

**HEALTH FINANCING  
AND SUSTAINABILITY PROJECT  
STRATEGY**

**Submitted to:**

**Health Services Division  
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**Health Financing and Sustainability (HFS) Project  
Abt Associates Inc., Prime Contractor  
4800 Montgomery Lane, Suite 600  
Bethesda, Maryland, 20814 USA  
Tel: (301) 913-0500 Fax: (301) 652-7791  
Telex: 312636**

**Management Sciences for Health, Subcontractor  
The Urban Institute, Subcontractor  
Clark Atlanta University, Subcontractor  
Tillinghast, a Towers Perrin Company, Subcontractor**

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# HEALTH FINANCING AND SUSTAINABILITY PROJECT STRATEGY

## INTRODUCTION

This strategy paper is intended to guide the operations of the Health Financing and Sustainability (HFS) Project. The strategy will be organic. Its implementation will adapt and change in light of circumstances and opportunities. It begins by stating the project's view of the health financing problem in less developed countries (LDCs) and then describes the five focus technical areas for the project. The resources available to the project are laid out in the following section. The project's approach to the problem is next explained by delineating its purposes and expected outcomes. The following section describes the four types of activities the project will undertake. The last section details the project's implementation plans, including criteria for selecting opportunities to pursue and plans for using project resources.

The HFS Project is a five year effort by the U.S. Agency for International Development (A.I.D.) to assist LDCs to improve the financial status and efficiency of their health sectors. It addresses key financial policy and organizational constraints hindering the ability of developing countries to provide access to health services of acceptable quality for all citizens.

## HEALTH FINANCING IN DEVELOPING COUNTRIES

### THE PROBLEM

Most developing country governments have economic and physical access to services of an acceptable quality as objectives for their health sectors. This typically means high levels of coverage of preventive and promotive services, effective public health activities, and access to basic curative health care regardless of ability to pay. In practice, a narrow financial base, extremely constrained and variable availability of resources, and inefficient use of those resources cause many countries' health sectors to fall short of this ideal. LDCs often rely heavily (sometimes exclusively) on government provision and financing of health services. Resources in general are limited, and allocations to the health sector more so in many countries. What is achieved with the limited resources is suboptimal. Available resources often are not allocated efficiently among components of health programs nor within the components. Moreover, when faced with declining economic conditions, many governments have reduced their commitment to the health sector and, in so doing, have increased inefficiencies. An indicator of the extreme limits on government financing of health services and the accompanying inefficiencies is the disproportionate share of total spending going to salaries of health workers.

The difficult financial condition of LDC health sectors has exacerbated a large number of problems. The resources that are available often are not used efficiently. Funds have been concentrated on the operation of hospitals, at the expense of preventive and outpatient care. Over-utilization and inappropriate use of expensive specialized services exist alongside under-use and under-funding of more cost-effective basic services. The reliance on financially-weak governments as the primary providers and financial supporters is compounded by governments' lack of capacity to plan and allocate resources efficiently.

Further, the strong government role in providing and financing health services frequently adversely affects the financial viability of private providers. Compounding this situation is the inability of health policymakers to devise and implement solutions to the financial constraints of the health sector.

To attain and sustain achievement of health sector goals, financial and organizational policies must be developed and implemented to broaden the financial base, increase resource availability, and improve efficiency. Concurrently, the effects of the policy and organizational changes on quality and distribution of access to services must be monitored. Further, the capacity of health-sector policymakers and analysts to analyze, formulate, implement, and modify financial and organizational policies must be strengthened. A summary of the project's view of how health services currently are financed in LDCs, and how the situation could be changed through the application of improved policies is shown in Appendix A.

These issues have received increasing attention in the past decade. LDCs and donors alike have recognized the need for attending to the financing of the health sector. As a wide variety of alternative policy initiatives has been tested and evaluated, there has been widespread acceptance of several components of the health financing tool kit. The resulting policy and organizational reforms have been popular for their ability to permit the delivery of more and higher quality care at lower cost. However, questions remain about some financing initiatives and the replicability of successes under different conditions and in other settings. Moreover, many LDC policymakers are unaware of successful initiatives to confront problems similar to their own and have little opportunity to learn about them.

The HFS project will assist LDCs in policy and organizational reform to improve health financing using the tested and successful tools. These include implementation of user charges for government-provided services, budgeting and planning methods, management improvements, etc. It will conduct applied research to answer key questions about unproven tools. These include pre-payment systems, methods for waiving fees for those with limited ability to pay, and managed-care arrangements, among others. Additionally, HFS will assist public and private LDC institutions in improving their capability to employ and test new policies. HFS efforts will focus on the following technical areas:

#### FOCUS TECHNICAL AREAS

In general, the health financing initiatives that are the focus of this project have two aims. They are intended to increase the available revenues for the health sector by sharing the burden now principally shouldered by the government, and to increase the efficiency of resource allocation and use. At the same time there is concern that policy choices take into account effects on equity of physical and economic access and the quality of services.

The project will focus on five technical areas. These five areas actually constitute four overlapping and interlocking categories of approaches to health financing policy, and one set of analytical techniques, costing and production. The latter will be used in the analysis accompanying each of the categories of approaches. In different settings, each of the four approaches (resource

generation through cost recovery, social financing of demand, public-private collaboration, and resource allocation, use, and management) will be appropriate ways to address health financing problems, alone or in combination. HFS will apply an approach or combination of approaches in a given country depending on the project's, host government's, and USAID's joint assessment of the relative costs and benefits of each.

The areas of priority that fall under each technical area, the main issues and constraints identified for each, and the project's approach to them are summarized in Appendix B. How the focus technical areas fit into the overall health financing situation is shown in Appendix A.

### 1. RESOURCE GENERATION

Initiatives designed to secure more resources for the health sector are of major importance. Governments have a limited ability to support the health system through tax revenues. Government resources may be increased by the introduction of user charges, including mechanisms for routine collection, administration and management of fee revenues, development of pricing schemes, and incentives to encourage facilities to collect fees.

### 2. SOCIAL FINANCING

Social financing (insurance) initiatives can spread the risk and the burden of health care among rich and poor, sick and well. Project-assisted initiatives in this area may include public and private insurance programs, community and drug revolving funds, prepayment schemes, extending urban insurance programs to rural areas, insurance as a means of quality and price control, catastrophic coverage, and facilitating the development of managed care arrangements such as health management organizations (HMOs).

### 3. PUBLIC-PRIVATE COLLABORATION

The resources of the private sector frequently are under-appreciated and under-utilized in LDC health sectors. The project will assist governments to identify private-sector resources and how they may be used to meet health-sector needs. Policies designed to stimulate private sector involvement will include provisions to ensure that private-sector behavior will be influenced to contribute towards sector goals. Such policies would eliminate legal and other restrictions and promote a competitive marketplace. Other policies may develop arrangements for private management of public facilities or services, encourage private involvement in insurance and managed care systems, and stimulate employer-based health services, particularly their provision of preventive and curative services.

#### 4. RESOURCE ALLOCATION, USE, AND MANAGEMENT

All resources, whether generated from traditional or new sources, private or public, should be used efficiently. Initiatives in this area may include measures to contain costs, improvements in drug procurement, distribution, and management, human-resources and budgetary analyses, improvements in budgeting and control systems, applications of tools for financial management, and cost-benefit analyses of public health programs.

#### 5. HEALTH SERVICES PRODUCTION AND COSTS

Any changes in a health system require a base of information on how and at what cost the sector operates. Such information is generated through estimates of costs in public and private facilities, cost analysis of packages of services, examination of costs of alternative arrangements for service delivery, private sector examples of cost containment and efficiency, and cost-benefit and cost-effectiveness analyses. This area also encompasses assistance in the design and use of management and financial information systems (MIS and FMIS). This will permit health-system managers to have routine access to cost and other information needed to improve efficiency.

#### HFS PROJECT RESOURCES

The HFS project has financial, personnel, and institutional resources at its disposal to allocate toward the pursuit of this strategy. The value of the HFS contract is \$16.5 million over the five years from September 1989 to September 1994. The project's staff is supplemented by resources of the five partner institutions and a roster of consultants.

The \$16.5 million of funding is divided roughly 50-50 between "central" funding through A.I.D./S&T/Health and "buy-ins" from USAIDs and A.I.D./Washington bureaus. This means that a large fraction of field activities must be paid for by USAID-generated and funded requests. "Central" funds must be allocated to project management and activities that do not generate USAID or bureau demand.

The staff of the project (listed in Appendix C) includes the Director; three Deputies, technical specialists, and operations and administrative staffs. Operations are organized along the lines of A.I.D.'s regions, Africa (AFR), Asia-Near East (ANE), and Latin America and the Caribbean (LAC).

The partner institutions, Abt Associates Inc., The Urban Institute, Management Sciences for Health, Clark Atlanta University, and Tillinghast a Towers Perrin company, provide a pool of technical personnel in economics, financing, planning, management, business, and training through their staffs and access to consultants. The project has a mandate to work with host-country personnel, both as counterparts and as project consultants. Host-country personnel are expected to conduct most of the smaller applied research activities and fill many of the long-term technical assistance advisor positions.

## HFS PROJECT OPERATION

### GENERAL APPROACH

The emphasis of the HFS project is on the development and implementation of financing policies and organizational arrangements that will contribute to sustainable health services of acceptable quality for all segments of the population. Thus, the project gives precedence to assistance with permanent policy changes with long-term effects, over activities for short-term relief of immediate problems. In this regard, the HFS project will focus on the development of institutional capacity within assisted countries to produce and implement health financing changes.

An underlying assumption is that the evidence from recent work around the world and the country-specific analytical work performed by the project will persuade national leaders of viable alternatives to traditional health financing systems. These alternative policies will aim to increase the quantity and quality of health care for target populations.

Given the dynamic state of the world and rapid change in health technology, however, no static set of policies can be considered sustainable. Hence, a high priority of this project is to develop the institutional ability to adapt financing policies to changing conditions and to preserve efficiency and desired equity outcomes.

In addition to its work in LDCs, HFS is the principal technical resource on health financing for the Office of Health of A.I.D.'s Science and Technology (S&T) Bureau. At the request of S&T, HFS will answer technical questions, provide input into policy statements, and represent A.I.D. in the field of health financing.

### PURPOSES AND OUTCOMES

This approach has implications for the specific purposes of the project. The project will concentrate its activities in a limited number of countries. Within those countries, the project intends to:

- Influence policy change
- Assist in policy implementation
- Demonstrate and/or evaluate the effect of alternative financing policies and mechanisms
- Determine potential adaptability or replicability of policies and organizational arrangements in other settings

Hence, HFS intends to achieve changes in health-financing policy in its emphasis countries. Further, the project will demonstrate and test the policies in those countries that advance to the stage of implementation.

The project's assistance is expected to produce the following outcomes:

- Increased understanding of policy alternatives by public and private policy makers
- Understanding and use of effective financing policy tools
- Strengthened partnerships between the public and private sectors
- Understanding and use of diagnostic and financial management tools
- Country-specific operational plans for reform of financing policy, including: design, implementation, applied research, demonstration projects, monitoring, and evaluations
- Analysis of effects of policy reforms on target populations and formulation of policy modifications
- Recommendations for further policy initiatives, applied research and demonstrations
- More and better information about what works and what does not in the hands of policymakers, analysts, and researchers in LDCs and the developed world
- Research, analysis, and consulting skills developed among collaborating host-country personnel

#### PROJECT ACTIVITIES

To achieve these outcomes the project will undertake four types of activities: technical assistance, applied research, information dissemination, and training. The project's applied research will be carried out mainly in settings where technical assistance is provided. The effort to combine research and technical assistance will be beneficial to both. Research will be practically oriented, technical assistance will be better informed, and the array of technical solutions and confidence in their applicability in various contexts are expected to grow.

#### TECHNICAL ASSISTANCE

Project technical assistance (TA) will provide guidance and expertise to A.I.D. Bureaus, USAIDs, and host country institutions. The goal of TA is to assist in problem identification, diagnosis, analysis, and policy improvement and implementation. Through on-the-job training of local counterparts, the capacity to analyze health finance issues and implement reforms, and to improve national, sectoral and operational policies will grow. Major TA activities will include:

POLICY DIALOGUE to improve understanding of policy options for health financing, leading to policy initiatives

DIAGNOSIS and ANALYSIS using tested techniques and approaches to identify and quantify problems and formulate and evaluate policy responses

IMPLEMENTATION of new policies including pilot testing, systems design, monitoring, and evaluation

#### APPLIED RESEARCH

The underlying principle in choosing topics to pursue in HFS's applied research program will be to seek to advance knowledge in areas which are likely to have the greatest impact on sustained improvement in health status. Specifically, project AR is intended to advance knowledge concerning the advantages and disadvantages of untested health financing initiatives, especially as they affect equity, efficiency, and quality of care. In addition, AR will seek to determine the adaptability or replicability of initiatives in other socio-economic settings. It will complement technical assistance by conducting both major and smaller policy focused studies to evaluate the results of policy interventions and provide guidance on future changes. This includes:

EVALUATION of health financing initiatives to determine the extent to and conditions under which they have been effective in improving financing of the sector

GUIDANCE on future policy interventions, including studies conducted to inform policy decisions and to assist in designing and supporting other activities, and research in conjunction with pilot projects

#### INFORMATION DISSEMINATION

The information dissemination component seeks to attain the broadest possible spread of knowledge about what the project learns about health financing. The new information generated about health financing policies will be disseminated to target audiences. The audiences include LDC policymakers, analysts, and researchers; A.I.D. staff in Washington and Missions; developed-country financing specialists and researchers; other donors' staffs; and PVO personnel. A variety of channels will be used to reach these audiences, including glossy policy briefs, quarterly newsletters, theme papers, reports from project TA and AR, and journal publications.

#### TRAINING

Through its training activities the project will increase the capability of LDCs to diagnose, formulate, implement, and evaluate financing policies. The approach to training primarily is based on on-the-job learning. All in-country activities are intended to include local analysts and researchers as counterparts to external experts. Some long-term TA positions are expected to be filled by local experts. Most smaller AR activities will be conducted by local researchers, with

external guidance and oversight. Workshops will be conducted on research, analysis, and consulting methods in all long-term TA and many short-term TA countries. The project also will support a few specific training activities. These include workshops in countries where major TA and AR activities are undertaken, regional conferences, study tours, and a fellows program to help develop U.S. graduate students' skills and capabilities in health financing.

## IMPLEMENTATION

In the broadest sense, implementation of the HFS project will be motivated by opportunities to attain and sustain improved health status among developing countries' populations through health financing initiatives. The implementation of specific project activities will be guided by the expected outcome of achieving health financing policy change which will contribute to sustained improvement in health status. Priority will be given to opportunities for major long-term policy change. Further, policy change will be sought in all of the focus technical areas, in a variety of socio-economic, cultural, and administrative settings, and in roughly-equal distribution among A.I.D.'s three regions. Project resources will be leveraged to the extent possible by conducting most AR in countries where long-term TA is provided, collaborating with other donors, and working where local political and technical commitment to policy change exist. Thus, the project will favor opportunities to make major impacts over a longer term over discrete TA assignments. The criteria to set priorities among requests for project assistance include both substantive and practical considerations:

### SUBSTANTIVE CRITERIA

**MAXIMUM IMPACT** The project will consider which interventions are likely to have the greatest impact for the level of project resources required. An element of using this criterion is to choose to work in countries where addressing a major constraint would be expected to have an important impact on the health status of the population. However, HFS is likely to have to struggle to be able to define and evaluate its impact. This is so since the ultimate impact of financing policies on health outcomes may come long after the changes are made and be difficult to attribute to the health financing change alone. Further, it is often not enough to change policies, but it is necessary to change practices, which may or may not follow policy. An intermediate indicator of impact may be changes in health sector finances as a result of policy and practice change. This, too, may be difficult to measure during the life of the project. Finally, in applying the criterion of attempting to maximize impact, the achievement of it must be expected to be feasible, i. e., the prospects for success in addressing the identified problem must be judged to be good.

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

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

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

#### PRACTICAL CRITERIA

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

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

**OPPORTUNITIES FOR LEVERAGE** Most major and smaller AR will take place in countries where the project is providing long-term TA. This will permit integration of the two forms of activity and facilitate AR with data gathered for the TA effort. Another form of leveraging is collaboration with other donors. HFS work may build on financing policy initiatives already undertaken by other donors or, HFS may provide technical resources to complement another donor's support for other costs of policy reform, such as the purchase of commodities. Further, HFS's resources are weighted strongly toward analytical, rather than implementation, capabilities. Thus, HFS will be able to provide quite well the analytical underpinnings of financing reforms, but will require complementary resources to perform the nuts and bolts implementation of those reforms (e.g., training of clerical staff of health centers in the handling of the funds generated by user payments). HFS will seek to work in sites where such complementary resources are likely to be forthcoming and will help to identify sources for them in others.

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

There are three ways that major, long-term project activities will be generated:

- Missions express interest in activities, initially in response to the announcement cable and, later, based on familiarity with the project's work and development of circumstances in the country
- The project identifies opportunities of interest for TA or AR work and initiates contact with the Mission
- Short-term work leads to the development of interest in longer-term work by the host government, USAID, and project

In all three cases, assessment trips, funded by core money, will be made by senior project staff and technical experts, sometimes accompanied by the project officer, to promising countries. From the assessment trips, the project will determine the appropriate type of activity to conduct, the likelihood of successful completion, probable amount of resources required, possibilities for collaboration with other donors, availability of funding, and the likely schedule of activities. In choosing opportunities to pursue, the project will seek technical area balance, opportunities for major AR, and possibility of involvement of local analysts and researchers. The project expects all long-term TA and most short-term TA and smaller AR to be funded through USAID buy-ins. Core funds will support much of the major AR.

Country assessments will be conducted using an instrument (see Appendix D) developed by the project staff. The goal of the first round of assessment trips will be to identify three likely long-term TA countries.

The initial assessments are part of a five-year schedule for TA and AR to pace the use of project resources. The project will concentrate on a few countries to achieve maximum impact. Long-term TA and major AR will take place in the same countries as often as possible. Project planning calls for:

- Six assessment trips, two to each region, in the first year; six additional assessment trips, two to each region, conducted in the second and third years
- Six countries where long-term TA and major AR will be combined, complemented by smaller AR
- Two countries with long-term TA complemented by smaller AR

- Three major AR activities independent of long-term TA: the first to set the project research agenda, the second a cross-country study, and the third to synthesize research findings
- Approximately 40 short-term TA activities, sometimes complemented by smaller AR
- Approximately 30 smaller AR activities, about three-quarters in long-term TA countries
- Annual theme papers summarizing TA and AR activities and findings in the five technical focus areas, culminating in a synthesis at the end of the project
- Two regional and three country training workshops

At least one long term TA and one major AR activity will begin in the first year, along with a review of experience in the field of health financing to set the research agenda. Most remaining major long-term activities must begin in the second through fourth years. A major project staff activity in the fifth year will be the synthesis of project TA activities and findings.

The project will accommodate the demand for specific short-term TA as time and budget permit. Decision criteria for accepting requests for short-term TA will be similar, though less rigorous, than those for long-term work. First priority will be given to those assignments that may lead to long-term work. Second priority will go to assignments that have technical content that complements other project work. For example, such assignments might allow the project to do TA or AR work in focus technical areas that otherwise have received little attention.

Initial AR will include major activities in two of the first three long-term TA countries. The AR topics to be pursued will be developed by project staff with advice from the Technical Advisory Group (TAG). The cross-country study is likely to take place about midway through the project. A synthesis of AR findings will be produced at project end.

Smaller AR activities will be identified in all long-term TA countries and funded through buy-ins, with an additional 6-10 smaller AR activities taking place in short-term TA countries.

## APPENDIX A

### Policies to Improve Health Financing in LDCs

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

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

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

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

Governments have many tools available to them to overcome the constraints. Exhibit A.2 shows a stylized picture of what a health system would look like, and how resources and services would flow, after the application of those tools. In addition, Exhibit A.2 shows where the focus technical areas come into play in the process of achieving the desired outcome.

To overcome the constraint of limited resources, the tools of user charges for government provided services, policy changes to allow an expanded role for the private sector, and the institution of management systems with incentives for efficient and effective performance will be used. The former produces resources directly, the latter two result in cost savings for the government.

To address the constraint of lack of tools and criteria for the efficient allocation of resources within the government sector, training and hands-on experience with budgeting and planning techniques that integrate financial and health objectives and constraints will be used.

To improve the efficiency of service delivery, training and hands-on experience will be provided in the use of cost-effectiveness and cost-benefit analyses and management and incentive systems. These tools will allow rational choices, based on the ratios of costs to expected outcomes, to be made about what technologies to use in delivering health services (e.g., ORS versus IV therapy, OPV versus IPV, whether government facilities should spend scarce public resources on expensive procedures that benefit few, like kidney dialysis). In addition, these tools will be used to analyze the advantages and limitations of government versus private provision of various types of services, and the advantages of making policy changes to encourage private organization of social financing mechanisms, as well. Further, the management and incentive systems will allow government facilities to deliver the chosen services at low cost.

The over- and inappropriate use of government-provided services by consumers will be reduced by the setting of the level and structure of user charges. The level of charges may be set to deter frivolous use. Charges may be structured to discourage use of costly services when less costly are appropriate by setting higher prices for more costly services and penalizing the bypass of referral systems.

The constraint of governments' inability to address system constraints through the formulation and implementation of new policies and management systems will be overcome by collaboration among external and local consultants and policymakers and analysts in devising, applying, monitoring, and revising new policies and practices. In addition to hands-on experience, policymakers, analysts, and local consultants can benefit from training and exposure to technical advances and implementation experiences elsewhere via information dissemination.

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

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

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

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

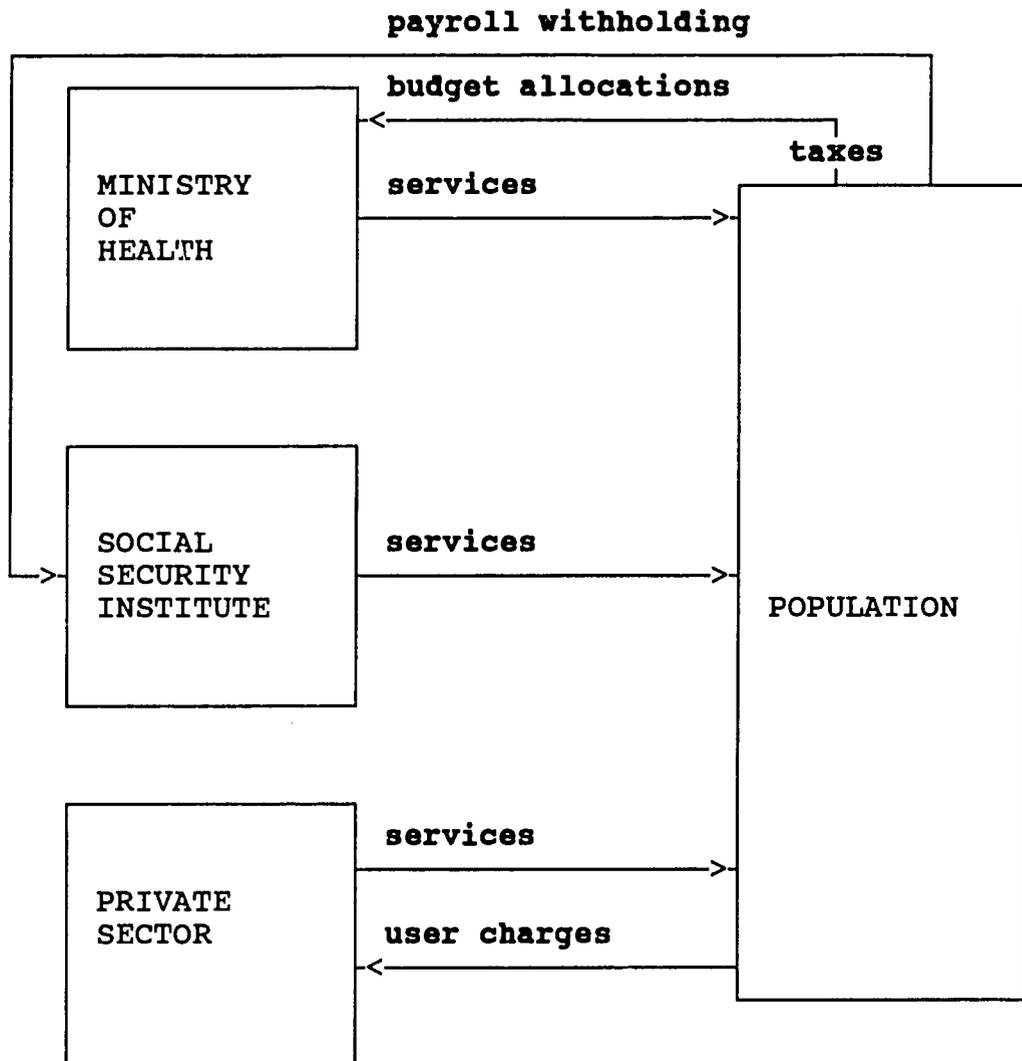
Resource allocation, use, and management enters in three ways: tools in the hands of government policymakers and analysts to decide how to allocate resources among government programs and the extent to which the private sector may be encouraged (D1), in the management and incentive systems put into place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

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

APPENDIX A

Exhibit A.1

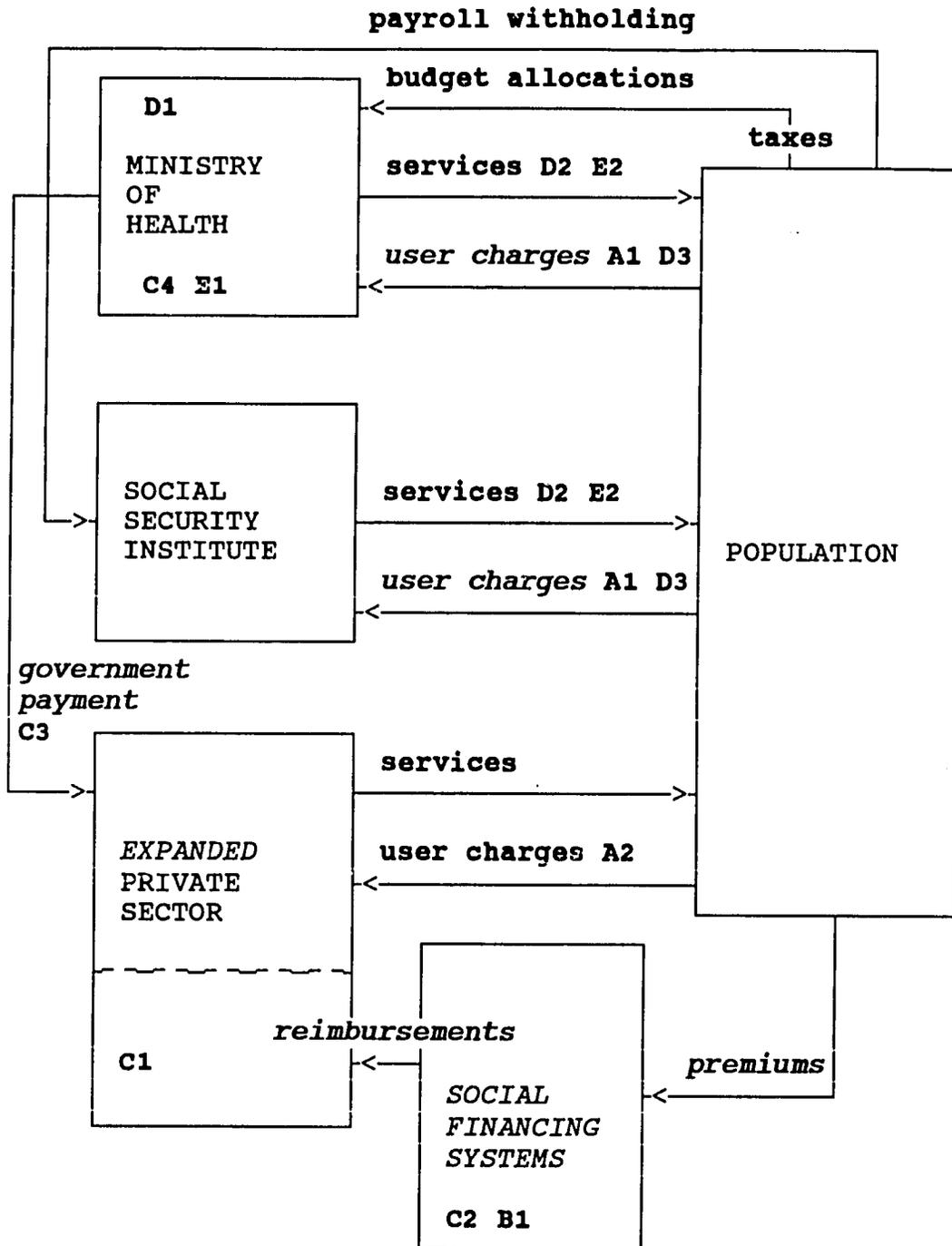
Stylization of the Current Health Financing Situation  
in LDCs



APPENDIX A

Exhibit A.2

Stylization of How the Health Financing Situation  
Could Look in LDCs



## Appendix B: Summary of Project Approach

<u>Priority Areas</u>	<u>Issues and Constraints</u>	<u>Project Approach</u>
<b><u>PUBLIC-PRIVATE COLLABORATION</u></b>		
Private sector constraints	Policy and legal constraints hinder development of private health care and insurance industries.	Policy dialogue and analysis to identify constraints, then assist in policy and legal changes.
Private delivery and financing	Low government awareness or use of private financing and delivery alternatives; little public purchase of private services or privatization.	Policy dialogue, analysis of advantages of private provision; contracting out public services; tax incentives to companies for health benefits; evaluate parastatal drug companies. (ANE, LAC)
Management	Improving public and private hospital management.	TA on contracting hospital management and alternatives such as parastatals and privatization. (ANE, LAC)
Privatization	What services can be privatized; lack of experience with privatization; MOH resistance.	C/B analysis of services to privatize; TA in management/business to prepare offer; create personnel plan to ease transition. (ANE, LAC)
Regulation	Public oversight to regulate and promote private health care.	TA for govt. and professional associations to design/implement regulations and oversight; employer insurance incentives. (ANE, LAC)
<b><u>COST RECOVERY</u></b>		
Demand	Unknown ability and willingness to pay for care; unknown demand for insurance.	Measure demand by quality and type of care to guide pricing and fee waiver decisions; pilot test insurance.
Equity	Whom to charge; ensuring access for those with limited resources.	Demand studies; experimentation and evaluation of methods to identify the poor, sliding fee scales, alternative payment mechanisms.
Revenue generation	Level and structure of prices; services for which to charge.	Analyze costs and ability and willingness to pay; apply AAI cost and demand simulation model.

## Appendix B: Summary of Project Approach

<u>Priority Areas</u>	<u>Issues and Constraints</u>	<u>Project Approach</u>
<b><u>SOCIAL FINANCING OF DEMAND</u></b>		
Management	Management of fees; administrative feasibility; how to encourage fee collection.	Management systems design and training; design incentives for accountability; allow facilities to retain revenues.
Promotion and Regulation of Private Insurance	Government policies inhibit private insurance initiatives in health care.	Identify constraints; TA to government to revise law and policy; design and disseminate regulations. (ANE, LAC)
Social Security/National Insurance	Linkage between revenues and service costs weak; over emphasis on curative services; overlap with MOH.	TA on budgeting and planning, CEA of programs and demand analysis; promote SSI/MOH coordination. (LAC)
Reaching the poor	Third party coverage reaches only to middle class.	Investigate govt. reimbursed HMO care; possible cross-subsidization; analysis of rural and urban informal sector insurance feasibility. (ANE, LAC)
HMO and other managed care	Insufficient information, policy or legal framework to promote prepaid care.	Policy dialogue, TA to government and potential organizations to establish or expand coverage, change legal framework. (ANE, LAC)
Community and Drug revolving funds	How to establish and operate community financing schemes; administrative complexity.	Training in management, administration for community representatives; evaluation of local circumstances; design of financing mechanisms, including cooperatives or employer based. (AFR)
<b><u>RESOURCE ALLOCATION, USE AND MANAGEMENT</u></b>		
Institutional Development	Weak, over-centralized decision making process; poor channels of communication and ill defined responsibilities.	Analyze and recommend modifications to management structure, communications, responsibilities/authority.
Efficiency	How to discourage over and inappropriate use of system resources by consumers.	Relate prices to costs; structure prices to reinforce use of referral system; management assistance to strengthen referral practices.

## Appendix B: Summary of Project Approach

<u>Priority Areas</u>	<u>Issues and Constraints</u>	<u>Project Approach</u>
Cost Containment	Inefficiencies in public system; lack of cost information, management and fiscal controls; no quality control.	Evaluate practices, introduce incentives for cost consciousness; implement financial information systems and quality monitoring.
Budget Planning	Inefficient allocation of resources within MOH and within facilities; lack of long term planning.	Assist MOH and facilities to acquire and use improved resource allocation tools; assist in integration of financial and health planning.
Drug Procurement Costs	Drug procurement systems inefficient and highly regulated, with high leakage.	Analyze alternative procurement production and distribution systems; expand private sector participation.
Financial Management	Lack of financial controls and oversight of expenditures and inefficient financial management.	TA and training to upgrade financial methods; design and test incentive systems for financial performance; improve reporting systems.
Hospital Administration	Lack of effective management in public and private hospitals.	On-the-job training for hospital managers; management consulting to perform efficiency and systems analyses.

### HEALTH SERVICES PRODUCTION AND COSTS

Cost of Service	Public facilities allocate resources based on budgets rather than costs; cost effectiveness of programs not addressed in planning.	Develop cost accounting systems and incentives to be cost conscious; determine units costs; private sector costing to guide public sector; train in use of CEA.
Program Planning and Evaluation	CBA and CEA not employed for program choice, design and evaluation.	Build host country capacity to conduct and use CBA and CEA to assist in program choice and resource allocation.
Recurrent Costs	Recurrent costs not considered when planning public investments.	Assist governments to institute cost estimates and analysis of financing options when considering investments; apply AAI sector-financing model.

## APPENDIX C

### HFS Project Staff

Project Director: Marty Makinen

Deputy Director for Administration: Denise Lionetti

Deputy Technical Director: Maureen Lewis

Deputy Director for Operations: Richard Roberts

#### Technical Specialists:

Applied Research: Ricardo Bitran

Hospital and Financial Management: Stan Hildebrand

Public/Private Collaboration: Harry Cross

Health Insurance: TBA

Health Planning: TBA

#### Regional Operations Managers:

LAC: Harry Cross

ANE: Holly Wong

AFR: Joanne Bennett (acting)

#### Regional Operations Associates:

LAC: TBA

ANE: Kirsten Frederiksen

AFR: Brad Barker

Information Specialist: Jennifer Lissfelt

Administrative Associate: Georgette Wright

Administrative Assistant: Rosalind Chatman

## APPENDIX D

### ASSESSMENT INSTRUMENT

- o Assess government laws and policy regarding alternative delivery and financing arrangements: private sector, charging for services, social financing mechanisms, and others
- o 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)
- o Analyze trends in government expenditures on health services (investment, operating, foreign exchange)
- o Analyze resource allocation trends (hospital versus non-hospital, personnel versus drugs, supplies, and maintenance)
- o Summarize efficiency problems and gaps in knowledge relevant to health financing problems
- o Assess degree of decentralized decision making, resource control, planning
- o Establish extent of social financing arrangements, public or private insurance, prepayment, HMOs, other managed care
- o Collect and review documents, papers, or research on health financing related topics
- o Identify data collection, analysis, and research needs and priorities
- o Determine the willingness of the host country to effect change, and of USAID and the host country to contribute financial, human, and logistical resources
- o Assess the opportunity to leverage project resources through cooperation with other donors
- o Assess the availability of local consultants to carry out or participate in major or smaller applied research or play the role of long term technical advisor