



Technical Assistance Report

Project Number: 41252
Research and Development Technical Assistance (RDТА)
November 2008

Impact of Maternal and Child Health Private Expenditure on Poverty and Inequity (Cofinanced by the Government of Australia)

CURRENCY EQUIVALENTS

(as of 27 November 2008)

Currency Unit	–	Australian dollar (A\$)
A\$1.00	=	\$0.65
\$1.00	=	A\$1.53

ABBREVIATIONS

ADB	–	Asian Development Bank
AusAid	–	Australian Agency for International Development
DMC	–	developing member country
OOPE	–	out-of-pocket expenditure
MDG	–	Millennium Development Goal
MNCH	–	maternal, newborn, and child health
TA	–	technical assistance
UNICEF	–	United Nations Children's Fund
WHO	–	World Health Organization

TECHNICAL ASSISTANCE CLASSIFICATION

Type	–	Research and development technical assistance (RDTA)
Targeting Classification	–	Targeted intervention (Millennium Development Goals 4 and 5)
Sector	–	Health, nutrition, and social protection
Subsectors	–	Health systems, social protection
Themes	–	Inclusive social development, gender and development, governance
Subthemes	–	Human development, gender equity in opportunities, financial and economic governance

GLOSSARY

catastrophic expenditure	–	Health care payments reaching or exceeding 40% of a household's capacity to pay in any one year. The household capacity to pay is, in turn, defined as its nonfood spending (World Health Organization [WHO] 2008). An alternative definition that is sometimes used is health payments reaching or exceeding 10% of overall household consumption.
out-of-pocket expenditure	–	Payments borne directly by the individual without subsequent reimbursement by the government or insurers.

NOTE

In this report, "\$" refers to US dollars unless otherwise stated.

Vice-President	U. Schäfer-Preuss, Knowledge Management and Sustainable Development
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Director	R. Dobias, Gender, Social Development, and Civil Society Division, RSDD
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Team members	I. Bhushan, Director, Pacific Department J. Jeugmans, Practice Leader (Health), RSDD

I. INTRODUCTION

1. There is increasing evidence that out-of-pocket expenses act as a financial barrier to essential health care, are a source of impoverishment, and can exacerbate inequity.¹ This is especially true in Asia where out-of-pocket expenditure (OOPE)² plays such a dominant role in health care payments. The adverse effects of OOPE are also particularly noticeable when it comes to maternal, newborn, and child health (MNCH), where medical expenses can be large, sudden, and unexpected. Many Asian Development Bank (ADB) developing member countries (DMCs) therefore wish to better understand the impact that OOPE—especially for MNCH—has on household expenditure patterns, poverty, and inequity. There are, however, gaps in the analysis at country level in many DMCs, and little comparable analysis at a regional level. Better data and insights would therefore help DMCs identify the scale and intensity of the problem, the possible policy responses, and the likely budgetary implications for improving equity and access to essential health care for poor women and their children. Development partners are also interested in such better data and analysis for the same reasons. The newly formed—and influential—Maternal, Newborn, and Child Health Network for Asia and the Pacific³ has specifically asked that ADB undertake analytical work on this issue.

2. ADB has been asked to undertake this knowledge product for three main reasons. First, ADB has the capacity to take a genuinely regional approach. Second, this proposed technical assistance (TA) draws on ADB's comparative advantage in economic analysis, and builds on recent analytical work in this field.⁴ Third, ADB has taken quite a prominent role in the writing of an investment case for MNCH in Asia and the Pacific, where issues of finance, equity, and public expenditure management are prominent. As such, the study would clearly be consistent with the directions set under ADB's long-term strategic framework 2008–2020 (Strategy 2020),⁵ given the focus on poverty reduction, financing, social inclusion, and public expenditure management.⁶ Given its interest in MNCH in Asia and the Pacific, the Government of Australia, through AusAID, has offered to cofinance this study.

II. ISSUES

3. **Health—A Development Issue.** Health is central to development. For individuals, poor health undermines education and income opportunities. Ill health means loss of income and

¹ Xu, K. et al. 2007. Protecting Households From Catastrophic Health Spending. *Health Affairs* 26, No. 4: 927-983.; Wagstaff, A., and van Doorslaer, E. 2002. *Catastrophe and Impoverishment in Paying for Health Care: With Applications to Vietnam 1993–1998*. Washington, DC: World Bank; van Doorslaer, E. et al. 2006. Effects of Payments for Health Care on Poverty Estimates in 11 Countries in Asia: An Analysis of Household Survey Data. *Lancet* 368.

² Out-of-pocket expenditures can be defined as payments borne directly by the individual without subsequent reimbursement by the government or insurers.

³ An informal network of senior officials responsible for MNCH issues in Asia and the Pacific. The organizations represented include those from the United Nations (The Partnership on Maternal, Newborn, and Child Health, United Nations Children's Fund [UNICEF], United Nations Population Fund, World Health Organization [WHO]), national development agencies (AusAID, Canadian International Development Agency, Department for International Development of the United Kingdom, Japan International Cooperation Agency, United States Agency for International Development), multilateral development banks (ADB and the World Bank), and the Bill and Melinda Gates Foundation.

⁴ For example: Bonu, S., I. Bhushan, and D. Peters. 2007. Incidence, Intensity, and Correlates of Catastrophic Out-of-Pocket Health Payments in India. *Economics and Research Department Working Paper Series* 102; ADB. 2002. *Strengthening Safe Motherhood Programs*. Consultant's Report. Manila; ADB. 2008. *Technical Assistance for Equity in the Delivery of Public Services in Selected Developing Member Countries*. Manila.

⁵ ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*. Manila.

⁶ The TA first appeared in the business opportunities section of ADB's website on 7 November 2008.

higher costs, further impoverishing poor people and increasing inequity. Indeed, after illiteracy and unemployment, health costs are the most important precursor to poverty.⁷ Health is a critical development issue at the national level; 30%–50% of Asia's economic growth between 1965 and 1990 can be attributed to favorable demographic and health changes.⁸ The United States Agency for International Development estimates that maternal and newborn mortality accounts for \$15 billion in lost potential production globally every year. Maternal mortality adversely affects the welfare of surviving children. Maternal morbidity affects basic wellbeing and economic productivity. Not surprisingly, three of the seven Millennium Development Goals (MDGs) explicitly target health,⁹ and those three interact with MDG 1 (poverty reduction).

4. Distinctive Level and Pattern of Health Expenditure. Appendix 2 reveals three important facts about expenditure on health in Asia and the Pacific. First, total expenditure on health is low, with per capita expenditure lower in South Asia than even sub-Saharan Africa. Second, private expenditure dominates in Asia, with government playing a relatively minor role. Third, out-of-pocket expenditure on health is much higher among DMCs in Asia and the Pacific compared to Sub-Saharan Africa and Latin America.

5. Effects on Poverty, Inequity, and Access. Several studies have found that “health shocks,” and especially the high level of OOPE, increase poverty. Equity in Asia-Pacific Health Systems (EQUITAP) studied 11 countries in Asia and found that 78 million people fell below the \$1.08 poverty line as a result of health payments.¹⁰ ADB analysis found that nearly 40 million people in India were below the poverty line as a result of health payments.¹¹ Others have estimated that nearly one-quarter of people admitted to hospitals in India were above the poverty line when they were admitted but were below it by the end of their stay because of health expenditure they incurred.¹² Studies also show that high OOPE is also associated with catastrophic expenditure¹³ that clearly serves to impoverish people. In summary, high rates of OOPE—so common in Asia and the Pacific—are regressive, can increase poverty, exacerbate inequity, increase household debt, and hinder access to essential health care.

6. Maternal, Newborn, and Child Health. The adverse effects of OOPE are particularly significant when it comes to MNCH because such medical expenses can be large, sudden, and unexpected.¹⁴ In Bangladesh the total cost of health care during pregnancy, delivery, and the postpartum period amounted to an average 15% of annual income for those women delivering at home, rising to 35% in a basic obstetric facility, and to 452% of annual income for delivery in a public comprehensive obstetric facility.¹⁵ Even a relatively small payment can mean either a financial barrier to essential care or a financial catastrophe to a poor person or household, forcing them to reduce spending on other basics such as food, shelter, or their children's

⁷ See World Bank. *Voices of the Poor*. Available at <http://go.worldbank.org/3940P1N170>

⁸ Bloom, D., and J. Williamson. 1998. Demographic Transitions and Economic Miracles in Emerging Asia. *World Bank Economic Review* 12 No. 3: 419–455.

⁹ MDG 4 (reduce child mortality), MDG 5 (improve maternal health), and MDG 6 (combat HIV/AIDS, malaria, and other diseases).

¹⁰ Van Doorslaer, E. et al. 2006. Effect of Payments for Health Care on Poverty Estimates In 11 Countries in Asia: An Analysis Of Household Survey Data. *Lancet* 368.

¹¹ Bonu, S., I. Bhushan, and D. Peters. 2007. Incidence, Intensity, and Correlates of Catastrophic Out-of-Pocket Health Payments in India. *Economics and Research Department Working Paper Series* 102.

¹² Gottret, P., and G. Schieber. 2006. *Health Financing Revisited*. Washington, DC: World Bank.

¹³ WHO defines catastrophic expenditure as health care payments reaching or exceeding 40% of a household's capacity to pay in any one year. The household capacity to pay is, in turn, defined as its nonfood spending.

¹⁴ It is also recognized that OOPE is also often high for other health events such as traffic accidents and noncommunicable diseases. However, for the reasons given in paras. 1, 2, and 7, this TA focuses on MNCH.

¹⁵ Borghi, J. et al. 2006. Household Costs of Healthcare during Pregnancy, Delivery, and the Postpartum Period: A Case Study from Matlab, Bangladesh. *Journal of Health, Population, and Nutrition* 24 (4) 446–455.

education. The most recent analysis by ADB finds that maternal health care expenditure was catastrophic (exceeding more than 40% of capacity to pay) for virtually all households from the poorest decile in India. It is also apparent that MDG outcomes for MNCH can be achieved at the national level for several DMCs in Asia, such as Viet Nam and the Philippines, but with little or no progress for the poorest quintile, thereby exacerbating inequity.

7. **Increasing Interest.** DMCs are increasingly interested in knowing more about how OOPE affects equity, access to health services, and poverty.¹⁶ This is especially true when it comes to expenditure on MNCH, because expenditure there affects so many households, and especially the poor. Development partners are similarly showing a great deal more interest in the analytical and policy implications of expenditure on MNCH. For example, the Maternal, Newborn, and Child Health Network for Asia and the Pacific has developed a strong investment case for MNCH in Asia and the Pacific. There is now an active program of rolling out this investment case in Asia and the Pacific. The United Nations Children’s Fund (UNICEF) has done pre-investment analysis in 11 countries. The Bill and Melinda Gates Foundation has joined with AusAID to fund research that will help identify investments with the greatest impact and cost effectiveness, either on the demand or supply side, for MNCH interventions in Asia and the Pacific. A coalition of Australian universities has been contracted to do this work. AusAID has also provided a research grant of A\$750,000, spread over 3 years, to the Institute for Health Policy to research catastrophic and impoverishing health expenditure, with particular reference to MNCH. Funding constraints means that study will be limited to Cambodia, the Fiji Islands, the Lao People’s Democratic Republic, possibly the Solomon Islands, and Viet Nam, . Appendix 2 maps these various initiatives.

8. **Incomplete Information.** Despite the importance and growing interest in these issues, governments and their development partners simply do not have enough up-to-date, reliable, and regionally comparable data and analysis on the implications of OOPE on MNCH. Even basic information, such as the amount of OOPE being spent on MNCH, is not routinely captured in national health accounts or demographic and health surveys. While such information may often be captured in household surveys, the validity of such data is unclear. Even when the data is robust, the analytical work to drive policy responses—such as the extent to which OOPE on MNCH is affordable, causing impoverishment, or resulting in catastrophic expenditure—is usually missing. Comparable data and analysis at a regional level is particularly needed but is especially rare.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

9. The impact will be a better and more reliable basis for policy making and resource allocation decisions, including measures to protect the poor, of both DMCs and their development partners when considering OOPE and MNCH. The outcome of the TA will be increased recognition and evidence-based understanding of the interactions between OOPE, MNCH, and impoverishment.

10. The proposed TA will have three benefits:

- (i) DMCs and their development partners will know how much—or how little—reliance they can put on their existing household surveys when trying to

¹⁶ Pakistan, for example, has just commissioned a study on the role of OOPE on MNCH. They are keen to liaise with ADB on this work. Viet Nam and Cambodia are also undertaking studies on the subject.

- understand the impact of OOPE on MNCH. This in itself will be an important insight for policy makers and planners in DMCs.
- (ii) Testing the reliability and comparability of the household surveys will inform and increase the impact and usefulness of all the other analytical work being done in this field (para. 7 and Appendix 2), both now and in the future.
 - (iii) Where there are gaps in the quantity or quality of data, DMCs will be able to see what needs to be done to make their data sets consistent with others in Asia and the Pacific, thereby being able to benchmark themselves.

11. The proposed TA will be conducted in two phases. The first phase will be to scope and validate the availability and reliability of household survey data as a basis for measuring the effect of OOPE and MNCH. This phase also consist of a concise literature review of the latest main findings related to OOPE and MNCH in Asia and the Pacific, and a summary of international developments. The second phase will be to then analyze and report on the relationship between OOPE and MNCH for those countries which are found to have reliable data. The second phase will answer questions such as: What is the level of OOPE on MNCH in absolute and relative terms? How much of such expenditure is catastrophic and how much is impoverishing? What is the distribution of such expenditure by wealth quintiles? How much would it cost per year at a national level for a government to defray catastrophic expenditure in its society? Where data sets are reliable and robust, the analysis will also extend to a multivariate analysis of those factors—such as income levels, age, geographical location, and ethnicity—that predispose a household to catastrophic expenditures. The output of that second phase analysis will be a report providing an accurate, up-to-date, regionally comparable set of analysis and insights on the affordability, impoverishment, and catastrophic effects of OOPE on MNCH for a range of countries in the region.

B. Methodology and Key Activities

11. The first scoping phase involves identifying, collecting, and then testing the extent to which household survey data in this region gives reliable insights into OOPE for MNCH. The quickest and most cost-effective way to achieve that outcome is to have one international consultancy team lead and coordinate liaison with the various national research institutions in a wide range of DMCs (Appendix 2). Field visits are likely to be required for Pakistan and Papua New Guinea,¹⁷ where the quality of data sets appears, *prima facie*, to be particularly problematic. For all other DMCs, electronic liaison with local counterparts will be sufficient. The international consultant will coordinate the comparability of overall findings and ensure quality control. After recruitment in early March 2009, the international consultant will undertake the scoping phase in an estimated 3 months. The international consultant will then present a draft report to ADB and AusAID in June 2009. This will be followed by a workshop in July to which interested DMCs, academic institutions, research institutes, and other key stakeholders of the Maternal, Newborn, and Child Health Network for Asia and the Pacific will be invited. Such a workshop will provide an opportunity for external review of the initial findings by the network and other stakeholders. It will also be timely as it will inform ongoing and future work in this area by ADB, AusAID, the Bill and Melinda Gates Foundation, UNICEF, and the World Bank (see Appendix 2).

12. In the light of that workshop, ADB and AusAID will then decide which narrower group of countries will proceed to the next, more intensive phase of detailed analysis. Such a choice will

¹⁷ Field visits to Timor-Leste are also possible if it is decided to extend the study to that country. There is much merit in doing so but the availability of data means that still needs to be decided.

take into account DMC interest, the breadth and depth of the problems identified, the desirability of complementing (but not duplicating) the analytical work of other development partners in this field, and the overall budget. The terms of reference for the second phase will then be fine-tuned and negotiated accordingly, with an increasing emphasis on the policy implications for DMCs and development partners arising from the more detailed findings. Detailed analysis and possibly survey work will then occur from July 2009 until November 2009. A draft report will be presented to ADB and AusAID in December 2009. A final report will then be published as an official ADB document. It will be tabled and presented at a suitable high-level conference on MNCH, such as the proposed Regional Countdown Meeting for MNCH envisaged to take place in Asia in early 2010.¹⁸

C. Cost and Financing

13. The total cost of the TA is estimated to cost \$626,000 equivalent. ADB will finance the equivalent of \$300,000 as a grant from ADB's TA funding program and the equivalent of \$326,000 will be cofinanced as a grant from the government of Australia through the Australian Agency for International Development (AusAID). The cofinancing from AusAID will be administered by ADB. Detailed cost estimates and the financing plan are in Appendix 3.

D. Implementation Arrangements

14. ADB will be the Executing Agency for the TA. Within ADB, the Regional and Sustainable Development Department will implement the TA in close collaboration with the departments and offices concerned. The Government of Australia, as a cofinancier of the TA, will be part of the steering committee that will liaise electronically through emails and video conferencing to provide oversight and monitor work progress. The study will be limited to five countries: Cambodia, the Fiji Islands, the Lao People's Democratic Republic, possibly the Solomon Islands, and Viet Nam. International and national consultants will be engaged through an international firm using quality-based selection procedures and simplified technical proposals. Quality-based selection is the appropriate selection method because the substantive content of phase 2 work cannot be determined with any certainty until after the phase 1 scoping study. Disbursements under the TA will be done in accordance with ADB's *Technical Assistance Disbursement Handbook*.¹⁹

15. It will be essential that the consultant has a high level of expertise and experience in cleaning, interrogating, and critically analyzing household survey data on health expenditure in a wide range of DMCs. The consultant must also have excellent networks and links to national research institutes in DMCs, and be able to coordinate and provide quality control over data from a wide variety of national sources. The consultants will be engaged by ADB in accordance with the *Guidelines on the Use of Consultants* (2007, as amended from time to time). Outline terms of reference for the consultants are provided in Appendix 4.

IV. THE PRESIDENT'S DECISION

16. The President, acting under the authority delegated by the Board, has approved (i) ADB administering a portion of technical assistance not exceeding the equivalent of \$326,000 to be financed on a grant basis by the Government of Australia, and (ii) ADB providing the balance

¹⁸ That is, a 'Countdown' on progress in reaching the MDGs by 2015.

¹⁹ ADB. 2008. *Technical Assistance Disbursement Handbook*. Manila.

not exceeding the equivalent of \$300,000 on a grant basis, for Impact of Maternal and Child Health Private Expenditure on Poverty and Inequity, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and/or Indicators	Data Sources and/or Reporting Mechanisms	Assumptions and Risks
<p>Impact A better and more reliable basis for policy making and resource allocation decisions, including measures to protect the poor, of both DMCs and their development partners when considering OOPE and MNCH.</p>	<p>Adoption of risk mitigation and social protection measures so that poor households are not impoverished as a result of essential expenditure on MNCH</p>	<p>Future household survey data National health accounts as they develop Poverty reduction papers Development partners' annual reports</p>	<p>Assumptions</p> <ul style="list-style-type: none"> • Political will to respond to the issues • Financing available to reduce inequity <p>Risk</p> <ul style="list-style-type: none"> • DMCs' inability to finance social protection measures for poor women and their children
<p>Outcome Increased recognition and evidence-based understanding by DMCs and development partners of the interactions between OOPE, MNCH, and impoverishment</p>	<p>A measurable and significant reduction in the level of catastrophic OOPE on MNCH over time as a first priority</p> <p>A measurable reduction in the level of impoverishing OOPE on MNCH as an important but second priority</p> <p>Increased preparedness by DMCs and/or development partners to support initiatives to help mitigate the worst effects of OOPE on MNCH</p>	<p>Future household survey data National health accounts as they develop Poverty reduction papers Policy statements by ministers of health and/or finance. National budgets of DMCs and official development assistance budgets of development partners</p>	<p>Assumption</p> <ul style="list-style-type: none"> • Sufficient and good quality household survey data available in the region for the TA to proceed quickly to the in-depth study envisaged in phase 2 <p>Risk</p> <ul style="list-style-type: none"> • Countries with very serious challenges in MNCH (Afghanistan, Pakistan, Papua New Guinea, and Timor-Leste) do not have household survey data of sufficient quality to be included in the more detailed phase 2 in-depth study
<p>Outputs</p> <ol style="list-style-type: none"> 1. Report on the extent and quality of existing data sets as a basis for understanding how OOPE on MNCH interacts with inequity and impoverishment 2. Workshop to determine which countries are then priorities for more detailed analysis in phase 2 3. Detailed, more focused study based on workshop cited in 	<p>Report and workshop covering the issues outlined in the supplementary appendix 1</p>	<p>Final report from international consultant</p>	<p>Assumptions</p> <ul style="list-style-type: none"> • National consultants can provide timely and consistent advice on the extent and quality of household data • Policy implications of OOPE on MNCH are acted upon by DMCs and development partners <p>Risk</p> <ul style="list-style-type: none"> • Reports and data sets not available, or not available in English, in those countries with serious challenges in MNCH

Design Summary	Performance Targets and/or Indicators	Data Sources and/or Reporting Mechanisms	Assumptions and Risks
output 2, analyzing in more depth the policy implications for a smaller number of high-priority countries.			(Afghanistan, Pakistan, Papua New Guinea, and Timor-Leste,)
Activities with Milestones 1.1 Recruit international consultants (March 2009) 1.2 International consultant contacts national consultants in each of the DMCs identified as part of the phase 1 scoping study and collects information on availability and quality of household survey data 2.1 International consultant assesses extent and quality of household survey data as it relates to OOPE on MNCH, and its impact on inequity, catastrophic expenditure, and impoverishment 2.2. International consultant does literature review of OOPE on MNCH 3.1. International consultant prepares analytical report and recommendations on the availability and quality of data and which countries have sufficient data, OOPE levels, and MNCH challenges to warrant more extensive analysis in phase 2 3.2. International consultant leads a presentation at a workshop attended by DMCs, ADB, AusAID, and other key stakeholders from Maternal, Newborn, and Child Health Network for Asia and the Pacific. 3.3 International consultant undertakes more in-depth survey work and analysis in a smaller group of selected countries based on priorities and decisions made at the workshop in milestone 3.2. 3.4 Draft report provided to ADB, AusAID, and DMC reporting results. 3.5 Final report presented by international consultant, together with ADB and AusAID, to the Maternal, Newborn, and Child Health Network for Asia and the Pacific. Possible option is the regional countdown meeting on MNCH to be held in Asia (venue still to be decided), possibly in February or March 2010.			Inputs ADB \$300,000 Cofinancing from the Government of Australia \$325,975 (not exceeding A\$500,000) \$120,000 for phase 1 scoping \$506,000 for phase 2 in-depth analysis of selected priority countries

ADB = Asian Development Bank; AusAid = Australian Agency for International Development; DMC = developing member country; MNCH = maternal, newborn, and child health; OOPE = out of pocket expenditure; ODA = official development assistance;

COMPOSITION OF HEALTH EXPENDITURE IN HIGH-, MIDDLE-, AND LOW-INCOME COUNTRIES, POPULATION-WEIGHTED AVERAGES IN 2002

Region	Per Capita Health Expenditure (\$)	Total Health Expenditure (% of GDP)	Public Health (% of total health expenditure)	Social Security Expenditure (% of total public health expenditure)	Private (% of total health expenditure)	Out-of-Pocket (% of private health expenditure)
South Asia	26.04	5.45	23.66	8.04	76.34	97.08
East Asia and Pacific	63.66	5.21	35.29	39.35	64.71	91.86
Sub-Saharan Africa	31.58	5.32	39.58	1.92	60.42	79.17
Latin America and Caribbean	217.85	7.04	50.27	32.50	49.73	74.28

GDP = gross domestic product.

Source: World Bank.

MAPPING OF ACTIVITIES ASSOCIATED WITH MATERNAL, NEWBORN, AND CHILD HEALTH EXPENDITURE, INVESTMENT, AND OUT-OF-POCKET EXPENDITURE

Organizations working on Maternal, Newborn, and Child Health	Central and West Asia		South Asia			East Asia		Southeast Asia					Pacific			
	Afghanistan	Pakistan	India^a	Nepal	Bangladesh	PRC	Mongolia	Cambodia	Lao PDR	Viet Nam	Philippines	Indonesia	Timor-Leste	Papua New Guinea	Fiji Islands	Solomon Islands
AusAID development research awarded to Institute for Health Policy (IHP)								✓	✓	✓					✓	✓
Priority countries for the Maternal, Newborn, and Child Health Network in Asia and the Pacific		✓	✓	✓						✓		✓				
Bill and Melinda Gates Foundation/AusAID grant to University of Queensland on bottlenecks to the investment case		✓	✓								✓	✓				
UNICEF country studies on MNCH for investment case		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓			
Possible ADB scoping study	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

^a five high-mortality states.

Source: Interviews with AusAID and members of the Maternal, Newborn, and Child Health Network in Asia and the Pacific

COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Total Cost
Cofinanced by the Government of Australia^a and the Asian Development Bank^b	
A. Phase 1: Scoping	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	45.0
ii. National Consultants	45.0
b. International and Local Travel	10.0
c. Reports and Communications	5.0
2. Training, Seminars, and Conferences	
a. Facilitators	5.0
3. Miscellaneous Administration and Support Costs	6.0
4. Contingencies	10.0
Subtotal A	126.0
B. Phase 2: Detailed Survey and Analysis of Selected Priority Countries	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	80.0
ii. National Consultants	30.0
b. International and Local Travel	15.0
c. Reports and Communications	20.0
2. Seminars and Conferences	55.0
3. Surveys	250.0
4. Contingencies	50.0
Subtotal B	500.0
Total (A+B)	626.0

^a Administered by the Asian Development Bank (ADB). The Government of Australia will provide an amount equivalent to but not exceeding A\$500,000 (\$325,975) as a grant. This amount includes ADB's administration fee, audit cost, bank charges, and provision for foreign exchange fluctuations (if any), to the extent that these items are not covered by the interest and investment income earned on this grant, or any additional grant contribution by the Government of Australia.

^b Financed by ADB's technical assistance funding program (\$300,000).

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. International Consultant

1. **Health Financing Specialist and Team Leader** (6 person-months, intermittent, for phase 1). The team leader will be a health financing specialist with in-depth knowledge of national health accounts in Asia and the Pacific. The team leader will also have demonstrated expertise in critically assessing the usefulness and usability of household survey data in developing countries in Asia and the Pacific, and drawing reliable and justified conclusions and inferences from them and similar data sets, especially with respect to health expenditure, equity, and poverty. The team leader will also act as principal supervisor and coordinator of inputs and reports, ensuring the quality and consistency of analysis and documentation.

2. The consultant will undertake the following activities in phase 1:
 - (i) Lead the liaison with the appropriate national agencies or research institutes responsible for household survey data in up to 15 developing countries (supplementary appendix 1) to determine what household survey data is available including its date, size and comprehensiveness, scope, and overall quality.
 - (ii) In the case of Pakistan, Papua New Guinea, and (possibly) Timor-Leste, undertake field visits to assess the availability and quality of data. In the case of Pakistan, discuss with the Ministry of Health in Punjab its proposed study on out-of-pocket expenditure (OOPE) on maternal, newborn, and child health (MNCH) with a view to ensuring compatibility and complementarity with their studies.
 - (iii) Lead and coordinate the identification of the extent to which such household survey data in developing member countries (DMCs) or similar data sources and capture expenditure on MNCH, especially OOPE on MNCH.
 - (iv) Lead and coordinate a critical assessment of the reliability of such survey data for understanding the nature and extent of OOPE on MNCH as a source of inequity, catastrophic expenditure, or impoverishment.
 - (v) Lead the identification of what priority actions would be needed to make such household survey data sets more reliable and comparable across Asia and the Pacific.
 - (vi) Lead the identification of any preliminary conclusions that the survey data already reveals about the impact of OOPE on MNCH, including the extent to which it acts as a barrier to essential care, increases inequity, or is catastrophic or impoverishing for the households concerned.
 - (vii) Recommend which countries should be priorities for more in-depth analysis in phase 2, taking into account the MNCH mortality and morbidity levels, poverty levels, and the extent and quality of survey data on which policy recommendations can then be made. Recommend and justify what areas should receive priority attention for follow-up analytical work in phase 2.
 - (viii) Lead a desk review of the most important literature over the period of 2003 through 2007 on the issue of OOPE and its relationship to inequity and impoverishment. While such a literature review should give strongest emphasis to Asia and the Pacific, especially as it relates to MNCH, it should be anchored by comparison to findings in other regions of the world. Include in that review insights and knowledge about how international organizations, including the Organisation for Economic Co-operation and Development (OECD) and research institutions, are approaching the

issue of OOPE for health care in Asia and the Pacific, especially as it relates to MNCH. Take into account recent research by ADB²⁰ and other relevant articles.

- (ix) Lead, and provide editorial quality assurance for, a draft document report to ADB and the Government of Australia that analyzes and reports on the above-mentioned findings, using the format in the supplementary appendix 1 as a guide. Finalize the report in light of comments from ADB and the Government of Australia.
- (x) Present the report and its findings to a workshop involving DMCs and invited members of the Maternal, Newborn, and Child Health Network for Asia and the Pacific.

3. The consultant will be expected to lead and provide quality assurance for more detailed analytical work for a smaller number of high-priority countries in phase 2. That analytical work will involve data cleaning and then interrogation of data sets. Once the data has been cleaned the consultant will lead a team that addresses the following questions: What is the level of OOPE on MNCH in absolute and relative terms? How much of such expenditure is catastrophic and how much is impoverishing? What is the distribution of such expenditure by wealth quintiles? How much would it cost a national government to defray catastrophic expenditure in its society per year? Where data sets are reliable and robust, the analysis will also extend to a multivariate analysis of those factors that predispose a household to catastrophic expenditure (e.g., income level, age, geographical location, and ethnicity). What are the main policy and programming implications for DMCs? Are subsidies, conditional cash transfers, or insurance schemes appropriate responses to the impoverishing effects of OOPE on MNCH? If so, what might be the budgetary implications for governments and their development partners? The exact nature of the research questions, and the countries to be considered, will be decided by ADB and AusAID at the workshop at the end of phase 1.

B. National Consultants (1 person-week per country)

4. In order to support the work of the team leader, national consultants will be hired in each of the DMCs to identify and provide the latest household survey data for each of those countries. The national consultants are required to have expertise and familiarity with national health accounts and national household surveys. The number of national consultants required will depend upon the size of the country, the availability of data, and its degree of complexity: one national consultant working for 1 week will be sufficient for Timor-Leste, but two national consultants working for 2.5 days each may be required for larger and more complex assignments such as in Pakistan or states in India. The national consultants are required to have informed insights into the strengths and limitations of the household survey methodology, especially as it relates to drawing inferences about OOPE and MNCH and its impact on poverty and inequity.

5. The national consultants will undertake the following activities:
- (i) Under the direction of the team leader, identify and provide information on the latest household survey data, especially as it relates to OOPE on MNCH. They will also identify other data sets that might be appropriate.
 - (ii) Provide advice and insights to the team leader on the strengths, weaknesses, reliability, and robustness of such household survey data, especially as it relates to OOPE on MNCH.

²⁰ Bonu, S., I. Bhushan, and D. Peters. 2007. Incidence, Intensity, and Correlates of Catastrophic Out-of-Pocket Health Payments in India. *Economics and Research Department Working Paper Series 102*; ADB. 2002. *Strengthening Safe Motherhood Programs*. Consultant's Report. Manila; ADB. 2008. *Technical Assistance for Equity in the Delivery of Public Services in Selected Developing Member Countries*. Manila.