Authority of Heads of Government through a Central Secretariat located in St. Lucia which is headed by a Director-General. The Director-General is the Chief Executive Officer of the Organisation and has responsibility for its general direction and control. The OECS Secretariat enjoys the highest esteem and confidence of member governments and its Director-General is recognized and respected throughout the Caribbean as one of the leading public figures and intellectuals.

The organization has the strongest institutional linkages in its member countries of any regional organization through not only its principal institutions, but through the several projects that it manages in various countries.

OECS has a strong record in managing donor funds and is presently managing, among others, the National Resource Development project (German Government); Fisheries Unit (FAO and CIDA); Technical and Vocational Education (CIDA, World Bank, CDB); and Tourism/Export Promotion (European Economic Commission).

OECS is currently implementing an important part of RDO/C-financed regional projects, namely

- . the Environmental and Coastal Resources (ENCORE) project, lodged in the National Resource Management Unit, St. Lucia.
- . the Tropical Producers (TROPRO) project being operated out of the Agricultural Diversification Unit in Dominica.
- . the Investment Promotion and Export Development (IPED) project housed in the Economic Affairs Secretariat in Antigua.
- . the Non-Formal Skills Project, ending in June 1992, operating from in Antigua.

In order that the OECS can be certified as capable of implementing this project, A.I.D. must be satisfied with the reporting and control mechanisms of the financial and budgetary systems of the Grantee. Based on a recent financial management capability assessment of the OECS, the RDO/C Controller Office noted significant improvements in the organization's accounting and internal control systems over the last two years, and concluded the organization's accounting and funds control procedures are adequate for USAID's purposes. The organization's procurement and contracting systems, however, were judged to be weak. The organization will require guidance and support from RDO/C, during project implementation, to improve its procurement and contracting systems.

It is important to note, nevertheless, that the Eastern Caribbean Drug Service (ECDS) -- an OECS project developed with and financed by RDO/C -- has been one of RDO/C's recognized successful projects. It is the ECDS model within OECS that this HCPPM project will follow, benefiting from ECDS stature in the OECS Secretariat and with health sector professionals in the region.

Among the major purposes of the OECS are:

- . to promote cooperation among the member states and at the regional and international levels;
- . to promote unity and solidarity among the member states and to defend their sovereignty, territorial integrity and independence;
- . to promote economic integration through the provisions of the Agreement Establishing the East Caribbean Common Market;

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- . seek to achieve the fullest possible harmonization of foreign policy among the member states; to seek to adopt, as far as possible, common positions on international issues and to establish and maintain, wherever possible, arrangements for joint overseas representation and/or common services.

In relation to the purposes and functions of the OECS, a number of areas of activity have been identified in the Treaty, in which the member states will endeavor to coordinate, harmonize and pursue joint policies. These include:

- . Overseas Representation
- . International trade agreements and other external economic relations
- . Financial and technical assistance from external sources
- . International marketing of goods and services including tourism
- . Economic integration among the member states, through the Eastern Caribbean Common Market Agreement
- . External transportation and communications including civil aviation
- . Matters relating to the sea and its resources
- . The judiciary
- . Currency and central banking
- . Tertiary education including university
- . Public administration and management
- . Scientific, technical and cultural cooperation
- . Mutual defense and security

The functions of the OECS are accomplished primarily through its principal institutions which are:

- (a) The Authority of Heads of Government
- (b) The Foreign Affairs Committee (Ministerial)
- (c) The Defence and Security Committee (Ministerial)

- (d) The Economic Affairs Committee (Ministerial)
- (e) The Legal Affairs Committee (Ministerial)
- (f) The Central Secretariat
- (g) The Policy Board (Health Ministers).

The Authority of Heads of Government and the Economic Affairs Committee meet twice a year and to date there have been eighteen and seventeen such meetings respectively. The other committees meet as may be necessary from time to time.

The institutions and agencies which function within the framework of the Organisation are the Central Secretariat (St. Lucia) the Economic Affairs Secretariat (Antigua and Barbuda), the Directorate of Civil Aviation and OECS AERADIO (Antigua and Barbuda), the Fisheries Unit (St. Vincent and the Grenadines), the Eastern Caribbean Drug Service and the Natural Resources Management Unit (St. Lucia), the Agricultural Diversification Coordinating Unit and the Eastern Caribbean States Export Development Agency (Dominica), the Eastern Caribbean Investment Promotion Service (Washington, D.C.).

Within the Central Secretariat there is a Legal Unit, an information network system, and a Sports Desk. Matters relating to joint overseas representation at the High Commissions in London and Ottawa are also dealt with through the Central Secretariat.

OECS has managed its donor funds relatively well and has dealt with the problems of managing so many disparate projects with the attendant differences of reporting requirements by strengthening its central financial division. The new strengthened division will, *inter-alia*,

- (a) review and consolidate all agency budgets for presentation to the Authority;
- (b) establish and supervise a uniform accounting system for all agencies;
- (c) review and consolidate financial statements and accounts of all agencies before submission to the Authority;
- (d) centralize and monitor the payment of annual contributions;
- (e) exercise cash budgeting, management and control.

Health Cooperation and the Eastern Caribbean Drug Service (ECDS). In the area of health, the OECS has in place a mechanism for consulting the Ministries of Health. This mechanism is in place through the Eastern Caribbean Drug Service (ECDS). The ECDS, originally funded jointly by RDO/C and the OECS but now by OECS, is a project aimed at improving logistics management and reducing unit costs of pharmaceuticals through a pooled,

tendering, contracting and procurement process. More effective and efficient use of public health resources is being realized through the ECDS.

In order to ensure that the ECDS remains responsive to the needs of participating countries, all policy and strategic decisions are made by the Ministers of Health who constitute the ECDS Policy Board. A Technical Advisory Committee (Tenders and Formulary and Therapeutics Sub-Committees) assists the Policy Board.

ECDS works closely with a network of OECS Ministries of Health and other health related organizations. Regular interaction with national regional and international health care professionals are maintained through visits, workshops, seminars, training programs, and Board and Sub-Committee Meetings.

ECDS is recognized as one of the most successful of the OECS programs and its Project Manager is highly regarded among member Governments and especially Health and Finance professionals. The ECDS is the *de facto* Health Desk of the OECS and any health financial management project could fit readily into this mechanism.

The OECS is considering the opportunity of housing the HCPPM within this ECDS framework of the OECS.

CARIBBEAN CENTRE FOR DEVELOPMENT ADMINISTRATION (CARICAD)

The Caribbean Centre for Development Administration (CARICAD) is a regional organisation established in 1975 by the CARICOM Heads of Government. It is governed by a Board of Directors made up of senior policy representatives of member countries. Its day to day operations are in the hands of an Executive Secretary.

CARICAD was established with a mission to provide a central organization to assist member countries in the Commonwealth Caribbean to improve their managerial performance and strengthen their systems of public administration in support of the social and economic development.

The Centre actively serves all the CARICOM Member states and also the British Virgin Islands and the Turks and Caicos Islands. Member governments make small annual contributions -- in total, amounting to less than one-third of CARICAD's annual budget -- with the host country Barbados providing headquarters offices, including maintenance and the services of a Senior Trainer. There is, therefore, heavy dependence on consultancies and funding agencies for critical financial and program support. Among the latter are UNDP, the Commonwealth Secretariat, CIDA, the British Development Division, CDB, ILO, RDO/C, OAS, and Shell Antilles. While CARICAD has developed a strong record in the

use of these donor funds, there have been lapses in the timely reporting on the use of some of these funds, occasioning a strengthening of the financial reporting system.

Within the framework of its role and mission, CARICAD has the following objectives and functions: provision of consultancy services to improve the public service and private sectors; organization of workshops and seminars to improve top management in the public sector; conducting systematic action research within and outside of the region for new approaches to apply to the process of training and administrative reform; strengthening of National Training Units by assisting them in developing and delivering training programs; facilitating improved cooperation and coordination in the region between National and Regional Training Centers; collaborating with governments in designing and implementing programs of administrative reform.

In light of the most recent socio-economic transformation in the region and the pressures for improved competitiveness in the global, regional and national market place, the regional governments (Heads of Government Meeting 1992) mandated CARICAD to emphasize the following:

- . Design and implement a human resource development plan which is integrated within the overall socio-economic development program. Such a plan should emphasize sector specific as well as organizational and management development training.
- . Assist governments to confront structural inefficiencies and determine the proper dimensions of their administrative machinery. Performance of institutions and personnel will need to be evaluated, with a view to increasing productivity, and where necessary, reorganize into compact or lean, well coordinated, and high-performance oriented units of government. In this regard provision for reformulated general orders and administrative and financial regulations should be made. Further, the machinery of government should be restructured to eliminate overlap and duplication, and to enhance efficiency, in the use of scarce resources.
- . New structures and processes should be meshed with the current needs of policy development and initiatives for social transformation. Policy units which are capable of designing and monitoring innovative policies and of developing frameworks for public/private partnerships, will need to be developed.
- . Assist governments in evolving a more proactive role in the design of macro-economic and financial management policy. This will demand the development and maintenance of appropriate capacities to implement those policies.
- . Assist governments to implement a new managerial orientation and strengthen the competencies in the public sector. There should be modernization of training curricula, materials and methods to encourage responsiveness, creativity and the new orientations.

- . In pursuing these recommendations for strategic improvement, there would be need to enhance the concepts and methodologies of strategic planning, to utilize appropriate processes for planning and implementing change, develop effective management information and evaluation systems, and utilize multi-disciplinary planning teams.

CARICAD is deliberately designed as a small organization that would collaborate with existing institutions and draw on the services of resource personnel from within the region and from outside. As a result, it depends heavily on a cadre of associates (consultants experienced in Caribbean administrative and training systems) to implement its various projects. Its core staff is made up of an Executive Secretary, Technical Advisor, Administrative Assistant, Senior Accountant, and support staff. While competent, this staff will have to be considerably strengthened to effectively implement the project.

The list of activities for the period 1980-1988 is impressive. It includes a range of activities in top management workshops (policy symposia), intensive administrative reform programs especially in Dominica and Jamaica, training of trainers programs and development of local case material to provide for the study of local problems, roundtables to clarify various management issues in the region, and the development of local and regional consultants to implement programs.

In that 1980-1988 period, CARICAD carried out 23 policy symposia for 45 politicians and 546 civil service managers; 102 workshops and 8 roundtables involving 2,869 persons; 222 missions including 73 for training, 105 on administrative reform, 9 on case study development, 29 on the UWI certificate in Public Administration; and 6 middle-management surveys covered 442 middle managers in 6 countries. In addition, CARICAD has carried out several policy and action research studies on public sector issues.

CARICAD commands the respect of the member governments at both the political and managerial levels as evidenced by its record and their continued requests for the organization to play an important role in their restructuring programs. The organization has recently appointed a new Executive Secretary who has a strong professional reputation in the region and who commands the respect of member governments and funding agencies.

The organization has a sound record of managing donor funds and implementing projects such as the UNDP Public Management Project (1980-90) and a host of others with various funding agencies. Its lapses have been in the timely reporting on the use of funds in some of these projects. It has not implemented any major RDO/C projects.

The disadvantages in CARICAD implementing the project lie in its lack of experience in the health sector; its unfamiliarity with RDO/C projects and the relatively small core staff of the organisation.

THE OFFICE OF UNIVERSITY SERVICES OF THE UNIVERSITY OF THE WEST INDIES (UWI)

The University of the West Indies (UWI) was established in 1948 as an affiliated College of the University of London at Mona, Jamaica, with Medicine as its first faculty. It became an independent institution in 1962. The St. Augustine Campus, Trinidad, grew out of the Imperial College of Tropical Agriculture in 1960 and in 1963 the Barbados College of Arts and Science, later to be Cave Hill Campus, was established. In addition, University Centres have been set up in the non-campus countries, developing out of a network of branches of the Extra-Mural Department (now Department of Continuing Education) which was set up in all contributing countries at the inception of the UCWI. A centre for Hotel and Tourism Management (later a department) was created in Nassau, Bahamas, in 1976, as part of the faculty of social sciences.

Over the years, UWI has experienced many reviews and changes instituted by the contributing governments through special appraisal, salaries and other committees along with its own continuing internal management and educational audits. Recent years have been marked by an intensification of reform activities -- the restructuring of its financial management systems, giving a greater measure of control to the campus country governments, and the establishment of the office of University Services (OUS) to give better service to the non-campus countries.

There is a rather intricate management system at the university. The emerging use of teleconferencing and a planned system of computer communication will no doubt relieve the situation, but there is nevertheless some concern with the speed of decision-making.

UWI has produced over 34,000 graduates and despite the brain-drain to the US, Canada, and the UK, and shortage of financial resources, has made important contributions to the political, economic, and social development of the region. Its contributions to the world's store of knowledge about the Caribbean and Caribbean people have been significant.

UWI's financial situation has never been satisfactory. The present system of contributions and the current differences in the strength of the economies of the campus countries have led to some problems of governments living up to their financial responsibilities.

UWI must be regarded as a major agent for Caribbean development through its capacity to meet the human resource productivity needs of its contributing governments.

UWI, through its professional institutions and faculties, plays an important role in ensuring the provision of quality services for all Caribbean people. UWI has made tremendous strides in identifying and researching many of the major issues affecting life in the Caribbean region.

Programs emanating from UWI have had a sound record of relevance and sustainability. Indeed, in a developmental sense it is of critical importance that governments and funding agencies recognize this point and consequently the need to involve UWI in project activities aimed at national and regional evolution and advancement.

The Office of University Services (OUS) Mandate. Historically, the impact of UWI within the region has been considered by many to be unevenly distributed in favor of the Campus Countries. Thus, in order to ensure the widest possible impact of the University upon the lives of all Caribbean people, the Office of University Services (OUS) was established to serve the non-campus countries (NCCs).

Within the University, the OUS serves to initiate and coordinate activities on behalf of the NCCs. The OUS was established in 1984 with a mandate to "facilitate the expansion of educational projects and programs in the non-campus countries at the tertiary level, ... and liaison with campus councils on programs which the campus countries might wish to offer in or for the non-campus countries" (Finance and General Purpose Committee, 1984).

The intention was to provide a coordinating unit to expedite the involvement of UWI within the NCCs. As the number and range of UWI programs increased, the potential areas for University activity would also be expected to increase within the NCCs and consequently by OUS.

The OUS has been primarily involved in tertiary education programs in the NCCs which have generally been funded by specific project grants (FORD, EDF, RDO/C, CIDA, etc.). "The prime activities of the OUS centered around the consolidation of institution development initiatives already in progress and the expansion of programs areas".

Activities generated by and/or emanating from the OUS have utilized the appropriate resources of the university through its three campuses, its faculty, equipment, and the UWI Department of Continuing Education facilities in the non-campus countries. The staff of OUS is small, with a Director, a Deputy, an Administrative Assistant, and support staff. The project will have to create a unit with a full staff complement if it is to be housed in the OUS.

As part of the University and in its own right, the OUS has the confidence of member OECS governments at both the political and managerial level. In the context of the health sector, the OUS director is well known and qualified (he is a Medical Doctor and Professor in the Medical Faculty) to operate in this sector. The OUS has implemented the AID/CLDT project and has demonstrated an ability to implement such projects. Some concern with the complex decision making and slowness of decisions has been articulated by RDO/C

The OUS has identified the following ten priority areas for immediate and future attention by UWI within the NCCs:

- a. Development of national tertiary education programs.
- b. Provision of professional training.
- c. Continuing education for professionals.
- d. Providing a resource of highly trained technicians, professionals and managers.
- e. Providing tertiary level health care through its teaching hospitals and sharing specialist skills and services.
- f. Conducting research into areas of major national and regional importance, and maintaining a data base of information relating to such activities in all NCCs.
- g. Assisting with the implementation of projects and programs necessary for national and regional development.
- h. Strengthening the facilities at UWI Schools of Continuing Education in the NCCs, so as to enable them to provide an expanded range of services.
- i. Utilizing and developing UWI facilities for distance education, communication, and materials production, for and within the NCCs, so as to facilitate an expanded role in meeting the overall needs of the contributing countries.
- j. Assisting with the development of trade, commerce and the service industries within and between the NCCs and the wider Caribbean in order to ensure the future prosperity of the region.

OUS will become the facilitating and coordinating center for all UWI activities aimed at meeting these needs.

The major disadvantage of OUS as the project implementing agency is in the complex decision-making apparatus of the University and the nature of the project and its lack of fit with the modus operandi of the OUS and the University.

3. COLLABORATING INSTITUTIONS

In addition to the institutions being considered as Implementing Agencies, a number of regional and international agencies are possible collaborating agencies. The level of collaboration between the project and these institutions will ultimately be detailed by the Project Director in collaboration with the RDO/C Project Manager, but some preliminary explorations and a framework for collaboration is suggested in this section.

Pan American Health Organization (PAHO)

PAHO is the most active donor in the health sector in the Caribbean and the most influential with Caribbean Governments and Health Ministries. The organization has focussed much of its efforts in the areas of policy, planning and human resource development through a variety of training programs.

PAHO operates out of its Barbados Headquarters with variety of health specialists and a network of short term regional and international consultants. PAHO is a major and important player in the health sector and should be closely linked to the project. This is especially true in the context of one of PAHO's new projects -- The Management Information Systems for Community Health Services. This project is complementary to the Health Care Policy Planning and Management project and as such, every effort for close collaboration, coordination, and rationalization must be made. The project includes the OECS countries and Barbados and Anguilla.

The overall objective of the project is to strengthen the capabilities of Barbados and other countries in the Eastern Caribbean to provide primary health care in an efficient and cost effective manner.

The specific objectives of the project are to: (1) design and develop a management information system for the provision of Community Health Services, implementation of which will strengthen the effectiveness of the health care delivery system, through improving the planning and management of activities such as purchasing of supplies, inventory control, personnel management, financial control and equipment and facilities maintenance; and (2) strengthen the institutional mechanism in the health care delivery system, especially human resources needed to manage, maintain and operate, as well as make full use of the potential of the data base management system.

The Project has two components of importance to HCPPM. One is the design and development of a health management information system (HMIS) and installation of the system in each Ministry of Health. The second is the strengthening of the institutional mechanisms that will be needed for the successful operation and management of the Project and the HMIS. The Project will be executed over a period of 30 months. Four consultants constituting the Project team, will be hired for the duration of the Project. In addition, two specialists will be contracted for a maximum of six months each to undertake specific tasks.

The central activity of the project is the design, development and installation of the HMIS. The HMIS will be designed to accomplish improvements in the following:

- a. Accurate and timely collection and processing of data at the local, national and subregional levels;
- b. Utilization of information at all levels;

- c. Monitoring and evaluation of programs at the local level;
- d. Improved management and planning at all levels;
- e. Integrated approach to the delivery of programs;
- f. Intra-sectoral coordination of regional programs such as Maternal and Child Health Program; planning human resources training and development; bulk purchasing of medical and other supplies.

The proposed HMIS will consist of six sub-systems, divided into two groups, Group 1 relating to operations -- drugs and medical supplies; general supplies and primary health care information; and Group 2 relating to Administration --personnel; finance; and communications, transportation, facilities and equipment maintenance.

It is proposed that PAHO be closely linked to the Health Care Policy Planning and Management project at (1) the level of the steering committee, and (2) the technical level especially, but not limited to the area of health management information systems. It should be noted that PAHO shows a high level of interest in collaboration and rationalization of this nature.

Caribbean Cooperation in Health

At their meeting in Georgetown in 1986, the Ministers of Health authorized the Caribbean Cooperation in Health (CCH) program, a decision which was approved by the Conference of Heads of Government in July 1986, and by Resolution of the Conference of PAHO/WHO in September 1986. CCH is organized around seven priority areas:

- . Environmental protection, including vector control;
- . Human resources development;
- . Chronic diseases and accidents;
- . Strengthening health systems;
- . Food and nutrition;
- . Maternal and child health, including population issues; and
- . AIDS.

PAHO and CARICOM were mandated to act as a joint secretariat for this initiative which aims at:

- . identifying and utilizing strategic priority areas as entry points for a more productive use of resources;
- . the improvement of the whole health delivery system by making an impact on the more critical health problems;
- . stimulating cooperation between countries, agencies and health institutions; and
- . mobilizing national and external resources for dealing with the most urgent problems of the neediest groups.

The program has either initiated or continued a wide variety of regional projects in training of allied health personnel, marine pollution monitoring, disaster preparedness and prevention, basic health management, primary health care. In general, PAHO has supplied technical support to the CARICOM Secretariat which is chiefly responsible for liaison with member countries and identification of programs and projects.

How far CCH meets its objectives is illustrated by the fact that its priority areas have become the framework for the great majority of health activities in the region. However, in some areas, progress is necessarily slow -- sometimes because a donor agency has not been found for a particular project. On the other hand, there has been improvement in the identification and formulation of projects.

CCH has proved to be a good framework for inter-agency collaboration. The fact that PAHO and CARICOM have functioned as its joint secretariat, has been advantageous. While in recent times there has been considerable difficulty in securing for any reasonable period the kind of leadership at CARICOM which the nature of the work demands, collaboration between the project and the CCH initiative is nevertheless foreseen at least at the level of policy dialogue and leveraging activities.

The Caribbean Development Bank (CDB)

Founded in 1970, the CDB is the premier mobilizer of development finance for regional governments. The Bank is run by a Board of Governors made up of the Ministers of Finance of Borrowing Member Countries as well as representatives of donor countries like the UK, France, Canada, Italy, etc.

The CDB is one of the best run development banks in the third world. It has been given a Triple A rating on Moody's International and is now raising its own funds on the private international capital markets.

The CDB is the best placed regional organization to promote a policy dialogue with Ministries of Finance who invariably are Prime Ministers and who sit on its Board.

The organization's "policy broker" role has been enhanced because of:

- . dwindling flows of external finance and development assistance and the growing dependence of Caribbean countries on CDB for such financing and technical assistance; and
- . its enhanced role in promoting greater cooperation among donors, development assistance agencies and borrowing Caribbean countries to sound macro-economic policies and actions and the acceptance of Caribbean governments of the role.

The CDB has a further advantage in that it has the strongest database and local knowledge on the respective Caribbean countries in general and OECS in particular.

The organization has recently approved, at the Board level, a significant shift in direction which sees it emphasizing not only economically but ecologically sustainable development and balanced growth. In particular, there will be a substantial increase in the flow of resources to four areas considered critical: human resource development; environmental protection; public health services; and poverty alleviation.

The CDB strategy paper on its direction for the year 2000 puts it thus:

CDB will also intensify and broaden its economic and sector work, with the objective of providing the macroeconomic and sector policy insights and helping to put in place macroeconomic management capabilities which would enable it and the BMCs to make optimal use of available resources in the challenging nineties environment. Towards this end, it will work towards improving its country socio-economic databases, provide greater support for research on issues of concern to BMCs and improve its assistance at the operational level in BMCs.

It is proposed that CDB be invited to collaborate on this HCPPM project as a member of the Steering Committee and as a partner in the policy dialogue activities. Not only does this approach ensure more leverage for the project but it has the added advantage of early linkage with a source of possible future financing for the project or for spin-off projects.

The Centre for Management Development of the UWI/Cave Hill (CMD)

The Centre for Management Development is a semi-autonomous unit within the University's Cave Hill Campus funded by RDO/C. The Centre operates under the policy direction of its own Board of Directors made up mostly of private sector members. Principal program

activities of the centre include (a) symposia and seminars, (b) A proposed Executive Masters in Business Administration (EMBA) program, (c) contracted research and consulting services, (d) materials development, and (e) support to collaborative management training institutions.

The CMD is also expected to put some emphasis on training in the non-campus Eastern Caribbean countries; this fits in with the priorities of this project.

It is proposed that the project collaborate with the CMD where appropriate in the areas of (a) implementation of symposia and seminars; (b) certification within the context of a possible health management emphasis in the proposed Executive MBA and (c) material preparation.

4. The Institutional and Administrative Framework

It is envisaged that the project will be implemented in the context of different levels of organization in the respective countries. Examination of the private health sector and the social security and health insurance schemes has already been done in the Technical Annex. This annex concentrates on three public sector levels:

- . The level of the overall public sector and more specifically the public service, its structure, functions and management.
- . The level of the Ministry of Health in terms of its ethos, organization, management systems and functioning and its linkages to hospital and other facilities.
- . The level of the hospital in terms of its organization, management systems, and functioning.

Caribbean/OECS Public Management Systems.

Given the turbulence of the environment and the challenges and pressures facing the public sectors in the OECS, a consensus has emerged that to deal with these challenges, public management systems needed reforming and improving, and the skills of both managers and rank and file public servants needed upgrading.

All of the OECS public sectors are organized in a highly centralized way. The core or controlling agencies are usually:

- . The Ministry of Finance which is responsible for the revenue and expenditure of public finance and the Ministry of Establishment or Personnel which, along with the Public Service Commission, is responsible for the recruitment, selection, maintenance, development, promotion, placement and termination of all human resources in the service.
- . A Planning Ministry or Unit which may be within or external to the Finance Ministry and which is responsible for overall sectoral planning as well as prioritizing projects from across the public service.

This project can demonstrate the effectiveness of decentralized planning, financial and human resource management systems by the improved results of decentralization in a health facility.

Change Capability of Public Service Structures. Caribbean public sectors still tend to place emphasis on enforcement of rules and regulations. Output goals and objectives are generally lacking, with little thought given to program planning despite the need to shift to more strategic and facilitative perspectives. While there is a growing recognition of the importance of reorienting the public service towards a more program management format, the changes need to be accelerated in order to reorient the planning and budgeting systems and develop skills such as program management, organisation development and change management which would allow managers to effectively plan and implement strategies in a more systematic and controlled manner.

Policy Analysis and Formulation. In the OECS public sectors there has been a lack of sufficient capability for policy analysis. The weakness in identifying policy options is compounded by a stated weakness in linking of decisions to structured cost effective implementation. The environment of the nineties will multiply the challenges and make more complex the decisions facing OECS public managers in general and health managers in particular.

These managers will need to develop the capacity to appraise the impact of new policies and projects, and to use that data for feeding into the decision process so that policies can be revised and reformulated. The weakness of the skills and information base to perform this task constitutes a major impediment to effective policy formulation in the various islands; hence, the need for this project to provide training in project formulation and analysis, as well as to help in developing and facilitating the discussion of health policy papers.

Human Resource Management Systems and Skills. Human resource management in the OECS public sectors is not proactive in the sense of planning ahead but reactive in the sense of problem solving. There is a need for more comprehensive, proactive and integrated HRM Systems that include:

- . manpower planning
- . more effective recruitment and selection
- . proper career planning
- . proper succession planning
- . proper classification systems that ensure equity
- . proper reward systems tied to productivity

proper performance appraisal systems

The project should aim to assist health managers to develop HRM competencies if they are to be able to effectively recruit, maintain, deploy, and motivate staff as well as to train staff to the new HRM systems and norms.

Technology and Operating Procedures. In the turbulent environment of the nineties, the OECS countries cannot afford to ignore the changing face of technology. OECS public officers find themselves using procedures, methodologies and machine aids that are becoming outdated. This project can contribute in the development of computer skills, (a technical and professional dimension), and introducing computers into the management and organizational systems of the health sector (the management dimension). Computer skills and competencies also need to be developed by staff at all levels.

Strategic and Operational Planning. Strategic and operational planning systems are generally weak and need to be strengthened so that international, regional and national trends could be considered and policy priorities developed leading to programs, projects and work plans which would be relevant and appropriate and which could then be developed into output linked budgets. There is also need for strategic/operational planning skills/competencies, and continual work on the development of a strategic and operational planning system linked to some kind of program budgeting to ensure better operational and financial control in the various public sectors.

The development of simple program budgets with descriptions of functions and a statement of functional objectives to be accomplished in the next financial period is a priority if various OECS public sectors are to become more cost effective.

The planning process by which these plans are developed will have to become more collaborative and consultative in terms of all public sector.

General Management Skills. There is also need for the political and managerial directorates to better understand their respective roles. General management skills which help to clarify roles and functions at the political-administrative interface can be emphasized in the various training programs and fora of the project.

Financial Management Systems/Skills. Many of the OECS public sectors still need to improve budgeting accounting, auditing, revenue collection and financial information and monitoring systems, as well as to train people to operate these systems. This is a particularly important area of emphasis for the OECS countries in the light of the various change pressures and challenges.

Information Systems. Improved information systems especially in the traditional Civil Service are needed for more effective and efficient information flows and systems both intra and inter departmental in the decade of the nineties. In addition, management information

skills are also crucial to man these improved systems. The project can contribute to improved management information systems in the MOHs in general and the hospital in particular.

Coordinating Mechanisms. The coordinating mechanisms in the public sector of the OECS countries need strengthening. In the nineties, many problems call for an inter-sectoral or interagency collaboration and coordination as well as public sector coordination. There is therefore the need for OECS public managers to develop clear understandings of public and private management structures, systems and realities to allow them to better effect such coordination. Such skills as problem solving and teamwork are therefore suggested as crucial in management training programs in support of reforming these systems. In addition closer public private sector collaboration will be encouraged by the project.

Implications of the Systems Improvement Agenda. The foregoing description and analysis of the OECS public management system as it now exists is one of generally inflexible rules bound centralized public sectors which do not have the range and level of skills in all the areas necessary for its effective functioning at a time of growing turbulence and rapid change.

It becomes clear therefore that a project which provides for ongoing training especially at the middle and senior management levels, helps in the drafting of policy analysis, does research to help identify policy and implementation options and provides technical assistance in implementing change and improvement is highly desirable.

The Level of the Ministries of Health and the Hospital.

Having looked at OECS public service structures and processes, it is crucial that an analysis be done at the levels of Ministries of Health and the hospitals that they invariably control.

Centralization. Just as the public service is centralized in terms of the core or controlling agencies so too are the OECS Health Ministries and their relation to the various hospitals and facilities. In most cases, there appear to be a number of conceptual and operational problems inherent in these structures which have developed in some cases within the framework of the colonial bureaucracy.

Frequently programs are isolated within disciplines, accountability blurred and operational authority not consistent with program responsibility. In many cases the reporting relationships are not clear and there are cases where Hospital Administrators have staff who report within their discipline or to the ministry. If the project can assist in organization redesign and the development of more effective decentralized structures, then this would be a significant contribution.

Change Capability. There is a strong commitment to establishing a regime of strategic change in the Ministries of Health in the OECS and this is a good beginning. St. Lucia, St. Vincent, Grenada, Dominica, St. Kitts and Monsterrat all seem particularly anxious to reform their management systems in their respective MOHs.

The project can assist the change process through creating and sharing a vision of the "end product"; clarifying policy issues; and building commitment around the direction, scope and rate of change.

Policy Analysis and Formulation. The Ministries of Health in the OECS do not see themselves as policy making or even policy analysis organizations. Rather they see "policy" as the preserve of the political directorate even if they do sometimes give some technical inputs. Within the various Ministries of Health there is usually no place in the structure to systematically anticipate and deal with policy issues.

At the hospital level the question of policy is even more far removed with hospital policy usually detailed in a set of outmoded regulations that need updating to better reflect contemporary conditions and needs. The project can assist in the development of policy papers, facilitate the discussion of same, and train health managers in policy analysis skills.

Human Resource Management Systems and Skills. In all the Ministries of Health, the central HRM problem is one of the centralized control of the Human Resource Management function by the Public Service Commission and Establishment Personnel Ministries. Theoretically, this leaves the Health Ministry and the Hospital without the necessary authority in this area. Further analysis discloses that Human Resource Management Skills are not a specialty among senior health managers in either the Ministries or Hospitals so they are not in a position to deal with delegated authority even when it has been tried as in St. Vincent and St. Lucia. The project can assist in researching more effective HRM systems and assisting with implementation and the development of HRM skills, viz organization development; personnel management; strategic planning; human resources; logistics; admissions, transfers, discharges, collections; financial management; computer appreciation; basic supervision; and managing change.

Technology and Operating Procedures. There are several and various types of technology that are involved in the operation of the health sector and the issue is one of decision making for cost effective utilization of these various technologies.

Strategic/Operational Planning/Control. There are few organized MOH strategic, program or operational planning processes. Where there has been planning it has been done by outside consultants and not owned by the key actors in the various Ministries. St. Vincent and the Grenadines is a notable exception in that it has developed a Health Sector plan which is participative and collaborative and relates to what is being done in the Ministry.

The project will help develop skills in strategic and operational planning with emphasis on priority planning and resource allocation as well as the development of program evaluation systems.

General Management Systems and Skills. Within the Ministry of Health and the level of the Hospitals a number of general management systems and the corresponding skills are weak and the project will assist in strengthening skills and developing these systems. Illustrative of these systems are performance management; supplies and material management including the development of inventory controls and security systems; maintenance management; and cost accounting systems.

Financial Management Systems and Skills. The Ministry of Health and the Hospital levels are locked into central systems of financial management where once the budget is approved by the Ministry of Finance, there is limited flexibility. There is need for stronger financial management skills as well as improved financial management systems.

The project can assist the improve health management by helping the Ministry of Finance officials to explore "reform options" in which delegation of authority is more acceptable. In addition, training in financial management and hospital financial management is recommended.

Information Systems. Information systems are generally weak at the Ministry of Health and Hospital levels with human resource, financial and epidemiological data not being available on a timely cost effective basis to allow for decision making.

The project will address aspects of the development of improved management information systems at both Ministry of Health and Hospital levels.

Coordinating Mechanism. Because the effective delivery of health care is a complex activity and calls for liaison at an inter/intra-sectoral level as well as private public sector cooperation and rationalization, it is crucial that improved coordinated mechanisms be developed within Ministries of Health in the Eastern Caribbean.

Through policy symposia, ongoing dialogue, studies, training programs and the development of collaborative planning systems, among others, the project can assist in strengthening the capacities of Ministries of Health to better coordinate the health agenda.

Implications of the Systems Improvement Agenda. The analysis of the nature of the public management systems of the OECS in general and the Ministries of Health and Hospitals in particular verify that the following general areas should be addressed by the project.

- . Policy research and diagnosis in support of policy analysis in addition to assisting health managers to develop policy analysis skills.

- . Action research and organisation development in which new management systems and approaches are examined and implemented.
- . Policy symposia workshops and management training in support of the policy dialogue and systems change and improvement.
- . Documentation and dissemination of all aspects of the project to ensure "institutional memory" and "possible replication" of successes in other countries.

5. Choice of Priority Countries for Phasing Activities of the Project

Since all OECS countries are not at the same stage or readiness, there will be different levels of intensity of project activities as appropriate in respective countries. The choice of countries for specific interventions will await country assessment and diagnosis of the implementing agency, but some criteria for choice of country is suggested.

- . Commitment to carrying out policy reform in the health care Financing area.
- . Commitment to involvement in the project by key members of the political and managerial directorate as demonstrated by formal ratification of agreements to implement the project.
- . Existence of an Administrative Reform or improvement program with a record that demonstrates some readiness for change.
- . Commitment to appointing a mutually acceptable National Coordinator for the project.
- . The stage of development and implementation of Health Care Financing reforms in respective countries.

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Annex H. The Public Sector Environment in the Caribbean

1. Global, Regional and National Trends

Caribbean public sectors in general and the OECS countries in particular are facing a period of rapid change and great turbulence in which the truths and paradigms of yesterday are not valid or useful in the decade of the nineties.

During the decade of the eighties, OECS countries in the main went through a period of sustained growth and development in which the economies expanded; external debt was kept under relative control for the most part and improved economic management characterized most of the countries.

The tourism and agricultural sectors were the major contributors to growth. Allied to this economic growth however were a number of "change pressures". These pressures have impacted directly on the physical and social infrastructure in the OECS and provided major challenges to the public sector. We may summarize these "pressures" thus:

Physical Infrastructural Pressures. During the 80s, physical infrastructure was greatly improved in various islands; nevertheless it is expected that within the next three to four years increasing demand will put pressure on port and airport facilities, ground transportation, water, etc., and the public managers and management systems will have to respond.

Social Service Pressures. There were also extraordinary pressures on the delivery of social services especially in the areas of education and health. In the case of the health services, they were (are) faced with the increased inflow of tourists which tended to stretch the system inordinately. It was agreed that only creative policy making, careful planning and implementation by public officers at all levels could alleviate the problems in the social sector and this calls for improved skills and competence of these officers.

Increasing Concern for the Integrity of the Natural Environment. The increasing concern for the environment was another change pressure for every sector of Caribbean society since it affects agriculture, tourism, industry, health, education, etc. This meant that managers in the public sector had to become more environmentally aware.

Rapid Shifts in Technology, Especially Computer Applications and Communications. The extent to which public managers can interpret changes in technology and help the public sector to adapt to these change will affect every other aspect of development. In this regard the challenge for OECS public managers was/is to be able to manage "technology" and "change" with knowledge of how to introduce rapid change in relatively stable systems.

While various OECS public sectors have gone some distance in the introduction and use of computers, they still lag behind in terms of the decentralization of these technologies in the various ministries and departments and there is need for extensive "computer appreciation" and "application" skills throughout all levels of the public sector, as well as the greater integration of these modern technologies into the key areas of government.

Disaster Management. There is a growing awareness of the impact of disasters on Caribbean societies to say nothing of the growing threats of hurricanes, oil spills, etc. Disaster management now has to be factored into all aspects of Caribbean life and especially in the public sector. This area of disaster management calls for planning, coordination and problem solving mechanisms and skills and is another area of some concern among OECS Governments.

Privatization. Caribbean public sectors in general and OECS public sectors in particular have come under growing pressure to privatize various aspects of traditional Government preserves. These pressures were partly international, but also emanated from regional and national interests which pointed to the poor performance of both public enterprises and some Government departments.

Economic Pressures. The pressures for privatization are also embodied in a series of measures called structural adjustment programs which are aimed at creating what was seen as a more efficient framework for resources allocation in the respective countries. The Structural Adjustment pressures were brought about by a confluence of many forces including the increasing debt burden of some countries, the rising price of oil, the growth of large trading blocs and the imminent removal of subsidized or protected markets. Structural adjustment calls for consideration of new policy options, new relationships between private and public sector and a range of new management arrangements.

Overall Pressures for Increased Revenue Earning and Collection. The economic pressures also provided both threats and opportunities for among others the diversification of economic activity, export development thrusts, tourism promotion, development of regional and extra-regional markets; the need to better access international financial flows and improved revenue generation and collection. These challenges called for flexible, strategically oriented, effective and facilitative public sectors to prosecute such an agenda as well as the ability of politicians and public managers to do effective policy analysis.

The Need for Regional Unity. All of the foregoing pressures have also heightened and accelerated the debate on regional unity in general and OECS unity in particular and a range of economic and administrative measures have evolved. While the Windward sub-region of the OECS is now engaged in a broad based debate on political unification.

Rising Expectations. An underlying element of the other pressures is an explosion of rising expectations fuelled by Caribbean immigration patterns and linkages to North America, the contact with tourism, the telecommunications revolution to name a few.

2. Implications

Given these change pressures or challenges the management and performance capacity of the OECS public sectors has become critical if the various governments are going to be able to follow the strategies as articulated by members of both the political and managerial directorates within the OECS countries. Implications include, inter alia:

Developing the Appropriate Policy Framework for Sustainable Economic Development of the Islands. This project can help by the kind of policy research, policy analysis and discussion to help frame the appropriate health financing policy decisions among the OECS countries.

Maintaining Social and Political Stability.

- . Regional unity
- . Improving the delivery capability of the public service
- . The project can also assist the OECS countries in improving various dimensions of the management of their health care delivery systems
- . Researching the effectiveness of management systems.
- . Strengthening of the management systems of MOHs and hospitals.
- . Strengthening of the managerial skills of health personnel.
- . Assisting health managers to introduce computers and other modern information technologies.

Developing the People and Ensuring Their Fullest Participation in Economic and Social Life of the Respective Countries. The project can contribute in this regard by programs of "social marketing" as well as other public education programs aimed at getting the populations of OECS countries more cognizant of the various underlying health care economic choices.

The project can also assist with getting more private sector involvement in the health care systems by the provision of relevant studies, facilitating dialogue between private and public sectors and assisting in systems change activities.

Annex I. Detailed Project Costs

- I-1. Project Costs
- I-2. Host Government Contributions
- I-3. Summary of Technical Assistance Allocation

Table I.1 Health Care Policy Planning & Management Project (HCPPM)
Project Costs (US\$)

	Unit Cost	Year One		Year Two		Year Three		Year Four		Year Five		Year Six		Total	
		Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost
I. HPMU(Staff & Operating Exps)			\$160,770		\$186,660		\$217,850		\$243,400		\$254,600		\$267,200		\$1,330,480
Project Director	\$3,333	11	\$36,667	12	\$42,000	12	\$44,400	12	\$47,200	12	\$50,400	12	\$54,000	71	\$274,667
Economist	\$2,500	9	\$22,500	12	\$31,500	12	\$33,300	12	\$35,400	12	\$37,800	12	\$40,500	69	\$201,000
Health Mgt	\$2,500	0	\$0	0	\$0	6	\$16,650	12	\$35,400	12	\$37,800	12	\$40,500	42	\$130,350
Administrative Officer	\$2,083	10	\$20,833	12	\$25,250	12	\$27,750	12	\$29,500	12	\$31,500	12	\$33,750	70	\$169,583
Secretary	\$1,250	10	\$12,500	12	\$15,750	12	\$16,650	12	\$17,700	12	\$18,900	12	\$20,250	70	\$101,750
Photocopier	\$5,000	1	\$5,000	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$5,000
Fax machine	\$800	1	\$800	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$800
Rent per month	\$1,000	10	\$10,000	12	\$12,000	12	\$12,000	12	\$12,000	12	\$12,000	12	\$12,000	70	\$70,000
Phone Calls/taxes per mth	\$700	11	\$7,700	12	\$8,400	12	\$8,400	12	\$8,400	12	\$8,400	12	\$8,400	71	\$49,700
Utilities/month	\$200	10	\$2,000	12	\$2,400	12	\$2,400	12	\$2,400	12	\$2,400	12	\$2,400	70	\$14,000
Office Supplies/ year	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	1	\$5,000	6	\$30,000
Executive desk/char	\$900	1	\$900	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$900
Professional desk/char	\$800	4	\$3,200	2	\$1,600	0	\$0	0	\$0	0	\$0	0	\$0	6	\$4,800
Secretarial desk/char	\$850	1	\$850	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$850
Conference table/10 chars	\$1,500	1	\$1,500	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$1,500
Courier/Postage	\$300	9	\$2,700	12	\$3,600	12	\$3,600	12	\$3,600	12	\$3,600	12	\$3,600	69	\$20,700
Airfares	\$150	18	\$2,700	24	\$3,600	30	\$4,500	24	\$3,600	24	\$3,600	24	\$3,600	144	\$21,600
Per diems	\$160	144	\$23,040	192	\$30,720	240	\$38,400	240	\$38,400	240	\$38,400	240	\$38,400	1296	\$207,360
Transport	\$20	144	\$2,880	192	\$3,840	240	\$4,800	240	\$4,800	240	\$4,800	240	\$4,800	1296	\$25,920
Contingencies(5%)			\$8,039		\$9,333		\$10,893		\$12,170		\$12,730		\$13,360		\$66,524
Inflation(2.75%)			\$4,421		\$5,133		\$5,991		\$6,694		\$7,002		\$7,348		\$38,588
TOTAL FOR LINE ITEM I			\$173,230		\$201,126		\$234,733		\$262,264		\$274,332		\$287,908		\$1,433,592
II TECHNICAL ASSISTANCE (includes salary, per diems, etc)			\$462,993		\$766,186		\$776,178		\$562,424		\$428,878		\$232,435		\$3,229,093
Regional Short Term Consultant	\$15,413	5	\$77,063	8	\$123,300	10	\$154,125	11	\$169,538	8	\$123,300	8	\$123,300	50	\$770,625
Contingencies(5%)			\$3,853		\$6,165		\$7,706		\$8,477		\$6,165		\$6,165		\$38,531
Inflation(2.75%)			\$2,119		\$3,391		\$4,238		\$4,662		\$3,391		\$3,391		\$21,192
Sub - Total			\$83,035		\$132,856		\$166,070		\$182,677		\$132,856		\$132,856		\$830,346
US Long Term	\$20,833	7	\$145,833	12	\$250,000	11	\$229,167	0	\$0	0	\$0	0	\$0	30	\$625,000
US Short Term Consultants	\$21,827	11	\$240,097	18	\$392,886	18	\$392,886	18	\$392,886	14	\$305,578	5	\$109,135	84	\$1,833,468
Contingencies(5%)			\$19,297		\$32,144		\$31,103		\$19,644		\$15,279		\$5,457		\$122,923
Inflation(2.75%)			\$10,613		\$17,679		\$17,106		\$10,804		\$8,403		\$3,001		\$67,608
Sub - Total			\$415,840		\$692,710		\$670,262		\$423,335		\$329,260		\$117,593		\$2,648,999
TOTAL FOR LINE ITEM II			\$498,875		\$825,565		\$836,331		\$606,011		\$462,116		\$250,449		\$3,479,348

	Unit Cost	Year One		Year Two		Year Three		Year Four		Year Five		Year Six		Total	
		Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost
III. COMMODITY SUPPORT			\$31,300		\$31,000		\$22,000		\$2,000		\$2,000		\$2,000		\$90,300
A. Computers			\$29,300		\$29,000		\$20,000		\$0		\$0		\$0		\$78,300
1. Desktop-HPMU	\$2,000	3	\$6,000	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	3	\$8,000
2. Laptop-HPMU	\$1,800	4	\$7,200	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	4	\$7,200
3. Software-HPMU	\$400	14	\$5,600	5	\$2,000	5	\$2,000	0	\$0	0	\$0	0	\$0	24	\$9,600
4. Printer-HPMU	\$1,500	1	\$1,500	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0	1	\$1,500
5. Systems-HGs	\$9,000	1	\$9,000	3	\$27,000	2	\$18,000	0	\$0	0	\$0	0	\$0	6	\$54,000
Contingencies(5%)			\$1,465		\$1,450		\$1,000		\$0		\$0		\$0		\$3,915
Inflation(2.75%)			\$806		\$798		\$550		\$0		\$0		\$0		\$2,153
Sub-Total			\$31,571		\$31,248		\$21,550		\$0		\$0		\$0		\$84,368
B. Reference Materials			\$2,000		\$2,000		\$2,000		\$2,000		\$2,000		\$2,000		\$12,000
1. Journals	\$1,000	1	\$1,000	1	\$1,000	1	\$1,000	1	\$1,000	1	\$1,000	1	\$1,000	6	\$6,000
2. Books	\$500	1	\$500	1	\$500	1	\$500	1	\$500	1	\$500	1	\$500	6	\$3,000
3. Other	\$500	1	\$500	1	\$500	1	\$500	1	\$500	1	\$500	1	\$500	6	\$3,000
Contingencies(5%)			\$100		\$100		\$100		\$100		\$100		\$100		\$600
Inflation(2.75%)			\$55		\$55		\$55		\$55		\$55		\$55		\$330
Sub-Total			\$2,155		\$2,155		\$2,155		\$2,155		\$2,155		\$2,155		\$12,930
TOTAL FOR LINE ITEM III			\$33,726		\$33,403		\$23,705		\$2,155		\$2,155		\$2,155		\$97,298
IV TRAINING			\$102,720		\$128,580		\$223,180		\$223,160		\$223,180		\$93,860		\$994,640
A. US course	\$12,000	2	\$24,000	2	\$24,000	4	\$48,000	4	\$48,000	4	\$48,000	0	\$0	16	\$192,000
Contingencies(5%)			\$1,200		\$1,200		\$2,400		\$2,400		\$2,400		\$0		\$9,600
Inflation(2.75%)			\$660		\$660		\$1,320		\$1,320		\$1,320		\$0		\$5,280
Sub-Total			\$25,860		\$25,860		\$51,720		\$51,720		\$51,720		\$0		\$208,880
B. Regional course	\$3,000	0	\$0	4	\$12,000	8	\$24,000	8	\$24,000	8	\$24,000	4	\$12,000	32	\$96,000
Contingencies(5%)			\$0		\$600		\$1,200		\$1,200		\$1,200		\$600		\$4,800
Inflation(2.75%)			\$0		\$330		\$660		\$660		\$660		\$330		\$2,640
Sub-Total			\$0		\$12,930		\$25,860		\$25,860		\$25,860		\$12,930		\$103,440
C. Workshop	\$17,000	3	\$51,000	3	\$51,000	4	\$68,000	4	\$68,000	4	\$68,000	4	\$68,000	22	\$374,000
Contingencies(5%)			\$2,550		\$2,550		\$3,400		\$3,400		\$3,400		\$3,400		\$18,700
Inflation(2.75%)			\$1,403		\$1,403		\$1,870		\$1,870		\$1,870		\$1,870		\$10,285
Sub-Total			\$54,953		\$54,953		\$73,270		\$73,270		\$73,270		\$73,270		\$402,985
TOTAL FOR LINE ITEM IV			\$80,813		\$93,743		\$150,850		\$150,850		\$150,850		\$88,200		\$713,305

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	Unit Cost	Year One		Year Two		Year Three		Year Four		Year Five		Year Six		Total	
		Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost	Units	Cost
V. PROJECT MGMT. (FDO/C)	\$80,000	1	\$80,000	1	\$80,000	1	\$80,000	1	\$80,000	1	\$80,000	1	\$80,000	6	\$480,000
Contingencies(5%)			\$4,000		\$4,000		\$4,000		\$4,000		\$4,000		\$4,000		\$24,000
Inflation(2.75%)			\$2,200		\$2,200		\$2,200		\$2,200		\$2,200		\$2,200		\$13,200
TOTAL FOR LINE ITEM V			\$86,200		\$86,200		\$86,200		\$86,200		\$86,200		\$86,200		\$517,200
VI. EVALUATION/AUDIT			\$9,609		\$45,000		\$84,000		\$9,000		\$9,000		\$84,000		\$240,609
A. Evaluation	\$75,000	0	\$0	0	\$0	1	\$75,000	0	\$0	0	\$0	1	\$75,000	2	\$150,000
Contingencies(5%)			\$0		\$0		\$3,750		\$0		\$0		\$3,750		\$7,500
Inflation(2.75%)			\$0		\$0		\$2,083		\$0		\$0		\$2,083		\$4,125
Sub - Total			\$0		\$0		\$80,813		\$0		\$0		\$80,813		\$161,625
B. Audit	\$45,000	0	\$9,609	1	\$45,000	0.2	\$9,000	0.2	\$9,000	0.2	\$9,000	0.2	\$9,000	1.8	\$90,609
Contingencies(5%)			\$480		\$2,250		\$450		\$450		\$450		\$450		\$4,530
Inflation(2.75%)			\$265		\$1,238		\$248		\$248		\$248		\$248		\$2,493
Sub - Total			\$10,354		\$48,488		\$9,698		\$9,698		\$9,698		\$9,698		\$97,632
TOTAL FOR LINE ITEM VI			\$10,354		\$48,488		\$90,510		\$9,698		\$9,698		\$90,510		\$259,257
PROJECT TOTAL			\$883,197		\$1,288,524		\$1,422,330		\$1,117,177		\$985,350		\$803,422		\$6,500,000

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BUDGET ASSUMPTIONS:

I. HPMU--Base salaries (annual)

Project Director	\$40,000 /yr
Local Economist	\$30,000 /yr
Local Health Mgt.	\$30,000 /yr
Local Fin. Analyst	\$25,000 /yr
Local Secretary	\$15,000 /yr

II.(a) Regional Consultant \$15,413 /mo, including all costs

One person month regional TA, loaded	
27 days @ \$225	\$9,113 (includes 50% Overhead)
Air, per diem, transport	\$6,050
Phone/fax/courier, Misc.	\$250
Subtotal:	\$15,413

II.(b) US Technical Assistance

Long Term Advisor	\$20,833 /mo, including all costs
One person year LTA	
260 days @ \$265	\$130,910 (includes 90% Overhead)
Air, per diem, transport	\$21,800
Miscellaneous, Post Allowances	\$97,290
Subtotal:	\$250,000

II. (c) Short Term Consultants \$21,827 /mo, including all costs

One person month expat TA, loaded	
27 days @ \$275	\$14,877 (includes 90% Overhead)
Air, per diem, transport	\$6,700
Phone/fax/courier/Misc	\$250
Subtotal:	\$21,827

III A. Computer Systems:

- 1 486, 2 386s--HPMU
- 1 laser printer--HPMU
- 4 laptop/notebook computers for field use by HPMU Staff and consultants
- 1 486, 1 printer -- host governments
- 8 pieces of software

III B. Reference materials include journal subscriptions, books/materials to be purchased for host governments.

IVA. U.S. course covers all expenses (tuition, room & board, medical, domestic airfare) for 12 week course

Regional course covers all expenses for 3 week course

IVC. Workshop costs include all expenses (facility rentals, materials, per diems) exclusive of TA costs.

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Table I.2 Health Care Policy Planning and Management Project
Host Government Contributions
(US\$)

Personnel -----	Annual Salary	% of time on HCPPM	Annual Contrib	LOP Contrib	# of Countries	# of Personnel	TOTAL LOP	ALLOCATION TO COMPONENTS		
								#1	#2	#3
National Coordinator	\$14,400	25%	\$3,600	\$21,600	8	1	\$172,800	60,480	95,040	17,280
Permanent Secretary	\$15,600	10%	\$1,560	\$9,360	8	1	\$74,880	14,976	56,160	3,744
Hosp Administrator	\$12,000	10%	\$1,200	\$7,200	8	1	\$57,600	11,520	43,200	2,880
Other staffing	\$10,000	15%	\$1,500	\$9,000	8	5	\$360,000	90,000	270,000	0
Subtotal Personnel, for region							\$665,280			
Training Courses -----										
U S –based courses, participants =		16								
Airfare	\$500			\$8,000						
3 month salary	\$14,400	25%	\$3,600	\$57,600						
Regional courses, participants =		44								
3 week salary	\$14,400	6%	\$864	\$38,016						
Subtotal, training for region:							\$103,616			103,616
Health education campaigns (8) -----										
Printing of materials	\$2,000	8	\$16,000							
Radio time	\$2,282	8	\$18,258							
Other	\$1,000	8	\$8,000							
Subtotal, health education for region:							\$42,258		42,258	
TOTAL HOST GOVERNMENT CONTRIBUTIONS:							\$811,154	176,976	506,658	127,520

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TABLE I3: Health Care Policy Planning & Management
 ALLOCATION OF TECHNICAL ASSISTANCE
 U.S. and Regional Sources

ACTIVITY	LOE in PM	#	Total LOE	USTA	RegTA	Total	Component
Brief Assessment	0.50	3.00	1.50	0.00	1.50	1.50	I
Long assessment	1.50	5.00	7.50	4.00	3.50	7.50	I
Cost study	3.00	4.00	12.00	8.00	4.00	12.00	I
Demand study	6.00	2.00	12.00	8.00	4.00	12.00	I
Focus groups	0.50	4.00	2.00		2.00	2.00	I
Insurance feasibility	2.00	3.00	6.00	6.00		6.00	I
Hospital management	6.00	3.00	18.00	12.00	6.00	18.00	II
Resource allocation	1.50	2.00	3.00	1.50	1.50	3.00	II
User fee pilot	5.00	2.00	10.00	6.67	3.33	10.00	II
Mgmt reform	5.00	3.00	15.00	10.00	5.00	15.00	II
Health planning	2.00	2.00	4.00	1.33	2.67	4.00	II
Privatization	6.00	1.00	6.00	4.00	2.00	6.00	II
Insurance	4.00	1.00	4.00	4.00		4.00	II
MOH policy w/s	1.00	8.00	8.00	4.00	4.00	8.00	III
Consensus bldg	1.50	8.00	12.00	6.00	6.00	12.00	III
Regional W/s	1.50	6.00	9.00	4.50	4.50	9.00	III
Public Ed campaign	2.00	2.00	4.00	4.00		4.00	II
TOTAL			134.00	84.00	50.00	134.00	
Long Term Advisor	30.00	1.00	30.00	30		30.00	
			164				

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10/10/2014



U.S. AGENCY FOR
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DEVELOPMENT

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29 JUL 1992 14 20

LAC-IEE-92-40

REQUEST FOR A CATEGORICAL EXCLUSION

Project Location : Eastern Caribbean

Project Title : Health Care Policy Planning
and Management

Project Number : 538-0181

Funding : \$6.5 million

Life of Project : 6 years (FY 92-FY 98)

IEE Prepared by : Samuel Dowding, RDO/C
HPE/Senior Health Advisor

Recommended Threshold Decision: Categorical Exclusion

Bureau Threshold Decision : Concur with Recommendation

Comments : None

John O. Wilson Date JUL 16 1992
 John O. Wilson
 Deputy Chief Environmental Officer
 Bureau for Latin America
 and the Caribbean

Copy to : Mosina Jordan, Director
RDO/C

Copy to : Samuel Dowding
RDO/C/HPE

Copy to : Larry Armstrong
Deputy Director, RDO/C

Copy to : Gerald Cashion, C/PDO

Copy to : Drew Luten, RLA

Copy to : Emily McPhie, AC/PRGM

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