

ASIAN DEVELOPMENT BANK

TAR:STU 35013

**TECHNICAL ASSISTANCE
(Financed from the Japan Special Fund)**

FOR

A REGIONAL STUDY

OF

HEALTH CARE FINANCING FOR THE POOR

August 2001

ABBREVIATIONS

ADB	–	Asian Development Bank
DMC	–	developing member country
MOH	–	Ministry of Health
NGO	–	nongovernment organization
TA	–	technical assistance
WB	–	World Bank
WHO	–	World Health Organization

NOTE

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

I. INTRODUCTION

1. Poverty and poor health are closely intertwined. Poor health traps the poor into poverty and living in poverty contributes to poor health. Investments in health are key to poverty reduction: Under its Policy for the Health Sector, the Asian Development Bank (ADB) supports efforts of its developing member countries (DMCs) to provide broad access to basic preventative, promotive, and curative efforts to the poor. As populations grow and as new health threats emerge, however, most government allocations to the health sector become increasingly inadequate. A key aspect of the health policy mandates ADB to help DMCs diversify their financing for the sector. Designing alternative health financing schemes that address the needs of the poor and are sustainable presents health planners with numerous challenges in design and implementation. Many lessons can be drawn from the experience of DMCs that are currently implementing alternative health financing arrangements. Some mechanisms for targeting health services to the poor were cited in the *Health Sector Reform in Asia and the Pacific*,¹ but finding the most appropriate ones requires more information relating to their design and implementation. All the experience and information will assist ADB and DMCs in designing innovative alternative financing strategies to more effectively address the health needs of the poor.

2. Through this regional technical assistance (TA),² ADB, with the cooperation and parallel efforts of the World Bank,³ will consolidate and analyze the experience of selected DMCs with various health financing schemes and develop recommendations for the design of optimal health coverage systems for the poor. A logical framework for the TA is in Appendix 1.

II. BACKGROUND AND RATIONALE

3. Two thirds of the world's poor⁴ live in Asia: South Asia counts over half a billion people living in poverty while East Asia and the Pacific have a quarter of a billion. The health status of the poor is not encouraging: the incidence of illness and poor health and the likelihood of falling ill are higher than among the non-poor. Since the main asset and source of livelihood of the poor is their labor services, poor health renders them less economically productive and makes them vulnerable to remaining in poverty.

4. Insufficient access to basic health services and the high prevalence of diseases explain much of the worse health status of the poor. Communicable diseases are the leading causes of morbidity and mortality among the poor. When poor health is expressed in terms of disability-adjusted life years (DALYs), its foremost causes are diseases that can be prevented easily and cheaply, provided effective health systems are in place. These include respiratory infections, diarrhea, tuberculosis, malaria, and malnutrition. But the poor face a double burden of disease—they bear the major brunt of communicable diseases but also suffer from noncommunicable diseases, which are very costly to treat. The major noncommunicable diseases facing the poor include heart diseases, cancers, accidents, and mental illnesses.

5. The poor face significant barriers to obtaining health care. The cost of health care is unaffordable to many of the poor: the direct costs include user fees, expenditures on medicines and transportation, lost wages, and, in some instances, informal payments. The quality of

¹ Paper produced under Technical Assistance (TA) 5668-REG: *Study of Regional Health Policy Priorities*, for \$600,000, approved on 9 January 1995.

² The TA was first listed in *ADB Business Opportunities* (Internet version) on 5 February 2001.

³ See paragraph 20.

⁴ Living on less than \$1 per day.

government health care services to the poor is often poor; resources are insufficient to adequately staff and furnish the health centers with the necessary health equipment, supplies, and medicines. Alternatives to government-delivered service, e.g., nongovernment providers and referral hospitals, are often not found in areas where the poor live. Lack of information and low education contribute to incorrect health assessments and lead to delays in seeking treatment and to reliance on traditional, often ineffective and unsafe, care. In addition, the poor may live in unsanitary environments and have greater exposure to unsafe work conditions.

6. The economic consequences of poor health and illnesses to a poor household are severe. The high direct costs of ill health deplete their meager savings. Households are deprived of the income generated by their main asset, their labor services. For the poor household, this renders them vulnerable to falling deeper into poverty. For the household living on the borderline of poverty, poor health or a catastrophic illness pulls them back into poverty. However, some of these consequences are largely preventable: the main determinants of the poor's health status can be addressed at relatively low cost.

7. Low-income countries spend a very low percentage of their gross domestic product on the health sector, typically 3-4 percent. Narrow tax bases and weak collection capacities limit governments' revenues and allocations. And as populations increase and new health threats emerge, most governments' outlays for the health sector become inadequate for meeting the needs of their constituencies. As a consequence, the greater proportion of health-related expenses come out of households' own financial resources. Health financing schemes currently undertaken by governments and funding agencies span a broad spectrum with respect to the financial burden on the poor, ranging from paying user fees to full subsidization. Governments finance health services⁵ using (i) greater allocations in government budgets, (ii) loans and grants from external sources, (iii) social insurance, and (iv) user charges. DMCs rely more on external sources of funds while user fees account for a small percentage.

8. Increasing access to the poor, delivering quality health care, and ensuring sustainable financing are the main challenges to be addressed in designing and implementing alternative arrangements of financing health care for the poor. The most important factors toward obtaining care and participation by the poor are affordability and quality. The health care needs and financial positions of the poor need to be considered in deciding the range of services to offer and the payment arrangements to be put in place. At the same time, health service providers have to put in place mechanisms to ensure sustainability, providing for financial and risk management in terms of pricing and coverage, the range of care and services provided, conditions and exclusion criteria, and procurement arrangements. In the case of social insurance, health planners are presented with the challenges of adverse selection, moral hazard, cost escalation, and fraud.

9. Health financing schemes being implemented in DMCs fall under four major classifications: (i) free services for everyone, (ii) cost recovery with exemptions for the poor, (iii) health equity funds, and (iv) health insurance for the poor.⁶ Free services are easy to implement and may encourage the use of preventive and curative services among the poor. However, in most DMCs, this is financially unsustainable and, often, the non-poor take greater advantage of such services than the poor do. Cost recovery schemes provide health facilities with more revenues and allow for

⁵ R28-99: *Policy for the Health Sector*, 25 February.

⁶ Examples of regional studies that address some of these are *Sustainable Health Care Financing in Southern Africa (1996)* and *Policy Choices and Practical Problems in Health Economics (Cases from Latin America and the Caribbean) (1996)* from the Economic Development Institute of the World Bank. *Health Care in Asia: A Comparative Study of Cost and Financing (1992)* by Charles Griffin provides an overview of health care in Asia in the 1980s. This TA study will complement it by providing lessons and greater detail from selected health financing schemes.

cross-subsidization for the poor. However, it is difficult to target the most needy and there is little incentive for providers to provide exemptions to the poor as this reduces their revenues. Health equity funds reduce the disincentive for the provider to serve the poor since the schemes do not affect provider revenues. However, such schemes need an effective communication campaign to inform people of how to access the fund. Health insurance schemes take various shapes, including government-financed, private, and community-based schemes. Health insurance for the poor can reduce the financial constraints of the system and of the poor in seeking health care because it allows the poor to “prepay” for services in small amounts and offers greatly reduced rates for some services, sometimes free. However, health insurance schemes are difficult to establish and operate. Administrative and financial expertise is required to ensure that the schemes are run well and offer quality health services; otherwise, the insurance would have no value. Moral hazard among the participants is a problem and, if participation is not compulsory, problems of adverse selection can arise. The International Labor Organization and World Bank are currently experimenting with reinsurance schemes to improve the financial viability of community health insurance plans

10. These health-financing schemes have met varying degrees of success in terms of sustainability and in addressing the health needs of the poor. Multilateral development organizations, development agencies, and health sector researchers have individually documented and analyzed some of the experience. The documentation should be compiled, organized, and analyzed to better inform policy planners on possible initiatives for designing alternative health financing arrangements, particularly as they pertain to the health care needs of the poor. Current research and documentation reveal gaps on issues that relate to the poor, including (i) participation and payment mechanisms; (ii) level and quality of basic preventative, promotive, and curative care given; (iii) cost efficiency and sustainability; (iv) financial burden on the client; (v) impacts on the provision of health care by the government and by private providers; and (vi) effects of these schemes on client health and on their spending on basic human needs.

11. An evaluation of experience across schemes and countries in Asia will yield lessons for similar situations in other DMCs. Country case studies will be most helpful in examining different aspects of a health program in view of country-specific, socioeconomic, and health system characteristics, and legal and political environments.

III. THE TECHNICAL ASSISTANCE

A. Objectives

12. In line with ADB’s Policy for the Health Sector, the objective of the TA is to identify a range of health financing options that could assist DMC governments to diversify their sources of financing of health services for the poor. The TA will

- (i) identify and analyze a range of innovative and sustainable health financing schemes that serve the health needs of the poor,
- (ii) analyze and consolidate the results of the studies and produce “user friendly” recommendations documenting best practices, and
- (iii) disseminate this information to policymakers and health planners.

B. Scope

13. The TA will (i) undertake case studies in the selected countries including comparative analyses of health financing schemes; (ii) develop recommendations for policymakers and health planners for the design of optimal health coverage systems for the poor; and (iii) support dissemination activities through (a) a regional workshop focusing on the findings of the study; and (b) publication of the case studies, topic briefs, recommendations, and a guide (regional study) for designing health care financing alternatives that address the poor.

14. The study will be conducted in two phases. During the first phase, the TA study will document, collate, and analyze information related to the experience of selected DMCs with different health financing schemes. Available data, research, and country reports will be brought together to examine household, government, and private sector experience. In addition, relevant stakeholders will be interviewed whenever necessary. Details of implementation arrangements will be recorded, and socioeconomic conditions and legal frameworks within which these schemes have been executed will be examined. In analyzing the schemes' impacts on the poor, the questions to be addressed include (i) who pays for health care and what are the mechanisms for payment; (ii) what are the determinants of participation; (iii) what is the service mix and quality of care that participants receive; (iii) how these schemes have worked in terms of targeting, including pricing; and (iv) how these schemes have affected participants' use of health care services, health-related behavior, health status, spending patterns, and income and consumption.

15. The TA will consider health service delivery and financing issues, including the following: (i) who are the participants and the mechanisms of payment, (ii) the pricing structure and coverage, (iii) the range of care and services provided, (iv) the schemes' limitations and exclusions, (v) risk management steps undertaken, and (vi) procurement arrangements. The interaction of financing arrangements and the health sector will be examined with focus on (i) the impact of the payment schemes on the government's allocation of resources to the health sector and the rest of the social sector, (ii) how the schemes have affected the provision of health care by nongovernment providers, and (iii) the legal and regulation frameworks that guide health sector activities.

16. At the end of the first phase, a roundtable discussion of findings of the country case studies will be held to obtain an initial comparative perspective, to learn from the issues and experience from the other study countries. This comparative analysis will be a major input to developing the regional study and guide. The researchers will review each other's draft studies and draft topic briefs with a view towards addressing gaps in them and thereby improve their quality.

17. The second phase will orient key government personnel in the health and/or economic planning units of the countries participating in this study, as well as representatives of NGOs and other agencies, on the experience relating to health finance for the poor. A regional workshop meeting will be organized to share the countries' experience with modes of health care financing and prepare the regional study and guide on health care financing for the poor. The guide will include the case studies and offer options for optimal coverage of the poor with respect to: (i) financial sustainability, (ii) financial burden on the client, (iii) public-private partnership, (iv) degree of insurance, and (v) level of primary and curative care given. This document and the topic briefs will be posted on ADB's web site and translated into key languages of the region.

18. Five countries will be included in the study: Bangladesh, Mongolia, Pakistan, Papua New Guinea, and Viet Nam. These countries have been selected because of their experience that include a variety of instruments for meeting the health needs of the poor and that may be replicable elsewhere. They are also in diverse stages of economic and political development. Bangladesh

has numerous community health initiatives sponsored by nongovernment organizations (NGOs). Pakistan has nongovernment providers that offer sustainable quality health care. Papua New Guinea has decentralized health services to local-level governments. Viet Nam has recently shifted from a highly subsidized system into one requiring greater out-of-pocket payments. Mongolia is a transition economy that initiated a national insurance program in 1994.

C. Cost Estimates and Financing Plan

19. The total cost of the TA is estimated at \$450,000 equivalent. The amount will cover the cost of international and domestic consultants' services, international and domestic travel, studies, regional workshop, monitoring, and consultations. ADB will provide \$400,000 on a grant basis from the Japan Special Fund funded by the Government of Japan. The participating DMCs will provide \$50,000 in kind through the provision of information, statistics, and data on financing schemes; administrative support; and staff time of personnel. Cost estimate details are in Appendix 2.

D. Implementation Arrangements

20. The TA study will be coordinated by ADB's Education, Health and Population Division (West) and supported by a small group of ADB health specialists and economists. Concurrence from the governments of the study countries has been obtained. The TA will coordinate closely with the World Health Organization (WHO) and World Bank; the ministries of health of the study countries and other aid agencies will be consulted. ADB will finance the study of five countries. WHO will offer technical advice and make available relevant documents and materials. World Bank will be undertaking complementary parallel efforts in the People's Republic of China, Indonesia, Philippines, Thailand, and Viet Nam. Terms of reference, study frameworks, study materials, and related documents pertaining to these parallel studies will be shared between ADB and World Bank.

21. The TA implementation will take 11 months, starting in August 2001 and finishing in June 2002. The first phase of the TA is expected to take six months, and the second phase, five months. ADB will engage individually one international consultant for four person-months, and five domestic consultants for three person-months each, every one an expert in health financing in her or his country of coverage. The international consultant will be the team leader and will write the final report and recommendations on policy design in health financing for the poor, with input from the other team members. The outline terms of reference for the consultants are in Appendix 3. The consultants will be engaged individually by ADB in accordance with the *Guidelines on Use of Consultants* and other arrangements satisfactory to ADB on the engagement of domestic consultants, using simplified technical proposal procedures. Consultants will serve as workshop facilitators and/or resource speakers.

IV. THE PRESIDENT'S DECISION

22. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance, on a grant basis, in an amount not exceeding the equivalent of \$400,000 for a Regional Study of Health Care Financing for the Poor and hereby reports such action to the Board.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<p>Goal</p> <ul style="list-style-type: none"> Support the efforts of developing members countries (DMCs) to increase access to quality basic health services by the poor by putting in place more equitable health financing schemes. 	<ul style="list-style-type: none"> DMCs are able to meet the health needs of a greater number of poor people. 	<ul style="list-style-type: none"> Demographic and health surveys. 	<ul style="list-style-type: none"> Continued political commitment to increasing the poor's access to health services. Policy and program designers use the technical assistance (TA) outputs for planning and design of health care financing for the poor. DMCs will conduct regular surveys to gauge the change in the poor's health and economic status.
<p>Objectives</p> <ul style="list-style-type: none"> Identify sustainable health financing schemes that serve the health needs of the poor. Analyze and consolidate the results of the studies and produce "user friendly" recommendations documenting best practices. Inform health planners about alternative health financing arrangements and design of optimal health coverage systems for the poor. 	<ul style="list-style-type: none"> Five health financing schemes in five countries are identified as promising in terms of meeting the health needs of the poor and sustainability. Information relating to these schemes are documented, compiled, and analyzed. Successful elements of schemes are examined through comparative analysis. Publish a user-friendly regional study and guide for designing health care financing for the poor. Key health policy makers and decision makers have a better understanding of alternative health financing schemes that could be potentially used for serving the health needs of the poor. 	<ul style="list-style-type: none"> Report on the initial researchers' workshop relating to health schemes in each country. Monthly progress reports of the consultants First drafts of country case studies and country briefing notes. Frequent discussions. Regional workshop draft of case studies and country briefs. Draft of regional study and guide. Feedback from officials of Asian Development Bank (ADB), World Bank (WB), and World Health Organization (WHO). Feedback from the attendees of the regional workshop. Report on the activities and proceedings of the regional workshop. 	<ul style="list-style-type: none"> Health care financing initiatives are available to consider. Documentation, data, and research papers are available for review. Country health personnel, health researchers, and personnel of selected schemes appreciate the study and willingly extend their assistance to the consultants/ researchers. Key country health and poverty reduction personnel attend the workshop.

(Reference in text: page 1, para. 2)

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<p>Outputs</p> <ul style="list-style-type: none"> • Country case studies. • Topic briefs on health financing for the poor. 	<ul style="list-style-type: none"> • 5 country case studies that document, collate, review, and analyze information on health schemes with focus on the poor and sustainability, including <ul style="list-style-type: none"> (i) financial burden on the poor, including pricing and subsidies; (ii) level and quality of care to the poor; (iii) health outcomes and expenditures on basic human needs; (iv) coverage of services and population groups; (v) sustainability, procurement, and risk management; (vi) conditions and exclusions; and (vii) role of the government and the private sector. • 10 two-page topic briefs that mainly summarize the results of the country case studies and can be used with ease by policy makers and designers. 	<ul style="list-style-type: none"> • Monthly progress report from each consultant. • Report on consultants' roundtable discussion. • First drafts of country case studies and country briefing notes. • Feedback from officials of governments, ADB, WB, and WHO. • Monthly progress report from each consultant. • Report on consultants' roundtable discussion. • First drafts of country case studies and country briefing notes. • Feedback from officials of governments, ADB, WB, and WHO. 	<ul style="list-style-type: none"> • Country health officials and health researchers appreciate the study and willingly extend their assistance and input to the consultants. • Country health officials and health researchers appreciate the study and willingly extend their assistance and input to the consultants.

Design Summary	Performance Targets	Monitoring Mechanisms	Assumptions & Risks
<ul style="list-style-type: none"> • Regional workshop for sharing country experience and case studies on health care financing schemes. • Regional study and guide and recommendations for designing health care financing for the poor. 	<ul style="list-style-type: none"> • Workshop of key government personnel in the health and/or economic planning units of the countries participating in this study, as well as representatives of nongovernment organizations. • User-friendly guide and recommendations, based on the country case studies and comparative analysis. This is aimed at health policy planners and poverty reduction personnel, and translated into the key languages of the region. 	<ul style="list-style-type: none"> • Feedback from workshop attendees. • Report on the activities and proceedings of the regional workshop. • Regional workshop draft of case studies and country briefs. • Draft of regional study and guide. • Feedback from officials of ADB, WB, and WHO. • Feedback from users. 	<ul style="list-style-type: none"> • Key country health and poverty reduction personnel attend the workshop. • Country health officials and health researchers appreciate the study and willingly extend their assistance and input to the consultants.

COST ESTIMATES AND FINANCING PLAN
(**\$**)

Item	Total Cost
A. Asian Development Bank (Japan Special Fund)	
1. Consultants	
1. Remuneration and Per Diem	
a. International Consultant	97,000
b. Domestic Consultant	118,000
2. Travel	
a. International	12,000
b. Regional	20,000
c. Domestic	8,000
2. Workshops	
1. Cross-Country Meetings	12,000
2. Final Workshop	50,000
3. Reports and Communications	20,000
4. Miscellaneous Administration and Support Costs	12,000
5. Contingencies	51,000
Subtotal (A)	400,000
B. Participating DMC Governments	
1. Staff Time	30,000
2. Government Reports and Studies	20,000
Subtotal (B)	50,000
Total	450,000

(Reference in text: page 5, para. 19)

OUTLINE TERMS OF REFERENCE FOR THE CONSULTANTS

A. General

1. The Asian Development Bank (ADB) will engage the consultants individually in accordance with the ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB on the engagement of domestic consultants using the simplified technical proposal procedures.

2. Each participating country's ministry of health (MOH) will nominate a counterpart to guide in matters of data collection, case studies, policy, programs, and financing.

B. International Consultant—International Health Economist (4 person-months)

3. The consultant will have at least 10 years experience in health economics, including health care systems and financing, preferably in developing countries and in the region. The consultant will be the team leader and will:

- (i) organize and coordinate the study in cooperation with ADB, each study country's MOH, World Health Organization (WHO), and World Bank;
- (ii) conduct a one-day workshop with the team members and domestic researchers to develop a common framework for the country and regional studies, including a report format and a general outline for the regional study and guide and the topic briefs. The consultant, in cooperation with the team, will discuss and identify promising health financing schemes in each country. The consultant will provide ADB a summary of the workshop discussion, and a copy of the study framework, report format, and outline, for comments and approval.
- (iii) review country-specific study frameworks and work plans of team members, and coordinate the assignments so that all activities are completed in time;
- (iv) keep ADB updated about the monthly progress and other issues relating to the technical assistance (TA);
- (v) coordinate the preparation of the country studies, topic briefs, the workshop reports, regional study and guide, and the final TA report for dissemination;
- (vi) be responsible for the regional study and guide and the final TA report and furnished these to ADB in hard copy and electronic formats, including web-ready files;
- (vii) provide advice, whenever necessary, to team members in identifying and analyzing economic and financing issues in health financing for the poor, including management and implementation issues, and in preparing the case study and recommendation for health financing aimed at the poor;
- (viii) undertake a comparative review of the literature regarding health financing schemes and assist country researchers in identifying acceptable, cost-effective and financially sustainable strategies;

(Reference in text: page 5, para. 21)

- (ix) provide a comparative review of the policy and institutional framework in health financing, including the roles of the central and local governments, communities, nongovernment organizations, and the private sector, and identify organizational issues like service delivery; and
- (x) carry out other assignments requested by ADB that may be reasonably expected within the scope of the study with the help of the team members.

C. Domestic Consultants—Health Economists (5 economists for 3 person-months each)

4. The consultants will have at least 5 years experience in health economics in the country of assignment. The consultants will:

- (i) coordinate with the team leader, the other team members, the government counterpart, and the WHO representative;
- (ii) participate in the one-day workshop for developing the general framework of study, country work plans, report format, and outline of the regional study/guide and topic brief (and will take part in discussing and identifying promising health financing schemes in each country);
- (iii) compile all the available studies, published and unpublished, on health financing in the country of assignment and provide ADB a copy of each;
- (iv) collect information on health schemes and clients from primary and secondary sources, including interviews of relevant personnel, whenever necessary, especially on matters relating to implementation, and provide ADB a copy of the data and/or documentation;
- (v) perform quantitative and qualitative analysis of the schemes' impact on the poor and low-income members of the population from collected information with respect to their expenditure patterns on various basic needs, utilization of health services, health outcomes, and other indicators of household behaviors;
- (vi) analyze the changes in the following brought about by the scheme: level and quality of health care services delivered to low income groups, participation in the scheme, affordability of health care services, provision and quality of health care services from private providers, and financial sustainability of the scheme;
- (vii) prepare a case study on the chosen scheme of the study country according to the agreed report format incorporating all the information collected and analyzed;
- (viii) prepare two, two-page topic briefs from the country case study;
- (ix) compare the results of the case studies with the results in other countries and comment on the other case studies prepared under this TA during the consultants' workshop;
- (x) present the case study in a regional consultation workshop;

- (xi) revise the case study, incorporating comments and suggestions from workshop participants;
- (xii) contribute actively to drafting the regional study and guide and the final TA report;
- (xiii) provide ADB monthly progress reports; and
- (xiv) perform other duties as may be assigned by the team leader and ADB that may be reasonably expected from the scope of study.