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U N C L A S S I F I E D

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D. C. 20523

**PROJECT PAPER**

ANE and Europe Regional  
398-0351  
Health Sector Financing and Support

U N C L A S S I F I E D

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT DATA SHEET**

1. TRANSACTION CODE  
 A = Add  
 C = Change  
 D = Delete  
 Amendment Number \_\_\_\_\_

DOCUM ENT CODE 3

2. COUNTRY/ENTITY  
 Asia, Near East and Europe Regional

3. PROJECT NUMBER  
 398-0351

4. BUREAU/OFFICE  
 ANE/TR/HPN

5. PROJECT TITLE (maximum 40 characters)  
 Health Sector Financing and Support

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)  
 MM DD YY  
 05 31 97

7. ESTIMATED DATE OF OBLIGATION  
 (Under "B" below, enter 1, 2, 3, or 4)  
 A. Initial FY 90 B. Quarter 3 C. Final FY 97

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

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	450	50	500	6300	700	(7,000)
(Grant)	(450)	(50)	(500)	(6300)	(700)	(7,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1. ANE Mission	0	0	0	17,550	1,950	19,500
2. Host Country						
Other Donor(s)						
<b>TOTALS</b>	450	50	500	23,850	2,650	26,500

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	590					500	0	7,000	0
(2)									
(3)									
(4)									
<b>TOTALS</b>						500	0	7,000	0

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

11. SECONDARY PURPOSE CODES

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

A. Code \_\_\_\_\_ B. Amount \_\_\_\_\_

13. PROJECT PURPOSE (maximum 480 characters)

To assist countries at the ANE region to address current and emerging health problems through expanded market pluralism and improved resource management, so that needs of the poor and most vulnerable are more effectively met.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
 05 93 05 96

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.)

17. APPROVED BY  
 Signature: Carol Adelman  
 Title: AA/ANE  
 Date Signed: MM DD YY  
 06/11/90

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION  
 MM DD YY

a

PROJECT AUTHORIZATION

Name of Country: Regional  
Name of Project: Health Sector Financing Support Project  
Number of Project: 398-0351

1. Pursuant to Sections 104 (b) and 531 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Asia, Near East and Europe (ANE) Regional Health Sector Financing and Support Project (the Project) involving planned obligations of not to exceed Seven Million United States Dollars (\$7,000,000) in grant funds over a seven year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB allotment process, to help in financing the foreign exchange and local currency costs for the Project. In addition, it is anticipated the ANE Missions will utilize project services in the approximate amount of \$19.5 million from their own authorized health activities, for a total potential life of project amount of \$26.5 million. The planned life of the Project is seven years from the date of initial obligation.

2. The Project will assist countries of the ANE Region to address current and emerging health problems through expanded market pluralism and improved resource management, so that needs of the poor and most vulnerable are more effectively met.

3. The Project obligating documents, which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority, shall be subject to the following essential covenant and major condition, together with such other terms and conditions as A.I.D. may deem appropriate.

4. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the United States or the country in the ANE Region in which the Project activity is being undertaken, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States or the country in the ANE Region in which the Project activity is being undertaken as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed on flag vessels of the United States.

Carol C. Adelman  
Carol C. Adelman

6/11/91  
Date

Clearances:

DAA/ANE:John Blackton SB Date: 6/7/90  
ANE/PD:Bruce J. Odell BO Date: 6/1/90  
ANE/DP:Peter Davis PD Date: 6/1/90  
ANE/TR:Barbara Turner BT Date: 6/1/90  
GC/ANE:Herbert E. Morris HM Date: 5/25/90

W  
ANE/PD:RNachtrieb/ANE/TR:PSGibson:5/22/90:DOC5044n

**Health Sector Financing & Support Project  
ANE Regional Project No. 398-0351**

**ANE/TR/HPN**

*d*

## EXECUTIVE SUMMARY

This Project Paper describes the Asia, Near East and Europe (ANE) Bureau's seven year **Health Financing and Support Project**. The Project will be authorized at a level of \$7,000,000, to be provided from ANE Bureau funds, subject to the OYB process and funds limitations. An estimated \$19,450,000 is expected from mission add-ons/buy-ins.

### **The Setting**

The ANE Bureau has developed a health sector finance strategy in response to Agency guidance, and in recognition of the fact that the underlying demographic and health changes are particularly evident in the countries of the region. The strategy correctly notes that the real action will be in the field and that Missions will have to choose among many potential opportunities. The governments of cooperating countries of the ANE region are increasingly concerned about the growing costs of health care, and are, to varying degrees, moving to deal with the complicated and critical problem of health sector finance. This project has been designed to help field Missions to support these host country efforts.

### **The Problem**

The problem is clear. Publicly funded health sector programs in ANE are stretched beyond their managerial and budgetary capability to provide even basic health services to their populations. At the same time, they are faced with changing epidemiology and increasing demand for more sophisticated and more costly health services. As demand shifts to higher cost technologies, hard won gains in public health and family planning may be lost, and, at best, further progress will be seriously threatened. In the absence of change, already constrained government budgets will not be able to cope with greater demands, and existing inequities in government allocations will only worsen. Private sector spending will increase, but much of it will go for services that are high cost and almost entirely curative in nature.

The ANE countries must provide a policy and financial environment to generate resources and improve efficiency in the health marketplace. The result will be more open and plural health markets, which, in and of themselves, will be powerful forces for greater efficiency in resource utilization. And, governments will be better able to target their resources where they should -- primarily on assuring services for those least able to pay and on public health monitoring and standard setting.

Achieving this solution will require a wide range of activities. The U.S. health care industry has much to contribute, both in terms of technical expertise and potentially in terms of financial resources. (The U.S. health industry includes those groups involved in financing health sector expansion, in the actual delivery of services, business schools which train financial and management personnel and those state level departments of health which reimburse the private sector for service provision to the poor.) The ANE Bureau is committed to a concept of project execution which will draw on the U.S. health industry to the maximum extent possible. It will also be important to coordinate A.I.D.'s efforts closely with those of other donors, in order to leverage A.I.D.'s relatively limited resources and to avoid potential conflicts.

### **Project Activities**

Planned project activities fall into three major categories. They are:

- **Policy and Regulation.** The project will promote public policies and regulations which deepen pluralism and encourage private sector participation in health care finance: by helping health and other relevant ministries to understand the importance, costs and options of policy and regulatory reform; by providing assistance in policy and regulatory revision; by providing assistance to improve the capacities of host governments to stimulate and broadly oversee private sector health activities; and by helping host governments to develop public/private systems of quality control.
- **Awareness and Skills.** The project will develop, for instance, broader awareness and skills in financial management, cost accounting, cost containment and financial systems needed to improve health sector performance. The project will contribute to increased knowledge and skills through tailored short-term training, seminars and workshops.
- **Resource Generation and Management.** The project will assist host countries to generate additional resources for effective health care by: promoting effective involvement and participation of the public and private sectors in health; improving revenue generation (publicly supported bonds, etc.); more efficient utilization of health resources; leveraging increased U.S. and local investment in health care industries; and leveraging the participation, as possible, of other donors.

In addition, the Project will provide assistance to ANE Missions in project design and evaluation, and will regularly distribute health care financing update notes to Missions and selected public and private leaders in ANE countries.

### **How the Project Will Work**

The project will be executed through three separate contract modalities, which will be coordinated by a designated Project Manager in ANE/TR/HPN. The first will be a longer-term continuation of the present RSSA with the Health Care Financing Administration (HCFA) of the Department of Health and Human Services. It will access HCFA's staff and roster of consultants, to provide technical assistance in the areas of policy analysis, regulation and cost containment.

The second will be a competitively let consortium agreement for technical assistance, conference management, training and information dissemination, premised on the maximum participation of firms or organizations that are actively involved in the U.S. health care industry. The agreement will support a modest core staff who will manage contract activities and draw from the U.S. health care industry networks that are essential to project success. The core agreement, or a companion requirements-type contract, will provide substantial authorization for Mission and additional Bureau add-ons.

Third, a small amount of project funds will be reserved to provide a set of IQCs or for future contracts to insure Mission access to the full range of U.S. health care industry skills. Funds set aside in this category will also be used for planned external evaluations.

TABLE OF CONTENTS

	Page
Executive Summary . . . . .	i
Table of Contents . . . . .	iv
Chapter I Program Factors . . . . .	1
A. Relationship to A.I.D. and ANE Bureau Strategy . . . . .	1
B. Relationship to Host Country Strategies . . . . .	2
Chapter II Project Description . . . . .	3
A. The Problem . . . . .	3
B. Project Goal and Purpose . . . . .	5
1. Goal . . . . .	5
2. Purpose . . . . .	5
3. End of Project Status . . . . .	6
4. Assumptions for Project Success . . . . .	6
C. Project Activities . . . . .	7
1. Policy and Regulations . . . . .	7
2. Awareness and Skills . . . . .	7
3. Resource Generation and Management . . . . .	8
D. Project Outputs . . . . .	9
E. How the Project Will Work . . . . .	9
1. Project Implementation . . . . .	9
2. Evaluation . . . . .	11

Chapter III	Factors Affecting Project Selection. . . . .	12
A.	Socio-Cultural Considerations . . . . .	12
1.	Socio-cultural Factors . . . . .	12
2.	Beneficiaries . . . . .	13
3.	Women in Development . . . . .	13
B.	Economic Considerations . . . . .	14
C.	Relevant Experience with Similar Projects . . . . .	15
D.	Proposed Borrower/Grantee and/or Implementing Agency . . . . .	15
E.	A.I.D. Support Requirements and Capability . . . . .	15
F.	Estimated Costs and Methods of Financing . . . . .	16
G.	Recommended Environmental Threshold Decision . . . . .	16
H.	A.I.D. Policy Issues . . . . .	17

**ANNEXES**

A.	Financial Plan and Funding Tables
B.	Logical Framework
C.	Illustrative ANE Data
D.	Health Care Financing Administration (HCFA) Basics
E.	Bibliography of Selected References

## I. PROGRAM FACTORS

### A. Relationship to A.I.D. and ANE Bureau Strategy

In his 1989 report to Congress, former A.I.D. Administrator Alan Woods stated that "the biggest challenge facing health sectors in the next century will be finance. Easy solutions to isolated health problems, which have dominated donor assistance programs for the past ten years, have run their course. As people live longer, reduce their family size, and become more urban, their needs will change. And those needs will be more costly than in the past ... major investments and/or more comprehensive medical services often bring with them more extensive options for finance than do simple therapies. Developing pluralism in financial participation in the health sector will thus be both crucial and advantageous in the future...both for investments and for operating budgets. Without it, the gains of the past will fall prey to the limits of public budgets."

The ANE Bureau strategy, Creating Resources for Health: A Strategy to Expand development of Health Sectors in the ANE Region, was developed in response to this guidance, and in recognition of the fact that the types of demographic and health changes cited by Alan Woods are particularly evident in the countries of the region. The goal of the strategy is, "to expand financial pluralism and improve financial management in the health sectors of ANE countries such that governments have the opportunity to cost-effectively allocate public budgets to the poor most in need and to public health activities."

The strategy's intent is to enable the emergence and/or strengthening of market pluralism in health sector finance and service provision. It has three objectives: to increase efficiency and effectiveness through improved financial management skills and institutional systems; to improve equity by creating/tapping plural pools of local resources for cost recovery; and to extend coverage and access by expanding or creating plural pools of resources for investment.

While the strategy covers a range of activities, it correctly notes that, "...the real action will be in the field. There is, of course, a long shopping list of things that ANE Missions could do in the field. ... Making a list is easy. Choosing among the opportunities is not." This project has been designed to help field Missions do just this. It will assist in opportunity selection and evaluation, through analyses and other preparatory work leading up to bilateral health sector finance activities. The project will also help Missions and cooperating countries with the analysis and implementation of more limited targets of opportunity, often for pilot or demonstration purposes. It will enhance the ability of local decision makers to make informed choices, through short term training, conferences and workshops. And, it will arm choice-makers with information on successes and

problems encountered elsewhere in the region through regular information dissemination.

## **B. Relationship to Host Country Strategies**

The pressures which make finance the biggest challenge that health sectors will face in the next century are already being felt throughout Asia and the Near East, and the host governments of the 13 A.I.D. recipient countries are, to varying degrees, moving to deal with the complicated and critical problem of health sector finance.

Indonesia is just completing the second year of a large, five-year health sector financing project. Egypt is beginning to implement a health sector finance project with five major components. The Government of the Philippines has requested A.I.D. assistance in revamping its social security system, which already covers approximately 50 percent of the population, and is working with the Mission on the design of a bilateral project to expand coverage to the non wage-based population.

Jordan, Morocco and Pakistan are beginning to define their health financing problems and have requested A.I.D. assistance in the initial analyses that will enable them to do so. Specific assistance requests from Yemen and Oman could open broader opportunities in these countries as well. This evident interest indicates these countries will almost certainly be requesting additional assistance in the next few years.

Project activities in the remaining ANE countries will create a better understanding of sustainability issues, and are almost certain to help them begin work on their health finance problems. This project is designed to provide the kind of assistance that they will certainly require as they make that beginning.

## **II. PROJECT DESCRIPTION**

### **A. THE PROBLEM**

The economic, demographic and epidemiological factors that are creating or exacerbating the problems of health sector finance are not unique to the ANE region, but they are particularly strong there. Many of these factors have their roots in the economic and social progress that has been achieved in ANE. Quantitative and qualitative changes in the demand for health care are creating financial pressures which are compounded by existing resource and management problems.

#### **1. The Changing Demand**

The factors which are effecting qualitative and quantitative changes in demand include the following:

- Rates of GDP growth in nearly every ANE country meet or exceed A.I.D. targets and are creating rising expectations for health care that the governments cannot meet financially on their own.
- Continued population growth, despite a widespread pattern of fertility reductions, will persist well into the 21st century and will create increasing demands for health and family planning services as the numbers of young adults increases over the next decade.
- As fertility and infant mortality decline and life expectancy rises, there will be increasing numbers of adults in every country, and a rising median age in most, which will increase chronic illness and demands for more expensive curative care. Industrialization and urbanization will accelerate this change in disease patterns.
- Rapid urbanization, which is creating megacities across ANE, will increase the political demands for the types of health services most susceptible to private sector involvement. These political forces are the ones that have already skewed current public health budgets. This will only change when the public sector assumes a policy and regulatory role which encourages alternative financing mechanisms and partnerships to add new health sector resources.

#### **2. Resource and Management Problems.**

Changes in demand are being compounded by the following resource and service distribution problems:

- Government budgets for health services are declining in real per capita terms and as a percentage of total government budgets. They cannot keep pace with current growth in population demand, let alone changes in demand patterns.

- As government budgets decline, increasing numbers of those previously served by publicly funded services seek out private health care alternatives. Governments cannot keep pace with the higher unit costs of service delivery for chronic and degenerative disease treatment, let alone train their providers in these specialized clinical areas.
- Government budgets for health care are generally not equitably distributed. In most countries, the majority of the publicly funded health care expenditures are going for urban hospital-based curative care that is being provided to those who would be able to pay for all or part of it.
- Government and private systems for providing health care are inefficient in terms both of operations and the use of health inputs (pharmaceuticals, equipment, personnel and facilities).
- Consumer spending on health care, in most countries, exceeds 50 percent of total health care expenditures, but data is fragmented and seldom used by government planners. In some countries much of this private spending is for traditional care that may not be effective or for inappropriate care (as in the public sector).

Thus, the problem is clear. Publicly funded health sector programs in ANE are stretched beyond their managerial and budgetary capability to provide even the basic health services which they are politically committed to provide to their populations. At the same time, they are being faced with increasing levels of demand for health services and changes in the pattern of demand toward more sophisticated and more costly curative services.

In the absence of change, already constrained government budgets will not be able to cope with these demands, and existing inequities in government allocations will only worsen. Private sector spending will increase in any case, but much of it may go for services that are not fully effective. In this process, hard-won gains in basic health and family planning may be lost, and, at best, further progress will be seriously threatened.

If the problem is clear, the need for new solutions is equally clear. Increasing the level of public expenditures with domestic or donor resources or even attempting to shift expenditures within the public budget is not enough. The role of government and its relationship with the private sector must change. The countries of the region will be able to deal with the increased unit costs of service delivery only through improved financial management of the sector, supported by greater efficiency in the use of public and private health resources. Increased private

resources will create larger resource pools to cope with growing and more costly demand. Improved public-private partnerships will bring new and better mechanisms for mobilizing and using these resources. The end result should be more open and more plural health markets, which, in and of themselves, will be powerful forces for greater efficiency in resource utilization. And, governments will be better able to target their resources where they should -- on ensuring services for those least able to pay and on true public health measures.

However, achieving this solution will not be quick or painless. We can only hope to begin a process which may take countries a decade or longer to complete. There will be false starts and countries must be allowed to learn through failure as well as success. Through this project, the ANE Bureau commits itself to sharing the risk with ANE field Missions as they participate in this effort. These activities are also ones where the U.S. health care industry has much to contribute, both in terms of technical expertise and potentially in terms of resources. The ANE Bureau is committed to a concept of project execution which will draw on the U.S. health sector to the maximum extent possible.

It will also be important to work in collaboration with other donors, especially the multilateral institutions, to leverage A.I.D.'s relatively limited resources and to avoid potential conflicts. The type of market change envisioned here is an instance where donors can all too easily work at cross purposes -- one promoting privatization of public hospitals, while another supports construction of new public hospitals, for example. Raising the level of awareness and debate may help to ensure that this does not happen.

## **B. Project Goal and Purpose**

### **1. Goal**

The **Goal** of the project is to help ANE countries to address current and emerging health problems through expanded market pluralism and financial management so that the health needs of the poor are more effectively met.

### **2. Purpose**

The **Purpose** of the project is to assist and support ANE field Missions in their efforts to improve host country financial capability to meet changing health demand and to increase the equity and efficiency of resource use.

### **Sub-Purposes**

Promote public policies and regulations which deepen pluralism and encourage private sector participation in health care finance and services.

Develop broader awareness among top policy makers of the legislative and regulatory issues and options for improving health sector financial viability, and improve the knowledge and skills of public and private managers.

Generate and manage additional financial resources for effective health care in host countries.

### **3. End of Project Status**

By the end of the project, it is expected that:

- Seven ANE countries will have significant health sector financing activities underway;
- Private sector participation will have demonstrably increased and additional health sector resources will have been generated in at least three countries;
- Selected top officials from key ANE countries will have participated in at least two conferences on health sector financing;
- Public and private managers will have acquired relevant skills in at least eight countries; and
- Continuing U.S. private health industry relationships with LDC private sectors and Missions will have been established.

### **4. Assumptions for Project Success**

Rational changes in resource allocation are possible, and can be made.

Governments will enact policies and regulations encouraging private sector participation in the health sector.

Political, economic and social conditions are not absolute barriers to rational use of resources.

Health status and welfare are beneficially affected by more efficient and more rational use of scarce public and private resources.

More adequate resources for health, population and child survival services for the poor will be available if additional resources are mobilized and efficiently used in the health sector as a whole.

## **C. Project Activities**

The project consists of three major components designed to support achievement of the three sub-purposes set forth above. They are:

### **1. Policy and Regulations.**

The project will promote public policies and regulations which deepen pluralism and encourage private sector participation in health care finance through the following activities:

**It will help health and other relevant ministries to understand the importance, costs and options of policy and regulatory reform.** These analytic and advisory activities will often begin with an overall analysis of health sector costs, demand trends and sources of finance in a given country -- to identify problem areas and to define component areas where further study and action is needed. In these activities, it will be essential to involve other ministries of government, since policies and regulations which inhibit the growth of financial sources and limit private sector financial participation are most often controlled by ministries of finance, planning, commerce, trade, and so on.

**It will provide assistance in policy and regulatory revision.**

**It will provide assistance to improve the capacities of host governments to stimulate and broadly oversee private sector health activities,** through a variety of means ranging from changes in policy and regulations, to health data systems and promotional activities, to co-financing arrangements.

**It will help host governments to develop public/private systems of quality control,** through advisory assistance, regulatory design and short-term training.

### **2. Awareness and Skills.**

**To develop broader awareness among top policy makers of the legislative and regulatory issues and options for improving health sector financial viability,** the project will sponsor a series of high level conferences. They will include an ANE region-wide conference, an international conference with a primary focus on ANE, and at least six sub-regional conferences or workshops on health care financing and financial management. The project will also regularly distribute health care financing update notes which will disseminate information on successful and unsuccessful health sector finance activities. The notes will be distributed to Missions and selected public and private leaders in each ANE country.

**To improve the knowledge and skills of public and private managers,** the project will design and execute tailored short-

term training programs in the U.S. and third countries. The programs will cover such topics as regulatory controls, health resource management and financing alternatives. They will be tailored to specific host country needs and will draw on both public and private expertise, as required.

**3. Resource Generation and Management.** The project will help to generate additional resources for effective health care in host countries through the following activities:

**It will promote effective involvement and participation of the private sector in health throughout ANE.** Technical assistance will be designed to draw primarily on the extensive relevant experience of the U.S. health care industry. Specific small project activities will involve the local private sector. Examples may include cost containment, cost recovery in public facilities, or development of reimbursement systems. Other activities could include the establishment of managed health care organizations, tapping or creating employer/employee-based insurance schemes, creating a private insurance system, and revisions to banking codes or tax structures that stimulate health care investment. These activities can also have a pilot or demonstration effect, but they will be selected on the basis of their individual merits and viability.

**It will promote more efficient utilization of public and private health resources.** Assistance will be provided for a range of activities that will promote increased efficiency, such as more effective use of manpower, material and facilities, and improved systems of hospital and clinic management. Opportunities for improved efficiency through privatization will be actively pursued.

**It will leverage increased U.S. and local private sector investment in health care activities in the region.** In the execution of all project activities which will require additional investments, priority will be given to local and U.S. firms and organizations that are potentially willing to invest in such activities, rather than those interested only in providing advisory help.

**It will leverage the participation, whenever possible, of other donors.** Other donor participation in the conferences described above will be actively sought. Missions will be encouraged to continually coordinate with other donors, and to seek out activities where this project can support, and thus help target, larger health sector financing activities funded by other donors.

In support of these components, the project will provide assistance to ANE Missions in the design and evaluation of specific health sector interventions, and larger bilateral health sector finance projects.

#### **D. Project Outputs**

The following major outputs are expected over the life of the project:

Policy studies and inventories conducted in every country, ranging from overall sector analyses to studies of selected management problems.

Short-term finance and management training for health care planners, managers and investors from at least eight countries.

One international, one regional, and six sub-regional conferences or workshops on health care financing and financial management.

Design and initiation of activities in prepaid health care in at least six countries.

Demonstrations of more efficient use of health resources -- e.g. manpower, facilities, pharmaceuticals, supplies and support services -- through privatization, improved management or other means in at least five ANE countries.

Policy changes or regulatory reform to expand coverage or improve service quality through public-private health sector participation effected in at least four countries.

Expand or initiate public social insurance schemes in at least three countries.

Facilitate private U.S. investments in health care finance.

Information on health care financing options, opportunities and potential efficiencies disseminated -- to all ANE countries.

#### **E. How the Project Will Work**

##### **1. Project Implementation**

Since maximum access to U.S. health care industry expertise is required to successfully implement the project, several different modalities will be tapped. Implementation will be coordinated by the designated Project Manager (PM) in ANE/TR/HPN. The PM will establish an informal Project Coordinating Committee to ensure coordination within the ANE Bureau and AID/W. The Committee will include representatives of ANE/PSDS, ANE/PD, ANE/DP and other offices as may be appropriate.

The first modality will be a continuation of the present Resources Support Services Agreement (RSSA) with the Department of Health and Human Services and the Health Care Financing Administration (HCFA). The RSSA provides access to HCFA staff, and, as necessary, to HCFA's roster of consultants as well as to state level health professionals. Resources from the RSSA will

provide short-term technical assistance in the areas of policy development, regulation and cost containment. (A copy of the agreement with HCFA, and a brief description of its capabilities are contained in Annex C.)

The second modality will be a competitively secured consortium to provide technical assistance, conference management, training and information dissemination. The RFP for this agreement will be designed to solicit maximum participation of firms or organizations that are actively involved in the U.S. health care industry. Preference will be given to proposals which provide, through consortiums or other arrangements, for such participation and which identify innovative arrangements for accessing the broad range of firms and organizations that comprise the industry.

Through this modality a modest core managerial staff will be funded. This staff will provide a linkage to the U.S. industry networks that are essential to its success. Also included will be modest ANE bureau funding for technical activities which affect more than one country, or are required as a prelude to Mission funded activity in a given country. The core agreement will provide substantial authorization for Mission and additional Bureau add-ons. Conference costs will be funded under the core agreement, but after the first two years of implementation, it is expected that most training activities will be Mission funded.

Third, a small amount of project funds will be budgeted for a set of IQC or other complementary contracts to insure Missions access to the full range of U.S. health care industry expertise and to meet unforeseen analytic requirements. While additional contracts will complicate project management, they will help ensure the flexibility to meet field needs which is essential to the success of this project. If such funds are not required, they can be added to the primary contract at a later date.

When requests are received from the field for ANE funded assistance, or for the execution of an add-on, the project Manager will be responsible for determining which of the project implementing components can best meet the requirement in a timely fashion.

In addition, the Project Manager will establish a four to six member Technical Advisory Group (TAG) to advise on issues in health financing and new technologies for the project. The TAG will be composed of representatives of the U.S. health care industry and others who reflect the range of issues to be addressed. The TAG will meet twice a year or as may be required to explore selected issues in health care financing and management.

Meetings of the TAG will help to identify issues and approaches but the impact of the project and its country-specific activities may not be fully evident during the life of the project. Results

of the TAG meetings will be shared with the cooperating agencies and will be reflected in annual implementation plans as appropriate.

## **2. Evaluation**

Since this is a field support project, evaluation will be based on the level and types of assistance provided to Missions. Formal evaluation and monitoring will be based on the annual workplans of the cooperating agencies and Mission feedback. At least annually, the Project Manager will assess the degree to which project activities being implemented by the cooperating agencies are contributing to the planned project outputs. Follow-up actions will be identified and the results will be reflected in the annual implementation plans.

Missions will be requested to report briefly on project activities carried out in their countries, including program results or impact, at least annually. These reports will contribute data for the annual reviews and the mid-project evaluation.

Formal evaluations are scheduled at the end of FY 1993, the third project year, and in FY 1995/6. The first will be an external mid-term evaluation designed to assist in identifying any necessary mid-course corrections in the project. This evaluation will consider the quality of work performed to date, including timeliness; the levels of demand; the appropriateness of activities with respect to the project criteria; the management process; and the effectiveness of the project in identifying, promoting and responding to innovation and new opportunities. The final evaluation is intended to help determine whether the project has succeeded as planned and whether continued project assistance is warranted and appropriate. In the case of larger or more complex country-specific activities, such as pilot or demonstration activities, a more formal evaluation plan may be developed.

### III. FACTORS AFFECTING PROJECT SELECTION

#### A. Socio-cultural Considerations

##### 1. Socio-cultural Factors

The movement to open societies and open markets is sweeping the globe at an astonishing rate. Nowhere is it more dramatic than the sudden political liberalization of Eastern Europe. And in the countries of Asia and the Near East, measured but profound social and economic progress has laid the foundation for open societies and provided the climate for more open markets. It is this pattern of change which overarches the extreme cultural heterogeneity of the region, and which makes a regional health sector financing project culturally feasible. This is evident in the broad interest in health sector finance which is being expressed by the participating countries in the region.

Significant progress in health and quality of life indicators is also generating additional demand for health services. At the same time, urbanization and increasingly wage-based employment are creating a social setting which is propitious for change in the organization and finance of health services. By 1985, A.I.D.'s infant mortality target of not more than 75 deaths per thousand live births had been achieved by Sri Lanka, the Philippines, Thailand, Jordan and Tunisia, and substantial progress was made in other countries as well. By the year 2005, if the rates at which infant mortality declined during the 1980s are maintained, all but four ANE recipient countries (Bangladesh, Pakistan, Nepal and Yemen) will have achieved the A.I.D. goal for infant mortality, and all but five should be able to achieve the A.I.D. goal for child mortality.

Similarly, life expectancy has improved in all countries of the ANE region. Babies born in 1987 can expect, on average, 10 more years of life than those born in 1960. Half of all ANE recipient countries currently have life expectancies over 60 years of age. Only two, Nepal and North Yemen, continue to languish in the less than 50 years range which characterized the entire region in the 1960s. This expanded horizon, coupled with structural shifts in the countries' economies, both contributes to the problem of health care finance, and offers potential for its solution.

In line with the trends cited above, epidemiology in the region is changing. While comprehensive data for the region are not available, higher standards of living, urbanization and the changing age structure of populations will increase the prevalence of chronic and degenerative diseases. Prevention through diet and behavior change are difficult, and simple technological solutions are not available in the fight against such growing killers as hypertension or diabetes. The costs of health care programs will grow. New managerial and market solutions will be crucial to control costs and to generate deeper, more plural pools of resources. Otherwise gains in basic

health of women and children are not likely to be sustained. For example, the population of women of reproductive age will nearly double by the end of this decade; access to reproductive health services must also nearly double just to maintain current coverage levels.

Thus, although equity will be difficult to measure as a part of this project, the project's outcomes are a necessary precondition for improving equity in health care. The experience to date in most ANE countries shows clearly that, when health resources are constrained, it is the poorest who get left out.

## **2. Beneficiaries**

The primary beneficiaries of this project will be poor underserved groups in the participating countries. Their improved access to more effective care is expected to result from more effective mobilization and management of resources within the health sector. Other beneficiaries of this project will be the policy makers who will be exposed to health care financing concepts, and the public and private managers who will receive training in relevant subjects. In addition, private entrepreneurs and health care providers and recipients who are involved in specific subprojects will benefit directly. U.S. health care industry organizations that participate in the project will benefit from the knowledge they gain, and exposure to, potential health care markets abroad.

As larger bilateral health sector financing activities create more open health markets and improve the financial base of the health sector, the pool of ANE beneficiaries will expand exponentially.

## **3. Women in Development**

Women are key target beneficiaries as they are now underserved. The project will aim to ensure that women's and child health needs are included and addressed in insurance schemes and managed care options. Improved efficiencies in resource use will permit specific attention to more adequately meet the special needs of women. Women are an additional beneficiary group through their employment in the health care industries of cooperating countries. As local health industries grow to meet changes in demand for health services, additional opportunities for women's employment will emerge.

### **B. Economic Considerations**

The long range prospects for economic growth in ANE are generally good. Between 1950 and 1986, annual growth rates ranged from a high of 3.4 percent for Jordan to a low of 0.6 percent for Nepal. Over this period, only four countries failed to achieve A.I.D.'s performance target of two percent annual growth in per capita GDP. Between 1986 and 1988, per capita GDP growth in South Asia

has climbed above A.I.D.'s target although annual rates are still highly volatile. It has dropped sharply in the Near East and returned to robust levels in East Asia, responding to earlier structural changes. The prospects for 1990's are for continued growth. GDP growth is expected to range from four to six percent in Asia and from three to five percent in the Middle East.

This growth has been accompanied by structural change, as the region has seen an expansion of the manufacturing and service sectors as a percentage of GDP. If present trends continue, by the year 2000 the agricultural sector will account for more than 30 percent of GDP in only two countries, Bangladesh and India; agricultural workers will comprise more than half the labor force in only five countries, compared to 11 such countries in 1970. Twenty years ago only one ANE country enjoyed a pattern of such economic diversity.

As personal incomes rise, the pattern of demand for health care will expand, primarily in the direction of more costly services. At the same time, these economic changes will enhance the Project's ability to design and implement the financial changes necessary to cope with the increased demand. Growth will generate more resources. The shift away from agriculture will enhance the opportunity to enlist the local private sector as increasing numbers of salaried workers expand the pool of persons potentially interested in employer-based health programs.

It is possible to show theoretically the economic benefits of improved health care, and especially preventive care. However, it is difficult to link this theory with this Project, in part because it will be comprised mainly of small activities, but primarily because it is difficult empirically to show a correlation between health expenditures and health outcomes. What can be shown are the economic benefits of more efficient use of health resources to achieve a given set of health outcomes. Greater efficiency in health sector resource use, and cost containment are important elements of this Project.

More importantly, by involving U.S. industry, the project is hoping to attract and create new resources for expanded health investments in the health sectors of ANE countries. If this happens, at the end of the project, more health resources will be available than those provided and used through the project.

### **C. Relevant Experience with Similar Projects**

A.I.D.'s emphasis on health sector finance is relatively new, and its experience with projects in this field is limited. Within the ANE Region over the past two decades, there have been a range of initiatives and projects on health care financing options and demonstrations which have contributed to our current level of knowledge. More recently, the Philippines, Indonesia, Egypt, Jordan and Morocco have made significant efforts to begin to address resource allocation and management issues. Recent

Mission responses to the new Science and Technology Bureau health financing initiative indicate that there is significant unmet demand for technical assistance in dealing with health financing issues.

The Agency has had substantial experience in health, and other sectors, with support projects of the type proposed here. Often this type of project has been used successfully as a catalyst for innovation. Health sector examples include the REACH Project, which created sufficient demand for health financing assistance to warrant a separate agency-wide project complementary to this one, and TIPPS and ENTERPRISE, two projects which pioneered private sector involvement in family planning. This Project is specifically designed to address the problem of limited access to U.S. health care industry expertise which has not been tapped effectively through other projects.

#### **D. Proposed Borrower/Grantee and/or Implementing Agency**

A wide mix of public and private grantees and implementing agencies will be involved in the project. By definition, ANE Missions will be directly involved in project activities. The HCFA and a range of U.S. health industry groups will provide technical services. Within host countries, public and private organizations will be involved in implementation, depending on the nature of the subproject activity. Host country contributions will be determined on a case by case basis, but are expected to include significant private investment in some instances. U.S. private investment, and other donor assistance will also be actively sought.

#### **E. A.I.D. Support Requirements and Capability**

Since this project is intended to support ANE Missions, Mission staff will be substantially involved in project execution. However, activities will be initiated only with the concurrence of, or at the request of the concerned Mission to insure that there is sufficient interest and capability in the Mission to oversee the execution of subproject activities.

Central project management will be provided by the ANE Bureau's Office of Technical Resources (ANE/TR/HPN). A member of the staff will be designated Project Manager, responsible for overall management of the Project. Experience with similar projects within A.I.D. indicates that this level of management support will be sufficient.

#### **F. Estimated Costs and Methods of Financing**

ANE Bureau funds for this project are quite modest and add-on funding from USAIDs for each modality will be required to achieve the goals and outputs. Adequate ceilings within agreements for such add-ons are essential. Although this project is designed to stimulate innovative health sector financing and management

activities and respond to targets of opportunity, the costs are estimated based on the experience with costs for similar activities. In addition, expenditures will generally be limited to the following cost categories:

- technical assistance
- in-country, U.S. and third country training;
- training, conferences, information dissemination and administrative supplies; and
- local costs to support surveys, training, conferences.

Approximately ten percent of regional funds will be used for local costs. Costs have been estimated through a review of existing ANE and IQC contracts and in consultation with ANE Missions. Requirements for funds have not been broken down into DA and ESF requirements, but it is expected that funds from both categories will be used by Missions for add-on or co-financing activities. Host country contributions are to be identified with each add-on or co-financing proposal.

#### **G. Recommended Environmental Threshold Decision**

This project qualifies for a Categorical Exclusion because it supports basic health care in ANE countries through education, training and policy assistance. Health care projects involving education, training and policy assistance are included in section 216.2 (c) (2) of the Agency's Environmental Procedures as Categorical Exclusions for which an Initial Environmental Examination or Environmental Assessment is not required because there is no direct impact on the environment. These activities are not subject to the procedures in Section 216.3.

#### **H. A.I.D. Policy Issues**

1. A.I.D. Health Financing Strategy. The project is in direct consonance with A.I.D. policy, as enunciated by Administrator Woods and set forth in other recent documents.
2. Eastern Europe. This project has been designed to serve the countries in the Asia and Near East parts of the Asia, Near East and Europe Region. As needs in the countries of Eastern Europe become clearer and resources become available, consideration will be given to the inclusion of those countries in this Project.
3. Contract Proliferation. Implementation of this project will require putting in place or continuing several different contract mechanisms in order to ensure access to the full range of skills and experience available in the U.S. health industry. This range of skills and experience will be needed to deal with the diverse and complex types of issues encountered in the health sectors of ANE countries. ANE/TR/HPN will remain conscious of the need to streamline management and avoid either duplication or diversity in contracting which does not address specific needs not otherwise available.

## ANNEXES

### A. Financial Plan and Funding Tables

#### Financial Plan

#### ANE Regional Health Financing and Support Project

I. Introduction. This is a support project intended to create access to skills and resources to assist USAIDs and cooperating countries to begin to address the organizational and financial problems which inhibit health sector performance and efficient use of health sector resources. Country-specific activities supported under this project will be time-limited and of relatively short duration (generally less than 18 months). The project is expected to generate spinoff activities and, when appropriate, projects to further test and generalize the results and options developed through the project. It is expected that specific activities, e.g. changes in health insurance regulations or modified health sector investment codes, will generate additional health sector investments. Cooperating institutions or host country funding will be sought to match project contributions, although in the start-up phase, we anticipate such matching will be limited.

There will be competition for the limited ANE Regional project funding and support. Activities proposed for implementation will be ranked, subject to final approval of the Director, ANE/TR/HPN, based on Mission requests, use of established criteria, innovative approach, and limitation of funds. Priority for ANE Bureau funding will be given to activities which demonstrate relatively greater potential (and greater risk) for clarifying health sector policy options or impacting on resource allocation decisions. Total regional funding for any country-specific activity supported by the project is intended to be modest, rarely over \$200,000.

The project will use cabled Mission requests and an annual work plan to document activities to be undertaken each fiscal year. The work plan, approved by the Director of ANE/TR with appropriate clearances, will reserve funds for specific country financing activities. These will be documented with PIO/Ts as required to obligate funds within availabilities of the current year OYB. Once the work plan is approved, the Director of ANE/TR/HPN will be able to approve modifications up to a \$200,000 limit within the annual OYB allocation.

Conformity to Agency and ANE Bureau directives and policy will be controlled through the approval process for PIO/Ts and Action Memoranda.

It is not intended that funds from this project will be used for incremental, multi-year funding of country specific activities, unless specific prior authorization is noted in the approved annual work plan. Termination of this project is planned upon final expenditure of FY 96 funds, at which time project activities should have served their purposes, and the need for an ANE regional health financing project may have declined substantially. We would expect to determine in the final evaluation during FY 94-95 whether a follow-on project is appropriate.

While health financing and the multi-contractor assistance strategy of this project are in the main new to ANE, there is substantial A.I.D. experience in supplementing and complementing bilateral programs with specialized ad hoc assistance in other technical areas. This is a pioneering effort in many ways but, based on years of similar experience in other areas, there is no reason why this approach should not succeed.

II. **Selection Criteria.** The following criteria and or factors will be considered in approving specific country requests for assistance:

- Size of population to be affected by the effort
- Relative development of the health marketplace
- Importance of innovation to the country and the region
- Commitment of the host government to open markets
- Potential for linkage to the U.S. health marketplace
- Potential for attracting additional health sector investment.

III. **Funding Requirements.** Tables I-IV present project funding requirements. Funding projections for Mission add-ons are illustrative and reflect the level of project ceiling required to implement this project.

IV. **Budgeting Procedures.**

1. Operational Year Budget: The OYB will be established through the normal annual budgeting process. Funding levels will be requested in accordance with levels in the Project Paper. See Table I, Life of Project Funding, and Table II, Distribution of Funds by Implementation Mode, attached. The project will be incrementally funded, subject to the limitations of the budget

process.

2. An annual implementation plan will be prepared during the first two months of each fiscal year based upon the best estimates of the OYB level. The implementation plan will be approved by the Director of ANE/TR and cleared by ANE/DP, ANE/PSDS, ANE/PD and appropriate desks.

The ANE/TR/HPN project manager will have primary responsibility for developing the implementation plan in consultation with USAIDs and with the contractors and participating agencies engaged under the project. USAIDs will be specifically asked to propose activities and comment on the implementation plan.

3. Mission funding for add-on activities approved in the implementation plan or requested separately will be effected by PIO/Ts. Requests for country-specific activities not included or anticipated in the implementation plan will require separate approval by the Director, ANE/TR and clearance as outlined above.

4. For funds reserved for obligation by A.I.D. Missions, budget allowances will be held in AID/W, with informal reservations for country activities, but financial data may be provided to the field by the ANE/DP so that obligations can be incurred in the field with AID/W concurrence.

For ANE countries without A.I.D. Missions, an informal reservation of funds may be made by ANE/DP against which the A.I.D. Affairs Officers will be advised that they can draw with ANE/TR/HPN approval. Additional procedures to permit USAID execution of PIO/Ts locally will be developed with ANE/DP as required.

TABLE I  
HEALTH FINANCING AND SUPPORT PROJECT  
FINANCIAL PLAN  
PROJECT OBLIGATIONS BY CONTRACT MODALITY AND SOURCE  
(\$000's)

	YR1 FY90	YR2 FY91	YR3 FY92	YR4 FY93	YR5 FY94	YR6 FY95	YR7 FY96	ALL YEARS
<b>REGIONAL OBLIGATIONS</b>								
OIH/HCFA	-	200	200	200	200	200	100	1,100
BASIC AGREEMENT	500	800	975	900	900	625	700	5,400
EVALUATION/OTHER		100	100	50	100	50	100	500
<b>SUBTOTAL</b>	<b>500</b>	<b>1,100</b>	<b>1,275</b>	<b>1,150</b>	<b>1,200</b>	<b>875</b>	<b>900</b>	<b>7,000</b>
<b>MISSION ADD-ONS</b>								
OIH/HCFA	300	800	800	600	600	450	150	3,700
BASIC AGREEMENT*	500	2,600	2,800	2,750	2,750	2,550	1,800	15,750
<b>TOTAL</b>	<b>800</b>	<b>3,400</b>	<b>3,600</b>	<b>3,350</b>	<b>3,350</b>	<b>3,000</b>	<b>1,950</b>	<b>19,450</b>
<b>GRAND TOTAL</b>	<b>1,300</b>	<b>4,500</b>	<b>4,875</b>	<b>4,500</b>	<b>4,550</b>	<b>3,875</b>	<b>2,850</b>	<b>26,450</b>

\*Includes Mission funds which may be allocated to IQCs or other contracts.

**TABLE II**  
**Regional Health Financing and Support Project**  
**Distribution of Regional Bureau Resources**  
**by Output Category and Contract Modality**  
**(\$000's)**

	HCFA	Basic Agreement	Miscellaneous Contract	Total
Policy Analysis/Resource Inventories, DATA	\$500	\$1,850	\$200	\$2,550
Financial Generation Management	250	2,700	50	3,000
Skill Development Conferences Workshops/Material	250	750	-	1,200
Project Evaluation	100 =====	- =====	150 ===	250 =====
<b>Total</b>	<b>\$1,100</b>	<b>\$5,300</b>	<b>\$400</b>	<b>\$7,000</b>

**TABLE III**  
**Regional Health Financing and Support Project**  
**Illustrative Distribution of Mission Add-on Resources**  
**by Output Category and Contract Modality**  
**(\$000's)**

	HCFA	Basic Agreement	Miscellaneous Contracts	Total
Policy Analysis/Resource Inventories, DATA	\$2,000	\$3,500	\$500	\$6,000
Financial Generation/Management	1,250	7,250	500	9,000
Skill Development, Workshops, Conferences, Materials	-	750	1,500	3,500
Project Evaluation	450 =====	- =====	500 =====	950 =====
<b>Total</b>	<b>\$3,700</b>	<b>\$12,750</b>	<b>\$3,000</b>	<b>\$19,450</b>

TABLE IV  
 Illustrative Year I Core Costs  
 Consortium Agreement  
 Health Care Financing and Support Project

1.	Salaries (25% Fringe)	
	Technical Manager (GS 15/5) 60%	\$50,334
	Deputy Technical Manager (GS 15/1) 60%	44,412
	Training Specialist (GS 14/4) 100%	69,220
	Program Assistance (GS 9/4) 100%	33,971
	Secretary (GS 6/8) 100%	<u>28,020</u>
	SUBTOTAL	225,957
	OVERHEAD 80%	<u>180,766</u>
	SUBTOTAL	406,723
2.	Office Expenses (Direct Costs)	
	Telephone, fax, photocopy, etc.	<u>15,000</u>
	SUBTOTAL CORE COSTS, Items 1&2	421,723
3.	Program Costs	
	A. Technical Assistance	
	1) Short-Term Consultants	
	75 days @ \$450.00	33,750
	2) Travel	20,000
	3) Per diem - 100 days @ \$120	12,000
	B. Training Materials/Curriculum Dev.	<u>12,500</u>
	SUBTOTAL	78,250
	TOTAL (Items 1, 2 & 3) (Rounded)	\$500,000

ANNEX B  
A LOGICAL FRAMEWORK

Life of Project:  
From FY 90 To FY 96  
Date Prepared: April 19, 1990

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Goal:</b> The Goal of the Project is to help ANE countries to address current and emerging health problems through expanded market pluralism and financial management, so that the health needs of the poor are more effectively met.</p>	<p><b>Measurement</b></p> <ul style="list-style-type: none"> <li>- Increased resources generated.</li> <li>- Resource allocation changes.</li> <li>- Improved efficiency in resource utilization.</li> </ul>		<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>- Rational changes in resource allocation are possible, and can be made.</li> <li>- Governments will enact policies and regulations encouraging private sector participation in the health sector.</li> <li>- Political, economic and social conditions are not absolute barriers to rational uses of resources.</li> <li>- Health status and welfare are beneficially affected by more efficient and more rational use of scarce public and private resources.</li> <li>- More adequate funding for health, population and child survival services for the poor will be available if additional resources are mobilized and efficiently used.</li> </ul>
<p><b>Purpose:</b> The Purpose of the project is to assist and support ANE field Missions in their efforts to improve host country financial capability to meet changing health demand and to increase the equity and efficiency of resource use.</p> <p><b>Sub-Purpose</b></p> <ul style="list-style-type: none"> <li>- Promote public policies and regulations which deepen pluralism and encourage private sector participation in health care finance.</li> <li>- Develop broader awareness among top policy makers of the legislative and regulatory issues and options for improving health sector financial viability, and improve the knowledge and skills of public and private managers.</li> <li>- Generate additional financial resources for effective health care in host countries.</li> </ul>	<p><b>End of Project Status</b></p> <ul style="list-style-type: none"> <li>- Seven ANE countries have significant health sector financing activities underway.</li> <li>- Private sector participation will have demonstrably increased and additional resources will have been generated in at least three countries.</li> <li>- Top officials from every ANE country will have participated in at least two conferences on health sector financing.</li> <li>- Public and private managers will have acquired relevant skills in at least eight countries.</li> <li>- Continuing U.S. private sector relationships with LDC private sectors and Missions will have been established.</li> </ul>	<p><b>Objectively Verifiable Indicators:</b></p> <ul style="list-style-type: none"> <li>- Approved projects</li> <li>- Private sector investments</li> <li>- Change in total public and private resource flows</li> <li>- Conference attendance</li> <li>- Short term training completed</li> <li>- Continuing U.S. private sector activities</li> </ul> <p><b>Means of Verification</b> Project approval documents, Mission reports, Contractor reports, budget and cost analyses.</p>	<p><b>Purpose Level Assumptions</b></p> <ul style="list-style-type: none"> <li>- Public resources should be targeted to ensure the needs of those least able to pay are met.</li> <li>- Public-private partnerships can lead to improved health sector productivity and efficiency, and resources availability.</li> <li>- U.S. private sector resources and capabilities are available, interested, and can be tapped.</li> <li>- Politically and culturally adapted pre-paid health care options can be developed and implemented in ANE countries.</li> <li>- Host governments will be receptive to innovative approaches to the solution of their growing health care financing problems.</li> <li>- The private sectors in the host countries will respond positively to opportunities to participate in the health sector.</li> <li>- A more open health marketplace offers the best means for expanding the quality and quantity of equitable health services.</li> </ul>

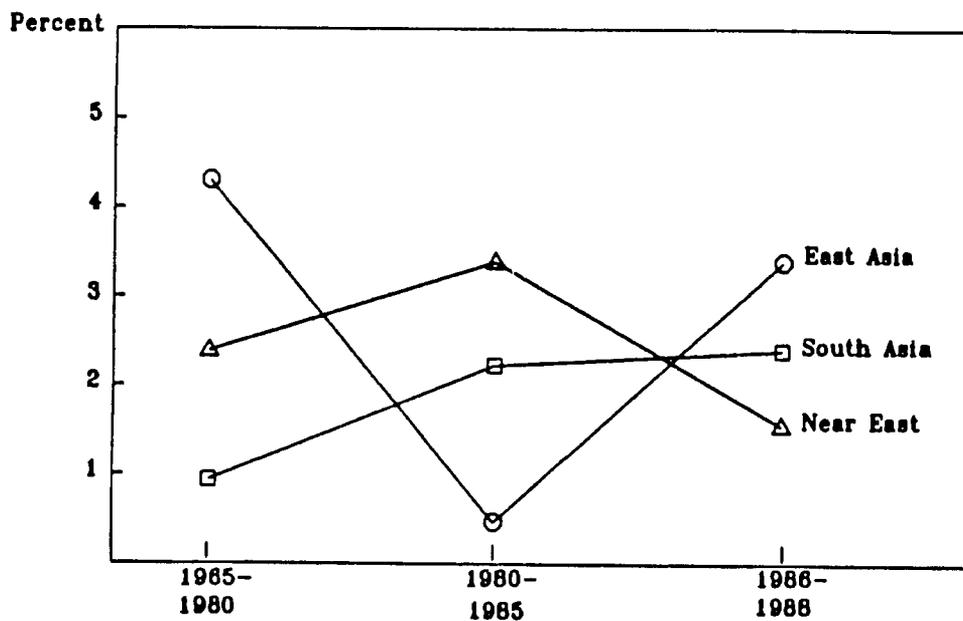
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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																												
<p><b>Outputs:</b></p> <ul style="list-style-type: none"> <li>- Policy studies/inventories</li> <li>- ST finance and management training for 8 countries.</li> <li>- One international, one regional, and six sub-regional conferences or workshops.</li> <li>- Design/initiate prepaid health care activities in 6 countries.</li> <li>- Demonstrations of efficient use of health resources by privatization, improved management, etc. in 5 countries.</li> <li>- Policy changes or regulatory reform for coverage or quality through private sector participation in 4 countries.</li> <li>- Expand or initiate public social insurance schemes in 3 countries.</li> <li>- Facilitate private U.S. investments in health care finance.</li> <li>- Better use of the skills and resources of U.S. health industry.</li> <li>- Information on HCP disseminated – all ANE countries.</li> </ul>	<p><b>Objectively Verifiable Indicators:</b></p> <ul style="list-style-type: none"> <li>- Analytical study reports</li> <li>- Training programs completed</li> <li>- Conferences and workshops conducted</li> <li>- Pilot projects initiated</li> <li>- Demonstration projects completed or underway</li> <li>- Reforms adopted</li> <li>- Investments in place</li> <li>- Actual utilization of U.S. private sector capabilities</li> <li>- Information materials published and distributed</li> </ul>	<p><b>Means of Verification:</b></p> <p>Same as for end of project status, plus government budgets, consultant reports, and economic studies.</p>	<p><b>Assumptions:</b></p> <ul style="list-style-type: none"> <li>- Public resources should be targeted to ensure the needs of those least able to pay are met.</li> <li>- Public-private partnerships can lead to improved health sector productivity and efficiency, and resources availability.</li> <li>- U.S. private sector resources and capabilities are available, interested, and can be tapped.</li> <li>- Politically and culturally adapted pre-paid health care options can be developed and implemented in ANE countries.</li> <li>- Host governments will be receptive to innovative approaches to the solution of their growing health care financing problems.</li> <li>- The private sectors in the host countries will respond positively to opportunities to participate in the health sector.</li> <li>- A more open health marketplace offers the best means for expanding the quality and quantity of equitable health services.</li> </ul>																												
<p><b>Inputs:</b></p> <ul style="list-style-type: none"> <li>- Long- and Short-term technical assistance, including RSSA/HCFA, Consortium and IQCs:</li> <li>- Skills development seminars, conferences, training materials</li> </ul>	<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: center; width: 10%;">LOP ANE</th> <th style="text-align: center; width: 10%;">LOP ADD-ONS</th> <th style="width: 20%;"></th> </tr> <tr> <th></th> <th colspan="2" style="text-align: center;">(\$000's)</th> <th></th> </tr> </thead> <tbody> <tr> <td>Policy Analysis/ Resources Inventories</td> <td style="text-align: center;">2,550</td> <td style="text-align: center;">6,000</td> <td></td> </tr> <tr> <td>Financial Generation/ Management</td> <td style="text-align: center;">3,000</td> <td style="text-align: center;">9,000</td> <td></td> </tr> <tr> <td>Skill development/ Workshops, Conferences, Materials</td> <td style="text-align: center;">1,200</td> <td style="text-align: center;">3,500</td> <td></td> </tr> <tr> <td>Project Evaluation</td> <td style="text-align: center;">250</td> <td style="text-align: center;">950</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center; border-top: 1px solid black;">7,000</td> <td style="text-align: center; border-top: 1px solid black;">19,450</td> <td></td> </tr> </tbody> </table>		LOP ANE	LOP ADD-ONS			(\$000's)			Policy Analysis/ Resources Inventories	2,550	6,000		Financial Generation/ Management	3,000	9,000		Skill development/ Workshops, Conferences, Materials	1,200	3,500		Project Evaluation	250	950			7,000	19,450		<ul style="list-style-type: none"> <li>- Project Activity and Contract Reports</li> <li>- Controller Records</li> <li>- OYB levels</li> </ul>	<p><b>Assumptions:</b></p> <ul style="list-style-type: none"> <li>- Funds available as planned</li> <li>- Opportunities and needs identified as planned</li> <li>- Contracting mechanisms in place to permit Mission co-funding</li> </ul>
	LOP ANE	LOP ADD-ONS																													
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5

- C. Illustrative ANE Data
  - C.1 Average GDP Growth - ANE Region
  - C.2 Urbanization - Selected ANE Countries
  - C.3 Total Fertility and Crude Birth Rates - ANE Countries
  - C.4 Infant Mortality Rates and Child Mortality
  - C.5 Working and Dependent Populations: 1985 to 2000  
(Indonesia and Pakistan)

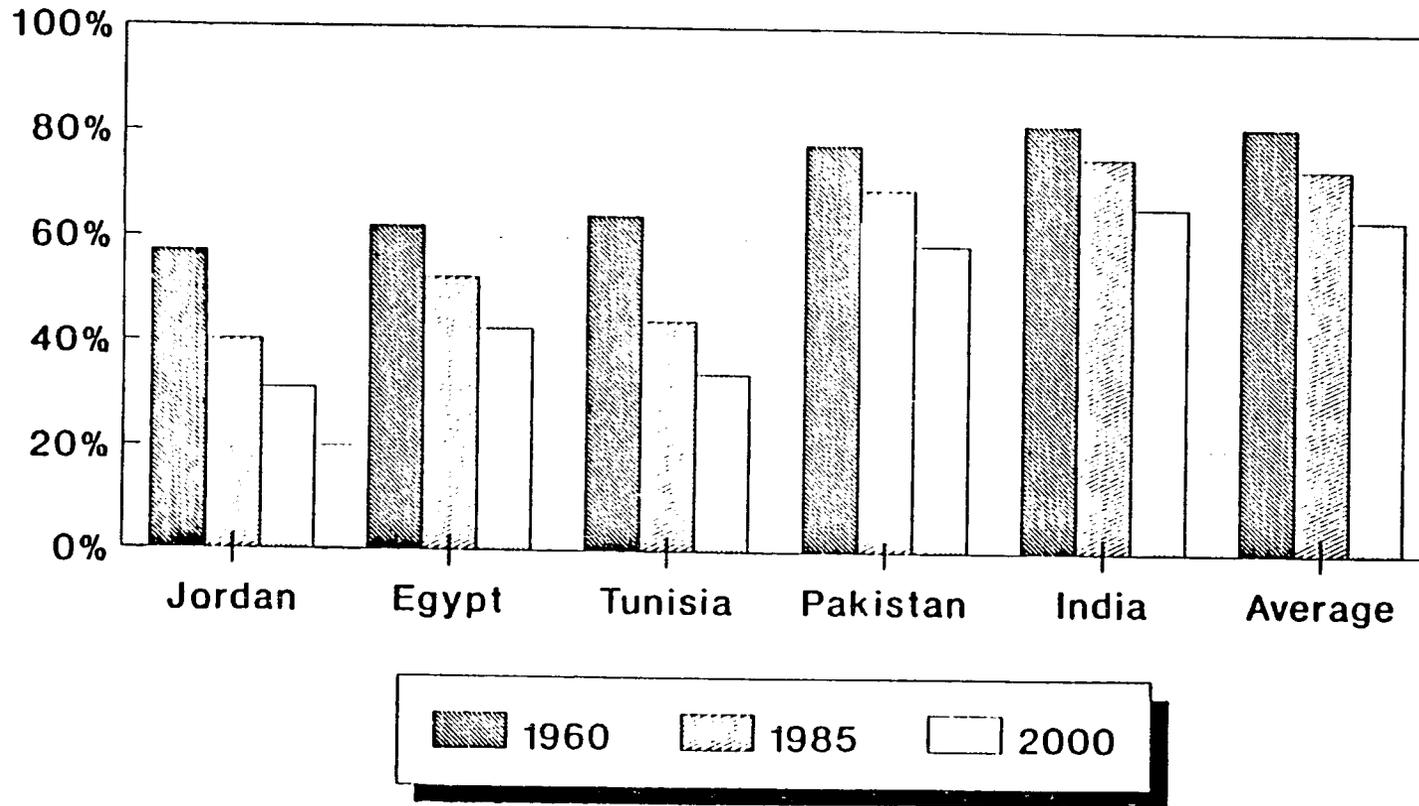
### Average Annual Per Capita GDP Growth ANE Region



Source: ANE/DP

# Urbanization

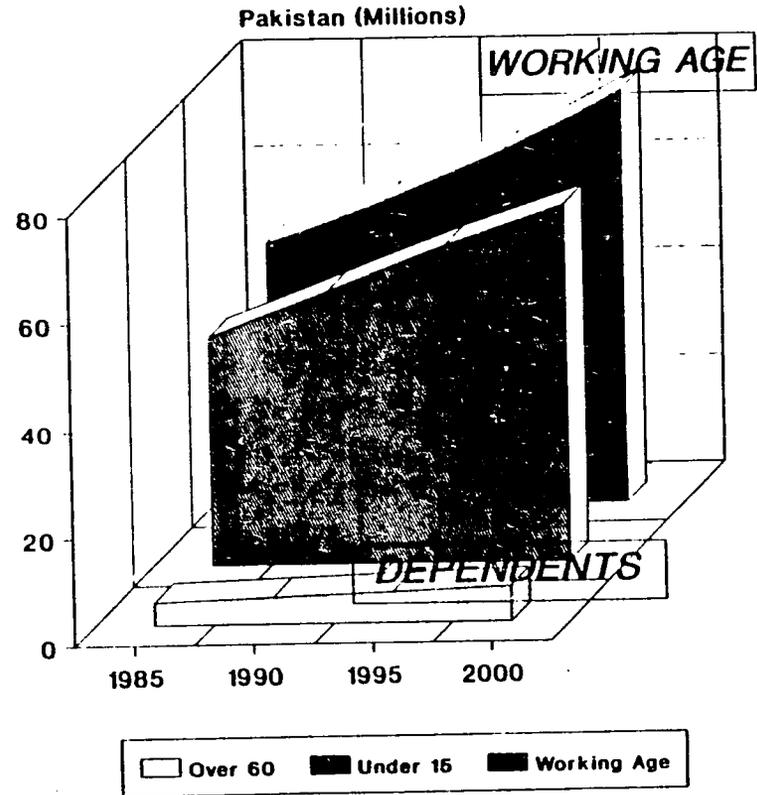
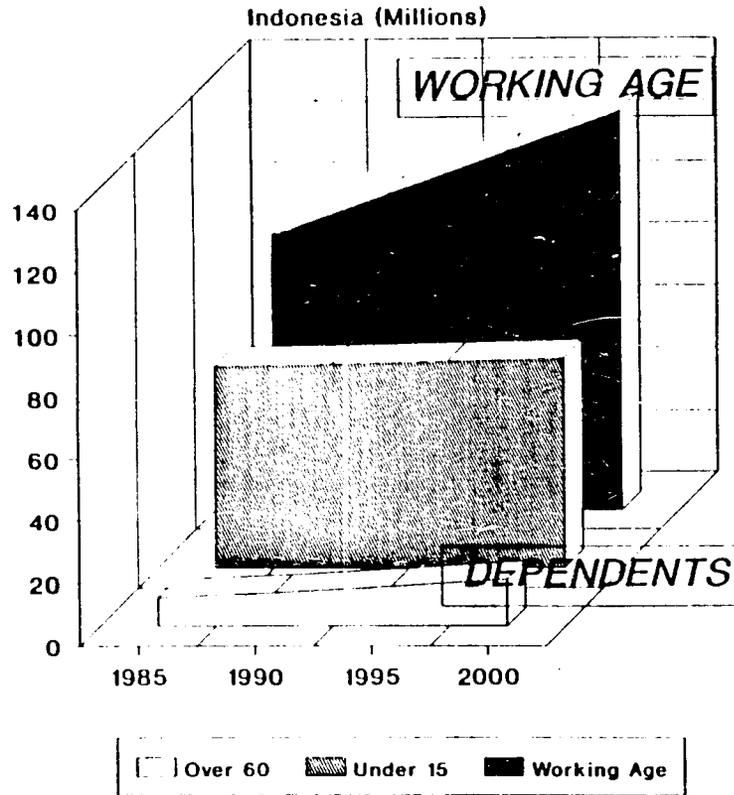
## % Rural by Country



Source: WPP:1988;  
UN Demographic Indicators, 1980  
(\rururban\rurtrnd.CHT)

# Working and Dependent Populations 1985 to 2000

192-



Source: Asia Region Pop Projections  
1985-1995 Edition, World Bank

D. Health Care Financing Administration (HCFA) Basics

D.1 HCFA Background Information

D.2 HCFA Organigram

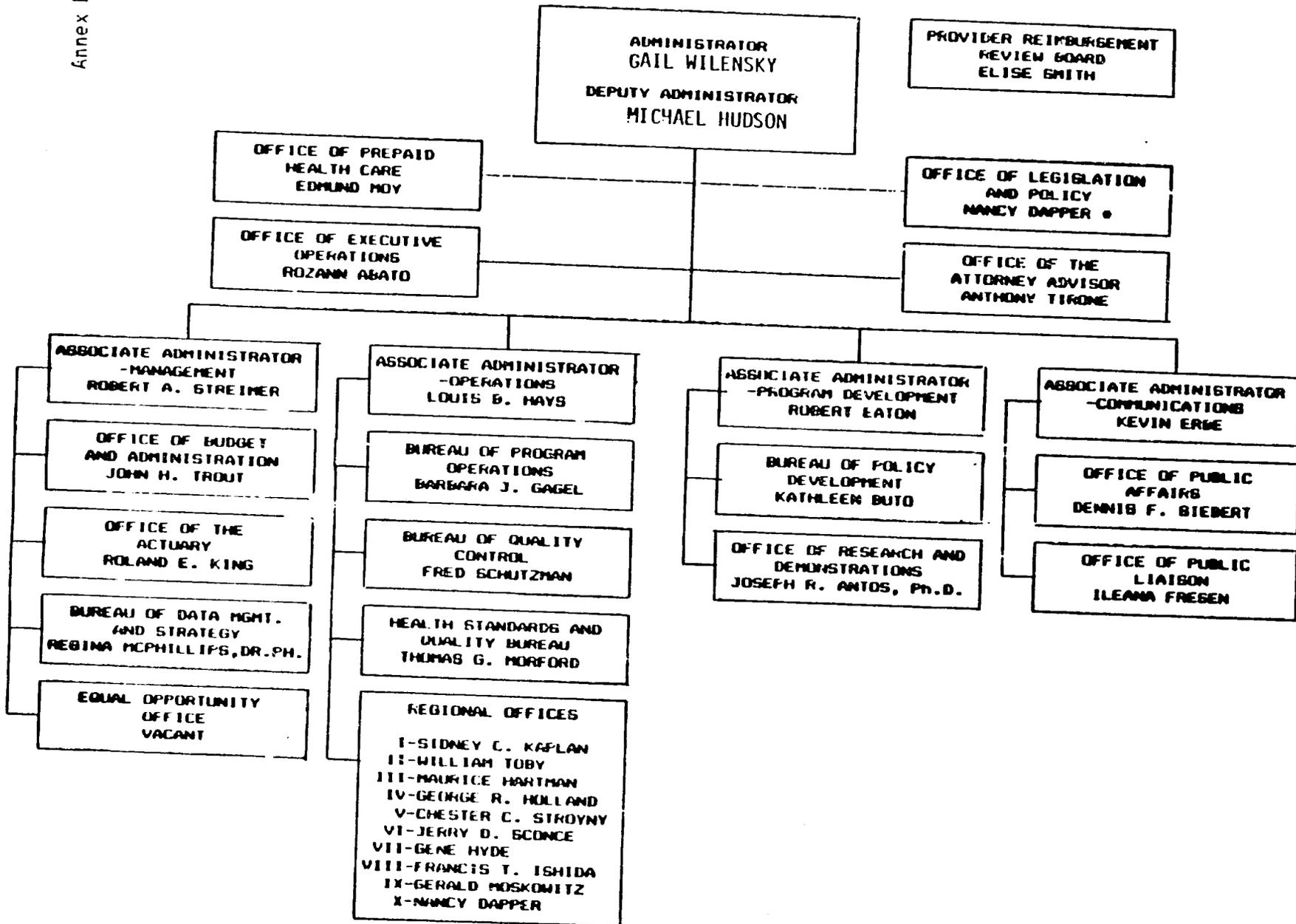
D.3 HCFA/OIH Memorandum of Agreement

32

D.1 HCFA BACKGROUND INFORMATION

The Health Care Financing Administration (HCFA) administers the Medicare program for some 30 million elderly beneficiaries, and another 3 million disabled persons. Together with the States, HCFA also administers the Medicaid program for another 23 million poor and medically needy persons. These programs were created by the Congress in 1965, and account for about 30 percent of the nation's spending for health care. The combined Federal budget for these programs will reach about 150 billion dollars in FY 1990, including 30 billion dollars for physician services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION  
HCFA LEADERSHIP



MEMORANDUM OF AGREEMENT  
 BETWEEN  
 THE HEALTH CARE FINANCING ADMINISTRATION  
 AND  
 PUBLIC HEALTH SERVICE  
 THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH  
 OFFICE OF INTERNATIONAL HEALTH

This memorandum of agreement for reimbursable services establishes the basic provision under which services are to be furnished by the Health Care Financing Administration (HCFA), DHHS, pursuant to Resource Support Services Agreement Number ANE-0249-R-HI-9049, between the Office of International Health, PHS, and the Bureau for Asia, Near East and Europe (ANE) of the Agency for International Development (AID).

I. TITLE OF AGREEMENT:

Health Care Financing in Developing Countries - PHS-HCFA-AID Cooperation

II. PURPOSE:

The purpose of this agreement is to establish a mechanism for the provision and exchange of HCFA professional expertise to the Bureau for Asia, Near East and Europe of the Agency for International Development on a reimbursable basis.

III. CATEGORY OF SERVICES, SUPPLIES, OR MATERIALS TO BE FURNISHED

Reimbursement for personnel services and other agreed expenditures.

IV. DURATION OF AGREEMENT:

October 1, 1989 through September 30, 1991

V. BACKGROUND:

The Agency for International Development and the DHHS have jointly collaborated for many years to assist developing nations in the improvement of their health care services, disease control programs, and in other areas to help meet the needs of their people. Economic and social progress in assisted countries of the Asia, Near East and Europe region has been steady and impressive. Further improvements in health, however, will depend in large measure on the extent to which countries and governments are able to improve efficiency in the mobilization and use of public and private resources for health. Ensuring the adequate financing and distribution of quality health services is the ANE Bureau's most important initiative in health and the cornerstone of its assistance strategy for the next decade.

Within the United States, the Department of Health and Human Services (HHS) and its component agency, the Health Care Financing Administration (HCFA), have played a major role in the development and expansion of insured, prepaid and managed health care systems and of reimbursable payment arrangements which have extended health care benefits and coverage to the poor and elderly in the U.S. population.

The developing countries with which AID works are seeking experience in the design and management of prepaid health care and related systems as well as health care financing mechanisms. Such experience resides within HCFA and groups with which HCFA interacts, but this internal HHS expertise cannot be readily accessed by AID through its usual contracting mechanisms. Several important areas have been identified where specialized expertise is needed. Examples of these include, but are not limited to:

- o Insurance and prepaid systems, including HMOs, reimbursement schemes, etc.
- o Cost management and quality control of health services and facilities.
- o Regulatory and legal aspects governing private and public collaboration in the health sector.

It is anticipated that HCFA's participation in developing and advising on these aspects of the health sector will enhance their professional skills while providing needed expertise to developing countries and AID.

VI. SCOPE OF WORK:

- A. Establishment of Working Group: A working group will be established to facilitate the implementation of activities under this agreement. This will include appropriate representation of ANE/AID; the Office of International Health, PHS; and HCFA. The Office of International Health will be responsible for convening the working group and for providing secretariat support for it.
- B. Short-term technical assistance: Subject to the availability of appropriate staff, HCFA will provide, on a reimbursable basis, through the PHS/OIH RSSA with the AID/ANE Bureau, the services of HCFA professional staff who will assist in the planning and implementation of a program of technical assistance and related activities to developing countries. The following areas are illustrative of the types of assistance that will be provided:
  - 1. Technical assistance on health care development activities ranging from:
    - a. expanded trade in health systems (e.g. management information systems, claims processing software, insurance/

risk management/reinsurance technologies, cost containment techniques and privatization of client and support services);

b. health policy analysis and problem resolution (e.g. assessing coverage/pricing policies, health benefit package design, projecting requirements for age-specific treatment programs); to,

c. preparation of portfolios for investments in designated ANE countries.

2. Design and management of reimburseable, catastrophic, managed care or prepaid insurance systems.
3. Actuarial services, risk assessment techniques, and benefit packaging.
4. Legislation and regulatory requirements for program operations, cost management, reimbursement activities, quality control and the enhancement of investments.
5. Information systems for cost containment, facility management, program management and quality control.
6. Policy analysis specific to areas identified above.

C. Short Courses/Workshops on Health Care Financing Issues and Technologies:

HCFA will provide advice and assistance on the design and will participate in the implementation of short courses/workshops on health care financing issues and technologies. These will be designed to introduce ANE countries to the disciplines and options inherent in the delivery of health services, a more efficient public sector, and an enhanced private sector participation in health services. These courses will include regional examples and comparisons, where appropriate, and will be made available to ANE Mission staff. The courses will be implemented to the extent possible in conjunction with other expert visits in the region. It is anticipated that four courses/workshops will be organized. This will include the preparation of technical papers, materials and workshop follow-up.

D. Seminar:

HCFA will provide advice and assistance on the design and will participate in the implementation of a seminar to familiarize U.S. health care industry groups with opportunities in the ANE region in health. A portfolio of opportunities and needs will be prepared for selected (up to eight) ANE countries. A workshop will be held in the U.S. with the participation of ANE country representatives.

75

VII. RESPONSIBILITIES OF THE PARTIES TO THIS AGREEMENT:

OIH/OASH:

1. Liaison with ANE/AID, on matters related to the overall administration of the RSSA. Coordinate the overall management of the ANE/OIH RSSA.
2. Convene and support the working group called for in VI (A) above.
3. Work with HCFA and ANE/AID in the development of a workplan for activities under this agreement including a schedule.
4. Work/coordinate with HCFA regarding short-term assignments of governmental and non-governmental experts who may from time-to-time undertake assignments, including obtaining clearance from AID as required by the RSSA, and facilitation of logistical arrangements (e.g. travel) and initiation of official communications to AID missions (these will be cleared with ANE/TR/HPN).
5. Assist/work with HCFA in the establishment of a roster of experts both within HHS and outside of the government with expertise which can be drawn upon for the work described in this agreement.
6. Reimburse HCFA for the costs associated with provision of services.
7. Address policy issues related to this program, in close cooperation with HCFA and ANE.
8. Prepare, in cooperation with HCFA, consolidated fiscal and progress reports for submission to ANE as required by the RSSA.

HCFA:

1. Designate a coordinator to work with OIH and ANE on the implementation of this program.
2. Develop, in cooperation with PHS/OIH and ANE, an annual workplan for implementation of the RSSA, including specific objectives and tasks.
3. Cooperate with PHS in the development of a roster of experts who are qualified to fulfill short-term consultancies. This will include both governmental and non-governmental experts.
4. Identify both governmental and non-governmental experts for specific short-term consultancies which may be defined either by AID Missions, in cooperation with AID headquarters, or HCFA, or both.

5. Assure that trip/assignment reports are prepared by all HCFA personnel who provide short-term technical assistance.
6. With ANE and PHS/OIH, provide the requisite orientation for short-term consultancies. Keep OIH apprised of the development of these assignments.
7. Work with AID Missions, through visits to the field and correspondence, to develop the requirements for assignments. These developmental visits will be specified in the workplan called for above.
8. Monitor and evaluate assignments, including assessment of progress based on written reports received from the assignees and through visits to the field. Notify OIH and AID of problems as soon as they surface.
9. Provide quarterly reports to OIH of expenses incurred under this agreement. This is a RSSA requirement.
10. Prepare and submit to OIH semi-annual reports on the progress of work carried out by HCFA for inclusion in a consolidated report to AID.

VIII. IMPLEMENTATION:

1. OIH, HCFA and AID/ANE will each designate a liaison who will serve as a member of the working group. Other staff should, as appropriate, be encouraged to participate on an ongoing basis.
2. The HCFA and OIH liaisons will take the lead in preparation and monitoring of a workplan which provides a schedule of activities to be undertaken in the ANE region.
3. The mechanism for identifying activities and experts to be employed under this agreement is as follows:
  - o ANE field missions and staff will work with the HCFA liaison to identify country priorities, consultant/expert needs and terms of reference for collaboration over the implementation period.
  - o HCFA will identify professional staff, or other experts, available for short-term assignments in the designated skill areas from governmental and non-governmental contacts and shall advise which experts may be appropriate and available for a given assignment. Maximum use of HCFA and PHS staff for short-term assignments under this RSSA is planned in order to maximize benefits to AID.

Exceptions to use of PHS or HCFA staff may be appropriate in the following instances:

- o When such expertise is not available within a reasonable time frame (one month from time of request).
- o When special language requirements apply and the expert is only available through a HCFA non-governmental contact.
- o When U.S. private sector expertise is indicated and no HCFA staff have the expertise or the time available.

The roster of experts will be regularly updated by OIH and HCFA to respond to emerging needs identified by missions and HCFA experts during implementation. Experts should have strong professional skills and excellent interpersonal and communication skills. It is highly desirable that they have overseas experience, "teaching" or technology transfer experience and skills. Experts may be senior- or mid-level professionals since both may be required at different times in the evolution of specific activities.

Handling of specific short-term requests: When a specific request is received, ANE/AID will forward the request directly to the HCFA liaison with a copy to OIH/PHS. After any necessary clarifications, the HCFA liaison will review the available HCFA professional staff and the expert roster and make recommendations to AID/ANE on the person or persons suitable to fulfill the request. AID/ANE will review with its missions and provide concurrence. If nongovernmental experts are to be used the AID Agreement Officer will be provided with biographical and rate-of-pay information prior to assignment. The AID Agreement Officer will review the information to assure that the rate of pay conforms with AID policy. The expert will be considered cleared if a reply is not received from the AID Agreement Officer within three business days. OIH will assist with logistics and travel support arrangements.

Activities requiring broader planning and implementation efforts: For activities such as the design of a training course which may require a level of effort exceeding HCFA staff availabilities, the HCFA liaison will prepare a scope of work to obtain the required expert services through a contract. The scope of work will be reviewed and approved by AID/ANE and the AID Contracting Office and a decision made on the contract mode and its management.

IX. BUDGET:

The HCFA budget set forth in this section provides for a level of effort by HCFA personnel, subject to the availability of staff. The budget for the RSSA as a whole is provided in Annex A. It is agreed that HCFA will bill, on an as-used basis, for these direct personnel charges, not to exceed the amount given below:

Salaries (calculated at GS-15/6 level) 26 man months	\$ 150,000
Benefits @ 35.75%	<u>53,625</u>
TOTAL	\$ 203,625

It is understood that the foregoing level of commitment can be revised as mutually agreed by the parties to this agreement.

Funds for travel are retained by the Office of International Health for use when required.

X. RESPONSIBLE OFFICIALS:

Harold P. Thompson  
Director  
Office of International Health  
Office of the Assistant Secretary for Health  
Public Health Service  
5600 Fishers Lane, Room 18-87  
Rockville, Maryland 20857  
Telephone: (301) 443-1774

George J. Schieber, Ph.D.  
Director  
Office of Research  
Office of Research and Demonstrations  
Health Care Financing Administration  
6325 Security Boulevard  
Room 2-F-8 Oak Meadows Building  
Baltimore, Maryland 21207  
Telephone: (301) 966-6504 or FTS 646-6504

Patricia S. Gibson  
Deputy Chief  
Health, Population and Nutrition Division  
Office of Technical Resources  
Bureau for Asia, Near East and Europe  
Agency for International Development  
2201 C Street, N.W., Room 4720 NS  
Washington, D.C. 20523-0053  
Telephone: (202) 647-8940

XI. PAYMENT TO BE MADE BY:

Payments under this agreement will be made by the Office of the Assistant Secretary for Health to HCFA based on quarterly billings/vouchers to OIH. Expenses must be broken down by object class code.

Billings will not be made electronically directly to the PHS Finance Office. The billings, in the form of Standard Form 1081, will be submitted to the PHS Finance Office through OIH.

The following information will be included on all billings under this agreement for salary and other costs by object class:

OIH Fiscal Data

RSSA No: ANE-0249-R-HI-9049  
Proj Name: Health Sector Financing  
and Sustainability, ANE/AID  
PIOT No: 3-9633007  
OIH Agreement No: OIH-001-274  
Agency Symbol: 75-03-0030  
Appropriation No: 7501101  
CAN No: 0-A734274  
Object Class: 25.34  
Allotment: 0-48000  
Allowance: 0-48274

HCFA Fiscal Data

Agency Symbol: 75-05-0020  
Appropriation No: 7500511  
CAN No: 059932456221  
Object Class: 2514  
Allotment: 32 60  
Allowance: 345 620

Invoices are to be sent to:

Jerome Rutkoski  
Budget Officer  
Office of International Health  
5600 Fishers Lane, Room 18-87  
Rockville, Maryland 20857  
Telephone: (301) 443-4560

HCFA Financial Contact:

Gerald Hankin  
Director  
Division of Accounting/HCFA  
P. O. Box 17255  
Baltimore, Maryland 21203-7255  
(301) 966-5457 or FTS 646-5457

XII. AGREEMENT NUMBER:

OIH-001-274

XIII. EXTENSION OF AGREEMENT:

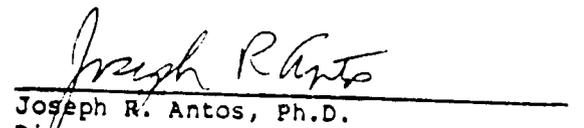
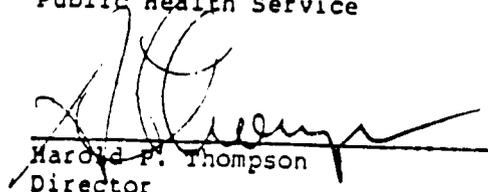
It is understood that this agreement may be extended by mutual agreement of all parties, subject to availability of funding under the OIH-ANE RSSA.

Full implementation of this agreement will not duplicate any existing agreement.

This agreement is made under the authority of the Economy Act approved June 30, 1932, as amended (31 USC 1535 and 1536).

Public Health Service

Health Care Financing Administration



Harold P. Thompson  
Director  
Office of International Health

Joseph R. Antos, Ph.D.  
Director  
Office of Research and Demonstrations

Date: 27 MAY 1970

Date: 3/29/90

Annex

BUDGET FOR OIH-AID RSSA

Short-Term Technical Assistance	\$100,000
HCFA Technical Assistance	203,625
Other Technical Assistance PHS, Training & Workshops	97,267
Travel & Per Diem	<u>96,000</u>
Subtotal	\$496,892
Overhead @ 10% (OIH)	<u>49,688</u>
TOTAL	\$546,580

E. Biography of Selected References

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