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PROJECT PAPER

HEALTH FINANCING AND SUSTAINABILITY

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## SUMMARY

The Office of Health, Bureau of Science and Technology is starting a new project, Health Financing and Sustainability, that will continue the health care financing (HCF) work that began under the REACH Project. This project has a ten year life and a funding level of \$40 million (\$18.4 million of S&T funds and \$21.6 million of buy-ins). The purpose of this project is to, achieve a more rational and equitable distribution and utilization of private and public resources to achieve improvements in health status at local, national and regional levels.

Over the last two decades economic growth rates in most developing countries have deteriorated substantially. One of the consequences has been declining allocations of public funds to health services. Ministries of Health have found themselves without the funds for equipment, supplies and other recurrent expenses so essential to a functional system. Personnel budgets, which are more difficult to cut, have come to represent from 89-90% of total recurrent expenditures in many countries. Even though the staff is there, they do not have that supplies and transportation to provide an adequate service level. In some instances devaluations of local currencies have resulted in income declines for personnel. This further compounds the problem as workers take on additional jobs in order to support their families. Still another problem, even in the most developed countries, is that medical technology is developing faster than the capacity to pay for it.

This project is designed to work with selected developing countries that are interested in improving the financial viability of their health sectors. An essential part of this effort will be identification of areas where public/private collaboration can increase the resources available to the health sector and also result in a more efficient allocation of resources.

The project has five primary areas of emphasis. They are; resource generation through cost recovery, social financing of demand for health care through insurance, public-private collaboration, resource allocation, use and management, and health care costing. A broad, integrated program of technical assistance, applied research, training and information dissemination will target these emphasis areas.

The project will be implemented in two five year phases. Each phase will be implemented primarily through a competitively selected contractor which will have expertise in health economics, public finance, policy development, financial

management, applied research and private sector provision of health services. Some funds will be set aside to allow implementation of project activities outside of the central contract, to support, for example, the further development of the World Health Organization's Programme in health financing. A Technical Advisory Group will be established to provide advice to AID in establishing priorities, developing new activities and evaluating the project's work.

## BACKGROUND

### I. Relationship to AID Priorities, Policies, Strategies and Other Donor Assistance

The goal of AID's health assistance program is to improve health status in AID-assisted countries through selected primary health care interventions aimed at child survival. A central component of this strategy is the sustainability of gains in health status through the promotion of economically viable health programs, with improvements in resource allocation, efficiency and self-financing. AID's health policy also recognizes financing and resource management issues as key to the performance of the health sector as a whole, committing AID to the resolution of these issues in the secondary and tertiary levels of the health system as well as at the primary health care level.

Health financing activities are explicitly supported as part of AID's child survival programs. Current policy states that "...health financing concerns should be addressed in all health projects. However, in some countries, improving the financing of health care may be the main A.I.D. activity. This may include policy dialogue or design and implementation of activities in the development of private services, fees-for-service, improvements in resource allocation and utilization, cost containment and reorganization of the health system. Special attention should be directed to research on improved approaches to financing health care, including operations research and pilot activities which involve the private sector in health service delivery". (A.I.D. Policy Paper, HEALTH ASSISTANCE, Revised. PPC, Dec. 1986)

Health financing has become an issue of central importance in the domain of donor assistance and a focus of research, policy discussions and technical assistance among donor and other international organizations within the last decade. AID has shared this worldwide concern for sustaining and financing health care in developing countries and has undertaken several important initiatives in this arena. In 1986, AID organized a effective interagency meeting with WHO, UNICEF and the World Bank to discuss technical and policy issues relevant to health financing. AID followed up on this initiative with a grant to WHO to undertake several country specific studies on recurrent cost problems intrinsic to the health sector. The implicit objective of the grant was to establish a constituency within WHO to support health financing as essential to the WHO strategy for primary health care. Both objectives were met. The studies generated political awareness at top levels within each of the three countries of Mali, Costa Rica and Jamaica; Mali has already submitted an unsolicited proposal to WHO for additional assistance in this area. There is now an full time health economist within WHO; a position for a second; and talk of regional health economists in the WHO regional offices.

AID also played a key role in the World Health Assembly Technical Meetings of 1988 on health financing, through participation in the technical advisory group, the preparation of technical papers and financial support of developing country participants. Finally, AID has collaborated with UNICEF, PAHO, the Economic Development Institute, and the World Bank in health financing activities and has collaborated with these institutions in the field.

## II. AID Project Experience in Health Care Financing

AID involvement in health financing has included operational and applied research; design, implementation and evaluation of health financing initiatives; policy dialogue; training; publication and dissemination of information; and bilateral project activities. S&T/H has led the Agency in financing with two initiatives, the Primary Health Care Operations Research Project (PRICOR) and the Resources for Child Health Project (REACH). The LAC Bureau has also developed some technical capabilities in health financing through the Health Care Financing (LAC/HCF) component of the LAC Regional Project in Health Technology and Transfer.

### A. The REACH Project

In 1985, the Technologies for Primary Health Care Project funding level was increased from \$20 to \$40 million to allow the start of the Resources for Child Health Contract. The objective of this contract was to support the sustainability of child survival programs worldwide through technical assistance in health financing and immunizations. A central objective of the project was to assist developing countries in establishing sound strategies for financing health care through both government and non-government sources.

Assistance has been provided to over 35 countries and several international organizations under this contract, reflecting their priorities and concerns with financing issues. Such assistance has included costing and efficiency studies of public and quasi-public hospitals; privatization of hospital services in public hospitals; demand studies documenting how much people pay for health care, to whom and for what; evaluations of existing cost recovery schemes; setting up and expanding government funded health insurance schemes; studies of resource allocation and flow of funds within the health sector; and creation of a privately managed health maintenance organization. The common thread among these diverse activities was the potential "freeing up" of government resources which could then be used to strengthen the delivery and quality of preventive and primary health care to target population groups.

The demand for technical assistance in health financing grew at an unprecedented rate. By the end of the third year of operation, Mission and Regional Bureau buy-ins for project assistance had to be turned down due to ceiling constraints under the contract. USAID mission staff have expressed considerable concern regarding this situation. Many missions have initiated health financing activities in policy development, research studies and pilot projects with REACH technical assistance and feel that the continuation of such technical support is critical to the success of these efforts. USAID missions have stressed the necessity of a long term commitment on the part of AID in order to make lasting reforms in the health sector. A.I.D./Washington should continue to play a strong role in the coordination of health financing work and its subsequent dissemination to others throughout the developing world.

The recently completed mid-term evaluation of the REACH Project also stressed the importance of developing a follow-on health financing project, in recognition of the growing need for technical assistance in this domain. The evaluation attributed the burgeoning sensitivity to and awareness of health financing issues among donors, AID personnel and senior policy makers in LDC's, in large part, to AID's support of health financing, vis-a-vis the REACH Project. The evaluation team noted that REACH has contributed to the limited body of operational knowledge about health financing issues, and "...have had an enormous impact on those working in the field...They [REACH] have created an explosive demand for technical assistance in health financing".

#### B. Primary Health Care Operations Research Project (PRICOR)

S&T/Health's PRICOR Project began in 1981. Its purpose was to use operations research techniques to investigate and overcome factors which impinged on the delivery of health care services at the community level. Community financing of health care was one of the three areas the project focused on. Operational research was undertaken to investigate impediments to financing of health care in ten countries and monographs addressing these and other issues were subsequently disseminated. Most importantly these initial investigations heightened the awareness of financing as an important issue in its own right and provided one of the first sources of funding for such investigations. The importance of this seed funding can be seen in two examples.

#### C. LAC/Health Care Financing (LAC/HCF)

LAC/HCF was designed primarily to undertake studies analyzing costs of health services, demand for particular health services and alternative health financing arrangements. A secondary

purpose was to provide technical assistance. As with REACH, the demand for technical assistance in health care financing far exceeded the response capacity of the project. Missions felt that resolution of the impinging financial issues on the delivery of health care was so important that the LAC Bureau is in the process of designing a follow-on project of much greater breadth and scope, with a more active technical assistance component. This project will have a regional focus, and will emphasize issues specific to LAC countries such as social security.

AID should continue to be a leader in the field of health financing. To do this a strong central capacity must be maintained. The mandate for S&T/H to develop a more comprehensive health financing project has been clearly stated by the flood of mission requests for assistance. International agencies continue to look to AID for collaboration in health financing; other centrally funded projects have also sought technical assistance from REACH and will continue to seek guidance on health financing issues. Knowledge on practical approaches to financing issues is growing and with that growth comes an urgent need to get this information to practitioners and policy makers. This is another area where AID is in a position to make a significant contribution.

## THE PROBLEM

Over the last two decades, overall economic growth in most developing countries, and particularly in sub-Saharan Africa, has deteriorated substantially, resulting in often dramatic declines in the standard of living. In middle to high income countries, where macroeconomic conditions have remained more stable, Ministries of Health have been able to claim relatively stable or in some cases, larger proportions of the national budget. But in most developing countries, where governments have responded to inflation and declining exports with measures such as devaluation and reductions in public expenditure, health budgets have been sharply cut back, often at the expense of those who need public subsidies the most. Capital development budgets have been slashed, and many countries now show a corresponding increase in the proportion of the health development budget financed by donors. However, the most severe problems have arisen from the paucity of funds available for the recurrent expenditures of routine operation and maintenance.

Diminishing recurrent budgets have had immediate and disastrous effects on the ability of LDC governments to provide health care. The MOH, unable to reduce the size of its public labor force, has seen wages and salaries increase dramatically as a percentage of their total recurrent budget. However, the real value of those earnings has fallen sharply during the last decade. Morale of public employees in the health sector has plummeted and many have been forced to work outside of their regular jobs in order to maintain a minimal standard of living. The inability of the MOH to cut back on personnel has left them no recourse but to cut back on other critical items such as drugs, medical supplies, vehicle and equipment maintenance and operation, supervision and training, leaving many health facilities virtually inoperable for months at a time.

### I. Origin and Consequences

The origins of this crisis in health financing lie in the heavily subsidized system of government health care, with a large portion of the budget spent on hospital care rather than more effective uses of funds on public health objectives, and slowing levels of economic growth in many areas. Government inefficiency manifests itself in many ways. Poorly planned importation of pharmaceuticals can unnecessarily deplete foreign exchange; an emphasis on increasing the number of doctors has resulted in overproduction in some areas, while a severe shortage of nurses and auxiliary health workers paralyzes the system; and recurrent budgets for complementary and necessary inputs are inadequate and greatly reduce the productivity of health personnel all of which has led to the breakdown of the quality, quantity and effectiveness of the government system of health care.

The impact of this deterioration of government health services on the health status of the population, and particularly, of the poor is the real cause for concern. Improvements in health status depend, in large part, on the capacity of the health care system to deliver basic types of services and information to households that are often poor, uneducated and uninformed. (Financing Health Services in Developing Countries: An Agenda for Reform. World Bank, Washington, DC, 1987). Evidence relating declines in health status among the poor to reductions in health budgets is surfacing in developing countries. For the first time in decades, Costa Rica's acclaimed level of low infant mortality began to rise shortly after the MOH began experiencing declining budgets. Zambia, a country hit hard by economic stagnation, has seen hospital deaths from protein energy malnutrition rise from 15%-40% over the last decade among children under five years of age. (Health Economics: A Programme for Action, WHO, Geneva, 1988). These are only two examples among many.

The economic prospects for many of the developing countries are worsening and as a result, so are the prospects for an increase in government resources for health. Traditional mechanisms for increasing government contributions through taxation, debt financing or reallocation of resources from other sectors are no longer politically tenable. LDC governments must find other means to simultaneously finance health care and improve the quality, accessibility and efficiency of health care services.

## II. Are There Solutions?

There are a number of countries who are actively pursuing alternatives to the public financing of health care. These countries charge for services, drugs, medical supplies and diagnostic tests. Shifting the burden of payment from the government to the consumer or a third party payor stimulates several crucial events. First, increased reliance on private sector financing of the demand for health care relieves the government of the financial burden of fully subsidizing the nations' health care. Those resources which are no longer committed could be used to subsidize the poor and to support those public health programs with social benefits, such as the surveillance and control of communicable diseases. Second, the collection and discretionary use of fee revenues at the local level brings decision making closer to those who must carry out the decisions, and may create incentives for improving performance and operational efficiency. Third, by pricing services, the government allows the market principles of consumer preferences to ration the quantity demanded. Although rationing by price does not always have desirable effects with respect to equity, it is important for establishing an efficient referral system, which discourages unnecessary and costly use of tertiary facilities.

This shifting of priorities and responsibilities would, in theory, commit the government to a more equitable and efficient use of resources. Those who could afford to pay for all or part of their health care would do so, while the government would subsidize the poor, in addition to supporting public health programs. The economic principles underlying this theory reflect the classification of public and private goods. "Public" goods are those goods and services which provide benefits to all members of a community such as immunizations, control of vector-borne diseases, sanitation and sewage control and health education. For the most part, individuals generally do not want to pay for public goods and tend to wait for others (i.e. government) to assume the financial burden. On the other hand, individuals are usually willing to pay for goods and services with "private" or individual benefits, such as setting a broken leg, or heart surgery. The distinction between public (usually referred to as preventive) and private (referred to as curative) goods is not always so clear cut. A preventive programs such as prenatal care does have individual benefits and individual treatment of tuberculosis has public benefits. But these general principles can be used to govern decisions about what should be publicly financed and what can be paid for through private sources.

Given current economic realities governments are faced with the necessity to pursue alternative sources of financing the health sector. Public resources must be used to support an equitable and viable system of health care and to use those resources more efficiently to sustain priority health services over the long term.

## PROJECT STRATEGIES

The financial crisis in the health sectors of many developing countries is not new and is not going to go away. Even in those countries where economic growth is on the upswing government will have to give first priority to productive investments thus leaving the pressures for reductions in health spending in place.

It is also clear that there is no one correct answer for how to finance health services. The question of whether health care is most efficiently organized by the private or public sector has produced much theoretical debate among economists. The debate has been inconclusive in that it has not been possible, on theoretical grounds, to prove that one system of organization is more efficient than another. What matters are the objectives that a country seeks to achieve through its health sector. (The Economics of Health in Developing Countries, p. 64, Ann Mills and Kenneth Lee, Oxford, 1983) The developed and developing world supplies many models for care. None are perfect. Some get high marks for equity, but do much worse when reviewed for efficiency and vice versa. The approach adopted by any one country will most likely be influenced by political philosophy as well as macro-economic, equity, efficiency and effectiveness criteria.

Different strategies and approaches will be called for if additional resources are to be found for the health sector and these resources are to be used as efficiently as possible.

### I. Private Financing of the Demand for Health Care

Private financing refers to all sources of paying for health services other than through government revenues. The decision to charge fees for services (both curative and preventive), regardless of how the costs are shared, is the premise underlying private financing. Fees for services and/or drugs and the accompanying risk-sharing, insurance schemes such as prepayment, employer benefit plans, social security type arrangements and community revolving funds have been supported by A.I.D. in countries all over the world and will be supported under this project.

Social financing of the demand for health care through health insurance, prepayment schemes, employer health benefit plans and social security type arrangements serves equity as well as efficiency objectives. Under such schemes, well persons help to support the nation's health care system rather than out-of-pocket payments made by the sick at the time of illness. Under out-of-pocket schemes, consumers are at risk for making large and unanticipated payments or they may be at risk of not being able to use needed services due to the inability to pay. Full cost charges would be prohibitive for most, yet without

sufficient cost recovery, providers are unable to operate efficiently.

Insurance is not a new concept to either the developed or developing countries and is found in many forms throughout the world. However, in aggregate, no more than 15% of low income households in LDC's (excluding China), are covered by either public or private insurance. The majority of those households are covered under government sponsored social security programs in the middle income countries of Latin America and Asia. This project will actively seek opportunities to work with LDC governments to experiment with insurance programs; and/or improve and expand existing insurance efforts.

Employment-related plans are the most common form of insurance. A certain proportion of income is withheld from employee payrolls, supplemented with an employer contributions it becomes the premium payment to the insurance plan. Another type of insurance arrangement is prepayment, whereby individuals form a group and make designated payments in return for regular care. Included in this group are managed health care organizations such as HMO's (health maintenance organizations), village cooperative funds and employment related health cooperatives. These account for only a fraction of those covered under an insurance scheme. This project will encourage these alternative forms of service delivery and organization. Prepayment schemes have been strongly endorsed in the U.S. because their incentive systems are structured so as to discourage unnecessary utilization.

## II. The Supply Side, Financial and Organizational Resources

An under utilized resource for financing the delivery of health care in developing countries is the private sector. Religious missions and other nonprofit groups, independent physicians and pharmacists, and traditional healers and midwives are all active health care providers. Direct payments to these providers account for up to, and sometimes more than, half of all health spending in many countries. Governments could reduce their administrative and fiscal burdens as well as increase the options for consumers by selectively supporting the expansion of qualified profit and nonprofit entities, for example church supported mission facilities, or health maintenance organizations. Nongovernment providers are not always qualified to receive government endorsement, a factor which should be weighed carefully as governments seek to encourage consumers to use the private sector. Nonetheless, consumers all over the world have shown a willingness to pay for certain kinds of health care from non-government providers, and in many instances, the private sector may be a more efficient and less costly provider than government. This project will actively seek opportunities to engage the private sector in health service delivery.

Employers are frequently providers of health care services. They may provide on-site health care for their employees and their dependents or they may contract out with an organization to provide care. A number of countries have set up legal requirements to enforce establishment of this practice; others have set up pecuniary incentives for employers to provide care for their employees as well as the surrounding communities.

There are other avenues for private sector involvement, and though they do not result in major reductions of public subsidies to the health sector as a whole, they may significantly improve the efficiency and quality of service delivery within a given institution. For example, government may contract out selective hospital services to the private sector, such as laboratory, laundry and food; they may contract out hospital management and administration; or they may divest themselves of the hospital completely. Government may also contract out pharmaceutical procurement, distribution and storage; emergency vehicle services; or training of health and medical personnel.

Although there are distinct advantages of public-private cooperation, many governments actively discourage such cooperation through policies which range from legal restrictions to informal non-cooperation. Those governments which seek cooperation from the private sector do so through tax incentives, direct subsidies for training, salaries, drugs, etc., and access to credit and foreign exchange. Examples abound of public-private partnership and this project hopes to foster many more. In Indonesia, the government health insurance scheme pays private providers to provide services to some of its clients. In Colombia, the Social Security Institute contracts for beds in private hospitals. In the Philippines, the social security scheme pays for health care in the private sector on an indemnity basis. In some countries in Africa and the Caribbean, governments pay private hospitals to maintain wards for the indigent in those areas not covered by public facilities.

### III. The Role of Government

Public-private arrangements do not obviate the need for government involvement. On the contrary, governments must assume the responsibility of ensuring that people have the means to pay for health care. For the very poor, government must be prepared to subsidize care. Governments must also maintain some form of quality control, encourage competition among providers, and establish an operable legal framework for private providers and financiers. And finally, governments must continue to support public health programs such as surveillance and control of communicable diseases, vector control, family planning, health and nutrition education, sanitation and water supply, though

arrangements may be made for public-private cooperation.

#### IV. Resource Management

Securing additional resources for health will be of greatest value when those resources are used efficiently and effectively. In some instances it may be necessary to improve the utilization of existing resources before policy makers can be convinced that additional resources should be applied to the health sector. While major resource allocation decisions at the central level lie in the hands of politicians, there are tools for decision-making at the ground level which may vastly improve the efficiency of resource use. These tools are rooted in the dynamism of the private sector, whereby people (i.e. the providers) are at risk for success or failure. For example, through discretionary use of fee revenues, facility managers could improve staff performance through pecuniary incentives; ensure the availability of an adequate stockpile of drugs and supplies; and maintain a presentable facility. Prospective budgeting is another tool for managers to institute cost containment within their facility through prospective rather than retrospective reimbursements. Improvements in efficiency will be a major component of technical assistance, training and applied research in this project.

Changes in pharmaceutical procurement from brand name to generic has resulted in significant savings for a number of developing countries. Cost savings have also resulted from revision of the manpower mix used to provide health care in government facilities. Perhaps herein lies the silver lining in an otherwise dark cloud. The impetus for all of these changes in the health sector, structural and managerial, was born out of governments' increasing inability to finance and deliver efficient and equitable health care to its population. The opportunity to reshape the system of health care to be efficient and responsive to the needs of its population has never been so golden.

Developing countries differ dramatically in their political, organizational and socioeconomic structures. Consequently, the options for financing health care vary. This project will not attempt to develop a conceptual model of health financing issues and options to apply across the board to all countries. Rather, the project will propose country specific solutions grounded in the general principles of economics, anthropology, political science, management and administration.

## PROJECT DESCRIPTION

This will be a ten year, \$40.0 million program focused on financing the delivery and sustainability of health care services. Project activities will be implemented through a number of mechanisms. There will be a primary technical assistance/applied research/information dissemination contractor. Agreements with the World Health Organization and other institutions are anticipated as is a limited fund for unsolicited proposals for research that will further the purposes of the project.

I. Goal: To improve the health status of target population groups in developing countries through improvements in the allocation and use of resources within the health sector.

II. Purpose: To achieve a more rational and equitable distribution of public and private resources in the health sector.

### III. Project Focus:

To accomplish these objectives, the project will provide technical assistance in the following six areas:

A. Resource generation through cost recovery: Technical assistance in resource generation may include the implementation, evaluation or expansion of user charges; mechanisms for routine collection, administration and management of fee revenues; development of pricing schemes; improvements in quality of services with fee revenues through establishment of incentives to improve staff performance and procurement of essential drugs and supplies; and subsidization of preventive health care with fees from curative care.

B. Social financing for low income populations: Technical assistance in social financing may focus on the establishment or strengthening of public and private insurance programs; community revolving funds; prepayment schemes; support to the Bamako Initiative; methods of extending urban programs into rural areas to cover the poor; use of insurance as a means of quality and price control; establishing catastrophic coverage in some settings; and facilitating the development of health maintenance organizations in a variety of settings.

C. Public-private collaboration: Technical assistance to encourage private sector involvement may take many forms. Governments could be encouraged to work together with private providers to establish a competitive marketplace for service delivery by eliminating legal or other restrictions faced by the private sector; facilitate divestiture of public facilities or services within those facilities; and private sector cooperation

in providing public health services. Opportunities to work with employers, particularly large, rural employers could be sought with the objective of establishing health service arrangements for employees, dependents and persons in the immediate community.

D. Resource allocation, use and management: Technical assistance in the areas of resource allocation, use and management may include cost containment; improving efficiency; innovative practices in drug procurement and distribution; manpower analyses; capital and recurrent budgetary analyses; improvement in existing budgeting systems and mechanisms for financial control, and cost benefit studies for public health programs such as vector control and control of communicable diseases.

E. Health care costing: Technical assistance in costing may include cost analyses of providing specific types and packages of services, particularly PHC to the poor, in order to insure adequate resource commitment to PHC. Cost benefit and cost-effectiveness analyses could also be undertaken when appropriate.

#### IV. Project Implementation Modes

This project will assist developing countries in the these six technical areas through four modes of implementation: technical assistance, applied research, training and information dissemination.

#### Evaluation Recommendations and Project Focus

These four modes of project implementation are similar to those characterizing the REACH Project, though the relative emphasis has been changed based on the recommendations of the evaluation team. The evaluation team recommended that resource generation become a major element of technical assistance and other activities. The team also recommended that significant attention should be devoted to applied research activities, particularly those which demonstrate and evaluate the viability of alternative arrangements for financing and delivering health services. In an era where financial constraints are severely impeding the ability of LDC governments to deliver health care to its populations, new arrangements must be sought to protect public health. Furthermore, knowledge on the subject of what works where and why is limited. AID's contribution to answering some of these critical questions will be of great significance. The team also urged AID to consider a stronger role for the routine publication and dissemination of technical information on health financing issues. Host country policy makers, managers, USAID staff and academicians have a great need to read about other experiences in

this arena. USAID staff, in particular, expressed a strong desire to receive technical updates, literature reviews and occasional training on selected health economics and financing topics.

#### A. Technical Assistance

Technical assistance, both short and long term, will concentrate on four areas:

**Policy Dialogue:** working with public and private national leaders to design and implement health financing strategies within the realities of the existing legal and regulatory environment. Resource allocation issues within the health sector will be a major area of dialogue and the concomitant development of analytic tools for this purpose will be of high priority.

**Sector diagnosis, assessment and options development:** diagnostic assessment of major financing issues accompanied by public and private alternatives to address those issues. The legal and regulatory environment will also be assessed for impediments to effective financing options.

**Design, implementation and evaluation of health financing schemes:** working with both public and private interests to develop, pilot test and evaluate health financing schemes among different population groups and in different scenarios.

**Institutional development/training:** assisting in the expansion of host country analytical capacity to design, implement and evaluate strategies and programs. Short term training of key host country representatives and development of systems/tools to improve financial management and cost accounting of public and private institutions will be included.

Short term technical assistance will be carried out over four months or less in as many countries as possible, to:

1. Identify and explore potential areas for policy discussion with both public and private LDC leaders
2. Undertake rapid sector diagnoses of major health financing issues, with proposals for longer term assistance
3. Develop health financing strategies for USAID missions; host country public or private institutions

4. Assist in AID project development process, related to bilateral project design
5. Undertake training seminars and small workshops for host country officials and/or USAID mission staff
6. Respond to technical inquiries, requests for information and review/development of technical papers; participation in international conferences and/or workshops
7. Develop financial or cost accounting tools for public or private institutions
8. Assist in the development of host country research agenda
9. Provide assistance to USAID and other donors in reprogramming funds to address health financing and sustainability issues
10. Assist host countries with developing plans directed at improving efficiency and/or cost-containment.

The major source of funding for short term technical assistance will be Mission or Regional Bureau "buy-ins".

Long term technical assistance will be provided in eight to ten carefully selected countries to assist in the development of a national or regional capability and commitment to improving the delivery and financing of health services. In some instances, long term advisors will be sought to manage the activity, ensure continuity and provide regular oversight and guidance. There may be instances where these long term advisors will serve in a regional capacity. Long term activities will be responsive to the concerns of USAID missions and their host country counterparts, though a component of all long term assistance will address the impact of reforms on the poor. Every measure will be taken to ensure that the poor are protected from any direct or indirect financial hardship arising from project activities. Technical assistance may include, but is not limited to:

1. The design, application and evaluation of financing reforms in a pilot area/facility
2. Improvements in the operational efficiency of a specific public or private health facility
3. Development and application of policy tools for senior host country officials, which address resource allocation issues within the health sector

4. The design, application and evaluation of alternative delivery mechanisms in a pilot area
5. The integration of financing reforms into the national plan for financing health
6. Design, implementation and evaluation of public-private arrangements to deliver and finance health services

All long term assistance will require discussions with and approval from the Regional Bureau, S&T/H and the Mission. The following procedure will apply to all such activities:

1. Preliminary visit of approximately three weeks duration, to proposed country. The site visit may either be initiated by the project, the Regional Bureau or the USAID mission. The purpose of the visit is to discuss health financing issues with relevant USAID mission staff and host country officials within the country setting; discuss options for long term involvement, including proposed activities, inputs and expected outputs; and a time frame for proposed involvement. All initial site visits will be undertaken by core project staff.
2. 15 days after the return of project staff, a trip report will be submitted to the CTO for review. The report should include an assessment of the problems, a proposal to address those problems through the project. The proposal should be part of an overall financing strategy for that country. In addition, an activity plan, time frame and budget should be included.
3. Discussions will be held with the Regional Bureau, USAID mission staff (by phone) and project staff. Pending CTO approval, the project will identify appropriate staff or consultants to undertake the activities. Candidates for long term advisors must be reviewed and approved by the CTO and the host country.
4. Long term activities will generally evolve over a period of one to four years, with an average cost of no more than \$1.0 million.
5. Formal and informal training and transfer of technology should be an essential component of the activity.
6. Expected outcomes of the activity will be identified at the start, in order to evaluate the success and effectiveness of the activity. Evaluation methodology will be agreed upon at the start of the activity.

7. All activities will be distilled for lessons learned and major findings, which will be disseminated to all countries deemed relevant by the CTO.

The primary source of funding for long-term technical assistance will be "buy-ins" from Missions and Regional Bureaus .

## B. Applied Research

Due to the limited knowledge that currently exists about the effectiveness and long term success of various health financing options relevant to developing countries, applied research will have an important role in the project. All research activities will be designed to address critical questions regarding the delivery and financing of health care to LDC populations, with an emphasis on protecting the poor. Specifically, the research results will assist in determining to what extent and under what conditions specific interventions are effective in improving the delivery and financing of health services, with the larger goal of improving health status of the target population groups. The purpose of the research will be to guide the design and implementation of health financing activities. Although some research may be free-standing, most will be integrated with other project activities, particularly the long term technical involvement in selected countries.

Each study design will be approved by the CTO, pending approval from the host country and USAID mission. These studies differ from long term assistance in that they are intended to answer critical technical questions which require empirical evidence. They may not be foremost on the agenda of either the USAID mission or the host country, but are deemed essential by the project, the TAG and the CTO to furthering knowledge in this arena. However, research activities will be designed and conducted in countries and settings that will assure that their results be incorporated into national or regional policy, strategy or operational activities of that country.

The anticipated number of major research projects, with a budget of \$200,000 or more, will be limited to 2-3 per AID Region per each five year period of this project. There will be no numerical limit on the number, or country site of small (\$25,000 or less) research efforts.

Long term advisors may be necessary to provide guidance and sustain continuity throughout the research period. Every attempt will be made to identify developing country candidates for these positions. There will be host country collaboration in all research efforts. It is anticipated that most research will be conducted by host country researchers working out of local universities. One outcome of the research will be the

development of local capabilities in health economics and health care financing research. All applied research will be submitted for publication in one or more respected journals of AID's selection.

Most questions for applied research will fall under the five technical areas of project focus described in the Project Description. Illustrative topics are as follows:

Resource generation through cost recovery: What factors determine where people seek health services? How much do they pay for health care relative to their level of disposable income? What proportion goes to drugs? Are the poor excluded from adequate health care because of inability to pay? What charges should be levied for what services at different points in the health care system? How can the poor be protected? How should the fee revenues be managed and what are the short and long term financial implications at participating facilities? What are the appropriate roles for central and local decision makers in cost recovery decisions?

Social financing for low income populations: What insurance type arrangements exist in the public and private sectors? How much do they cost? How efficient are they? Whom do they benefit? How are prices and quality controlled? What opportunities exist for extending coverage under insurance programs into rural areas? into the informal sector where income is irregular at best? How much can insurance revenues be used to supplant government revenues? Are there ways to arrange major insurance programs such that the duplication of services and inefficiency found in countries with parallel Ministry of Health and Social Security care systems can be avoided?

Public-private collaboration: What financing arrangements have been set up in the private sector to recover costs of operation? What is the scope for private activities in public hospitals? What areas do private providers have a comparative advantage? How can governments take advantage of this in their mandate to provide health care to all? What incentives trigger efficient operation and quality performance? What legal, regulatory or financial incentives could be considered to entice private sector collaboration in the delivery and financing of health care?

Resource allocation, use and management (efficiency): What factors determine the allocation of public resources within the health sector; what are the opportunities to alter that allocation; and what are the appropriate tools necessary for relevant policy changes? What are the relevant public finance issues which affect health financing? How can improvements in the efficiency of service delivery affect the quality and quantity of health services available to the public? What tools

are available for improving efficiency? What changes could be instituted to facilitate organizational reform directed at more efficient operation?

Health care costing: How much would it cost to routinely provide basic health services to different population groups in different geographic settings? How much is presently being spent on the delivery of a similar set of health services? Are there more cost-effective ways to deliver those same services? What factors have the greatest impact on costs of delivering services?

One of the first research activities to be carried out should be a review of the research and service experiences of other AID projects and organizations that have dealt with the five technical areas of health financing/economics covered by this project. The REACH, PRICOR and LAC/HCF Projects are in the process of analyzing lessons learned under the current projects. This information must be supplemented with the experiences of; other bilateral and multilateral groups, such as WHO and the World Bank, national projects, PVO experiences, Foundations' efforts in health care financing, and of course AID Mission projects. Modifications in project activities and direction may result from this investigation.

This preliminary investigation should also examine any settings in which health financing initiatives or policy reforms have been particularly effective. The intent is to identify common exogenous factors which have led to successful interventions, in order to incorporate them into the design of long term and applied research activities.

The identification of innovative health care financing activities world wide, the collection of documentation and its analysis will remain an important activity over the life of this project.

The project's Technical Advisory Group (TAG) will play an important role in the development of the research agenda for this project. The initial meeting will be used to review a draft research agenda and research implementation proposals that will have been developed by the project contractors and the CTO. The TAG members will also serve as a committee to review the methodological aspect of each potential research study. Based on the TAGs review and recommendations research efforts will be undertaken. The review of updated research agendas as well as the review of preliminary and final research results will be a regular function of the TAG.

In the some cases the funding for applied research will come from the S&T budget, particularly if the research has implications outside of the particular country where it is being conducted. If research results are more country specific and the AID Mission

or Ministry of Health is particularly interested in the results, "buy-in" funding will be required.

### C. Training

Training activities carried out under this project will be implemented in four ways.

1. Training of key host country officials will be a key part of all project activities. Seminars, workshops and conferences, to be held either in an AID-assisted developing country or in a region, will address those areas designated above, upon request by USAIDs.

2. Study tours or observational travel will be utilized very selectively as a means to educate national leaders about experiences in other countries.

3. The project will set aside limited funding to be used for training grants to graduate students. Experience with the REACH project has shown that there are only a limited number of individuals in the U.S. that are interested and knowledgeable about health care financing in developing countries. Project funds will be used to provide grants of up to \$15,000 to encourage graduate students to undertake research in health care financing in LDCs. These grants will be considered when the research topic proposed is in line with the research agenda of this project.

4. In addition, all long term technical assistance and applied research activities will be accompanied a series of workshops designed to encourage full participation, interest and longer term involvement with the relevant issues. This training will be funded under the technical assistance and research budgets.

Many crucial decisions which affect health financing throughout the sector lie within the confines of the Ministries of Finance and Planning. MOH officials are generally unequipped to communicate their rationale for budget requests or explain the repercussions of various budget decisions to these ministries. Facilitating interministerial dialogue by targeting relevant policy makers and practitioners and arming them with useful tools for communication will be one of the objectives of this component. Both the EDI of the World Bank, and the WHO sponsor training in the areas of health financing to this cadre of officials. As was the REACH Project, this project will be encouraged to work with EDI and WHO to assist in the development of appropriate materials and participate in their conduct. These training courses would provide the project with a ready venue for both dissemination of project activities and experiences as well as expose senior officials to the availability of technical

expertise through AID.

Training efforts through international organizations will be supported with central funds, as will training that has a regional focus. Training that is country specific will be conducted when "buy-ins" are available.

#### D. Information dissemination

Publication and dissemination of information on project activities, research findings, reviews of the literature, and technical updates will be an important component of this project. Information will be packaged for a wide variety of audiences including AID personnel, host country policy makers and senior officials and academic and research institutions. As a routine function of the project, distribution of information will be timely, well-packaged and well-targeted. The project contractor will develop an information center that will be responsible for these activities.

Within AID health care financing issues touch not only health officers, but program officers and economists as well. Mission Directors are likely to have to intercede in gaining country acquiescence to sensitive and difficult policy changes inherent in many health financing initiatives, many of which must be dealt with outside of the health sector. Training materials aimed at these audiences will be developed and used for training purposes. There is also a need to keep AID staff better informed of developments in health financing and economics. Newsletters, technical updates and synopses of project activities, experiences and research findings will be sent to the field missions regularly.

Within developing countries there is also a need for information. In addition to technical updates and newsletters, a special effort will be devoted to the production of "policy" publications for senior government officials. These will be a simplified (and/or) condensed version of technical updates packaged in a glossy format. The objective is to attract attention to the issues, rather than to inundate policy makers with technical information.

Other donor organizations are struggling with the issues of health care financing. The project will continue to promote AID's leadership role in health financing within the international donor community. Information dissemination will be directed at UNICEF, WHO and others, to promote strategies which support the financial sustainability of child survival programs, within the realities of a country's economic context.

The academic/research community is expected to be a participant

in this project. Most project activities will include data collection, developing research and evaluation methodology, testing hypotheses and generating new findings. Because of the limited knowledge in this arena, it would be useful to publish such information and have it undergo review by the scientific community. Furthermore, academic conferences and settings are the primary recruiting grounds for professionals interested in pursuing this type of applied economics and public health work. Engaging them at an early stage in their careers could substantially increase the limited pool of available and interested professionals.

Finally, private voluntary organizations, many with AID funding, are involved with delivering health services in many developing countries. Many of the more effective cost recovery systems in Africa have been developed by PVOs. The information dissemination element of the project will both look to PVOs for examples of how to approach financing problems and will target PVOs as an important group that will be able to utilize information developed and/or disseminated under this project.

Most of the information dissemination will be funded by S&T. This activity will be implemented primarily through the information center that will be established by the contractor. It is also anticipated that support will be provided to WHO's efforts in this area and possibly those of other international and regional organizations.

## V. Project Sites

*Over 5 years*

This health financing project will have a worldwide focus. Any country eligible for AID assistance can be considered. However, since long term assistance and applied research will be intensive both in terms of AID project resources and those of the host country, long term activities will be limited to three countries per AID region and major applied research activities will be limited to two to three countries per region. Smaller research activities (under \$25,000) can be conducted in any number of countries. At each site, collaboration with a host country institution will be required over a two to four year period.

Primary consideration will be given to those countries with:

- A. severe financing problems within the health sector
- B. opportunities for the project to have a significant impact on improving the delivery and financing of health care during the project period
- C. evidence of a desire on the part of the MOH and related organizations to improve the delivery of health services

within the country

D. evidence of a desire on the part of the USAID mission to commit resources to project activities

E. availability of host country institution for collaboration over the project period

F. evidence of MOH commitment to improve the relative allocation of resources to primary health care

Countries in each of the three regions with different levels of socioeconomic and political development will be selected so that financing reforms may be tested under a variety of scenarios. Consideration will also be given to opportunities to coordinate with other donors (World Bank, UNICEF, WHO, etc.) so as to maximize impact.

## VI. Related Activities

A certain portion of project resources will be reserved for activities of a worldwide nature that will further efforts in improving the financing and delivery of health care to developing countries. The funding source will be S&T. These resources will not be bid competitively with the rest of the project funds, but will be administered separately by the Office of Health, Bureau of Science and Technology. Activities under this category will include, but not be limited to:

A. Support to WHO for training in health financing and economics, including the development of materials and LDC participation. The countries involved should be AID-assisted countries.

B. Support to WHO for research related to health financing issues covered under the mandate of this project, including participation of LDC officials.

C. Support for unsolicited proposals which directly fall under the mandate of this project. Preference will be given to proposals from private non-profit, not-for-profit or for profit groups which request support for an on-going or new health financing initiative. Award will be based on the technical merit of the proposal, credibility and credit-worthiness of the proposing institution as assessed by the CTO and concurrence of the relevant USAID mission.

D. Support for the publication and dissemination of relevant information generated outside of the project, that is deemed useful to planners and policy makers in LDC's. Funds will also be reserved for workshops/conferences that will bring

together organizations working on various aspects of health financing issues.

E. It is anticipated that some technical services may be required through US Government agencies. Existing PASA/RSSA agreements will be used to access these services. However, if funding under these agreements is not sufficient, limited project funds will be made available to put into these agreements.

## VII. Expected Achievements/Accomplishments (Outputs)

The objectives of this project are 1) to increase public and private resources available to the health sector; 2) to improve the efficiency with which those resources are used within the health sector; and 3) to incorporate equity considerations into resource allocation decisions. In order to achieve these three major objectives, project achievements must reflect the four programmatic modes of implementation, ie. policy dialogue, sector diagnoses, training and institutional development and information dissemination. Most activities will lead to expanded and improved policy discussions and actions by high level public and private sector leaders. The principal outcomes of these activities will be:

A. Increased understanding of health financing issues by public and private policy makers in developing countries through training, workshops, conferences and information dissemination;

B. USAID mission staff trained and prepared to manage health financing initiatives;

C. Effective policy /tools developed for furthering the discussion on health financing issues between and within ministries;

D. Strengthened partnerships between the public and private sector resulting in increased resources for health;

E. Effective tools/studies developed for instituting changes in resource management and use to improve efficiency;

F. Country-specific operational plans prepared for implementing, monitoring and evaluating the results of applied research, demonstration projects and evaluations;

G. Country-specific strategies and tools developed for ensuring that the poor have access to affordable health services;

H. Blueprints for further policy development, research and demonstration activities developed.

Outcomes of a smaller scale may be expected from demonstration activities, under both the long term and the applied research components. S&T/H expects to see adoption of specific financing reforms in a given facility, set of facilities or administratively defined area accompanied by enhanced managerial and financial skills. Strengthened community based efforts, such as drug revolving funds or community insurance funds may also be an outcome of this project.

The underlying assumption of these outcomes is that, through project interventions, convincing evidence will be generated which persuades national leaders that there are viable alternatives to the present system of government financing and delivery of health care. Furthermore, it is assumed that improvements in health financing will result in improvements in the quality and quantity of health care available to target populations in LDC's and that better health care leads to improvements in health status.

## IMPLEMENTATION ARRANGEMENTS

### I. AID Management

The S&T/H Cognizant Technical Officer (CTO) will manage both the primary contract and funds set aside for "Related Activities". The CTO will be the principal AID contact for the primary contractor. The CTO will be involved in all stages of the contract and will monitor the contractor's progress in fulfilling the objectives and the intent of the contract. The CTO will meet with other offices within AID as appropriate, including the Regional Bureaus, PPC, FVA/PVC and USAID missions to discuss and review project activities and will arrange for appropriate clearances for project activities. The Regional Bureaus and USAID missions will contribute to this project through reviews and clearances of respective country activities, submissions of requests and cost-sharing (buy-ins) related to in-country operations and technical assistance.

The CTO will exercise a variety of functions, including:

A. Approval of all technical staff proposed to participate as project staff by the contractor.

B. Approval of all activities carried out under this agreement including strategies; workplans; budgets; sub-agreements; applied research protocols; country technical assistance; study agreements; information dissemination and publication; consultancies; domestic and international travel; continuing education, training or participation of project staff in symposia.

C. Collaborative involvement and final approval of the selection of long term technical assistance and applied research sites and development of an annual workplan which describes the specific activities to be carried out under the agreement, by whom, when how, and at what cost.

D. Involvement in the design and implementation of applied research and long term interventions as appropriate.

E. Involvement in the publication and dissemination of project activities, findings, results.

F. Review of draft reports and substantive correspondence, participation in site visits, the Technical Advisory Group (TAG) and evaluations to review progress and future strategy.

G. Responsibility for recommending, in coordination with other AID officials, the allocation of funds under this project for support of health financing activities under other grants and contracts to meet the objectives of this project. Such allocations will be approved by the Director of the Office of Health.

H. Coordination with other AID projects such as PRICOR, REACH, WASH, etc. A specific line item in the budget contains funds for activities that will improve health financing initiatives of other projects/programs. For example, WASH may be undertaking financing studies on water use and distribution and may request assistance from this project. PRITECH may need assistance in developing a costing methodology for ORT; or VBC may need assistance in designing a cost-effectiveness study of alternative programs for malaria prophylaxis. Requests for such assistance will be approved by the CTO.

S&T/H anticipates that the management of this project will be a full time job for a CTO for the first two years of the project, during which time project strategy, workplans, site and activity identification and research questions are being determined. For the latter three years of the project, the CTO should be prepared to devote 2/3 to 3/4 time to project management. The CTO should have a strong background in health economics/financing; field experience and experience in project management.

## II. Contract Services/Capabilities/Staffing

The contract through which most of the project activities will be implemented will be competitively bid. The initial contract will be for a five year period. A second five year contract is anticipated. The scope of these contracts will be within the terms of this project paper and will be guided by the findings of the two evaluations scheduled over the first half of the project.

We expect the primary contract will be with a consortium that will include a private consulting group or groups and universities. Subcontractual arrangements will be encouraged in order to include the wide range of technical and managerial capabilities necessary to implement this project. Subcontractors will be adequately represented on the core technical staff and participate regularly in project/activity planning and budgeting. They will assume responsibility for project activities and the concomitant budgets, reports, briefings and debriefings and training workshops. Responsibilities will be divided either by technical, functional or geographic area to ensure full participation. It is intended that a well-integrated and technically sound approach to the contractor-subcontractor relationship be established and agreed to in writing by all involved parties. This relationship should be reviewed and approved by the CTO annually.

The contractor will be selected based on the demonstration of technical expertise in health financing, economics and public finance, including hospital administration and financial accounting, private insurance arrangements, social security and

alternative delivery mechanisms such as managed care organizations; health planning, including policy work; experience with culturally appropriate information dissemination, education and communication; skills in program/project management; skills and experience in applied research, including survey methodology and statistical analysis; experience in and demonstrated competence in providing technical assistance to developing countries. The contractor must present a core staff and roster of consultants who possess technical competence in the areas listed above. At least two members of the technical core staff must have a working knowledge of French and two in Spanish, at the S-3 and R-3 levels.

#### A. Contractor Activities

The contractor will be responsible for supporting project purposes through technical assistance, applied research, training and information dissemination. The steps involved in developing, managing, implementing and evaluating activities will follow the same general pattern for long term technical assistance, applied research, training and information dissemination. These steps include:

- A. Activity proposal, with well defined purpose, strategy, expected outcomes, time frame, budget, staff/consultant involvement
- B. Initial three week site visit to discuss and tentatively agree on activity with host country and USAID mission. Trip report should include refined version of activity proposal, with identification of local collaborating institutions and personnel; relationship of activity to identified problems and country need; and identification of potential obstacles.
- C. Approval of CTO pending review of work plan with appropriate Regional Bureau staff; clearances and budget approvals as necessary
- D. Periodic reports and AID/W debriefings of activity progress
- E. Final activity debriefing; final activity report synthesizing activity purpose, outcomes, inputs, lessons learned; recommendations to country for follow up; proposed follow up activities for AID or other donors
- F. Dissemination of report and translation, if appropriate; selected reports rewritten for journal publication or training purposes.

All activities should take place, to the extent possible and

appropriate, with the collaboration of local public and private health personnel. Particular emphasis will be placed on developing host country capacity to carry out systematic planning, monitoring and evaluation of project activities. All long term and applied research activities will have a training component and some form of policy dialogue.

These activities will all be conducted with the objective of improving the allocation, use and management of public and private resources for health, in order to provide health care efficiently and equitably to LDC populations. Resources include personnel, drugs and supplies, equipment and facilities and budgets. Improvements in efficiency are relatively determined according to host country standards, with the private sector often used as the model. Improvements in equity, that is, available, affordable and accessible health care for the poor, must also be determined according to the situation of each particular country. Each long term and applied research activity must address these two objectives, providing quantitative or qualitative indicators of achievement by the end of project activity, as appropriate. Formative applied and operational research are expected to feed back into the planning and implementation of project activities.

#### B. Gray Amendment Considerations

This project will be competitively bid, with all proposals considered on an equal basis. However, the request for technical proposals will encourage proposals from minority and women-owned enterprises, and will encourage all offerers to subcontract with qualified small businesses, small disadvantaged, and/or small women-owned concerns for services for which it might not have in-house capacity.

#### C. Contract Staffing

The contractor will need to establish a core group of individuals that will be responsible to the planning and implementation of the project. The members of this core staff should include representatives of the major contractor/subcontractors that are involved. These individuals will be expected to be available for work on this project on a full time basis, except in the case of unusual circumstances, which must be approved by the CTO. The following skills, experience and technical capabilities should be represented among the core group:

The Project Director (GS 15) should have technical competence and experience in health economics/financing, with work history in developing countries; managerial expertise with large project/program; preferred experience with AID; good speaking and represen-

tational skills; language competence in Spanish or French. Travel required about 30% of time.

The Deputy Director (GS 12-13) should have managerial and administrative competence with some knowledge of health financing and economics. Experience with AID is preferable though not required. Travel required 0-10% of time.

The Senior Health Economist (GS 14-15) will have technical competence in health economics/public finance/health financing issues, with PhD. International field experience; managerial expertise; research experience and appropriate methodological skills; publication in academic journals; language competence in Spanish or French. Travel required 25-30% of time.

The Senior Health Insurance Expert (GS 13-14) will have technical competence in health insurance arrangements, including payment and reimbursement mechanisms, social security systems; experience in private sector financing of health care; international technical experience preferable; good presentation and writing skills. Travel required 25-30% of time.

The Health Planner (GS 13-14) will have technical competence in health planning; experience in policy dialogue with senior level representatives of developing countries; substantial experience in developing countries; foreign language competence. Travel required 25-30% of time.

The Financial Management and Accounting expert (GS 12-13) will have technical competence and experience in public/private hospital administration, financial management, cost accounting; experience in developing countries preferred; foreign language competence preferred. Travel required 30% of time.

The Information Specialist (GS 13) will have an academic degree and experience in information management and dissemination, plus experience in report writing, abstracting and publication and knowledge of information dissemination networks in developing countries. No travel.

The Technical Associates\* (2) (GS 10) should have an MPH, MBA, MHA or similar degree with international health experience. Language competence in French or Spanish required. Travel about 15-20% of time.

\*One joins staff after first year.

The Administrative Assistant (GS 7) will have experience and competence in project/program administration; computer skills; good organizational skills. No travel.

The Secretary (GS 6) will have good typing and computer skills.

### III. Relationships with Host Countries

Due to the sensitive nature of health financing and the political visibility of consequent decisions, it is essential to have a high level of cooperation and agreement on activities between AID, the contractors, Ministries of Health, Planning and Finance, participating universities and PVO's. Prior to the initiation of long term or applied research activities in any country, there will be a written agreement between AID and the Ministry of Health (other relevant Ministries or research institutions) that describes project purpose, activities and responsibilities of all parties involved. The contractor will provide support to the AID mission in negotiating the agreement, upon request. It is expected that host country personnel will play a key role in all long term and applied research activities, in addition to participating in training workshops. Preference will be given to host country nationals in the case of long term advisors. As articulated earlier, an important component of this project is the development of host country capacity to design, implement, and evaluate health financing initiatives and longer term programs.

### IV. Technical Advisory Group

This project will have a Technical Advisory Group, whose major purpose will be to advise AID, and particularly the CTO, on technical and strategic issues related to the project. The TAG will serve in an advisory capacity to AID on the whole of this project, not just on the primary technical assistance contract. The TAG will be comprised of a select group of technical experts, chosen from international organizations, universities, donor organizations, PVO's, or relevant AID projects. The TAG membership will include private practitioners from the international health care industry as well as individuals involved with government financed health services. Approximately ten individuals will be identified CTO within the first three months of the project to participate on the TAG.

The TAG will provide expert review of the project and make recommendations for improvement or modification. TAG members are expected to meet formally at least six times during the course of the first five years, however, the CTO or the Project Director may consult with members of the TAG as frequently as need be. Attendance at the formal TAG meetings will include at least the Project Director, Senior Health Economist and Senior Health Planner. These meetings will be chaired by the CTO. Other AID staff may be included.

The first formal TAG meeting will be designated to review initial

work plans approximately four months after project start. The most important aspects of this review include project strategy, preliminary selection of target countries for long term activities and the nature of the activity, the research agenda which the project would like to address and the development of criteria against which project achievements will be measured. Relevant materials will be prepared by the Project and distributed to TAG members one week prior to the meeting.

The second TAG meeting will be held approximately one year later (16-18 months after project start). The purpose of this meeting will be to review progress to date, including the initiation of long term and applied research activities. Methodology will be reviewed for all research activities. The TAG will also review selected reports of short term assistance for technical merit and quality, to be identified jointly by the CTO and the Project. The Project will prepare synopses of all activities to date; obstacles to progress; and rationale for modifications in earlier work plan or project strategy. All materials for the TAG meetings will be distributed to TAG members one week prior to the meeting.

The third TAG meeting will be held approximately 10-12 months after the second TAG (28 months after project start). The third TAG meeting will review do the same thing as described above, with more attention devoted to long term and applied research activities. The TAG will also review the evaluation criteria and their appropriateness to project activities.

The fourth TAG will meet approximately one year after the last TAG (40 months after project start). The objectives of this TAG will be to review project activities and establish a paradigm to discuss and explain achievements, lessons learned and recommendations. Evaluation criteria will again be reviewed. The information dissemination and training aspects of the project will be reviewed for improvement or modification.

The fifth TAG will meet at the beginning of the fifth year of project operation, approximately 10-11 months after the last TAG. The purpose of this TAG will be to review the recommendations and findings from the project's fourth year external evaluation discuss possible project responses to the evaluation; assist the CTO in drafting the scope of work for the second five year project based on lessons learned and project evaluation findings and recommendations; and assist the CTO in revising evaluation criteria for second five year project.

The sixth and final TAG meeting will meet several months before the close of the first five year project in health financing. Their objectives will be to review the work of the project and make recommendations for strategy, type of activities, topics for research; nature and quantity of training; staff composition; and

modifications in the information dissemination component of the second five year project in health financing. It may be decided by the CTO that the agenda of this TAG would be more useful if it were included in the fifth TAG meeting, in which case, this last meeting would be cancelled.

Minutes will be kept at each TAG meeting and the Project will respond to any TAG recommendations within 20 working days after the TAG meeting. As the project evolves, the time and agenda of these TAG meetings may be changed by the CTO in order to maximize the contribution of the all of the technical experts. In the case of drop out, the CTO may choose another technical expert to participate in the TAG. All TAG members will be compensated for their time in review of documents and participation in the meeting out of program funds approved by the CTO. Travel and per diem will also be reimbursed as appropriate.

TAG members may be invited to participate in evaluations of the project. They will also assist the contractors and/or AID in developing research plans and protocols and reviewing technical proposals and reports.

The majority of TAG related work and expenses will be carried out through the primary contract under this project.

#### V. Implementation/Work Plans

An implementation plan is included as Annex D to this project paper. The contractor will submit a detailed work plan annually to the CTO. The first year's work plan will be submitted to the CTO within three months after the signing of the technical assistance contract, reviewed and distributed to the TAG members one week prior to the first TAG meeting. This work plan will 1) describe start up activities, including the orientation, responsibilities and proposed travel of staff and structure for project management; 2) potential countries for long term activities and proposal for initiating activities; 3) potential topics and sites for research activities; 4) structure for handling short term technical assistance requests; 5) strategy for information dissemination and training and 6) standardizing and reporting of project financial accounts. All of those areas mentioned above should be placed within the context of the project strategy, objectives and technical areas of activity.

The workplan will be modified to reflect the recommendations of the TAG, discussion with the Regional Bureaus and approved by the CTO.

### COST ESTIMATES AND FINANCIAL PLAN

The project will be a ten year, \$40.0 million effort, including \$4.0 million set aside under the program for project supported activities beyond the service of the primary contractor. Of the \$36 million devoted to the health financing contract, 40% or \$14.4 million will come from S&T/H funds; 60% or \$21.6 million will come in the form of buy-ins from USAID missions, PPC or Regional Bureaus. The \$4.0 million set aside for other activities will come from S&T/H and be used for unsolicited proposals, support to WHO and the costs of the TAG. (See Budget, Annex C)

The estimated buy-in level for this project has been calculated using; cable responses from missions regarding their anticipated levels of buy-ins (see Annex D), discussions with Regional and Central Bureaus' on their potential buy-ins, and the buy-in experience of the previous REACH health care financing contract. Previous contract experience is considered a particularly important criteria. There was no formal buy-in amount specified in that contract, but the informal goal of 37% was set by S&T/H's Health Services Division. This level of buy-in was achieved without problem. In fact, many addition buy-ins had to be turned down because the contract funding ceiling would not accommodate them. Based on these experiences the buy-in rate of 60% under the primary contract is considered reasonable.

The initial project implementation contract will be for five years of services, to be followed by a second five year contract. Project funding will be divided approximately evenly across these two five year periods.

The anticipated break down of obligations between central (S&T) funds and buy-ins will be as follows:

(\$ 000,000)

|         | FY89      | FY90       | FY91       | FY92       | FY93       | FY94       | FY95       | FY96       | FY97       | FY98       | total       |
|---------|-----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|
| S&T     | .9        | 2.0        | 2.2        | 2.0        | 2.1        | 2.2        | 2.2        | 2.0        | 1.5        | 1.3        | 18.4        |
| Buy-Ins | <u>.6</u> | <u>2.8</u> | <u>3.0</u> | <u>2.8</u> | <u>1.6</u> | <u>2.4</u> | <u>2.5</u> | <u>2.5</u> | <u>2.4</u> | <u>1.0</u> | <u>21.6</u> |
| TOTAL   | 1.5       | 4.8        | 5.2        | 4.8        | 3.7        | 4.6        | 4.7        | 4.5        | 3.9        | 2.3        | 40.0        |

The anticipated ratio of buy-ins to central funding across the different categories of project activities for the first five years is as follows:

|                                   | funding source (\$ 000,000) |           |            |
|-----------------------------------|-----------------------------|-----------|------------|
|                                   | central                     | buy-ins   | total      |
| Contractor services:              |                             |           |            |
| technical assistance (50%)        | 2.2                         | 7.8       | 10.0       |
| applied research (22.5%)          | 2.5                         | 2.0       | 4.5        |
| training (5%)                     | .5                          | .5        | 1.0        |
| information dissemination (12.5%) | <u>2.0</u>                  | <u>.5</u> | <u>2.5</u> |
| contract total                    | 7.2                         | 10.8      | 18.0       |
| Related activities (10%):         |                             |           |            |
| TAG/evaluation/consultants        | .5                          | -         | .5         |
| research                          | .9                          | -         | .9         |
| training                          | .3                          | -         | .3         |
| information                       | <u>.3</u>                   | -         | <u>.3</u>  |
| total                             | 2.0                         | -         | 2.0        |
| TOTAL - first 5 years             | 9.2                         | 10.8      | 20.0       |

The following is an indication of how funds are distributed among the four categories of project activity.

|                           | under the contract | total funding |
|---------------------------|--------------------|---------------|
| technical assistance      | 55.5%              | 52.5%         |
| applied research          | 25.0%              | 27.0%         |
| training                  | 5.5%               | 6.5%          |
| information dissemination | <u>13.9%</u>       | <u>14.0%</u>  |
|                           | 100.0%             | 100.0%        |

## MONITORING PLAN

### I. Reports

The prime contractor shall submit the following reports to the AID CTO:

A. Annual work plan, the first received three months after project start. The work plan shall detail technical activities by country and by technical component; level of effort, including involvement of staff and consultants; budget; collaborating host country institutions; timetable; travel.

B. Interim activity reports, submitted six months after project start and then at 12 month intervals. The reports should include, but not be limited to a description of all activities and their status to date, accompanied by planned activities for the next six months. All activity descriptions should depict level of effort of technical, managerial and administrative staff and consultants, expenditures to date, and the approved activity budget.

C. Project strategy, with attention to four modes of implementation, including technical assistance, applied research, training/institutional development and information dissemination.

D. Proposal for each long term activity prior to initial site visit, to be followed by refined country strategy and workplan, due 15 days after returning from initial site visit.

E. Proposal for each applied research activity, methodology, collaborating institutions, staff and consultants, budget.

F. Final reports for all activities, which should include but not be limited to description of purpose, methodology, findings and recommendations and final cost.

G. Monthly budget summaries, with activities grouped by region (AFR), mode of implementation (applied research), technical area (i.e. resource generation) and contractual expenditure category (salaries, travel, overhead, etc.). This is particularly important to ensure that project expenditures can be monitored by distinct categories of operation. As the project evolves, the CTO may add other categories for characterizing project expenditures. The project will maintain expenditure records including, but not limited to in-house training, participation in seminars and continuing education; recruiting.

H. Other financial reports and vouchers for payment and reporting of project expenditures will conform to standard AID regulations and procedures. Advance copies of vouchers shall be sent to the CTO for review.

## II. Evaluation Plan

The first five year project will be subject to two evaluations, an internal evaluation conducted by S&T/H at the end of the second year and a major external evaluation near the end of the fourth year of the project. The objective of the internal evaluation is to assess the effectiveness of the management structure of the project; project responsiveness to USAID missions and to AID/W; project direction and strategy; and any major issues which have arisen during the course of operation. Evaluators may include the CTO, TAG members, S&T/H or other AID/W staff. The evaluation should take approximately ten to fourteen working days and will require no travel. The recommendations from the evaluation should be used to modify the project to make it more effective.

The objective of the external evaluation will be to assess the contractor's effectiveness and success in carrying out the mandate of the project contract. This shall include, but not be limited to assessment of: the quality, effectiveness and accomplishments of technical assistance, training and information dissemination; financial management of the project; development and application of new tools to address financing, management, training and cost issues; and the effectiveness of applied research to respond to critical questions in the field.

The evaluation team shall make recommendations to AID regarding the contractors' ability and capacity to effectively carry out the second five year health financing project. The evaluation team shall make recommendations regarding operation of the final year of the project, particularly regarding the culmination, syntheses and presentation of lessons learned. The team shall also advise AID on appropriate direction, strategy, management and operations of the second five year project which reflect the experiences of the last four years.

The evaluation shall team may include but not be limited to the representatives from S&T/H, the TAG international or donor organizations, universities or research settings and AID staff. Funding for the evaluation will come from the project budget and will be held by S&T/H separately from the implementation contract. The evaluation will take place over 20-25 working days and will require travel to field sites of major activities.

The criteria against which the project activities will be evaluated will differ from site to site, but will reflect the country strategy documents and the workplan. The TAG will have as one of its agenda items in the third and fourth meetings, the review and finalization of the evaluation framework. However, at this stage, the most appropriate criteria with which

to judge project success are improvements in service delivery. Improvements in financing health services are the means to improved quality and accessibility of health care rather than an end in itself and this should be kept in mind during the development of all activities and their subsequent evaluation.

#### CONDITIONS AND COVENANTS

Agreements which may be negotiated under this project and executed by the officer(s) to whom such authority is delegated in accordance with AID regulations and Delegations of authority, shall be subject to the following terms and conditions together with such other terms and conditions that AID may deem appropriate.

#### Source and Origin of Goods and Services

Each country where research, training, technical or other assistance takes place under this project shall be deemed to be a cooperating country for the purpose of permitting local cost financing. The sum of all purchase orders, contracts and sub-agreements for goods and services under each subagreement in a cooperating country may be procured in the special free world category (Code 935) up to \$750,000 for the purpose of permitting local cost financing.

Annex A  
Women in Development

The Women in Development Office of A.I.D. has as its goal "ensuring that women have access to the opportunities and benefits of economic development". Improvements in the quality and accessibility of health care is clearly a benefit of development and women and children should be the primary beneficiaries. Through this project, women will have more options for seeking care for their children and for themselves. Women, as the decision makers of households in many societies, already spend up to half of their disposable income on health care. Due to the poor quality of care in public facilities, they bypass "free care" and seek care from a myriad of private providers of dubious value and at a significant cost. More than likely, they have no insurance against the resurgent illness that claim the health of their children and their money for food. This project will experiment with insurance programs for the rural, non-salaried workers; cooperatives; and prepayment plans in communities which will improve the financial security for women and children at risk.

The project will solicit the collaboration of women and women's groups in the project countries to be involved in the design, implementation and evaluation of activities. Input from women as to the expected impact of the project on their social, economic and household roles will be of high priority in shaping project decisions. Views of women in decision-making and policy roles and of women representing a more traditional role will be sought and used in project implementation. Collaboration with women who have positions of responsibility within the host country health structure will also be stressed, further assuring the goal of fully integrating women into all phases of AID project activities.

Annex B.  
Social Considerations

Questions of public finance, micro-economics or health economics are sometimes treated as something without a strong social context. This project will not accept that assumption.

The economic situation of each family in a developing country, their decisions regarding when to seek health care, who they will go to, and how much they may be willing to pay for these services are all elements of a larger social fabric. Economics, and more specifically health economics, has shed considerable light on the decision making process regarding the search for adequate health care. The economists' strengths are in quantifying the responses of groups of individuals through survey research.

But other disciplines, specifically sociology and anthropology have also made significant contributions to the understanding of health related behavior. Anthropologists have developed models of health decision making that can be applied in developing country settings and which can add important additional information on why people make the health care decisions they do.

The quantified information that economic research methodologies produce is important for policy makers, but it is not the only criteria upon which decisions on the most appropriate means of financing health care can be made. More qualitative data can provide additional insights into some of the social and personal consequences of particular decisions. This information is particularly important when the possibilities of deterring the genuinely poor and deserving from using health services through charges is being evaluated.

Social science methodologies, many of which have been utilized in quality of care research in the US, must be an important component in evaluation of cost-containment measures or imposition of fees. In both instances the perceptions of the patients are important. In the case of fees for services, if the perceived quality of the services is low, a reluctance to pay the fees can be expected. Thus when the imposition of fees is discussed there is usually a parallel discussion about improving the quality of the services. When cost containment measures are being taken it is necessary to monitor the quality of those services to make sure that they do not slip to unacceptable levels. Here again, the perceptions of individuals regarding quality of care is very important. The US Government has set up systems for monitoring the quality of care provided through Medicare, specifically to make sure that the cost-containment measures being taken under Medicare (the diagnostic related groups system of payment) does not have an adverse affect on services provided. We should do no less in developing countries

where we are supporting cost-containment efforts.

The role of socio-cultural analysis is not only appropriate when considering national programs and their consequences. Health care financing initiatives can also be designed to work with and support community level social institutions. For example, the traditions of communal labor still found in some parts of Africa can be utilized to facilitate community construction or renovation of health facilities. The traditional role of some town chiefs, where they continually collect presents from town members, but then turn around and use these presents to support a family in need might form the basis for a community health insurance fund. Just as traditional patterns of money lending have been used to pattern small scale agricultural loan funds in Asia, these same principles can be applied to small scale health insurance funds.

A multi-disciplinary approach is needed in looking at both the technical assistance and the research aspects of this project. A multi-disciplinary approach will be used starting with the selection of TAG members.

Annex C  
Estimated Budget

|                                   | (in millions of dollars) |             |             |
|-----------------------------------|--------------------------|-------------|-------------|
|                                   | S&T                      | Buy-ins     | Total       |
| <b>FIRST FIVE YEARS</b>           |                          |             |             |
| Contract Activities               |                          |             |             |
| Technical Assistance (50%)        | 2.2                      | 7.8         | 10.0        |
| Applied Research (22.5%)          | 2.5                      | 2.0         | 4.5         |
| Training (5%)                     | .5                       | .5          | 1.0         |
| Information Dissemination (12.5%) | 2.0                      | .5          | 2.5         |
| Related Activities (10%) *        |                          |             |             |
| TAG/evaluation/consultants        | .5                       | -           | .5          |
| Applied Research                  | .9                       | -           | .9          |
| Training                          | .3                       | -           | .3          |
| Information Dissemination         | .3                       | -           | .3          |
| <b>TOTAL - first 5 years</b>      | <u>9.2</u>               | <u>10.8</u> | <u>20.0</u> |
| <b>SECOND FIVE YEARS</b>          |                          |             |             |
| Contract Activities               |                          |             |             |
| Technical Assistance (50%)        | 2.2                      | 7.8         | 10.0        |
| Applied Research (22.5%)          | 2.5                      | 2.0         | 4.5         |
| Training (5%)                     | .5                       | .5          | 1.0         |
| Information Dissemination (12.5%) | 2.0                      | .5          | 2.5         |
| Related Activities (10%) *        |                          |             |             |
| TAG/evaluation/consultants        | .5                       | -           | .5          |
| Applied Research                  | .9                       | -           | .9          |
| Training                          | .3                       | -           | .3          |
| Information Dissemination         | .3                       | -           | .3          |
| <b>TOTAL - second five years</b>  | <u>9.2</u>               | <u>10.8</u> | <u>20.0</u> |
| <b>TOTAL - ten years</b>          | <b>18.4</b>              | <b>21.6</b> | <b>40.0</b> |

\*Reserved for allocation to project purposes not implemented through the principal contractor. This includes, but is not limited to, a midterm and final project evaluation, support for information dissemination, support for coordination of work with other agencies, grants to WHO, and other unsolicited proposals.

## CONTRACTOR CORE EXPENDITURES

|                          |                                 |
|--------------------------|---------------------------------|
| Contractor Staff         |                                 |
| Director                 | \$70,000                        |
| Deputy Director          | 65,000                          |
| Senior Health Economist  | 50,000                          |
| Insurance Expert         | 45,000                          |
| Health Planner           | 45,000                          |
| Financial Mgt/Accounting | 40,000                          |
| Information Specialist   | 40,000                          |
| Technical Associate      | 35,000                          |
| Technical Associate*     | 30,000                          |
| Administrative Assistant | 30,000                          |
| Secretary                | 25,000                          |
| total                    | 445,000                         |
| Overhead approx. 90%     | 401,000                         |
| Office Expenses          | <u>65,000</u>                   |
| YEARLY TOTAL             | 911,000 x 5 years = \$4,555,000 |

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 CONTRACT CORE EXPENDITURES APPORTIONED ACROSS CATEGORIES OF PROJECT ACTIVITY FOR THE FIRST FIVE YEARS

|   |                  |
|---|------------------|
| Technical assistance (55.5% of contract)      |                  |
| Activities                                    | \$7,472,000      |
| Contractor expenses                           | <u>2,528,000</u> |
| TOTAL   | 10,000,000       |
| Applied Research (25.0% of contract)          |                  |
| Activities                                    | 3,361,000        |
| Contractor expenses                           | <u>1,139,000</u> |
| TOTAL   | 4,500,000        |
| Training (5.6% of contract)                   |                  |
| Activities                                    | 745,000          |
| Contractor expenses                           | <u>255,000</u>   |
| TOTAL   | 1,000,000        |
| Information Dissemination (13.9% of contract) |                  |
| Activities                                    | 1,867,000        |
| Contractor expenses                           | <u>633,000</u>   |
| TOTAL   | 2,500,000        |
| CONTRACT GRAND TOTAL                          |                  |
| Activities                                    | 13,445,000       |
| Contractor expenses                           | <u>4,555,000</u> |
| TOTAL   | 18,000,000       |

## CONTRACT ESTIMATED BUDGETS - SPECIFIC ACTIVITIES - FIRST 5 YEARS

## Technical Assistance

|  |               |                        |
|--|---------------|------------------------|
| Long term - one country example          |               |                        |
| Expatriate ta (17.2 person months)       | 241,000       |                        |
| local ta                                 | 85,000        |                        |
| seminars                                 | 15,000        |                        |
| other expenses                           | 50,000        |                        |
| core contract home office/staff          | 125,000       |                        |
| travel/per diem of home office staff     | <u>30,000</u> |                        |
| Total                                    |               | 546,000x10 = 5,460,000 |
| Short term                               |               |                        |
| consultants (214 person months)          |               | 2,990,000              |
| contract home office/staff expenses      |               | 1,250,000              |
| travel/per diem of staff providing st ta |               | <u>300,000</u>         |
| Total                                    |               | 4,540,000              |
| Total technical assistance               |               | 10,000,000             |

## Applied Research

|   |              |                       |
|---|--------------|-----------------------|
| Major Study - One Country Example       |              |                       |
| core contract expenses                  | 63,666       |                       |
| core staff travel/per diem              | 8,000        |                       |
| expatriate technical assistance (8 pm)  | 112,000      |                       |
| local technical assistance (16 pm)      | 48,000       |                       |
| research assistants/field workers       | 20,000       |                       |
| in-country travel                       | 4,000        |                       |
| data analysis                           | 8,000        |                       |
| data presentation workshop(s)           | 10,000       |                       |
| misc.                                   | <u>4,112</u> |                       |
| total                                   |              | 277,778x9 = 2,500,000 |
| Small Studies                           |              |                       |
| core contract expenses                  | 13,000       |                       |
| core staff travel/per diem              | 3,000        |                       |
| expatriate consultants (1 person month) | 14,000       |                       |
| local technical assistance (3 pm)       | 9,000        |                       |
| research assistants/field workers       | 3,000        |                       |
| in-country travel                       | 2,000        |                       |
| data analysis                           | 4,000        |                       |
| workshops on results                    | 1,000        |                       |
| other expenses                          | <u>1,000</u> |                       |
| total                                   |              | 50,000x40 = 2,000,000 |
| Total Applied Research                  |              | 4,500,000             |

Annex D  
Mission Buy-in Estimates for the First 5 Years

|   | (\$000)      |
|---|--------------|
| <b>ASIA/NEAR EAST BUREAU</b>  |              |
| Jordan  | 850          |
| Yemen   | 150          |
| Morocco   | 500 (700)    |
| Egypt, estimate 48 pm st ta   | (1,250)      |
| Nepal, requests funding ceiling high enough<br>to allow their buy-in, ? amount        | (300)        |
| Oman, very interested, ? amount   | (100)        |
| Philippines possible buy-in regarding<br>cost-containment in hospitals                | (300)        |
| Pakistan expect to request 5 months of st<br>ta, final need may be 10-15 months st ta | (400)        |
| Indonesia, have their own hcf project   | -0-          |
| Thailand, want \$300,000 of central funds   | -0-          |
| Bangladesh  | -0-          |
| India   | -0-          |
| <b>AFRICA BUREAU</b>  |              |
| Chad, expect to need st ta, ? amount  | (150)        |
| Rwanda may be interested in private sector  | (150)        |
| Sudan   | 200          |
| Mali, expect to have needs, do not expect large<br>area, do not expect large buy-in   | (100)        |
| Zaire   | 200          |
| Kenya   | 450          |
| Burkina Faso, possible buy-in, ? amount   | (200)        |
| <b>LATIN AMERICA/CARIBBEAN BUREAU</b>   |              |
| Jamaica, \$200,000/year for 5 years   | 1,000        |
| Bolivia expect to need significant<br>amount of ta                                    | (400)        |
| Haiti   | 750          |
| RDO/C expect to buy-in, at this point<br>do not know if into LAC or S&T project       | (400)        |
| Ecuador, not now, maybe small in future   | (50)         |
| Costa Rica  | -0-          |
| Peru  | -0-          |
| El Salvador   | -0-          |
| Honduras  | -0-          |
| <b>TOTAL</b>  | <b>8,100</b> |

( ) estimated

PROGRAM GOAL

To improve health status of target population groups in LDCs through improvements within the health sector.

INDICATORS

Improved basic health indicators of target population groups.

VERIFICATION

Health service statistics; epidemiological surveys

ASSUMPTIONS

1. Changes and improvements in resource allocation and use will result in improvements in health status of the target pop.  
2. Additional resources allocated to preventive health will have a positive impact on health status.

PROJECT PURPOSE

To achieve a more rational and equitable distribution of public and private resources within the health sector

EOPS

Improved patterns of use of public and private resources within the health sectors of LDCs

As appropriate in various countries, this may include:

1. LDC policy agenda addressing financing reforms
2. Incentives for private sector to collaborate with public sector in health service delivery and financing
3. Improved fiscal mgmt. within the health sector
4. Improved MOH capability to present rational budgets to MOF/Treasury.
5. Improvements in resource allocation from curative to basic health care.
6. Development of research agenda on financing issues
7. Adoption of financing reforms in various settings within selected countries.

- MOH budget documents
- Demand/health expenditure surveys
- Official policy statements
- Project reports

- LDC governments will use and information/research to institute financing reforms.
- MOH has the political freedom to reallocate budgetary resources within the sector
- Target populations respond to instituted changes in predictable manner.
- Public and private resources can be mobilized in ways to improve overall efficiency and equity.
- Analytical and policy tools developed in project are effective and can be implemented by host country.
- Legal and financial environment conducive to effective reforms
- The poor have access to health service

OUTPUTS

1. Policy studies/tools which demonstrate utility and feasibility of financing reforms.
2. USAID Mission staff trained and prepared to manage health financing initiatives.
3. Increased understanding of health financing issues by public and private policy makers in LDCs through training, workshops, conferences and information dissemination
4. Results of pilot and demonstration activities prove effective in implementing financing reforms.
5. Dissemination of project activity results and findings to wide audience
6. Diagnostic and financial mgmt. tools appropriately designed for use by and within LDC settings
7. Demonstration of effectiveness of private sector as provider and financier of health care services
8. Economic analyses of effects of financing reforms on target population.

INDICATORS

1. Number of policy studies undertaken in LDCs
2. 5-7 bilateral HCF projects and strategies
3. Publication of project research and activities in related journals
4. Number of reports/newsletters regularly circulated to LDC policy makers, USAID mission staff.
5. Number of activities developed with private or public-private collaboration
6. Number of training workshops; number of policy seminars; number of regional conferences
7. Number of economic analyses

VERIFICATION

1. Project records, reports on activities
2. Mission/Regional Bureau portfolio; strategies
3. LDC policy documents
4. Journal articles
5. Project newsletters, research
6. Training documents
7. Interview with LDC officials, project activity managers, private sector.

ASSUMPTIONS

1. USAID mission staff interested and competent to pursue health financing agenda with LDC counterparts
2. Pilot and demonstration activities are well designed, managed and evaluated
3. Host country officials interested and able to pursue health financing reforms.
4. Project expertise in culturally, technically and managerially sound
5. Support of Medical community
6. Private sector interested in collaborating/participating in health delivery and financing

INPUTS

1. Core staff and consultant services in: technical assistance, training, applied research, mgmt. and administrations; information; communication
2. Funding for short-term TA; funding for applied reinfo. dissemination and training.
3. Local government and non-government resources (technical, managerial, political and financial)
4. Cooperative agreements with other international organizations, research institutions.
5. Management and technical skills of S&T/H C.T.O.
6. USAID Mission resources
7. Technical skills of TAG

INDICATORS

\*Budget

VERIFICATION

1. Qualification of staff and consultants;CTO;TAG members
2. S&T/H budgets
3. USAID Mission budgets
4. Project records, quarterly reports, work plan, budget.
5. Interviews with international academic and research institutions

ASSUMPTIONS

1. Best technically qualified wins contract
2. S&T/H identifies competent CTO
3. TAG advice is taken into consideration
4. Local and mission resources available for project
5. International academic and research institutions able to participate in project
6. Funding available at suggested levels