

**A.I.D. Health Projects:  
Comments on the "Sustainability" Issue**

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## Introduction

Health projects, like others, have termination dates. At some point, life-of-project funding comes to an end. Generally speaking, the sustainability issue has to do with what happens after that point -- what the prospects are that the project or some of its elements will continue to be implemented or that the effects of the project will continue to be manifest for some time into the future.

The sustainability issue vis-à-vis any given project is usually evaluated in terms of the probable availability of host-country financial resources to take over where A.I.D. funding has stopped or, more generally, to meet the continuing need for recurrent-cost funding implied by the project. In our engagement with this issue, however, we should recognize that projects may fail to be sustained for reasons in addition to shortfalls in available funding. Thus, projects may fail to be sustained owing to "organization failures" of various other kinds.

We should also explicitly recognize that the sustainability issue is apt to arise in rather different ways depending upon the particular kind of project or project component at issue. Thus, an appropriate typology of project components will help to organize and inform sustainability analysis.

## Types of Health-Project Components to be Distinguished for Sustainability Analysis

Health projects in the A.I.D. Project Paper (PP) sense usually will contain more than one of the following types of project components:

1. Attempts to change the health-related behavior of consumers of health services, e.g., oral rehydration therapy (ORT), immunization (EPI), nutrition and waste disposal.
2. Implementation of a health-services delivery system, say some components of a primary health care (PHC), basic-health-services network. This is the kind of project component which the PP is apt claim will "be replicated nationwide" after the project (to adopt the colorful terminology frequently found in PPs).
3. Training of health manpower - medical, e.g., midwives and traditional birth attendants (TBAs).
4. Training of health manpower - planning/administrative, e.g., Ministry of Health (MOH) officials who will be in planning roles.
5. Design and installation (implementation of) planning/management information systems.

No doubt various versions of such a project-component typology could be produced. This version will serve for the present purposes to illustrate the different ways in which the sustainability issue may arise and the implications of this for evaluating sustainability.

1. ATTEMPTS TO CHANGE HEALTH-RELATED BEHAVIOR OF CONSUMERS OF HEALTH SERVICES:

An example of a project which attempts to change the health-related behavior of consumers of health services is the National Control of Diarrheal Diseases Project (NCDDP) currently operating in Egypt. This project endeavored to teach mothers how to recognize the dehydration complications of childhood diarrhea and how to mix and administer oral rehydration solution (ORS) and related matters. The project sought to modify mothers' behavior such that mothers would in practice respond to dehydration signs and symptoms by properly administering ORS (and related behaviors). It appears that the project has been successful in changing this health-related behavior for the vast majority of mothers with children at risk. This was accomplished for the most part by television messages received by the mothers in their homes.

When we speak of "sustaining" a project component of this kind, we do not have in mind continuing in the post-project period to implement an activity just like the project, i.e., using all of the project inputs (e.g., television messages) at project rates of resource commitment. What we expect to be sustained is the change in health-related behavior. This may require no follow-on, project-type activity -- the behavior change once established in today's cohort of mothers, may simply propagate culturally, passed on from mother to daughter (tomorrow's mother). Or, this may require substantial post-project commitment of project-type resources. It is a distinguishing feature of the sustainability issue as it arises for such a project component that we typically will not know, ex ante project implementation, what resources will be necessary for sustaining the project (which in this type of case means sustaining the project's impact on behavior).<sup>1</sup>

We have used the NCDDP in Egypt (an ORT project) as exemplary of this type of project component, but many other kinds of A.I.D. projects include important components of this type.

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<sup>1</sup> We should also note (although perhaps this is something of an aside in this context) that it is a distinguishing feature of this kind of project component that conventional, life-of-project unit cost calculations, say, for "cost per case treated" will be of little or no use to inform judgments about the cost-effectiveness or cost worthiness of resource commitment to the project. This is so because most of the cases treated in consequence of resource commitment to the project will occur in the years following the termination of the project, accompanied by some unknown rate of continuing resource commitment during those years.

What are the implications of this type of project component for A.I.D. sustainability policy? That policy says, generally speaking, that we should not launch projects unless they can be sustained. But in this type of case, we do not know what resource commitment may be entailed to sustain a project.

A conservative approach would be based on a worst-case scenario. We would assume that to sustain the behavior change in the post-project period will require continuing resource commitment on the same scale as the project. We would then assess the probability that the host country would come up with the necessary resources. If this appeared unlikely, the project would not be launched.

The trouble with such a worst-case approach is that, although it may be prudential in some relevant sense, it is not otherwise a very "rational" way to respond to the uncertainties in this kind of case. In most instances, for project components of this type, the worst-case scenario will imply an unrealistically high requirement for post-project funding in order to sustain project outcomes. Thus, we might fail to launch a project when a more modest and more realistic estimate of post-project resource requirements for sustaining the project, would have permitted implementation of the project, in this way realizing the social benefits delivered by the project, both during its term and thereafter.

There would, of course, be some uncertainty in going with the "more modest" estimate of post-project resource requirements. But the expected yield to this strategy might very well be greater than the expected yield to the prudential strategy which would have foreclosed implementation of the project.

For various reasons, evaluating the prospects for sustainability is always a probabilistic kind of exercise with the probability that the project will be "100% sustained," so to speak, always less than 1.0. Discussion of this type of project component, namely, attempts to change health-related behavior of consumers, has identified one source of uncertainty in this domain -- namely, uncertainty about what resources will be necessary post-project to sustain project outcomes.

It is important to note that for this kind of project, the design of the project itself should be responsive to the source of uncertainty. Thus, a project such as NCDPP in Egypt should have built into it (probably during its final years) systematic procedures for testing post-project resource requirements (e.g., selective withdrawal of project inputs to determine what the impact is on the health-related behavior in question).

This suggests another important point. In some instances, social experiments may be necessary to assemble the information necessary to inform evaluation of project sustainability (e.g., what patterns of resource commitment over time are necessary to achieve various patterns of health-related behavior change over time?). If a project is itself

regarded as such a social experiment, the issue is not whether that project is itself sustainable. The sustainability issue relates to the implications of the information assembled by the social experiment, e.g., the question whether costworthy, sustainable projects can be designed in this project domain. Although they may pose problems for usual definitions of A.I.D.'s sustainability policy, such social-experiment-type projects may be among the more productive uses of project funding.

## 2. IMPLEMENTATION OF A HEALTH-SERVICES DELIVERY SYSTEM:

An example of a project which implements a health-services delivery system is the Primary Health Care Project now operating in Pakistan. This project in various ways assists the provincial health departments to operate a system of basic-health-services facilities cum staff and other inputs known as Integrated Rural Health Complexes (IRHCs). Pursuant to this, the project trains some categories of non-physician providers (NPPs) of health care, these intended to be posted to the IRHCs. The project also trains IRHC staff and health department staff in management/administrative skills. Other project activities are also carried out. Many A.I.D. projects around the world have had this general kind of format. It has been the stated intention that the IRHC system for basic health services will be "replicated nationwide" in the post-project period.

When we speak of "sustaining" a project component of this kind, we have in mind continuing to implement in the post-project period an activity similar to the project IRHCs, using inputs at project rates of resource commitment. It is a distinguishing feature of the sustainability issue as it arises for a project component of this kind that typically we can know, ex ante project implementation, what resources will be necessary for sustaining the project.<sup>2</sup> There may be requirements for both development funding (capital account) and recurrent funding (current account) -- e.g., in this case where the project-type IRHCs are to be extended to cover a large part of the population.

The sustainability question is whether, once project funding has ended, the host country government will come up with the funding necessary to sustain the project or whether such funding will be otherwise available in the host-country setting (e.g., fees for services delivered by the IRHCs). We have already remarked that evaluating prospects for sustainability is always a probabilistic kind of exercise. Here, the source of uncertainty is different from that discussed previously. It is not so much uncertainty about what resources will be necessary post-project to sustain. It is rather uncertainty about whether these required resources will in fact be provided by the host-country government or in some other way. We can never be 100% sure about the answer to this question.

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<sup>2</sup> We say "can" know (distinguish "do" know) to recognize that, in practice, costing of the project may have left quite a bit to be desired.

The Questions for A.I.D. Sustainability Policy Are:

- (a) What kind of information should be assembled pursuant to seeking an answer to this question? How much of what kinds of information do we require to make a credible case that the required funding will be available?
- (b) How high a probability that the required funding will be forthcoming is required in order for a project to pass the sustainability test? For example, will a 0.5 probability do, or do we require something closer to 0.9?

It is important to understand that if A.I.D. sustainability policy is to be administered in a serious (distinguish pro forma) way then it will be necessary to attend to questions such as these in a serious way.

Where the question under (a) is whether the host-country government will come up with the required funding, we frequently assemble information intended to cast light on "the feasibility of the fiscal effort" necessary to sustain the project. For example, a recent evaluation of the Pakistan Primary Health Care Project found that the per capita operating costs of the project IRHCs would work out to about Rs. 26.0, and then asked:<sup>3</sup>

"How may we evaluate the operating-budget loading implied by an IRHC operating cost of about Rs. 26.0 per capita? One way is to compare it with total expenditures per capita by the provincial health department to determine the proportion of these budgets that would be claimed by IRHCs on the project model. The following table exhibits data relevant for this purpose.

[table omitted]

Thus, it would also appear that an IRHC expenditure on current account of Rs. 26.0 per beneficiary would be more than total health department expenditure on current account per capita in Punjab and Sind and about 80.0% of such expenditure in NWFP and Baluchistan."

A finding of this kind is intended to cast light on the "feasibility of the fiscal effort" necessary to sustain the project. I have attached as Appendix I a more elaborate exercise addressing the feasibility of fiscal effort (on capital account this time) to give some idea of the nature and uncertainties of this kind of analysis. That analysis concluded that the

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<sup>3</sup>See Report of the Mid-Term Evaluation Team Pakistan Primary Health Care Project, December 8, 1985, pp. 53 et seq. The Report looked at the "fiscal feasibility" issue from other points of view as well.

required fiscal effort was feasible. The analysis reported above concludes that the required effort is not feasible. How do findings of this kind bear on the question of whether a given project passes the sustainability test?

We cannot provide an extensive discussion of this question here; a few points must suffice. Even though, based on recent past history of fiscal events, the fiscal effort necessary to sustain a project may be judged not very feasible, this does not necessarily mean that the fiscal effort cannot and will not be made. Indeed, it is not uncommon in these circumstances for host-country officials to urge that a newfound commitment to PHC, prevention/promotion and the like can be expected to have just such a result. What weight should be given to such testimony? Likewise, a finding that the fiscal effort necessary to sustain a project appears feasible does not necessarily mean that the fiscal effort will in fact be made. After all, to accommodate the resource requirements to sustain the project (however "feasible") will always require choice between activities for funding -- some other activity (say, hospitals) will have to be denied the resources which have been committed to sustaining the project and the decision makers may, in the event, be reluctant to make that choice. What weight is to be given to the testimony of host-country officials that, in reality, they will make the choice in favor of sustaining the project?

#### The "Expected Yield" Criterion

One useful way to look at this whole matter is as follows. Define as the "expected yield" to a project the yield to be realized if the project is fully implemented/sustained (say, for a hypothetical project, 100 units), discounted by the probability that the project will in fact be fully implemented/sustained (say, for the same hypothetical project, 0.5). The expected yield to this hypothetical project is 50 units.<sup>4</sup> We assemble information on relevant past fiscal history, policy declarations and the pronouncements of host-country officials in an effort to make a rough estimate, at least, of the probability that the project will be fully implemented/sustained. In allocating our scarce resources among the competing projects that are candidates for funding, we will want to choose those projects with the highest expected yields.

#### Not All Projects Should Be Required to Meet the Same Sustainability Test

This way of putting the matter makes one very central point. Where the "sustainability test" is put in terms of the probability that the project will be sustained (always less than 1.0), each project may have a different

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<sup>4</sup>Since we are developing here a conceptual framework to help sort out thinking about the sustainability issue, we can leave undefined the units in terms of which yield is measured. This exercise is not meant to imply that we need literally to undertake a numerical calculation of the yield -- indeed, for health projects, there is frequently no non-trivial way in which this could be done.

passing score. Projects with very high yields (if fully sustained) but rather modest probability scores may have higher expected yields than projects with modest yields (if fully sustained) but very high probability scores. Thus, the crucial test is the "expected yield" test and evaluation of projects for sustainability must be made in this context.

#### For How Long Must a Project Be Sustained?

As usually stated, A.I.D.'s sustainability policy tends to be silent on the matter of time horizon. For how long must a project be sustained to pass the sustainability test? Forever? One year? Two years? Obviously, there can be no rule of thumb here. The costs and benefits of projects are incurred and realized over a period of years. In deciding if expenditures on a project are costworthy, we compare them with the present (discounted) value of the future time-stream of benefits. (In principle, at least -- i.e., this is the way we think about it, if not literally calculate it.) Some projects may have high yields even during the project years themselves and in the immediate years thereafter such that resource commitment to them may be regarded as costworthy even if they are not expected to be sustained for very long. Other projects may require a longer period of post-project operation (i.e., require the project to be sustained for a longer period of time) in order to make resource commitment to them costworthy.

#### "Sustainability" Not to be Confused with "Self-Sustaining" or "Self-Financing"

The PP for the Primary Health Care Project now operating in Pakistan made the suggestion that some of the burden on health department operating budgets could be relieved if the IRHCs charged fees for services rendered. This suggestion raised a number of important questions, viz: (1) Considering the intended large public health component in the output of the IRHCs in Pakistan, to what extent would fees for IRHC services be consistent with economic (allocative) efficiency? (2) How much cost recovery could be expected from this financing strategy? We do not intend to discuss these questions here.

A couple of related points on this example are very much in order, however. In the context of various health projects around the world where question (2) above is being asked for government-provided services, there will be little relevant information upon which to base an estimate. This is owing to a number of circumstances (e.g., the probable irrelevance of demand estimates based on private-market experience) which cannot be rehashed here. This is another domain in which social experiments may be necessary to assemble the necessary information (see comments on A.I.D. projects in this role, p. 3 above).

Arrangements such as those suggested for the IRHCs in Pakistan (i.e., fees for services) may or may not make sense and may or may not work in that case, but they should not, in any event, be taken to imply that A.I.D.'s sustainability policy expects PHC programs assisted by A.I.D. to achieve sustainability and financial viability by generating private revenue. The sustainability of the PHC programs must derive from the

financial viability of, and appropriate resource allocation within, the MOH system as a whole. (See Appendix II for further discussion of these issues.)

#### Active Rather Than Passive Engagement with the Sustainability Issue

Historically, in implementing A.I.D.-assisted health projects, a rather passive approach has been taken to the sustainability issue. The PP may review some recent history of relevant fiscal events, review what appears to be national health policy for the country in question and perhaps allude to comments by various officials -- concluding on some such basis that the project will be sustained -- all of this subject, of course, to the stipulations set out in the "Assumptions" column of the Logframe. The big problem has been, of course, that the plausibility of the stipulations impounded in the "assumptions" seldom receives serious attention. The key to successful engagement with the sustainability problem is to resist the temptation to "bury" the problem in the "assumptions."

Let us suppose with respect to a given project that a thoughtful and candid evaluation of the prospects for financing leads to the conclusion that, as matters stand, the probability that the project will be sustained is no better than 50-50. Rather than simply assuming the problem away or abandoning the project, we might take a more active approach -- undertake, along with the main project, some additional project activity in the form of an accompanying financing project intended to remedy the situation as it stands such that the odds for sustaining the project are greatly improved. This, it may be argued, is the strategy suggested by the REACH project in combining EPI (and other PHC initiatives) and financing-project activity in the same project. (See Appendix II for further discussion of these issues.)

#### "ORGANIZATIONAL FAILURE" AS A BAR TO SUSTAINABILITY

In the health-services sector in LDCs, organization failure, both at the individual-facility level and MOH-bureaucratic level, is manifest in many ways. For example: vehicles and other equipment malfunctioning and down for long periods of time without repair; non-delivery or untimely delivery of vital supplies, such as drugs; little or no supervision of facility staff; little or no outreach by facility staff even though the job descriptions call for it; staff absent from posts during official government working hours; diversion of supplies to improper channels; records maintained in a careless, perfunctory way; low-quality services delivered by facilities to consumers -- and so on; anyone who has worked in the field will have no trouble adding to this list. The point here is not to rehearse these well-known matters. Rather, it is to direct attention to the fact that organization failure of one kind or another may be as important a bar to project implementation/sustainability as a shortfall in funding for project activities. The point also is to raise the question: What are the implications of organization failure for A.I.D.'s sustainability policy?

Our response to these problems frequently is to implement health-project components of types 4 and 5, i.e., train planners and administrators in these skills and implement planning/management information systems. When we speak of "sustaining" project components of types 4 and 5 what we have in mind is that the skills and information generated by the project will in fact be effectively put to work in the various facilities and bureaucracies that comprise the the health-services system system. What kind of evidence do we require that these events will in fact occur in order for type 4 and 5 project components to pass the sustainability test such that they can be launched?

If A.I.D. sustainability policy is to be taken seriously, it is important that serious attention be directed to this question. The main problem in this domain is, as most of us probably would agree, that the usually relied-upon type 4 and 5 project components are not in any fundamental way really responsive to the problem of diffuse organization failure. Management/administrative skills and appropriate information may be necessary for efficient organization performance, but they are not sufficient for such performance. Indeed, the major reason for much organization failure is not so much lack of skills and information as it is (1) lack of intra-organization and extra-organization incentives to motivate efficiency and (2) rules for personnel administration which frustrate any efforts to achieve efficient performance. How in the context of A.I.D. sustainability policy are we to respond to these real constraints on sustainability?

### Conclusion

The foregoing discussion is far from a comprehensive discussion of the sustainability issue. Nor has the discussion been intended as self-contained. Rather, it has selectively considered this issue with the hope of getting a few central points on the agenda for serious attention and discussion.

## ABBREVIATIONS

<b>A.I.D.</b>	<b>U.S. Agency for International Development</b>
<b>EPI</b>	<b>Expanded Program on Immunization</b>
<b>IRHCs</b>	<b>Integrated Rural Health Complexes</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>NCDDP</b>	<b>National Control of Diarrheal Diseases Project (Egypt)</b>
<b>NPP</b>	<b>Non-Physician Provider</b>
<b>ORS</b>	<b>Oral Rehydration Solution</b>
<b>ORT</b>	<b>Oral Rehydration Therapy</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PP</b>	<b>Project Paper</b>
<b>TBA</b>	<b>Traditional Birth Attendent</b>

This appendix is an excerpt from my January 17, 1977 memorandum to Mr. William R. McIntyre, AD/PHN (USAID/Islamabad) addressed to the "Feasibility of the Fiscal Effort Implied by Present Plans for Developing the Basic Health Services (BHS) Network."

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The question is whether it is realistic to suppose that there will be this kind of fiscal capacity on ADP account for development of the BHS network. What events and decisions may be regarded as crucial for the answer to this questions, i.e., such that an evaluation of them will be helpful in casting light on the answer? An approach to this question may be had by noting that the ADP available for the BHS system depends upon the following: (1) The rate of growth of GDP (6 percent). (2) The ratio of total ADP to GDP (12.5 percent). (3) The ratio of health ADP to total ADP (4.5 percent). (4) The ratio of BHS ADP to health ADP (40 percent).

The figures in parentheses reflect the status depicted in (and to some extent inferred from) the 1976/77 ADP - a few comments on each is in order.

1. Whether the economy will in fact grow at a 6 percent rate over the coming years remains to be seen. It seems to me, however, a reasonable assumption (in any case, its rather lower than the projected growth rate).

2. The 1976/77 ADP depicts the total ADP (Rs. 17,000 million) as 12.5 percent of GDP (Rs. 135,986 million - factor cost). The decisions yielding this percentage do not reflect the extent of the "commitment to basic health services" but they are crucial to the ADP fate of the BHS system. This figure reflects the intentions and ability of the system to generate real saving in the

APPENDIX I (2)

public sector -- for health and everything else. Other ratios constant, a one percentage point increase in the ratio ADP/GDP yields an 8 percent increase in BHS ADP at current levels. It seems reasonable to suppose that the ability of the economy to generate real internal saving will improve over the years, we may expect some upward drift in this ratio.

3. The 1976/77 ADP depicts the health ADP as 4.5 percent of the total ADP. This ratio has been very constant for some years now and the best assumption would be that it will remain at about this level for some years. This figure, of course, does say something about the "commitment to health" -- but the mere fact that it stays at the same (or assumes any given) level does not by itself yield a conclusion whether that commitment is "enough" by some norm. What counts is not this one ratio, but what BHS ADP is yielded by all the ratios and how this compares with some norm.

4. The ratio of BHS ADP to total health ADP is in some ways the most important figure for the instant prognostications. It is unfortunate that, to the extent that recent history might inform an estimate on this score, recent history has been distorted by the fact of the (largely externally financed) malaria program. Of the 1976/77 health ADP of Rs. 771.0 million, some Rs. 415.0 million is budgeted for malaria. Is the large malaria program temporarily inflating the health ADP such that the health ADP might be expected to retreat the lower levels once malaria is under control? I think not. The

1976/77 health ADP, with malaria, is at its historical level of 4.5 percent of total ADP, and, as mentioned, I would expect it to at least maintain this ratio. In computing the percentage of health ADP for basic health services, should we count the malaria program as a basic health service in the sense that funds released from it would go to other basic health services? If we count malaria in the BHS sector, that sector has some 65 percent of the health ADP. If we leave malaria out altogether (both numerator and denominator), the BHS sector comes out at about 26 percent of the health ADP. My assumed 40 percent roughly splits this difference and yields a figure which seems to me reasonable. The outcome of course depends in important part on future resource commitments to medical education. It now appears to be true that there are no current plans to add first-year places to the capacity of the medical-school sector. This does not mean that there will be no substantial commitment of funds to the sector. The sector is in a position analogous to population growth after ZPG net reproduction rates have been achieved. In this case, owing to the age distribution of the population in consequence of a period of prior rapid growth, the population will go on increasing, gradually approaching a limit. The medical-school and training sector is now, hopefully, at "ZPG" net reproduction status - but a good bit remains to be done (e. g., provision of hospital beds for clinical training -- much of this will be accomplished by using beds already in place) to bring the large

APPENDIX I (4)

number of recently sanctioned seats on line as properly staffed and equipped medical-education capacity. Nevertheless, the commitment to the medical education sector should taper off.

Starting from the 1976/77 ADP and looking to the next year and assuming 1(1.06), 2 (.135), 3(.045) and 4 (.40) -- yields a BHS ADP of Rs. 354.7 million. This figure is very much in the ball park of what appears to be implied by the PP's Phase II, even without substantial USAID loan assistance which might be forthcoming. And it seems also to be in the ball park of what's implied the current discussion of the 5th plan (which in turn, as pointed out, comports with Phase II).

Thus, on the basis of this rather rough and ready analysis, I conclude that the system does have the fiscal capacity of accommodate current plans for the BHS sector on development funding account.

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This appendix is an excerpt from the following:

October 16, 1985

**MEMORANDUM:**

**TO:** Anne Tinker, Cindy Clapp-Wincek

**FROM:** Carl M. Stevens

**REF:** AID SECTOR STRATEGY - HEALTH, USAID May 1984 (Sector Council for Health)  
A.I.D. POLICY PAPER - HEALTH ASSISTANCE, USAID December 1982 (PPC)  
A.I.D. POLICY PAPER - RECURRENT COSTS PROBLEMS IN LESS DEVELOPED COUNTRIES, USAID May 1982 (PPC)

**SUBJECT:** Some Implications of the Above Captioned Documents for the Financing Elements and Aspects of A.I.D. Health Projects and Hence for Resources for Child Health Project Activities

These documents contain a number of suggestions, recommendations and prescriptions directly addressed to health-sector financing. Other provisions of these documents have less direct but important implications for financing events. Initially we may consider the more directly-addressed material.

APPENDIX II (2)

Sustainability (Financial Viability) of Health Projects/Programs

Each of the above captioned policy documents addresses this issue in one way or another. Thus, STRATEGY 9p. 7) alludes to the "A.I.D. strategy to promote self-sustaining programs (sic.) and provides that:

"New projects should reflect careful consideration of recurrent costs (including costs to consumers) and include steps to be taken to resolve identified cost and financing problems prior to project approval."

And POLICY (p. ii) states:

"A.I.D.'s health program assistance will concentrate in future years on:...Promoting self-financing of health programs...A.I.D. will place special emphasis on encouraging LDCs to modify policies that inhibit self-sufficient, cost-effective programs. The agency will stress private sector approaches to providing health care and health-promoting measures and private resources to cover the costs generated by health programs."

And RECURRENT COSTS (p. 18) provides:

"Where recurrent cost problems are due to LDC government policy, and where that policy is not likely to change, A.I.D. should seriously consider reducing the level of activity in the affected sector...It makes little sense to invest in programs that are predicated on a given level of recurrent financial support, if that support is unlikely to be forthcoming."

APPENDIX II (3)

Clearly, the most direct method for alleviating recurrent cost problems is financing recurrent costs explicitly... Donors have open to them the option of...increasing the degree to which they are willing to finance recurrent costs...The recent decision to extend life-of-project funding to ten years makes more realistic the length of time needed for a project which will generate as much recurrent finance as it will recurrent expenditures...Any arrangements of this type will need careful stipulation of the way in which A.I.D. resources can be phased out and host country resources phased in."

The Implications of Sustainability Objectives for A.I.D.'s Assistance to PHC Programs

As explained foregoing, according to A.I.D.'s health-financing policy, user fees or charges would not be appropriate for most of the intended output of PHC systems -- for these public-good-type services, public finance is peculiarly appropriate. Thus, these programs cannot be expected to be "self sustaining" or "self-sufficient" in the sense of generating private revenue. Nevertheless, it is also A.I.D.'s health-financing policy that PHC programs assisted by A.I.D. must be financially viable over the long run in the sense that as A.I.D. resources are phase out, host country resources (in this PHC case, public finance resources) will be phased in. How can we achieve the effective "careful stipulation" on this score called for by RECURRENT COSTS? Or, what are "...steps to be taken to resolve identified cost and financing problems prior to project approval" called for by STRATEGY?

Thus, the most promising approach in most LDCs to recruiting an appropriate level of resources for PHC is to divert or reallocate public-finance resources from curative (mainly, inpatient hospital) urban services to primary health care in rural areas (one of the ways to improve the financial viability of PHC projects recognized, but not emphasized, in the Administrator's May 15, 1985 memorandum on this subject). And the best way to facilitate such a diversion of resources is to implement appropriately income-related fees for government hospital services.

If one accepts these propositions (we do not have the space to elucidate them here) then a scheme to implement fees for government hospital services must be regarded as a primary-health-care-financing strategy. More particularly, A.I.D. assistance to PHC programs may need to be accompanied by assistance to schemes for more private financing of the demand for government hospital services -- or some other accompanying financing scheme, if the A.I.D. PHC assistance activities are to be regarded as appropriately responsive to A.I.D.'s health-financing policy goal of the sustainability and financial viability of programs assisted by A.I.D.

The point here is an important one such that a restatement may be in order to make it clear. Operating under A.I.D.'s health financing policy and pursuant to what, in any case, makes economic sense, we do not expect the PHC programs assisted by A.I.D. to achieve sustainability and financial viability by themselves generating private revenue. These programs are, however, expected to be sustainable in the sense that host country resources will be there to carry the programs over the longer pull after A.I.D. assistance has terminated. In the nature of the PHC, public-good-type case, these host country resources will be public finance resources, the general tax

It is not unfair to say that historically for project implementation the approach has been simply to include in the Logframe an assumption that these financing events would come to pass -- perhaps adducing as evidence on the point pronouncements by host-country government officials. And it is not unfair to say that, in most instances, this assumption has not been credible. It seems to me to be the clear intention of current A.I.D. health-financing policy (as set out in the documents we have been examining), with its strong emphasis on the sustainability and financial viability of health programs, that more serious attention be given to this aspect of health-program assistance now than has been characteristic in the past.

In the context of assistance to PHC programs, responding to these expectations will require a more "systems" oriented approach than has been usual in this domain. It does not, in any case, make much sense to look at the requirement for health-program sustainability and financial viability just on a project-by-project or program-by-program basis. Rather, all of the programs and activities which comprise the health-services system should be regarded as related and interdependent parts of that system.\*/

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\*/ This is certainly the orientation called for by the policy documents we have been examining herein, e.g., that the government sector, the private western-medicine sector, and the private traditional-medicine sector be regarded as mutually interdependent and complimentary components of the nation's total health-services system. In the text discussion here, we are looking at this matter in a somewhat narrower frame of reference than suggested in this note.

revenues that support the MOH system as a whole. Thus, the financial viability of the PHC programs must derive from the financial viability of, and appropriate resource allocation within, the MOH system as a whole. To achieve health-system viability in this sense in the usual case will require health-financing project assistance -- and this project assistance, which will usually be in health-services domains other than PHC, must accompany the project activity which represents A.I.D.'s PHC assistance -- that is, the financing project, which may be addressed, say, to the hospital sector, is in this real, function sense, a part of the PHC intervention, if, that is, the PHC intervention is to be responsive to A.I.D.'s policy objectives with respect to sustainability. It is for this kind of reason that the RESOURCES FOR CHILD HEALTH PROJECT has wisely made financing a major agenda item along with immunization and other PHC activities.