

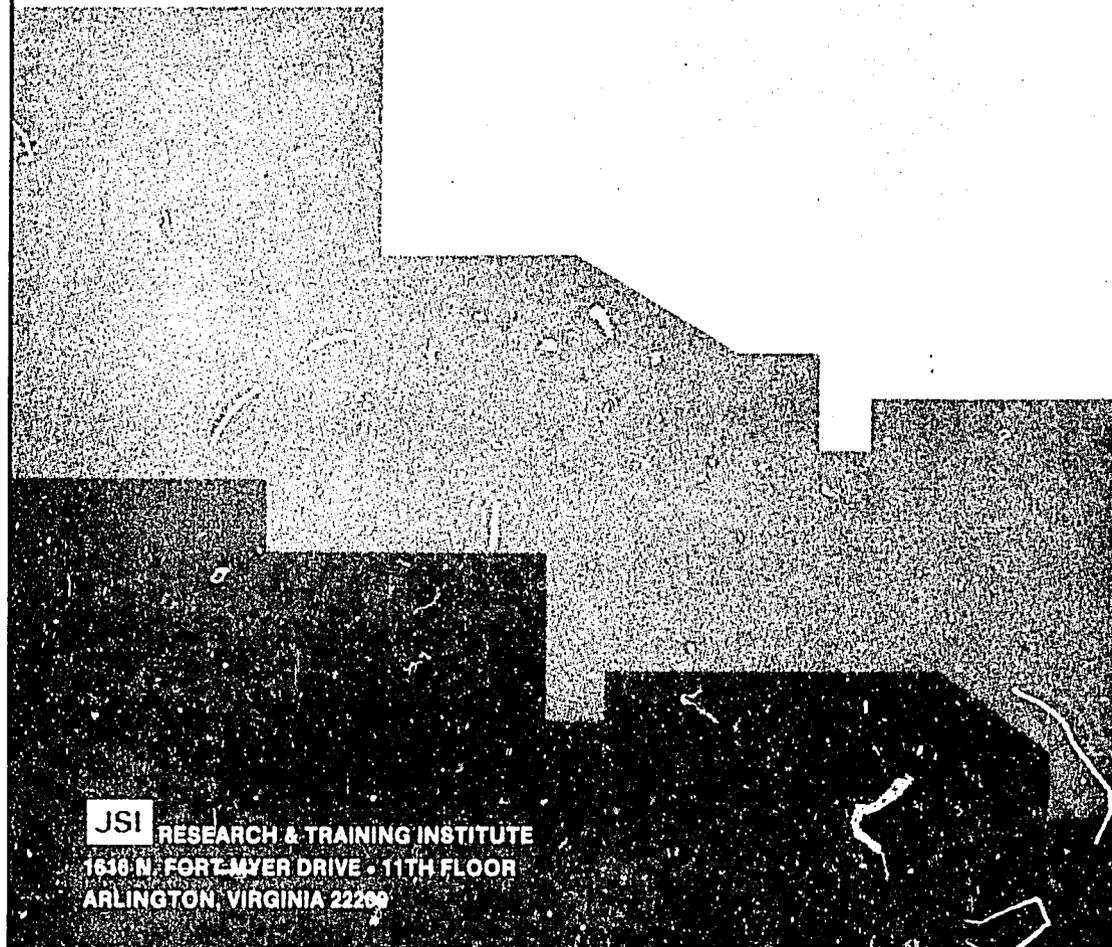
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# Task Force Meeting Report no. 2

March 16 - 18, 1994

# INITIATIVES

PRIVATE INITIATIVES FOR PRIMARY HEALTHCARE



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## Executive Summary

The **Private Initiatives for Primary Healthcare** project seeks to promote the health status of low-income, urban populations in developing countries through the development of private, basic health services. The project is funded through a cooperative agreement with the U.S. Agency for International Development, Office of Health, and is managed by the JSI Research and Training Institute. This report summarizes the second annual task force meeting of the project.

As specified in the cooperative agreement, the Initiatives project invites a task force comprised of "experts in the field" to provide specialized guidance to the project. The task force provides feedback and observations on project activities, and membership varies based on the identified needs of the project. The second project task force meeting was held March 16 - 18, 1994 at the offices of John Snow, Inc., in Arlington, Virginia.

For this task force meeting, the Initiatives project staff developed a list of five key activities or issues to be addressed during the upcoming project year. Each topic was addressed in terms of the main theme of the meeting: how the project can best contribute to the sustainability of health services provided through the private sector.

Experts with knowledge in one or more of these five areas were asked to participate as task force members. The task force members and their professional affiliations were:

- Ms. Susan Cheney O'Byrne, Director of Health Services Research and Development, Kaiser Permanente;
- Dr. Irwin Redlener, President, Children's Health Fund;
- Dr. Deborah Castle, President, People Development Ltd.;
- Mr. L. Dene McGriff, consultant, William & Mercer;
- Dr. Catherine Overholt, Vice President, Collaborative for Development, Inc.;
- Ms. Sara Tifft, Deputy Department Director, Program for Appropriate Technologies in Health.

The five topics were: promoting and collaborating with in-country management groups for the provision of technical assistance; evaluating the effectiveness and sustainability of private healthcare businesses that serve urban low-income groups; identifying sources of capital to finance private health projects; creating effective mechanisms for financing health services; and how to understand better and address urban health issues within the Initiatives project.

Throughout the discussions, the task force members returned repeatedly to one central observation: basic health services are unlikely to be sustainable in the absence of community involvement in their development and delivery. Consequently, the task force recommended that the project actively seek opportunities to promote significant community involvement in

the development, operation, and evaluation of the local initiatives. The importance of the community's role in sustaining private health initiatives emerged in all five topics addressed by the task force:

*Local management groups:* Community involvement could serve as an “external push” to move private providers toward meeting public health goals. Such involvement could legitimize financial incentives for local management groups, or it could empower existing organizations, such as cooperatives or labor unions, to take on the functions of a local management group.

*Sources of capital:* A community-supported health program would be attractive to potential lenders, who could take such support as an indicator of the venture's viability.

*Evaluation:* Community participation in evaluation activities ensures that judgements of project effectiveness include the community's assessment of its healthcare problems and the community's programmatic priorities. In addition, using the community to collect and analyze evaluative information develops sustainable evaluation skills.

*Financing mechanisms:* Community participation in the development of prepaid or insurance plans encourages communities to view such plans as a means of promoting good health behaviors, rather than an entitlement.

*Urban health:* Links with established community-based organizations can help the local initiatives understand and work within the highly complex social and political environments that characterize urban areas.

## Summary of the Symposium

The Initiatives project held a symposium describing the project's first year of activities on the morning of March 16th, 1994. This symposium served as a briefing to the task force members, USAID staff, and others working in development who are interested in the project.

During the symposium, Initiatives staff reviewed the mission of the project and the technical assistance activities undertaken during the first year, described how the project is collaborating with local management groups, and summarized lessons learned. A staff member presented the experience of two local initiative groups in Africa, and Dr. Enrique Hidrobo presented his own organization's activities in Quito, Ecuador. (See Appendix A for the agenda.)

The project sought and encouraged a dialogue between the audience and the project presenters. The following were points raised by the audience:

- While the Initiatives project is mandated to target the urban poor, the project has narrowed its target group to the working poor — urban populations with *some* income. The audience suggested using the term “low-income” instead of “poor” to indicate that the destitute are not the target of the project.
- By encouraging the private sector to target low-income populations, over the long-term, resources within the public sector could be redirected to the very poor. Audience members encouraged the project to evaluate if this indeed happens.
- Audience members asked for more information about the local initiative groups. Will they continue to provide preventive services, which do not generate much income? A discussion of the use of prepayment and cross-subsidizations to achieve this end included the possibility of government subsidies, including direct funding.
- Participants observed that, of the local initiative groups that have joined the project, few are nongovernmental organizations, which traditionally have provided good-quality healthcare, in response to community needs.
- Finally, one member of the audience suggested that the project expand the information dissemination activities to include leaders in non-health areas, such as business and trade association leaders. These leaders of other sectors may be valuable collaborators in the expansion of the private health sector.

## **Task Force Introduction**

Robert Clay, Acting Deputy Director of USAID's Office of Health, welcomed the task force members. He then introduced the Office's health sector priority areas, under which the project falls:

- Expanding access to healthcare services.
- Increasing the focus on periurban areas, which are often areas of greatest need.
- Defining "sustainability" and developing concrete methods for achieving it.
- Improving the quality of care provided.

Initiatives is a demonstration project intended to test a variety of approaches to the private sector provision of basic health services. In so doing, it contributes to policy changes that result in a balance between the public and private sectors' respective roles in meeting the health needs of their societies. Thus, the dissemination of these results will be important for USAID, other donors, and governments.

The project's USAID technical officer, John Tomaro, also welcomed the task force members. He presented the questions that USAID is hoping to explore through the Initiatives project, and asked the task force members to consider them throughout the meetings.

- How can USAID further the knowledge about the private health sector in developing countries?
- Are the project's technical assistance approaches enhancing the development of the private sector?
- How can the lessons learned from the project advance health reform in developing countries?
- What are the changes in the world environment that will affect private health services?
- What is USAID's comparative advantage in the private health sector?

The task force members were asked to give two areas of advice at the end of the meetings: 1) suggestions and comments to the Initiatives project, and 2) comments to USAID, to be presented to the Health Financing and Sustainability Project Technical Advisory Meeting.

## Local Management Groups

### Summary of the Briefing Paper

Initiatives does not employ any long-term advisors or use field offices. Instead, the project has attempted to identify and develop the capacity of local groups to manage, finance and, in other ways, support private health service delivery operations. The “local management group” is viewed as a mechanism to provide management support to the local initiative groups. While the initiative group focuses on the delivery of high-quality services to low-income urban residents, the management group provides the support necessary for the initiative groups to function efficiently and cost effectively.

Local management groups are expected to carry out the following activities:

1. Consulting in the areas of organizational development, business management, marketing, clinic management, quality assurance, training, and information systems.
2. Management services including joint procurement, diagnostic facilities, and information systems.
3. Financing of initiative groups' projects.
4. Networking between various provider groups, and participating in dialogue with the government on the nature of public/private involvement in the delivery of services.
5. Coordinating Initiatives' in-country activities.

Ideally, the relationship between the local management group, the local initiative groups, and the Initiatives project will develop the capabilities of the management group, leaving a sustainable support for the private delivery of health services in developing countries.

### Summary of the Discussion

This first task force session was facilitated by Dene McGriff. The discussion focused on two main issues: the purpose and viability of supporting the development of local management groups, and the approaches that might be taken to promote this development.

#### *Purpose and viability of local management groups*

There was considerable discussion of whether the functions listed above could be served by existing organizations, or whether a new organization was required. Examples of existing organizations are cooperatives and labor unions. In such cases, some modification or

expansion in mandate or operations was likely to be required. Initiatives would help with this expansion. Fostering the development of an entirely new organization would be a considerably larger challenge.

In either case, the existence of sufficient market demand for a local management group was questioned. It was noted that public health goals are not necessarily congruent with private, profit goals at a fundamental level. The insertion of private sector elements will not work without some external force pushing in that direction.

Financial incentives in the form of tax concessions were noted as an important mechanism for fostering the development of local management groups. Existing organizations might respond to these by expanding their activities or new organizations might be created by entrepreneurial health providers.

#### *Approaches to the development of local management groups*

The task force suggested the following actions to develop the concept of the local management group:

1. Look to venture capitalists, who typically will involve themselves in management as a way of minimizing their risk and maximizing their potential return on investment. They might serve as *de facto* management groups to the initiatives they finance.
2. Build on an existing base by providing local management groups with concessions or incentives to become involved in private health service delivery to poor populations — tax relief is one example.
3. Empower the initiative groups to perform these functions for themselves. They would be encouraged to join together to form their own cooperative or association that could take on or contract for common services (accounting, procurement), as well as represent their interests in discussions of health policy with public authorities.

## Sources of Capital

### Summary of the Briefing Paper

Initiatives is testing the hypothesis that it is possible to create viable, financially sustainable models of basic healthcare delivery that serve low-income urban and periurban residents by providing specific and targeted technical assistance to local provider groups but without the continuous infusion of grant funds from USAID or other donors. Initiatives recognizes that funds are a necessary and critical part of helping these groups succeed. The project has promised to assist each group to identify and obtain the capital required for start-up and the maintenance of operations until financial sustainability is achieved.

### Summary of the Discussion

Session facilitator Sara Tift led the discussion on issues relating to lending for social programs, then reviewed strategies for approaching lenders and named potential lenders.

Discussants agreed that financing for social programs can be difficult to obtain because traditional sources of lending consider the risks too high. An important role that the Initiatives project could play is to demonstrate that lending for healthcare services is not excessively risky. Just as lending to rural cooperatives has proven to be successful, as small farmers and entrepreneurs pay back their loans despite the small size of their businesses, so Initiatives can show lenders that loans to healthcare services are profitable.

Existing sources tend to fund “productive” ventures (such as weaving cooperatives or farms). It is more difficult to find funds for health services; the perception is that health is not something to put money into because it always has to be subsidized and can never be self-sustained or profitable. The local initiatives groups will be considered even more risky as they are planning to serve low-income groups.

The current challenge is to find the right lenders with whom to work. Initiatives will have to work closely with the local initiative groups to match lenders to their particular resource needs.

#### *The lenders*

The capital market ranges from venture capital (high-risk lending, unlikely for these initiatives) to grants, the softest form of capital. Initiatives should seek out lending programs all along this spectrum. Each source of capital should be examined closely for the types of ventures preferred and the level of return expected.

In normal commercial lending, the riskiest ventures pay the highest rates. Commercial banks may not be a good capital source for this project. Typically risk adverse, banks shun high-risk investments, such as start-up ventures, or charge high rates of interest. Commercial loan sources also want quick returns, which are not likely from the local initiative groups (which will not generate positive cash flows for several years).

The local initiative groups will need flexible terms — such as grace periods — not so much low interest rates. In general, however, concessionary loans have become less available over the last several years. Even foundations are expected to act in a “business-like” manner.

However, lenders often seek an overall return on their corpus of loans. This way they can invest in some social and some financial projects. For example, an overall return rate of 10 percent may mean that some loans may be as low as 8 percent and others as high as 12 percent. Lenders can also take advantage of government packages offered to encourage diverse lending portfolios.

One last concern is that while the local initiatives will generate local currency, most lenders will expect repayment in hard currency. Terms may be different for loans in hard currency compared with loans in local currencies. Lenders will face a major devaluation risk if they lend in local currencies.

#### *Positioning the local initiative groups*

The Initiatives project can assist the local groups to acquire capital by preparing them well for the capital application process, by assuring support to the local initiative groups from a variety of sources, and by assisting the groups tailor their presentation to individual lenders.

The Initiatives project is providing technical assistance in preparing business plans that can be used to pursue funding. The next steps are to determine what capital requirements are needed (such as start-up capital, land and building costs, operating costs), and put the whole proposal into a comprehensive package to approach capital markets.

The Initiatives project can give funders a sense of the larger context for the individual local initiative groups. This can be done through the project itself, on the part of USAID, or through the local management groups or local governments. Interest in the initiatives from outside parties would make them more attractive to lenders. Another group whose interest should be harnessed is the local community. A community-supported health program will also be attractive to lenders. In addition, representatives from the local commercial community on governing boards can offer financial advice, keep the group up to date on local businesses, and help create social pressure to repay loans.

The Initiatives project should find ways to present the local initiative groups so as to satisfy the lenders' individual needs for security and collateral. For each borrower, the project can

identify the characteristics that can help reduce risks in the eyes of the lender. Such strategies could include:

- Demonstrating that the services will generate some income.
- Highlighting cost shifting through service mix, or even non-health enterprises.
- Approaching lenders who favor certain types of investment (such as equipment, equity investment into property, or lending in a certain country) with borrowers that fit their interests.
- Identifying the local initiative groups' assets, which can serve as collateral for loans.
- Presenting local groups together as a cooperative.

### *Options to pursue*

The task force members suggested that Initiatives develop a prospectus of all the local groups and approach a loan management organization that would be interested in creating a loan fund. Potential sources of funding are:

- Corporations, which often try to fund social issues for marketing purposes;
- Local joint-venture options that merge local businesses with healthcare;
- Pharmaceutical companies and other suppliers;
- The Calvert Group, a company holding mutual funds, credit cards, and a social investment fund;
- The MacArthur Foundation, which often makes grants directly to a program and manages the grant itself;
- The Ecumenical Development Cooperative Society, which receives funds from many donors and lenders and acts as a responsible intermediary;
- Debt swaps, although they may be time-consuming and risky for the borrower.

Participants also suggested that Initiatives call a pledging conference in each country to bring together potential lenders. Each donor or lender will have specific interests, and the presentations must speak to these interests and offer the lenders possibilities.

## Evaluation

### Summary of the Briefing Paper

Little is known about private sector approaches to healthcare delivery, the cost of services, the quality of private care, willingness to provide primary healthcare services, or people's preferences for private versus public facilities. To find the most effective approaches to healthcare delivery in each of these countries, the project supports the development of various private sector models of service delivery. Given that the focus of this project is on service delivery, there are three main criteria against which the success or failure of the models will be assessed:

- Effectiveness
- Sustainability
- Replicability

To measure the impact of any of the proposed models, preintervention baseline data is being collected from a pool of patients and providers in each of the countries. Preimplementation assessments of the socio-political contexts in which each of the local initiative group functions, and the attitudes and policies of the national ministries of health toward the private sector have been made. Basic demographic data on initiative catchment areas will be acquired, in addition to data on the availability of public and private facilities, types of providers available, people's care-seeking behavior, frequency of use, and the cost of treatments. Where possible, existing data sources will be used. Where information is lacking, appropriate data collection instruments will be developed and the relevant information sourced.

### Summary of the Discussion

This session was co-facilitated by Catherine Overholt and Deborah Castle. The discussion covered three concerns about the evaluation of the project: the methods used, the types of information collected, and the limitations of the conclusions.

It was emphasized that the evaluation of the project overall and of the local initiatives individually should be practical and operational. As the project proceeds and the local groups begin functioning, evaluation activities should be used to improve implementation. The task force meeting participants discussed several methods for evaluating activities:

*Case study:* A case study could present the history of the local initiative and highlight special characteristics. This method would be especially useful if an initiative fails. Groups of case studies could be compared to identify factors associated with success or failure.

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*Process methods:* Implementation and evaluation should go hand-in-hand. As the initiatives become operational, they will require appropriate data collection systems to monitor their performance.

*Marketing audits:* Marketing audits routinely assess both institutional and community factors. This process, used for profit and nonprofit organizations, may be a useful method for the local initiatives to assess their institutional capacity, to scan and respond to their intended markets.

*Community and customer participation:* Evaluation methods should also take into account the customers and the community. Not only should the health of the community be improved, but community participation can ensure the success of the initiative. Participatory assessment and evaluation methodologies were suggested as an effective and inexpensive approach for acquiring this information. The participants suggested that the following questions should be raised: How does the community view its health problems? How does the community view the initiative? Does the local initiative groups work with the community to identify health problems? If the community and the initiative do not appear linked, what approach can be used to establish a relationship?

Finally, the language and terms used throughout the evaluation should be well defined and consistent. “Replicability”, “sustainability”, and “low-income”, for example, should be defined to ensure comparable results. This consistency will also be important when disseminating findings.

The current design of the project’s evaluation focuses on effectiveness, sustainability, and replicability. The task force discussed each component in turn. Effectiveness of service delivery and of management must be examined and can offer valuable lessons for the private sector. How does staff become more effective at delivering services? Can the evaluation add to the current knowledge of “best practices”? How will changes in the local initiative groups’ practices affect the larger provider community? Effectiveness should also examine the structure of the organization, such as the board of directors, and business planning. How realistic were the local groups’ business and financial assumptions? Have they reached their break-even point as outlined in their business plans?

Sustainability includes financial viability, but it should also include other factors that may affect the life of the initiative. Business evaluations have shown that the following factors are important in the success of enterprises:

- Market-based orientation: clients have a role in determining the services provided;
- Leadership: the management offers a strong vision and clear direction;
- Efficient organization: efficient organizational structures and skilled staff provide effective services;
- Resource mobilization: adequate resources are available when needed and at reasonable terms.

It may be found that effectiveness and sustainability are in conflict. For example, in order to be sustainable, local initiatives may move out of services targeted to low-income clients. For replicability, the evaluation should ask if items specific to one country can be taken to another.

The task force advised the project — and USAID — not to be too ambitious. Many questions will not be able to be answered during the five years of the project. And the project may not be able to draw global conclusions from these individual projects, because of the short time frame, the small number of initiatives, and the probability that some of these activities will indeed fail.

## Financing Mechanisms

### Summary of the Briefing Paper

Basic healthcare services in the countries in which Initiatives is currently active are typically provided on a fee-for-service basis, paid for either by the patient or his/her sponsor, or at no cost in company-run or public facilities. This situation has given rise to a tradition in which “logic” requires that payment for primary curative services be rendered at time of service and “justice” requires that preventive services be provided free of charge.

Important consequences follow from this tradition. Fees levied at point of service serve as disincentive to consumers or patients to obtain services. This disincentive effect is very important if applied to preventive services where the health benefits are not readily discernible but the financial sacrifice is clear and immediate.

Most participating local initiative groups are service-provider models. The method they choose for charging and collecting for their services is critical, not only to their financial sustainability but also to their impact on public’s use of basic health services.

### Summary of the Discussion

Susan Cheney-O’Byrne facilitated this session on ways to pay healthcare providers in the private sector. The private sector exists because people make money — someone is selling something that someone else wants to pay for. The private marketplace is more efficient than the public market if there are informed consumers who can make rational decisions, and if competing suppliers offer the quality and quantity of products required by the consumers.

But this is not the case when it comes to healthcare. Consumers are often ill, poorly informed and irrational in their choices of services. And the services are controlled by doctors, who are not really competing for customers. Customers will turn down treatment when they are unable to pay, but they will invariably listen to a physician if they are able to pay. Thus doctors do not really compete with anyone.

The project can extract lessons about reimbursement of health services from the U.S. healthcare system. The discussion focused on four payment mechanisms: fee-for-service, capitated fees, insurance, and copayments. The participants also discussed cost shifting as a method to subsidize services for poorer clients, independent of the provider reimbursement mechanism.

The task force members expressed reservations about the use of a fee-for-service approach for basic and preventive care. There is no incentive for patients to spend money if they are

not ill. Health services only make money for curative services, thus health workers have no incentive to provide preventative care.

Participants also agreed that salaried health workers are a bad option. Most public health systems rely on salaried physicians, which often leads to a lack of productivity.

These payment failures then lead to the concept of insurance as a solution. The participants discussed some of the problems with introducing health insurance where there was previously none. One major concern is that patients from communities that have never had adequate health services will need a range of major healthcare services when they finally enter a health system. An insurance or prepaid system must be prepared for this initial heavy service use, for these will be the first clients of a health plan. One option to overcome this deluge is to begin with employers — first with employers who already provide health benefits, and later with employers who do not.

Americans now treat healthcare as a free good because so many people have health insurance. This attitude is also seen in other countries. Beneficiaries of insurance or prepaid healthcare programs regard resources as benefits to them. For example, service utilization goes way up just before the end of a year — services are seen as an entitlement from whoever paid into them. People tend to think about healthcare, but not about health.

How can a community be reoriented not to view prepaid or insured health services as an entitlement? The key is with the community itself. Community participation in the health plans, such as direct contracts, and community-based efforts to improve health should be fostered.

Insurance or prepaid programs must include procedures for reimbursing providers for treating the urban poor. The system may start out with fee-for-service rates for a submitted bill, which would require procedures for coding and developing fee schedules. But the task force suggests that, based on the U.S. experience, local groups skip directly into a capitated system, with additional money to supplement services to the urban poor.

Many prepaid plans in the United States use a capitated payment system. For every member that joins a service, the physician gets a fixed amount of money. Because the physician will not get more money by providing more services, preventive medicine is more cost-effective than providing many curative services. There is no incentive to limit the number of patients that join the system, which could mean an overload for each physician if physicians are not continually added to the system to meet the demand. Or, physicians can delegate patient care to nurses or physician assistants, thus saving some of the capitated fee by using less-costly health workers.

The advantages for doctors in joining a capitated service is that they receive a steady revenue that they can rely on, without having to deal with billing or collections. If there is an over-supply of doctors in an area, patients can be divided up and the doctors can still work. If

there is an undersupply of doctors, such a system can ease the burden by helping doctors share the workload with others.

The economic incentive of such a system is that recruiters or doctors will seek out the most healthy patients, and thus reduce expenditures on high-cost technical or curative procedures. This incentive can be balanced by offering different capitation rates for different types of patients, thus rewarding physicians who serve high-risk patients.

A capitated system requires considerable data to adequately plan volume estimates, capitation rates, and types of services needed. This type of data may be difficult to obtain in developing countries before a plan is implemented. And once operational, the plan requires a monitoring system to track and control services and their related expenses.

Copayments — that is, requiring a nominal fee from the patient at the time of service — are increasingly used in the United States to discourage overuse of services. Task force members noted that copayments may not be appropriate for low-income communities. Recent U.S. data indicate that copayments do not change utilization patterns until the copayment rate is very high.

Task force members were skeptical that basic and preventive health services for low-income urban residents can be profitable, as such services are unlikely to cover costs. Cross-subsidization will be required to cover the costs of basic and preventive services. Such cost shifting can be done between service locations, between income groups within one location, or between types of services (such as raising money through curative and laboratory services).

Whatever the financing mechanisms used by the local initiative groups, there are many lessons still to be learned about financing basic health services for low-income clients. The project should share the lessons about consumer payment and provider reimbursements with many local private health programs.

## Urban Health

### Summary of the Briefing Paper

The Initiatives project is mandated to work in urban areas. The illnesses that plague the urban poor are directly related to poverty and the process of industrialization. In today's third-world cities, disease, disabilities, and death are exacerbated by deteriorating or nonexistent basic services and infrastructure, and ignorance and neglect by the state and its various agencies. Leaving the provision of health services to local governments will not ensure that the poor are reached. These supply-side difficulties are matched with equally challenging demand-side problems. The urban poor face many obstacles when seeking healthcare, including transportation costs, accessibility, and lost wages.

Addressing the healthcare needs of the urban poor is complicated by the lack of adequate data on the composition and dynamics of this population. Where data do exist, they are often misleading, making cities appear healthier than they really are because urban data is often not disaggregated by socioeconomic areas.

Adequate and consistent definitions of "urban areas" and "urban poor" are also lacking. What constitutes a city? The geographic size, population, level of infrastructure and facilities available? Who are the urban poor? Those living below an established socioeconomic level within a recognized urban area, or something different? Is the term "urban" a proxy for the characteristics of urban migrants, a self-selected group who tend to be the healthier individuals in the rural areas from which they come?

### Summary of the Discussion

Dr. Irwin Redlener facilitated the discussion on urban health, which considered a comparison of urban and rural communities, the advantages and constraints of working within an urban environment, and methods of reaching urban communities more effectively.

Urban areas create challenging health problems because of the stresses of urban life, especially crime and overcrowding. The social and economic structure of urban areas is much more politically complex than in rural areas — in many cities healthcare is tied to politics. Finally, healthcare services in urban areas must be easily accessible, such as "one-stop shopping" services that combine social and health services at one location. Because urban residents often get lost in the system and are difficult to reach, easy access to services is important.

Urban areas can, however, offer some advantages to residents and providers of health services. Theoretically, urban patients should have greater access to a greater variety of services than in rural areas. For providers, the greater mixing of socioeconomic groups in a

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city may offer more opportunities for cost-shifting, therefore allowing the development of services for the poor. Urban areas also offer more opportunities for health services to be connected to businesses than in rural areas. Health service programs should maximize their ability to create systems to take advantage of already existing health services, to take advantage of cost-shifting possibilities, and to reach communities through established institutions or businesses.

The session closed with a discussion of how providers can define an urban community that needs services. Most of the local initiative groups began with a concept that the founders had: as community members, they knew what services were needed. Initiatives asked the groups' founders to describe as clearly as they could the needs of the market. Initiatives did not require more extensive community data for participation in the project. The local groups have not done further work to reach their communities at this point.

The task force suggested that the initiatives increase community participation for several reasons:

- Established community links would increase the chances of success of the initiative.
- The local initiative group would be given credibility in the community.
- Increased customer feedback would allow the local initiative group to address needs more effectively.
- Lenders look for community support.

The project can also seek out communities that are already established but may be lacking health services. Initiatives is already working with is the Lawanson Health Plan, a health financing program for members of trade associations in Lagos, Nigeria. But the project has found few free-trade zones with captive communities of employees; Tema, Ghana, may be one city that fits this criteria. There are other experiences of community groups organizing needed services, such as churches that organize for garbage collection or immunizations. Such groups could be targeted by the project to identify a model of community-based healthcare delivery.

Most of the current local initiative groups have links with their local governments. Although political connections may be important for the success of the local initiatives, strong community participation would provide support for services to survive through changing local and national governments.

The project was encouraged to address adequately the challenge of ensuring community participation in the development of the local initiatives. Although the project plans to conduct marketing studies in each country, technical assistance in methods of reaching out to and involving the community in the development and delivery of health services should be provided to each initiative group.

## **Observations and Suggestions from the Task Force**

Throughout its discussions, the task force members returned repeatedly to one central observation: basic health services are unlikely to be sustainable in the absence of significant community involvement in their development and delivery. Consequently, the task force recommended that the project actively seek opportunities to promote community involvement in the development, operation, and evaluation of the local initiatives.

The importance of the community's role in sustaining private health initiatives emerged in each of the five topics considered by the task force:

### **Local Management Groups**

Community involvement could provide the "external push" required to move private sector health providers toward meeting public health goals. Community involvement could legitimize publicly-financed incentives, such as tax concessions, for the local management groups, or it could empower existing organizations, such as cooperatives or labor unions, to take on the functions of a local management group.

### **Sources of Capital**

A community-supported health program can be attractive to potential lenders, because active community involvement could be one indicator of the venture's viability. Strong community links, such as local representation on a venture's governing board, can make available important financial advice and current market information to the venture's management.

### **Evaluation**

Community participation in evaluation activities is important for two reasons. First, community participation ensures that the judgements of a project's effectiveness take into account the community's assessment of its healthcare problems and the community's approaches for resolving them. Second, community involvement in the collection and analysis of evaluative information is a potentially effective approach to developing a sustainable evaluation function.

### **Financing Mechanisms**

Community participation in the development and implementation of prepaid or insurance plans is one approach to encouraging communities to view such plans as a means of promoting good health behaviors.

## **Urban Health**

Community involvement can play a critical role in helping the local initiative groups respond to the highly complex social and political environments that characterize urban areas. Community groups already involved in providing local social services might be willing and capable providers of basic health services. Strong community links can also help negotiate needed support for the initiatives from local and national governments.

## Appendix A: Symposium Agenda

### **The Private Sector and the Provision of Basic Health Services to the Urban Poor**

- 9:00-9:20                      Welcome and Introduction  
*Richard Moore, John Snow, Inc.*
- 9:20-9:30                      The Initiatives Project: Its concept, evolution  
and place within USAID's health programs  
*John Tomaro, USAID's Office of Health*
- 9:40-10:00                    Initiatives' First Year: Innovations and lessons learned  
*Robert Pattison, Initiatives Project*
- 10:00-10:20                   Coffee break
- 10:20-10:50                   Initiatives' Approach to Technical Assistance
- Workshops  
*Robert Pattison, Initiatives Project*
- Local Management Groups  
*Lisa Hare, Initiatives Project*
- 10:50-11:30                   Examples of Local Initiative Groups
- The Lawanson Health Plan, Nigeria,  
and the Superior Medical Foundation, Ghana  
*Virginia Ward, Initiatives Project*
- AMEDICA, Ecuador  
*Enrique Hidrobo, AMEDICA*
- 11:30-11:55                   Questions from the audience
- 11:55-12:00                   Closing  
*John Tomaro, USAID's Office of Health*

## **Appendix B: Task Force Meeting Participants**

### **Task Force Members**

Ms. Susan Cheney O'Byrne, Kaiser Permanente  
Dr. Irwin Redlener, Children's Health Fund  
Dr. Deborah Castle, People Development Ltd.  
Mr. L. Dene McGriff, William & Mercer  
Dr. Catherine Overholt, Collaborative for Development, Inc.  
Ms. Sara Tifft, Program for Appropriate Technologies in Health

### **USAID Office of Health**

John Tomaro, CTO  
Robert Clay, Acting Deputy Director

### **Initiatives Project**

#### *Staff*

Lisa Hare  
Robert Pattison  
Elizabeth Pollard  
Cassia Douglass  
Eileen Hanlon  
Kathryn Gundrum  
Melissa Rubin  
Virginia Ward

#### *Subcontractors*

Joyce Mann, Rand Corporation  
John Peabody, Rand Corporation  
Andrea Usiak, Academy for Educational Development

## Appendix C: Task Force Meeting Agenda

### AGENDA

Initiatives Task Force Meeting  
March 16-18, 1994

JSI  
1616 N. Fort Myer Drive, 11th Floor  
Arlington, Virginia 22209

#### Wednesday, March 16, 1994

1:30 p.m.	Welcome and introduction	R. Pattison Acting Director
1:50 p.m.	Overview of Initiatives Project and HFS Project	R. Clay USAID
2:10 p.m.	Review of issues to be discussed during Task Force meeting	R. Pattison Acting Director
2:30 p.m.	Break	
2:45 p.m.	<i>Discussion:</i> Local Management Groups	D. McGriff Task force member
5:00 p.m.	Adjourn	

#### Thursday, March 17, 1994

8:30 a.m.	<i>Discussion:</i> Sources of Capital	S. Tift Task force member
10:30 a.m.	Break	
10:45 a.m.	<i>Discussion:</i> Evaluation	C. Overholt and D. Castle Task force members
12:30 p.m.	Lunch	

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Thursday, March 17, cont'd:

1:30 p.m.	<i>Discussion: Financing Mechanisms</i>	S. Cheney-O'Byrne Task force member
3:00 p.m.	Break	
3:15 p.m.	<i>Discussion: Urban Health</i>	I. Redlener Task force member
5:00 p.m.	Adjourn	

Friday, March 18, 1994

8:30 a.m.	Final discussions and wrap-up	Task force and staff
10:00 a.m.	Break	
10:15 a.m.	Summarize and prepare report to HFS TAG	Task force only No staff
12:00 a.m.	Lunch at JSI	
12:45 p.m.	Taxis to Department of State	
1:00 p.m.	Joint HFS TAG meeting Department of State, room 1107	
4:30 p.m.	Adjourn	

## Appendix D: Task Force Briefing Papers

### Local Management Groups

The *Local Management Group* (LMG) is viewed as a mechanism to provide management support to indigenous private sector healthcare delivery groups (*local initiative groups* or LIGs). While the LIG focuses on the delivery of high-quality services to low-income urban residents, the LMG provides the support necessary for the individual LIGs to function efficiently and cost effectively.

Initiatives, by design, does not employ any long-term advisors or use field offices. Instead, the project has attempted to identify and develop the capacity of local management groups to manage, finance and, in other ways, support private health service delivery operations. Ideally, the interaction between the LMG, the LIGs, and Initiatives develops the capabilities of the LMG, leaving a sustainable support for the private delivery of basic health services in developing countries.

The LMG carries out the following activities:

1. Consulting in the areas of organizational development, management, financial planning, marketing, clinic management, quality assurance, training, and information systems.
2. Management services including joint procurement, diagnostic facilities, and health and management information systems.
3. Financing of LIGs' projects, that is, seeking out venture capital, low-interest loans, and identifying other sources of financing.
4. Networking between the various provider groups, and participating in the dialogue with governments on the nature of public/private involvement in the delivery of health services.
5. Coordinating Initiatives' in-country activities and providing the necessary logistics.

During Initiatives' first in-country assessments, many local private providers or local initiative groups (LIGs) were identified. Additionally, Initiatives identified several local consulting firms that assisted the project during the first workshop, Strategic Business Planning. However, these firms saw their role as providing support to Initiatives in specific areas such as strategic planning. They had difficulty seeing their role as providing ongoing assistance to the LIGs. Based on this experience, Initiatives conducted specific assessments to identify groups that had the capability and vision to serve as LMGs to the LIGs.

Initiatives plans to enter into partnership relationships with the LMGs rather than the standard subcontractual arrangement. The concept of working with local management groups, developing their capability to support private health delivery groups is untested and breaks with the traditional USAID-funded approach. Initiatives believes that LMGs can function as businesses, offering a range of services to private service delivery groups. Initiatives anticipates that the LMGs can offer the following: management consulting, capital (as an equity position or a loan), records processing, centralized procurement for pharmaceuticals and medical supplies, and laboratory services. Initiatives intends to offer the LMGs exposure to start-of-the-art management approaches, access to training materials and software packages, further training in specific management areas, and assistance developing new areas of expertise, such as health insurance.

Initiatives is also willing to provide a limited amount of grant funds to the LMGs. These funds will enable each LMG to provide assistance to the LIGs during their start-up phase. However, once the LIGs are operating, Initiatives will phase out our financial support of the LMGs, requiring the LIGs to procure services from the LMGs. This approach is designed to get the LIGs operational quickly, and to promote the sustainability of both the LMG and LIGs.

### **Current Status**

Initiatives has identified potential LMGs in Nigeria, Ghana, and Ecuador. In Ghana and Nigeria, advertisements were placed in local newspapers describing the functions of LMGs and requesting that interested firms submit bids to Initiatives. Initiatives reviewed the bids received, and short-listed those groups that best fit Initiatives' needs and philosophy. An assessment visit was conducted in Ghana and Nigeria to meet with the short-listed firms. Each firm was evaluated based on the following criteria:

1. Demonstrated understanding of the purpose of Initiatives and our approach.
2. Understanding of the role of the local management group.
3. Strong management experience especially as applied to the health sector.
4. Experience working with the private sector.
5. Entrepreneurial in outlook. Visionary. Innovative.
6. Access to a wide network of professionals in the areas of relevance to the project (medical, accounting, computerization, procurement).
7. Understanding of the local health sector, and knowledge of the key players.

8. Clear idea of what is meant by the urban poor, their particular needs, and constraints in working with them.

Based on these criteria, Initiatives selected two LMGs in Nigeria and one LMG in Ghana. Each LMG is described below.

*B.E. Medical Services (BEMS)* is a healthcare management firm that has been soliciting donor assistance to provide consulting services. BEMS has experience in conducting feasibility studies and has served as a reference source for local bankers reviewing proposals from health-related organizations. Interested in moving into service delivery, BEMS attended the first Initiatives workshop on strategic business planning. Following the workshop BEMS submitted a proposal to develop a network of clinics within government housing estates, which was accepted by Initiatives. Subsequently, BEMS has participated in all of the Initiatives workshops and discussions concerning LMGs.

BEMS has given careful consideration to the role it can play in Initiatives and in developing the private sector capability to provide basic health services. BEMS appears to grasp the “big picture” — how Initiatives can grow into other geographic areas and new concept areas including health insurance. However, BEMS has only three professional staff in addition to Dr. Edun, the director. With limited staff, BEMS may not be able develop their own LIG while trying to function as a LMG.

*Medikonsult*, another health services management firm, is based in Ibadan. Dr. Adeyemo, the director, ran a small hospital in Ibadan and realized the importance that proper management systems have on healthcare delivery. As a result, he left the hospital to set up a firm focusing on the management of health services. He still maintains a close connection with the hospital, which is currently sourcing out their accounting, billing, and inventory control to Medikonsult. This arrangement is similar to the services we anticipate the LMGs will provide to interested LIGs.

Medikonsult’s strength is more in the area of day-to-day clinic operations rather than the “big picture.” Through his work with Nigerian hospitals and clinics in Lagos and Ibadan, Dr. Adeyemo identified a need for a computerized management system that would link together accounting, inventory and billing, medical records, and an analysis module. Medikonsult has spent the last year focusing on the development and testing of this software package.

Like BEMS, Medikonsult has few professional staff, though expertise is available in Ibadan and elsewhere in Nigeria, and can be recruited as business expands.

*Deloitte and Touche Consulting (D&T)*, an affiliate of Deloitte, Touche and Tohmatsu International, is owned and operated by Ghanaians. D&T has identified the health sector as an area for business expansion. D&T is currently implementing a health management project

at the Ashanti Goldfields Corporation hospital that is designed to improve the hospital's ability to track the services offered according to provider, client, and cost.

The hospital management information system developed by D&T suggests that the Ashanti Goldfields' hospital can be operated more efficiently and recover a greater percentage of its costs. Ashanti has been impressed by D&T's work and asked that D&T take over the management of the hospital and employee health services.

D&T's work with Ashanti has demonstrated the existence of a potential market for healthcare management organizations — a LMG — in Ghana. D&T intends to form a new company that would specialize in health systems management, including management of Ashanti's health services. Dr. N. Lam, the managing director of D&T, has met with the Ghanaian LIGs to assess potential areas in which a LMG could provide support. In addition to direct health sector experience, D&T has a background in business planning, obtaining capital, developing management systems, and conducting workshops.

It is a concern that D&T's predominately commercial orientation may make the firm less willing to work with provider groups who focus on delivering services to low-income, urban populations.

In Ecuador the LMG concept has evolved differently. Stern y Compañía, a local management consulting firm, has participated at all stages of the project, including the assessment, workshops and tutorials. However, Stern's involvement to date has remained along the traditional lines of a local consulting group; Stern provides discreet services in return for compensation from Initiatives.

Initiatives is working with Stern y Compañía to alter their relationship with us; encouraging the firm to take a more entrepreneurial approach to working with the Ecuadorian LIGs.

### **Options for the future**

The LMGs have been slow to develop. It is still uncertain about how the LMGs will evolve, how the relationship between the LMGs and LIGs will develop and grow, and what Initiatives' future role should be in regard to both the LMGs and LIGs. The following issues are under consideration:

*Other potential forms for LMGs:* The currently identified LMGs are all some type of consulting firm. Other models of LMGs need to be explored, such as local medical associations and employers as potential management resources. Such groups could provide different services than a consulting firm. For example, the Society of General Medical and Dental Practitioners in Ghana is interested in strengthening their association. Initiatives has suggested that they may want to consider developing an implementing body, such as a national secretariat, which would provide services to the members including training, joint procurement, and a diagnostic center.

*Other function areas for LMGs:* A sustainable LMG will need to provide services that provider groups require and for which they are willing to pay. Initiatives is uncertain whether the LIGs will support the LMG functions already identified, that is, consulting, direct management services, provision of capital, and so forth. Initiatives is interested in identifying other income generating services the LMGs can provide to the LIGs.

*Development of the partnership concept:* As described above, Initiatives views the LMGs as business partners. Instead of developing specific scopes of work and contracting out for the services, Initiatives is trying to develop partnerships where both parties contribute something to the partnership. Initiatives has considered offering the LMGs grant funds that can be used to address a broad set of objectives, existing management and training tools, links with U.S. insurance organizations, and study tours. In return, the LMGs will provide assistance to Initiatives, support to the LIGs, and develop an appropriate infrastructure to maintain their services.

Initiatives is exploring ways to provide grants, which reduce the administrative burden, while ensuring that the funds are used to develop the capacities of the LMGs and to provide needed services to the LIGs. The objective is to provide the LMG with the incentives necessary to ensure that the LIGs are properly supported without restricting the innovative potential of either the LMG or the LIG.

*Transition to direct LIG financing:* Over time, Initiatives will phase out financial support of the LMG. The LMGs' income will have to come from other sources, principally the LIGs. Consequently, the LIGs must be operating and have sufficient income to pay for the services of the LMG. In addition, the LIGs must see the value of improving their management systems, maintaining accurate accounts, and increasing their overall efficiency. The LIGs also must be willing to pay for the LMG services, an issue that needs to be carefully monitored.

## Sources of Capital

The Initiatives project seeks to promote access to primary and preventive healthcare services (basic health services as defined in the World Bank's *World Development Report 1993*) for the urban poor by developing and strengthening private healthcare providers known as "local initiative groups" (LIGS). Historically, USAID projects have assisted the development of local groups by providing technical assistance coupled with a significant and steady supply of outside capital, primarily through grants. These projects have typically ended or significantly scaled back once the direct funding ceased.

Initiatives is testing the hypothesis that it is possible to create viable, financially sustainable models of basic healthcare delivery that serve low-income urban and periurban residents by providing specific and targeted technical assistance to the LIGS but without the continuous infusion of grant funds from USAID or other donors.

Because Initiatives provides technical assistance but not finance, it has been necessary to identify and choose innovative models of providing primary healthcare that possess the potential to generate enough income to sustain their operations. Initiatives recognizes that funds are a necessary and critical part of helping these groups succeed, and the project has promised to assist each LIG to identify and obtain the capital required for start-up (for example, funds for equipment, supplies, building) and the maintenance of operations until financial sustainability is achieved. Without this capital some of the LIGs will not be able to open their doors and have the opportunity to provide basic healthcare to the urban poor.

To promote the sustainability of the LIGs, Initiatives is stressing local over international sources of capital and emphasizing the provision of loans rather than grants. By using local resources for capital an investors' market for private healthcare delivery will be developed and local funds for the private health sector will remain once Initiatives or other donors leave. The emphasis on loans rather than grants assures that the program is not reliant on ongoing outside funding. This approach ensures that the operations can remain financially viable once the investor divests.

### Current Status

Initiatives has provided assistance to the LIGs through a series of workshops followed by one-on-one consulting in the areas of strategic business planning, organizational improvement, and financial planning. Workshops have been designed to assist the LIGs develop their capacity as a successful business. The most recent workshop, Strategic Financial Planning, was designed to assist the LIGs prepare detailed business plans, including budgets and financial projections. The LIGS will be able to use these plans to obtain capital from local financing institutions and international foundations.

Initiatives has also identified local management groups that can provide the LIGs with on-going management support. The local management groups will work with the LIGs to finalize their business plans and identify local sources of capital.

Initiatives has begun to identify various local sources of capital in Ghana and Ecuador. These groups are now familiar with the Initiatives project and potentially interested in investing in one or more of the LIGs or lending funds.

- VALCO/Ghana is an aluminum processing company affiliated with Kaiser Aluminum International. VALCO is required by Ghanaian law to contribute a certain amount of capital each year to a community fund that provides grants to groups that promote social causes.<sup>1</sup>
- Social Security and National Insurance Trust (SSNIT)/Ghana is a parastatal organization that oversees the national pension system. SSNIT has a wide range of investments spanning most sectors including real estate, housing, industry, and health. SSNIT provides both debt and equity financing. SSNIT is also mandated to make “social investments” with lower returns than their more commercially oriented investments. SSNIT is currently reviewing a potential investment in a medical “center for excellence” concept similar to the Superior Medical Foundation, one of Initiatives’ LIGs.
- Ghana Venture Capital Fund (GVCF)/ Ghana, started in 1992 by the Commonwealth Development Corporation (CDC), a British-based investment company. CDC is the largest shareholder and controls 40 percent of the company. GVCF currently has US\$5 million available for investment in private sector businesses in Ghana. GVCF is not allowed, by mandate, to invest in the direct provision of health services. However, GVCF may be willing to invest in a health-related business, such as health insurance or the procurement of hospital equipment.
- PROFIT is a project financed by the Office of Population of USAID that provides capital through joint ventures, equity financing, and loans. The objective of PROFIT is to increase developing country resources for family planning by encouraging private sector involvement. A representative from the PROFIT project participated on an Initiatives field visit in November, and met with the LIGs. Based on her assessment, PROFIT may be willing to provide funds to support one or two LIGs. PROFIT is interested in financing only those components of a project that directly impact family planning and maternal and child health services.
- Ministry of Public Health/Ecuador is considering transferring the management and ownership privileges of primary healthcare facilities to selected private groups including

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<sup>1</sup> Many developing countries are requiring that multinational companies return a certain percentage of their profits to promote the development of local communities. Therefore, these companies are a potential source of capital.

some of the LIGs. USAID/Quito sent Ministry representatives to visit PROSALUD (Bolivia), which has taken over several public clinics in Santa Cruz and established a network of clinics with a referral hospital in La Paz. Initiatives and USAID/Quito have sponsored several meetings between the Ministry and representatives of the LIGs to discuss potential areas of collaboration.

- FISE (Emergency Social Investment Fund) is an Ecuadorian fund administered by the Department of Social Welfare. It provides grants up to \$100,000 to nonprofit organizations and professionals for social development purposes.

Currently, Initiatives is working with a fundraiser to identify U.S. sources of capital and their requirements. The information obtained will be shared with the LIGs and used to assist them with the application process. It has also been suggested that some of the LIG representatives come to the United States to present their request for funding to several foundations and other potential sources of capital.

Initiatives is also exploring the possibility of holding a pledging conference in each of the project's countries. This conference could take place once the LIGs' business proposals are complete. It would bring together parties interested in financing health services delivery in urban areas. In addition to donors and lenders such as USAID, UNICEF, the World Bank, the African Development Bank, commercial banks and local investors would be invited. The conference would provide a forum for the various donors and investors to familiarize themselves with the project concept and individual proposals and generate pledges of financial support to the LIGs.

### **Future Steps**

Initiatives continues to collect information on potential sources of capital. Below are examples of the level and type of funding required by a few of the LIGs.

- Superior Medical Foundation (SMF)/ Ghana, a group of U.S.-trained medical professionals who returned to practice in Ghana and envision establishing a nonprofit, 25-bed hospital in Accra. The hospital will focus on the provision of ambulatory care, with the facilities to provide secondary and tertiary care if necessary. SMF currently operates a small clinic, which has a strong community outreach component. SMF has also had discussions with the Ghana Medical School about the potential of having interns rotate through their hospital to allow them the opportunity to see the role of the private sector in the provision of health services. SMF is currently seeking approximately US\$ 1.3 million to build this hospital and purchase the necessary equipment.
- Royal Healthcare Ltd./Nigeria is proposing to start a financing and managed-care scheme in the Lawanson area of Lagos. The group plans to collect monthly dues from members of local trade associations (taxi drivers, carpenters, photographers, market women), which would cover the basic health services for members and their families at four

participating clinics. The dues collected are to be held in an interest-bearing fund at the community bank; providers' fees would be paid from the fund. In addition to covering basic health services, the Lawson plan proposes to cover secondary and tertiary care through low-interest loans provided to members of the plan by the community bank. The bank will use the health fund as collateral for the loans. Lawson requires: 1) some seed capital for the health fund, approximately US\$5,000-10,000, and 2) some money for clinic renovations and medical equipment, approximately US\$60,000.

- Fundacion Eugenio Espejo/Ecuador is a national foundation that supports development initiatives in low-income areas of Ecuador. It is already involved in the delivery of basic health services on a self-financing basis in Quito, but intends to increase the scale of its operations through the establishment of a network of six to seven clinics located in the south side of the city, a large low-income area. These clinics will be developed over a period of four to five years, with the first due to begin operations during 1994. As a part of this development process, the foundation proposes to develop a financing mechanism by which low-income families in the catchment area of their development projects will contribute to a fund to be used to support the expenditures of the participants on basic health services. Preliminary estimates of capital outlays for constructing and equipping a clinic are in the range of \$100,000 to \$200,000.

## Issues and Options

### *Difficulties in obtaining funding due to nature of LIGs*

Because each individual LIG is typically a small operation, lenders tend to be reluctant to spend the time necessary to understand their business. This situation is made worse by the fact that commercial lending organizations in developing countries have traditionally been absent from the health sector because of heavy public sector involvement.

In Ecuador, the LIGs have formed a task force composed of one representative of each LIG plus one member-at-large to investigate and recommend options for the formation of a mutual or cooperative organization to seek common access to capital. This option may work for other countries as well. The options for Initiatives are to:

- Encourage the development of organizations of this nature in each country as a means of reducing the risk to lenders, thereby improving access to funds.
- Take a neutral position, realizing that some of the stronger LIGs may resist the pressure to be involved in a cooperative effort in which the principal beneficiaries would likely be the smaller, weaker LIGs.
- Discourage the formation of such groups because of the potential for divisiveness in the event of default of an individual LIG and the obligation of the remaining groups to satisfy the terms of repayment.

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- Attempt to use the local management group in each country as a conduit through which credit could be obtained and channeled to LIGs.

### *The mix of capital sources*

One of Initiatives primary goals is to support financially sustainable organizations. While financial sustainability is not a precisely defined concept, it is clear that dependence on grant funding would indicate a condition of non-sustainability. Therefore, Initiatives is encouraging the recognition and adoption of the following principles by the LIGs:

- Only a relatively small portion of initial and operating capital should come through grant sources.
- Commercial banks are unlikely to be a major source of capital because of their traditional reluctance to fund health care activities. Likewise, venture capitalists are not likely to be attracted to LIGs because of their requirement of high potential returns as payment for risk accepted.
- International lending agencies and local governments or foundations will therefore continue to play the major role in capital funding for these groups.

### *Initiatives' support of LIGs' efforts to obtain funding*

Initiatives has provided technical support to the LIGs in the form of seminars, workshops, and consulting activities. The purpose of these activities has been to enable the LIGs to determine the amount and timing of their needs for seed capital. Most of the groups will quite soon be in a position to formally apply to financial institutions for initial capital funding. At issue is the extent to which Initiatives places its imprimatur on their efforts to obtain capital. Initiatives options are to:

- Provide a minimum of direct support, allowing the LIGs themselves to initiate and complete the application process. Initiatives' support would be limited to review and comment on documents, assistance in preparation of applications, and other consulting activities.
- Provide limited direct support, such as letters stating that the LIG is participating in the Initiatives project or accompanying LIG representatives to initial meetings with representatives of lending organizations.
- Provide vigorous support, including assistance in the search for potential sources of funds, direct involvement (where invited) in the preparation and presentation of funding proposals, and providing letters of support for the LIG's activities.

## Evaluation

The Initiatives project has set out to demonstrate that private healthcare providers can successfully provide sustainable, high-quality preventive health services to the working poor in urban and periurban areas in developing countries. Currently, very little is understood about the objectives and operations of private sector healthcare delivery in the four countries in which Initiatives works: Ghana, Nigeria, Ecuador, and Guatemala. Little is known about their approaches to healthcare delivery, the cost of their services, the quality of the care they provide, their willingness to provide primary healthcare services and people's preferences for private versus public facilities.

To find the most effective approaches to healthcare delivery in each of these countries, the project supports the development of various private sector models through *local initiative groups* (LIGs). These models may be provider-based, insurer-based, employer-based, community-based, or a combination of one or more of the aforementioned approaches. Each model will be financed and managed locally, and will provide preventive in addition to curative healthcare services to the urban working poor in the target centers.

Given that the focus of this project is on service delivery, there are three main criteria against which the success or failure of the models will be assessed:

1. *Effectiveness*: Has the initiative had a favorable impact on the availability, cost and quality of the preventive and curative health services provided? Is it adequately addressing the health needs of the population it intends to serve? Among other gender considerations, how does a for-profit approach to healthcare positively or negatively affect women?
2. *Sustainability*: Is the intervention financially viable in that it meets recurrent expenditures and is sustainable over the long-term? Is its market share increasing? Are there long-term strategic plans in place?
3. *Replicability*: Can the intervention be replicated elsewhere or does success depend upon special circumstances found only in that particular LIG's working environment? What aspects of the project are replicable and what factors would lead to their successful implementation elsewhere?

To measure the impact of any of the proposed models, preintervention baseline data is being collected from a pool of patients and providers in each of the four countries. Preimplementation assessments of the socio-political contexts in which each of the LIGs functions, and the attitudes and policies of the national ministries of health toward the private sector have been made. Basic demographic data on LIG catchment areas will be acquired, in addition to data on the availability of public and private facilities, types of providers available (physicians, nurses, midwives, traditional birth attendants, traditional healers, and so forth) people's care-seeking behavior, frequency of use, and the cost of treatments. Where

possible, existing data sources will be used. Where information is lacking, appropriate data collection instruments will be developed and the relevant information sourced. Household surveys, administered at regular intervals as part of the project's monitoring activities, will indicate and explain any changes in utilization patterns by clientele.

Given the nature of the projects supported by Initiatives, it is recognized that provider behavior will be the primary vehicle for effecting change, rather than large scale shifts in population-based behavior. Therefore, in order to better understand the characteristics of private facilities and the cost of providing health delivery services, provider surveys will also be administered. These surveys will examine the structure and function of provider practices to obtain information on the organization of private practices, the strategic planning and organizational development components of the business, facility utilization, prices and quality of services provided. These facility surveys will take place on an annual basis to monitor any changes in utilization patterns, staffing, financial performance, supply availability, and so on.

### **Current Status**

Existing data sources have been identified through government agencies and international donor organizations in Nigeria, Ghana, Ecuador and Guatemala, which provide useful population-based data on health conditions and status, utilization patterns and, to some degree, patient satisfaction. These data sets will enable the project to construct an epidemiological profile for some common conditions and to examine the determinants of care-seeking behavior such as willingness to pay and healthcare delivery patterns (that is, the mix of private, public and traditional sources of care).

This data is currently being analyzed by the Initiatives evaluation specialists at the Rand Corporation and information relevant to the project will be extracted. Any gaps in this information will be collected separately by the project in collaboration with local market research and survey firms, university-based demographers and health service researchers.

It is clear from the information acquired to date, that data on the private sector in these four countries is sketchy, at best. The best data sources focus on the provision of family planning commodities, sampling private providers in the major urban centers. While this provides an overview of the private sector, it does not give the project enough information about private sector activities in the catchment areas of the LIGs. To begin addressing this issue, a provider survey has been designed for Ghana and will be fielded in conjunction with a USAID/REDSO study on sexually transmitted diseases. Also, 15 questions on client care-seeking behavior and their perception of private versus public health facilities will be pilot-tested in the February 1994 round of the NIGERBUS, a national marketing survey. These questions will be fielded in April 1994 when the NIGERBUS sampling framework includes the catchment areas of the Nigeria LIGs.

## Options for the Future

The present evaluation framework focuses on the characteristics of the private sector and the effectiveness, sustainability and replicability of the models implemented by the LIGs. There are several other issues that are not addressed by this approach and should be considered as part of the evaluation process.

### 1. *The Urban Issue*

What factors make Initiatives an urban project, other than the fact that it is being implemented in urban settings? Are there other factors that the project should be cognizant of when operating in an urban environment that could affect the success or failure of the LIGs. For example, does improving the efficiency of healthcare delivery in a highly competitive environment improve access and quality of care to the urban poor? Would the privatization of portions of the public health systems be more viable than providing parallel services in the same catchment area? Are community health workers as effective in targeting the poor in an urban environment given the breakdown in social ties within communities and physician bias against academically unqualified health workers?

### 2. *Community-based Assessments*

Other methods of evaluating the impact of the project could include alternative community-based assessments such as participatory action research. This strategy would enable the LIG beneficiaries to define issues of concern to them, especially in the area of community involvement, and actively participate in the project assessment. Such qualitative information would provide a source of very rich data on community needs, perceptions and satisfaction with the services provided by the LIGs. Assistance could be sought from other USAID projects that have successfully used this methodology in addition to the Department of Development Studies at the University of Sussex, which pioneered this approach.<sup>2</sup>

### 3. *Local Initiative Groups as Businesses*

During the course of the project, the LIGs will prepare several planning documents to guide their implementation: organizational development plans, financial and business plans, and marketing strategies based on quantitative and qualitative studies. While the ability to generalize the findings of these studies to other urban centers may be limited, they will nevertheless offer benchmarks against which some measure of success can be gauged. Have the LIGs met their client targets as determined in the marketing studies? Were they able to raise the capital required to launch their business as outlined in their financial plans? Have

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<sup>2</sup> Dr. Robert Chambers of the Institute for Development Studies, University of Sussex, UK, developed the Participatory Rural Appraisal (PRA) technique and has successfully used it to assess community needs and evaluate community-based projects. The USAID-funded Water and Sanitation for Health project has successfully used PRA in their evaluation work.

their revenues, expenditures, profits, and market shares matched their expectations as outlined in their business plans? An analysis of the variations from these plans will provide much information about the viability and efficiency of the LIGs as business ventures.

#### *4. Local Management Groups*

The use of local management groups (LMGs) to provide technical assistance to the LIGs and to support the Washington management team is being tested by the Initiatives project. The present evaluation framework does not provide a mechanism to monitor and evaluate the effectiveness of this model and some thought needs to be given to this. How well have the LMGs met the needs of the LIGs? What kinds of incentives work best to ensure maximum collaboration between the LIGs and the LMGs and to ensure that the LIGs are profitable early in the life of the project? How successful have the LMGs been in identifying new ventures for the LIGs, an expanded role for themselves, and new initiative groups for the project? How best can such qualitative issues as changes in attitude and confidence of the LIGs as a result of their interaction with Initiatives and the LMGs be measured?

#### *5. The Policy Environment*

The project offers an excellent opportunity to understand the private sector in developing countries — its motivation, methods of service delivery, and client base. Given the public sector's inability to meet the health needs of the population in much of the developing world, the ministries of health in several countries are now recognizing the importance of the private sector in healthcare delivery. How can this project, through its evaluation activities, assist governments in understanding the vital role played by the private sector to ensure that appropriate resources are available and a favorable policy environment exists to facilitate the growth of the sector and expansion of its services to the poor?

## Financing Mechanisms

Basic healthcare services in the four countries in which Initiatives is currently active are typically provided on a fee-for-service basis, paid for either by the patient or his or her sponsor, or at no cost in company-run or public facilities. This situation has given rise to a tradition in which “logic” requires that payment for primary curative services be rendered at time of service and “justice” requires that preventive services be provided free of charge.

Important consequences follow from this tradition. Fees levied at point of service serve as disincentive to consumers or patients to obtain services. This disincentive effect is very important if applied to preventive services where the health benefits are not readily discernible but the financial sacrifice is clear and immediate.

Most participating local initiative groups (LIGs) are of the service-provider variety. The method they choose for charging and collecting for their services is critical, not only to their financial sustainability but also to their impact on public’s use of basic health services.

### Current Status

Several LIGs are currently considering adopting prepayment mechanisms for basic health services to:

1. Encourage use of these services by reducing their price to zero at the point of service.
2. Ease the financial burden on beneficiaries by allowing them to spread payments over time, thus allowing planning and budgeting and avoiding problem of (relatively) large one-time payments.
3. Smooth income and cash flow for the providers.

The options for action by Initiatives are conditioned by problems inherent in prepayment mechanisms, especially for basic health services. Some of these problems are:

1. Most important, the inability to predict usage (and therefore costs) where no prior experience exists.
2. Likely lack of acceptance on the part of the consuming public, which is not accustomed to paying for products or services until they are received.
3. Related to number 2, the possibility of over-use or fraud as consumers attempt to “cash in” on situations in which premiums have been paid but no services received during the period.

## Options for Initiatives

1. Discourage the use of prepayment mechanisms until the service delivery model is well established and experience has been gained, which will provide data and knowledge for establishment of prices and prediction of usage and costs.

*Advantages:* This will provide time to accumulate data, thus reducing risk once a prepayment scheme is established.

*Disadvantages:* Because consumer incentives are different under a fee-for-service system as compared to prepayment, additional usage data gained during transition period will only be indicative. Also, momentum may be lost as consumers and providers become accustomed to fee-for-service system, making them reluctant to accept change at a later time.

2. Provide extensive, individually-focused technical assistance to groups exploring use of prepayment mechanisms.

*Advantages:* This option has the advantage of introducing prepayment into the system earlier than would otherwise be the case, thus avoiding the perverse incentives inherent in fee-for-service.

*Disadvantages:* Extensive, individually-focused technical assistance is expensive and difficult to provide. Local, in-country experts are frequently not available because of lack of experience with prepayment models.

3. Support development of prepayment mechanisms for preventive and (perhaps) first-level curative services, but retain fee-for-service for higher-level curative services.

*Advantages:* Prepayment is most important for preventive services, where the intent is to encourage usage and where cost per treatment is typically low. For curative services, fee-for-service may be appropriate as a transition mechanism until experience is gained.

*Disadvantages:* As in Option 2 above, the introduction of a fee-for-service scheme at the initiation of a project may condition consumers and providers to resist a prepayment method proposed for later implementation.

4. For LIGs in which prepayment appears to be the preferred option, condition full and continued Initiatives support on group's commitment to development and implementation of prepayment mechanism.

*Advantages:* This option provides a strong incentive to groups to develop and implement a prepayment mechanism.

*Disadvantages:* It is not clear that Initiatives should insist on details such as payment mechanisms, as long as the LIGs are fulfilling our required conditions: 1) serving the target population, with 2) basic healthcare services, 3) in a financially self-sustaining manner.

5. Adopt a hands-off approach to this issue, allowing each LIG to adopt its own pricing and financing mechanism without any encouragement or discouragement from Initiatives.

*Advantages:* This leaves Initiatives in a neutral position, allowing tentative conclusions to be drawn about the role of payment mechanisms in assuring financial sustainability, without the interference of an outside organization.

*Disadvantages:* Initiatives, through its technical assistance, has encouraged the LIGs to adopt best-business practices. If this applies to such matters as financial planning and marketing, it should as well apply to an issue as critical as payment mechanisms.

## Urban Health

Between 1980 and 2000, 85 percent of the world's total urban growth will take place in developing countries. Within the next 30 years, more than two-thirds of the world's urban inhabitants will live in these countries. Here, urban areas are expected to grow at an annual rate of almost seven times the rate of developed countries (Olivola 1991).

While migration from rural and surrounding areas is responsible for some of this growth, the natural increase of the urban populations accounts for the majority of the increase. With annual growth rates of 3.0 percent and 3.2 percent in Nigeria and Ghana, and 2.6 percent and 2.9 percent in Ecuador and Guatemala, the existing infrastructure and social services in the congested urban centers are significantly challenged by this rapid increase in demand (World Bank 1993).

Urban areas with concentrated populations, are major reservoirs for disease and an ideal environment for disease transmission. The illnesses that plague the urban poor reveal a bimodal pattern directly related to poverty and the process of industrialization (Silimperi 1991). Infectious diseases such as cholera, diarrhea, diphtheria, meningitis, and tuberculosis are associated with poverty related problems such as inadequate housing, lack of access to clean water and sanitation, overcrowding, and low standards of education. Diseases associated with the industrialization process include cancer, hypertension, alcohol and drug abuse, traffic, industrial accidents, and violence. Each of these diseases take their toll not only on life but also on the general wellbeing and economic performance of the poor.

In today's third-world cities, disease, disabilities, and death are exacerbated by deteriorating or nonexistent basic services and infrastructure, and ignorance and neglect by the state and its various agencies (Aina 1990). The provision and maintenance of urban physical infrastructure such as roads, water supply, sewerage systems, and electricity has traditionally been the responsibility of municipal administrations. Poor leadership and management, government interference, and financial constraints often impede their ability to provide comprehensive, efficient services in most cities in developing countries. Social services such as healthcare may also fall under municipal jurisdiction but are often of lower priority (Olivola 1990).

Leaving the provision of health services to local governments will not ensure that they reach the poor either (Olivola 1990). The legacy of colonialism in many countries has left local governments with little capacity to plan and few resources with which to implement adequate health programs. In some countries, such as Nigeria, many local government areas receive funding from financially strapped state treasuries, which in turn receive considerable resources from the federal government. With the implementation of structural adjustment programs, often prescribed by the IMF, governments have typically restricted spending in the social sectors, concentrating the remaining resources to support large public hospitals and reducing the range and quality of services provided in the smaller health centers.

These supply-side difficulties are matched with equally challenging demand-side problems. The urban poor face many obstacles when seeking healthcare, one of which is the often prohibitive cost of the services themselves. Transportation costs to and from hospital are another significant part of out-patient costs. For in-patient services, hospital locations inaccessible to the urban poor mean that families must move into the hospital compound to provide food and tend to the personal needs of the patient. The cost and time required for such relocation is especially difficult for women who bear the burden of responsibility for tending to the sick and elderly. Unlike rural areas where support networks exist, poor families in cities must pursue both work and family care in an environment where the extended family is weaker and where income generating activities are necessary to survive. Lost wages incurred by taking time away from work to tend to the sick has a significant impact on the poor's ability to meet their basic needs. To compensate for such inconveniences, the poor increasingly rely on local pharmacies, patent medicine shops and traditional healers that provide low-cost, readily available services and convenient hours in a non-threatening, accessible environment.

Addressing the healthcare needs of the urban poor are complicated by the lack of adequate data on the composition and dynamics of this population (Silimperi 1990). Where data do exist, they are often misleading, making cities appear healthier than they really are because urban data is often not disaggregated by socioeconomic areas. Infant mortality rates in urban slums are often double the rate for the entire city, and incidence of diseases such as malaria, meningitis, and tuberculosis show higher proportions in densely populated, poor areas where overcrowding is common and drainage facilities are inadequate. Inadequate health information systems in state and national ministries, and the fact that the poor often do not use the facilities that regularly collect this data, can account for this.

Adequate and consistent definitions of "urban areas" and "urban poor" are also lacking (Olivola 1990). What constitutes a city? The geographic size, population, level of infrastructure and facilities available? Who are the urban poor? Those living below an established socioeconomic level within a recognized urban area, or something different? Is the term "urban" a proxy for the characteristics of urban migrants, a self-selected group who tend to be the healthier individuals in the rural areas from which they come? If other urban-related variables such as distance and education are controlled for, could the urban variable be a proxy for the so-called migrant personality (Akin 1985)? If so, what does that mean for project planning and implementation?

### **Current Status**

Initiatives works with private sector service delivery organizations known as "local initiatives groups" (LIGs) in Nigeria, Ghana, Ecuador, and Guatemala. By providing technical assistance in the areas of organizational development, financial planning, clinic management, health information systems, and marketing surveys, Initiatives will identify models of private sector healthcare delivery that effectively and efficiently meet the needs of the working urban poor in their respective environments.

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After 18 months of implementation, two areas that need further examination have been identified:

1. Large private corporations and industries operate in urban centers, and many of the urban working poor are employed by them. Targeting such employer groups as part of a basic health services scheme increases the possibilities for reaching large segments of the urban population in the workplace. Providing healthcare coverage to employees as benefits financed by employers is a possible avenue for reaching these people. While one opportunity to work with an employer-based model has presented itself in Ghana, how important is it for the project to locate and work with this model in the three remaining focus countries?
2. Financing healthcare programs for the urban poor is difficult. Even though the public sector is unable to adequately provide services to this segment of the population, there are few mechanisms through which the private sector can obtain financing to address this need. Foundations will not lend to for-profit enterprises, multilateral donors are not interested in such small ventures, and commercial banks are reluctant to lend money for such high-risk enterprises as health clinics for the poor when it will be virtually impossible to foreclose on a nonperforming operation. Identifying creative ways to meet these financing needs is a critical activity at this stage of the project.

## Issues for Further Discussion

### *Health Information and Data Systems*

Poor information systems are one of the major obstacles to dealing with health issues in the cities. While existing data tell us much about infant and maternal mortality, disease prevalence, and fertility at the national or major municipal levels, they do not provide accurate information about the neighborhood catchment areas of the LIGs. Using such data may under-represent the health problems found in high-density areas where the population is known to be low-income and under-served. LIG-specific data is necessary to identify needs and design appropriate programs. The project needs to determine how much of its resources (both time and money) should be allocated to the establishment of community health databases. A strategy for using this information must also be developed given that these databases may contain information that would be of use to the project, the LIGs, and the public sector in each of the countries.

There is also a need to collect information on the public/private mix of health services and people's utilization pattern for both. Understanding what services people prefer to receive from the public sector and what they prefer to get from the private sector is important when determining the range of services provided by each of the LIGs. Do the LIGs need to duplicate public sector programs or is it more appropriate to offer selected services to complement what already exists in the state-run health centers?

### *Defining "Urban"*

Initiatives has targeted major cities in the four focus countries because this is where there are large populations within a relatively small area and where the majority of private health providers are established. While most LIGs are expanding their services in clinics situated in low-income areas to facilitate easy access and convenient hours for their poor clients, others are offering outreach services in satellite clinics in high-density, low-income areas.

But the project has not yet established a clear definition of an "urban" area. This situation poses a problem if Initiatives has the opportunity to work with LIGs who are not from the capital or large secondary cities. In Ghana, for instance, most of the "cities" in the northern regions are little more than small towns with few people and minimum infrastructure in relation to the capital city, Accra. In Guatemala, there are opportunities to work with interesting private providers outside of the capital city in what is essentially a rural environment. Should these LIGs fit within the mandate of the Initiatives project?

### *Poverty*

Given that many of the health problems faced by the urban poor have their roots in poverty, treating the illnesses of the poor is only treating the symptom and not the problem. Can a health project such as Initiatives be used as an entry point to address the larger issues of poverty, ignorance, and illiteracy? Given that the provision of social services is not the mandate of the private sector, can the community development aspects of the LIG activities be the necessary catalyst for change, mobilizing these silent communities to bring their problems to the state. Such enhanced cooperation between the private and public sectors may force the state to meet the needs of the urban poor by providing jobs, education, water, and sanitation services and adequate health coverage for all? Would working with community groups as LIGs, rather than the traditional provider groups, offer the necessary opportunities for initiating and carrying forward this community activism?

### *Community Education Programs*

Several LIGs have proposed creating or expanding community health education programs to address some of the healthcare needs through prevention. While these programs have been successful in rural areas where the population is largely homogeneous, the population in any urban area may contain several ethnic groups with different norms, education levels, and distinct languages. These pose specific challenges for the implementation of any community-based urban program. Furthermore, because urban populations generally fluctuate given their migratory nature, there are constantly changing denominators in the target population which makes monitoring the effectiveness of such programs difficult. These challenges need to be considered in the evaluation component of the project.

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## Appendix E: HFS Combined Agenda

Agendas for HFS Technical Advisory Group (TAG) Meeting Rational Pharmaceuticals Management (RPM) and Initiatives Task Force Meetings March 16-18, 1994					
Date Time	HFS TAG Activity	Date Time	Rational Pharmaceutical Management Task Force Activity	Date Time	Private Initiatives for Primary Healthcare Task Force Activity
Mar. 16	No Meeting	Mar. 16	U.S. Pharmaceutical Convention 12601 Twinbrook Parkway Rockville, Maryland	Mar. 16	-Symposium- Rand Corporation 8th Floor 2100 M Street, NW Washington, D.C.
				9:00-9:20	Welcome and Introduction
				9:20-9:30	Initiatives Project
				9:40-10:00	Initiatives' First Year
				10:00-10:20	Break
				10:20-10:50	Approach to Technical Assistance
				10:50-11:30	Examples of Local Int. Groups
				11:30-11:55	Questions
				11:55-12:00	Closing
		12:30-2:00	Lunch		John Snow, Inc. 11th Floor 1616 N. Fort Myer Drive Rosslyn, Virginia
		2:00-2:15	Welcome to USP	1:30-1:50	Welcome and Introduction
		2:15-2:45	Introductions; Opening remarks	1:50-2:10	Overview of Initiatives Project
		2:45-3:00	Task Force objectives	2:10-2:30	Review of Issues
		3:00-3:45	Overview of USP activities	2:30-2:45	Break
		3:45-4:00	Break	2:45-5:00	Discuss: Local Mgt. Groups
		4:00-4:45	Overview of MSH-DMP activities		
		4:45-5:30	Issues for Task Force discussion		

**Agendas for HFS Technical Advisory Group (TAG) Meeting  
Rational Pharmaceuticals Management (RPM) and Initiatives Task Force Meetings  
March 16-18, 1994**

<b>Date Time</b>	<b>HFS TAG Activity</b>	<b>Date Time</b>	<b>Rational Pharmaceutical Management Task Force Activity</b>	<b>Date Time</b>	<b>Private Initiatives for Primary Healthcare Task Force Activity</b>
Mar. 17	Hyatt Arlington Hotel Ravensworth Center Room 1325 Wilson Boulevard Rosslyn, Virginia	Mar. 17	U.S. Pharmacoepial Convention 12601 Twinbrook Parkway Rockville, Maryland	Mar. 17	John Snow, Inc. 11th Floor 1616 N. Fort Myer Drive Rosslyn, Virginia 202-528-7474
8:30-9:00	Coffee	9:00-9:15	Welcome	8:30-10:30	Discuss: Sources of Capital
9:00-9:30	Opening	9:15-9:45	Summary of Wednesday discussions	10:30-10:45	Break
9:30-10:30	Overview of HFS Activities	9:45-10:15	Selection process for Long-term countries	10:45-12:30	Discuss: Evaluation
10:30-10:45	Break	10:15-10:30	Break		
10:45-12:30	HFS Strategy	10:30-12:30	Review of country assessments and workplans		
12:30-1:30	Lunch	12:30-1:30	Lunch	12:30-1:30	Lunch
1:30-3:30	HFS Technical Assistance	1:30-2:30	RPM add-on activities: Mozambique, Russia and NIS	1:30-3:00	Discuss: Financing Mechanisms
3:30-3:45	Break	2:30-3:00	Discussion	3:00-3:15	Break
3:45-5:15	HFS Information Dissemination	3:00-3:15	Break	3:15-5:00	Discuss: Urban Health
		3:15-5:30	Issues in context of RPM workplans		

**Agendas for HFS Technical Advisory Group (TAG) Meeting  
Rational Pharmaceuticals Management (RPM) and Initiatives Task Force Meetings  
March 16-18, 1994**

<b>Date Time</b>	<b>HFS TAG Activity</b>	<b>Date Time</b>	<b>Rational Pharmaceutical Management Task Force Activity</b>	<b>Date Time</b>	<b>Private Initiatives for Primary Healthcare Task Force Activity</b>
Mar. 18	State Department Building Room 1107 C Street NW, Bet. 21st and 23rd Washington, D.C.	Mar. 18	Management Sciences for Health Suite 920 1655 North Fort Myer Drive Rosslyn, Virginia 703-524-6576	Mar. 18	John Snow, Inc. 11th Floor 1616 N. Fort Myer Drive Rosslyn, Virginia 703-528-7474
8:30-9:30	TAG Members' Meeting (closed session)	9:00-12:00	Prepare report to TAG (Task Force only)	8:30-10:00	Final Discussions and wrap-up (Task Force and staff only)
9:00-9:30	Coffee			10:00-10:15	Break
9:30-11:30	HFS Applied Research			10:15-12:00	Summary and report preparation (Task Force only)
11:30-1:00	Lunch	12:00-12:45	Lunch	12:00-12:45	Lunch
1:00-1:45	HFS Contract Overview	<-----	Joint Meeting (see left column)	<-----	Joint Meeting (see left column)
1:45-2:15	Discussion				
2:15-2:30	Break				
2:30-3:00	Private Sector Initiatives Project				
3:00-3:30	Rational Pharmaceutical Management Project				
3:30-4:00	Discussion				
4:00-4:15	Closing Comments				
4:15-4:30	Conclusions				