

**SUMMARY OF RECENT A.I.D. PROJECT AND APPLIED RESEARCH ACTIVITIES  
IN THE AREAS OF HEALTH ECONOMICS AND HEALTH FINANCING**

**Prepared for the Second Informal Meeting of Agencies  
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## **SUMMARY OF RECENT A.I.D. PROJECT AND APPLIED RESEARCH ACTIVITIES IN THE AREAS OF HEALTH ECONOMICS AND HEALTH FINANCING<sup>1</sup>**

In the past ten years, the Agency for International Development (A.I.D.) has contributed to improved understanding in several areas of health economics and health financing (HE/HF) as well as other key aspects of health program sustainability. As A.I.D.'s HE/HF activities evolved over the decade of the 1980s, initial discrete efforts to identify and measure recurrent costs of operating A.I.D. health project interventions gradually broadened to include the more fundamental economic factors of efficiency, equity, and efficacy. In this brief summary of A.I.D.'s recent experience in HE/HF activities, we provide: (1) an outline of the Agency's priority areas in HE/HF; (2) summarize the scope of these activities; (3) impart lessons learned from this experience; and (4) suggest some trends and areas of future interest.

The sources of the data and information which provide the basis for this paper are A.I.D. project documents, the Annual Health and Child Survival Questionnaire, the A.I.D. Congressional Presentation, and interviews with A.I.D. health economists and regional experts.

### **I. Priority Issues for A.I.D.**

In its work on HE/HF, A.I.D. has identified the following key issues: the inefficient use of existing health resources, inadequate domestic resource mobilization, and the inequitable distribution of those resources. Continued shifts in demographic factors, including urbanization, aging of the population, represent underlying forces which substantially impair the financing situation of many developing countries and necessitate action. Together, these issues and factors may induce the following effects: lost opportunities to expand service coverage, diversion of scarce resources away from efficacious and cost-effective primary health care (PHC) interventions, and increased deterioration of health infrastructure. These financing-related problems have an impact on the lives of many who reside in the developing world and who suffer disproportionately from the lack of access to low-cost, quality health care services. Underlying

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many HE/HF issues is a pervasive lack of adequate data to guide policymaking, program management, and long range planning for solving financing and sustainability problems.

## **II. Policy Directions to Address Issues**

A key element in A.I.D.'s HE/HF strategy focuses on working with the governments, non-governmental organizations, and private organizations of developing countries to address economic and financing which constrain sustainability and effectiveness of child survival and related health, population, and nutrition programs. In addition to child survival efforts, HE/HF initiatives can also provide other welfare enhancing effects such as: improved financing, resources allocation, reducing the risk of financial loss, making more effective public investments, reducing distortions in consumer and provider behavior, and better targeting of public spending. Appropriate HE/HF policies are the foundation for building responsive health systems that target scarce resources to high-impact, low-cost interventions, such as oral rehydration therapy and immunizations, that lead to significant mortality and morbidity reductions.

In each program area, health financing initiatives are approached as a means to accomplishing health related ends. To achieve a more adequate, efficient, and equitable allocation of health resources, A.I.D.'s Health Financing Guidelines outline the following priority areas for HE/HF projects: resource generation through cost recovery; social financing of the demand for services; public private collaboration; and, health care costing, and resource allocation, use, and management. These areas are addressed through the mechanisms of policy dialogue, specific HE/HF project initiatives, and operations research.

## **III. Scope and Overview of Activities**

At the headquarters level, A.I.D. is sponsoring twelve projects which include extensive attention to health economics and financing (see **Table 1**). As the table suggests, each of the projects focuses on particular aspects of these issues in the health sector. For the most part, these twelve projects provide a combination of technical assistance, applied research, training, and information dissemination within its area of focus. Four of these projects (HFS, the Latin America Project, the Europe Project, and PROFIT) are directed to general health financing issues, including offering policy dialogue with public and private officials in host countries. The Quality Assurance and Data for Decision-making Projects represent efforts to address special economic, management, and sustainability problems facing health policymakers. Over the past few years, attention to economics and financing has been added to the work assignments of A.I.D. primary health, and disease control projects. The remaining projects in the table represent efforts to address financing and sustainability issues in those areas.

At the country level, A.I.D. projects vary across the geographic regions where A.I.D. operates. A few projects attempt to address all of the different HE/HF categories. Many have multiple objectives which are addressed through the various mechanisms. In A.I.D. country programs world-wide, approximately 85 HE/HF projects are now in varying stages of implementation. The Africa region has the greatest amount of HE/HF activity with approximately 30 projects in 18 countries. The Latin America and Caribbean (LAC) region follows with approximately 25 projects in 15 countries. The Asia region has approximately 15 projects operating in five countries, the Near East (NE) region follows with 6 projects in 4 countries, and the central office sponsors 12 projects which operate world-wide in as many as 27 countries. In addition, 2 recently approved projects will begin operations in the Europe region (see **Chart 1**).

A categorical breakdown of HF/HE activities is available for approximately 50 projects, included among the responses from the 1990 Annual Health and Child Survival Questionnaire. A review of this data provides a useful framework for identifying certain trends across the different regions (see **Chart 2**).

#### **A. Public-Private Collaboration**

Nearly all A.I.D. Missions report increased dialogue with host country ministries of health (MOHs) regarding expanding the role and involvement of the private sector. Specific activities range from private voluntary organization-public sector partnerships in the delivery of child survival services in Haiti, Peru, and Zaire to facilitating credit loans to private practitioners in Egypt. Privatization of hospitals is another important areas which focused private/public sector dialogue in Jamaica, Indonesia, and the Philippines.

Future studies by A.I.D. central HE/HF projects in the area of public private collaboration will address: the development of private health care markets; public and private differences in efficiency; and, public and private interactions.

#### **B. Health Care Costing and Resource Allocation, Use, and Management**

Unlike other areas of HE/HF that may inherently imply greater risk for host MOHs to adopt, health care costing is readily understood and accepted as a means for opening dialogue and initiating discrete activities. Through this activity, a MOH interested in increasing efficiency can gradually ascertain the importance of addressing more complex and volatile resources allocation issues. Within the LAC region, decentralization is increasingly addressed in the context of efficiency arguments.

HF/HE studies recently addressed recurrent cost expenditure analysis in Kenya, Guatemala, Peru, and Belize. Recurrent cost expenditure analysis provides a means to raise issues such as: the allocation and targeting of scarce resources, dependence of donor funding for primary care, and the identification of inefficient uses of resources.

### **C. Cost Recovery**

Many countries have had user fees in one form or another for a long time. A.I.D. worked recently with several countries in the Africa region, often with other donors, to develop ways of collecting fees for services and medicines as mechanism to enhance cost recovery. Fee for service arrangements also exist in A.I.D. projects in the LAC and Asia regions.

A.I.D. central HE/HF studies will address issues such as: the trade-offs consumers and providers make between quality and cost of care; the determination of cost efficient mechanisms to target subsidies to the poor; and the extent that prices direct consumers to the appropriate use of health facilities.

### **D. Social Financing of the Demand for Health Services**

Within A.I.D. programs, the Asia region has had the greatest amount of activity in this area. Within the region both Indonesia and the Philippines have ongoing programs addressed to both private and social insurance areas. In LAC region, dialogue continues by A.I.D. to address the development of a more efficient and effective social security systems, including in some cases greater private sector involvement.

A.I.D. central HE/HF studies will address social financing as an alternative to direct delivery of health services and explore different alternatives for the finance and regulation of private sector provision. Major issues are: extending coverage to larger parts of the population and finding feasible mechanisms to finance improved benefits, especially for basic and preventive services.

## **IV. Lessons Learned**

The above framework provides a structure for analyzing A.I.D. HE/HF projects. Although diverse, many projects share features that contribute towards an evolving, cumulative knowledge base which facilitates the design of future HE/HF projects. Although successful projects may inspire others, a model from one area may not be applied easily to another (even in the same country). Models must be scrutinized, adapted, and often extensively revised to meet local conditions and circumstances. Field experience indicates the importance of trying different approaches while developing a maximum number of available options.

## **A. Constraints**

Limited A.I.D. funding may restrict the degree to which an A.I.D. country program may influence substantive health financing reform. Moreover, the philosophical underpinning of MOH policy in many countries features the "right of free health care" which usually impedes the development of cost recovery activities. MOHs are often not willing or able to take chances and weather the political repercussions that may follow unpopular decisions which are linked to HE/HF reforms. These ideological issues are bound up in a terrifying lack of knowledge and information on health financing matters in most countries that adds to the risk-aversion of politicians. Limited expertise and available resources of Missions and MOHs alike constrain their ability to provide effective technical assistance and close the existing information/knowledge gap.

## **B. Factors that Support HE/HF Reform**

Regional experts and A.I.D. Mission staff cite the importance of developing and maintaining good working relationships with the MOH, financial and planning ministries, and private sector groups. They stress that attaining policy reform is a cumulative and iterative process that evolves over time. Patience and persistence pay dividends in the long run. In laying the ground work for long term reform, Missions should maximize the opportunities for success through a careful gathering and analysis of relevant information. Effective technical assistance facilitates this step, and leads to increased Mission credibility within the MOH. This in turn supports a higher level of HE/HF program activity. If HE/HF reform is to have a lasting impact, dialogue must move beyond the MOH level to the ministries of finance and planning where most financing decisions are ultimately made.

## **V. Country Specific Lessons**

A.I.D. has had a number of HE/HF projects operating for several years in many countries. These interventions generally developed as part of the on-going dialogue that A.I.D. Mission staffs undertake on a normal basis with the host country health ministries, non-governmental organizations, and other private organizations. In the projects described below, we provide illustrative examples of recent A.I.D. HE/HF activities in each of the four major areas discussed. A.I.D. anticipates that NPA programs will become a substantial aspect of its health sector activity, focusing on key elements of economic reform.

## **A. Non-project assistance in Kenya**

In the health sector, A.I.D. has worked in several countries to combine and leverage resources with other donor organizations to secure policy reform under structural adjustment. Non-project assistance (NPA) is the term used by A.I.D. for its activities in support of structural adjustment policy reform.

For example, in Kenya, a multi-donor collaboration in structural adjustment is assisting the government to increase the level of financing for PHC services within the MOH's recurrent budget. To further this goal, A.I.D. under its NPA program, along with the support of the British Overseas Development Agency and the Swedish International Development Agency, financed a resource gap study of the Kenya's MOH PHC services. The study provided baseline information on current allocations of MOH resources to PHC and provided a means of monitoring shifts resources to close the gap in the MOH's recurrent budget. This experience reveals the following:

- o Estimated large shortages in recurrent and capital funding if the PHC system in system is operated at full capacity.
- o Established the level of revenue to enable the system to operate as planned and allows the government to make informed strategic choices between funding PHC and other types of care.

## **B. Cost-recovery in PHC Facilities in Bolivia**

In Bolivia, A.I.D. supported the development of a network of private-sector PHC establishments, called PROSALUD, that provides services to urban and rural populations with user fees. From this experience and related studies, the following results emerged:

- o Based on earlier efforts to incorporate prepayment schemes into PROSALUD, it was found to be difficult to control high utilization, with only modest premiums; prepayment revenues did not approach fee-for-service levels of cost recovery.
- o To secure services to lower income populations in rural areas, which have higher unit costs, it was possible to utilize funds as cross-subsidies from financially higher performing urban clinics.
- o Linking staff salary bonuses to the financial performance of their respective clinics expanded clientele and improved the organization's financial performance.

- o Preliminary results from PROSALUD suggest that this model may be generally applicable, except to areas of abject poverty or low population density. This indicates the need for specific studies regarding methods and models for subsidizing certain services or population groups.

### **C. Social/Private Insurance in Indonesia**

Indonesia is one of a few countries where an A.I.D. project has involved both private and public insurance components operating as part of its HE/HF program. The insurance component of the project seeks to: expand the insurance coverage of the population; open the health insurance market; and, privatize civil service insurance. Over the three years of the project the following preliminary lessons emerge:

- o Hard data and good information are essential for policy change. The project focused its efforts the first two years on collecting the necessary HE/HF data and conducting analysis.
- o Consider a range of options for policy reform and incorporate middle level managers in formulating policy options that anticipate the problems of policy implementation.
- o Knowledge and understanding of political and economic climate of the country may provide unexpected windows of opportunity for HF/HE policy dialogue and reform.

### **D. Cost Recovery Hospitals in Egypt**

The aim of A.I.D. project is to support the Egypt MOH in converting approximately 40 MOH hospitals into cost recovery hospitals (CRHs). These CRHs will produce high quality marketable outputs that allow the facilities to recover approximately 60% of their operating costs. The project will confront the following issues:

- o Ensure effective operational coordination between the MOH, the CRHs, and the finance ministry. As planned, participating hospitals will deposit collected revenue in a bank account on which they can draw funds with ministry of finance approval.
- o Establish effective incentive mechanisms to support innovation and cost recovery. Efforts are being made to establish a policy of fee collection that permits a sizable portion to remain at each hospital.

- o Determine appropriate rates of state budget allocation with regard to the level of revenue. As planned, the government could not simply supplant budget allocations with earned revenue.
- o Determine appropriate levels of revenue allocation towards primary or public health services. Revenues can be redirected and thereby increase return on social investment.

## **VI. Collaborative Partners and Links**

Central to A.I.D.'s HE/HF strategy is the importance of consulting with other donors concerning the likely effects of different funding priorities on the current financial situation in the health sector. Benefits are gained by all parties through coordinating messages and contributing resources to support appropriate initiatives. A.I.D. continues to work with other organizations to address future recurrent cost requirements for sustaining donor-assisted programs. A.I.D. works closely with the World Bank, WHO, UNICEF, and other major multilateral and bilateral donor agencies to exchange ideas and information concerning the appropriate role of donors in dealing with HE/HF issues in developing countries.

## **VII. Future Trends and Issues**

HE/HF is just beginning to gather steam as a focus in the health sector. The past five years reveal a tremendous growth in the demand for technical assistance in this area. It is an important and popular area because it enables policy makers to gain control over the health sector and make informed choices among a wide menu of revenue sources and methods to achieve public goals. A.I.D. foresees continued growth and new challenges in HE/HF in the coming years.

In its new Eastern Europe program, A.I.D. anticipates HE/HF activities in many countries of the region. The program will operate under the theme of "Health Markets for Eastern and Central Europe" and aims to create competition and generate a market place for health care services. Program activities will involve: public policy; delivery systems; medical inputs and technology; and insurance systems. One component of the program focuses on developing linkages with prospective hospitals and health professionals to develop the necessary technical and organization skills to develop an active private sector for health services. The other main component focuses on health policy and intends to train bureaucrats on how to work with and regulate the private sector.

Beyond continuation of its current programs, A.I.D. regional experts identified the following issues which will challenge the donor community, and policy makers in the future:

- o Donor dependence -- that is, situations where a majority of a program's support comes from donor rather than host country sources -- should receive increased attention. Analysis of prospective programs could determine which programs governments could sponsor solely and therefore free donor funds for additional areas.
- o Changing demographics, urbanization, and an increased aging of populations will place a larger burden on the health sector in many countries. Strategies are needed to develop and deploy efficient and effective services to address such demographic shifts.
- o HIV/AIDS will place an additional burden on developing countries to make decisions on how to more effectively target existing resources and mobilize additional resources.
- o Broader options combining resource mobilization and cost recovery with the use of the price system to discourage unhealthy behaviors, such as direct taxes on the consumption of harmful goods could be used to face these issues.
- o Lack of trained specialists in the fields of health economics and financial management represent a continuing obstacle to progress in many countries.

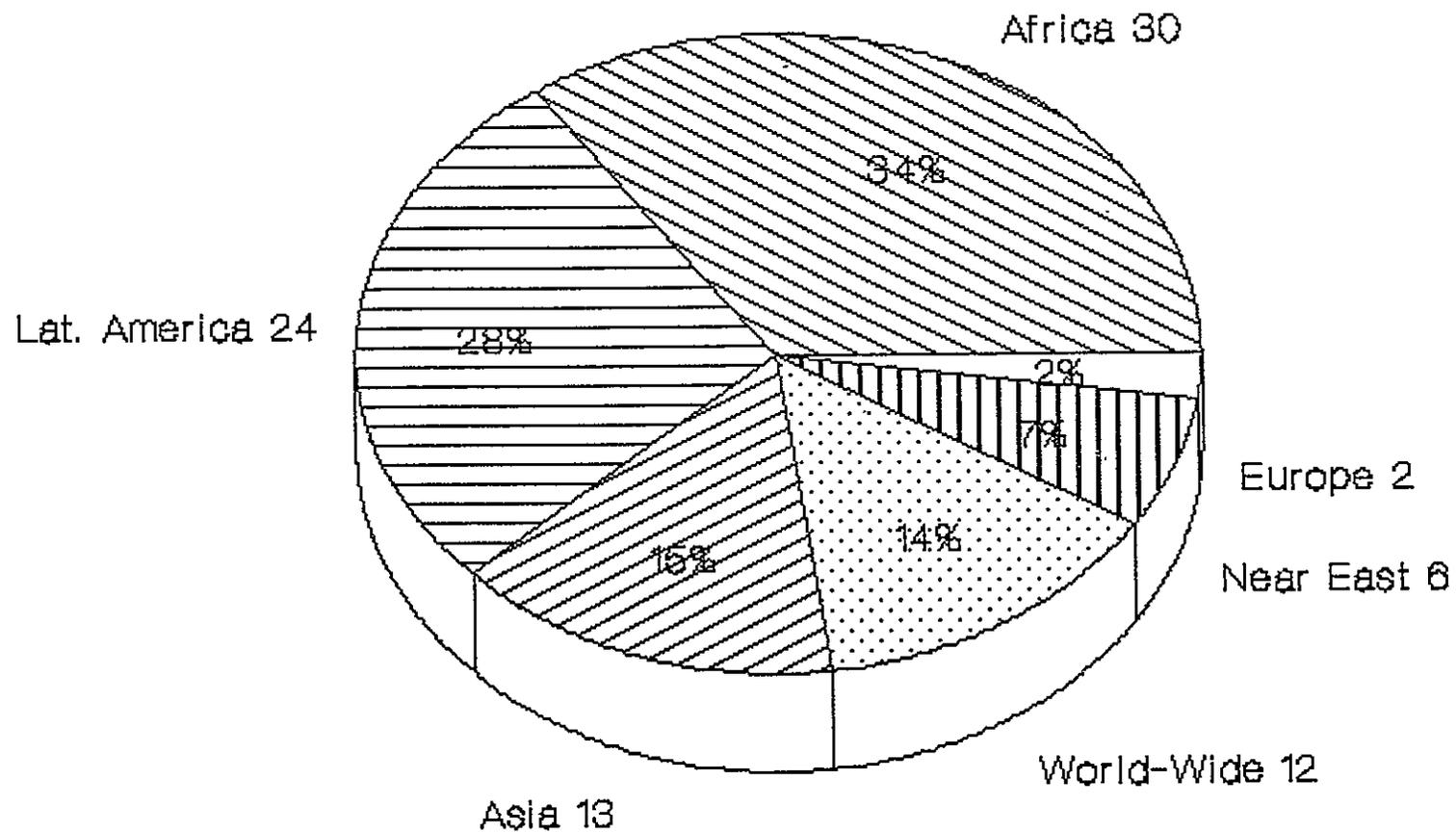
A.I.D. anticipates continued collaboration with health economics and health financing specialists to address these significant issues.

**Table 1. A.I.D. World-Wide and Regional Projects  
with Components in Health Economics and Health Financing**

Project Name	Scope	Project Officer*
Applied Research in Child Survival Services (or "Quality Assurance")	Measure and improve service provider performance; applied research to apply QA techniques in health.	James Heiby R&D/Health
Data for Decision Making in the Health Sector (DDM)	Technical assistance (TA) and training to develop tools to link data with decision-makers.	James Sheppard R&D/Health
Health Financing and Sustainability (HFS)	TA, applied research, and information dissemination in health economics, financing and management.	Robert Emrey R&D/Health
Communication for Child Survival (HEALTHCOM)	Communication and social marketing to increase use of ORT, immunization, breastfeeding, & child spacing	Holly Fluty R&D/Health
Maternal and Neonatal Health Nutrition (MOTHERCARE)	Increase utilization of services and influence behaviors that affect health and nutritional status of women and infants.	Mary Ann Anderson R&D/Health
Technologies for Primary Health Care II (PRITECH)	Implementation and institutionalization of oral rehydration/diarrheal disease control programs; emphasis is placed on strengthening linkages with nutrition and diarrheal disease prevention.	Robert Emrey R&D/Health
Technology and Resources for Health (REACH)	TA and training, operations research, cost analysis, information dissemination for EPI and ARI programs.	J. Gibson R&D/Health
Water and Sanitation for Health (WASH)	TA, services and information in urban and rural water supply and sanitation.	A. D. Long R&D/Health
Vector Biology and Control (VBC)	Create effective and cost efficient vector-borne disease control programs.	D. Carroll R&D/Health
Health and Nutrition Sustainability for Latin America (LAC)	TA and training to create cost efficient and sustainable program interventions.	Nicholas Studzinski LAC/DR
Regional Health Financing Project for Europe	TA and training to develop health care markets for the private sector in Europe, Near East, & Asia.	Linda Kelley ENE/TR
Promoting Financial Investments and Transfers (PROFIT)	Increased developing country resources for family planning by encouraging private sector involvement in: Innovative investments (local production, assessing trade barriers, and financial transfer mechanisms), private health care providers, and employer-provided family planning.	Jennifer Adams R&D/Population

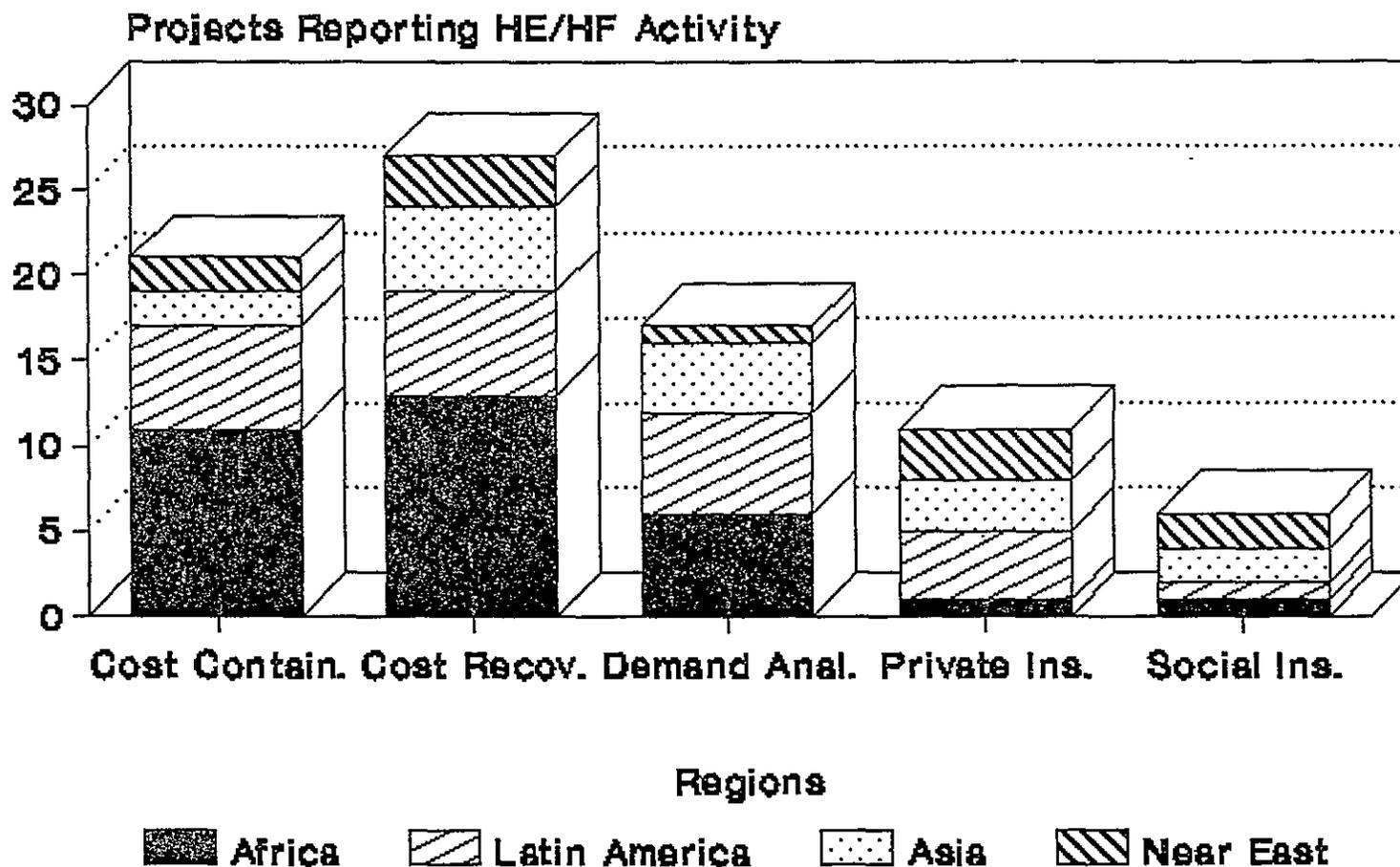
\*Note: Project Officers can be contacted at the following address: Name and Office, followed by: Agency for International Development, Washington, D.C. 20523, USA

# Chart 1: Ongoing A.I.D. HE/HF Projects By Geographical Region



**WW Prjs. operate in up to 27 countries**

# CHART 2: A.I.D. HE/HF Projs. by Category From 1990 Child Survival Survey



38 of 75 Missions responded to CSS Surv.

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