ADB

Technical Assistance Report

Project Number: 49152-001
Regional—Capacity Development Technical Assistance (R–CDTA)
October 2015

Universal Health Coverage for Inclusive Growth: Supporting the Implementation of the Operational Plan for Health, 2015–2020

Asian Development Bank

ABBREVIATIONS

ADB	–	Asian Development Bank
ASR	–	assessment, strategy, and road map
CPS	–	country partnership strategy
DMC	–	developing member country
NHI	–	national health insurance
PPP	–	public–private partnership
TA	–	technical assistance
UHC	–	universal health coverage

NOTE

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

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CAPACITY DEVELOPMENT TECHNICAL ASSISTANCE AT A GLANCE

1. Basic Data — **Project Number:** 49152-001

Project Name	Universal Health Coverage for Inclusive Growth: Supporting the Implementation of the Operational Plan for Health, 2015–2020	**Department /Division**	SDCC/SDAS
Country	REG	**Executing Agency**	Asian Development Bank

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ Health	Health system development	1.50
	Total	**1.50**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low
Regional integration (RCI)	Pillar 4: Other regional public goods		

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Institutional development Public financial governance	Effective gender mainstreaming (EGM)	✓
Knowledge solutions (KNS)	Application and use of new knowledge solutions in key operational areas Knowledge sharing activities		
Partnerships (PAR)	Bilateral institutions (not client government) Civil society organizations Implementation Private Sector Regional organizations United Nations organization		
Private sector development (PSD)	Promotion of private sector investment Public sector goods and services essential for private sector development		

5. Poverty Targeting		**Location Impact**	
Project directly targets poverty	No	Regional	High

6. TA Category: B

7. Safeguard Categorization Not Applicable

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**1.50**
Capacity development technical assistance: Technical Assistance Special Fund	1.50
Cofinancing	**0.00**
None	0.00
Counterpart	**0.00**
None	0.00
Total	**1.50**

9. Effective Development Cooperation

Use of country procurement systems	No
Use of country public financial management systems	No

I. INTRODUCTION

1. The technical assistance (TA) will support several developing member countries (DMCs) to achieve universal health coverage (UHC).[1] It will also inform the preparation of sovereign and nonsovereign projects that help achieve the recommendation of the Asian Development Bank (ADB) Midterm Review of Strategy 2020 to scale up health sector investments from the current 1%–2% to 3%–5% of total portfolio in the remaining period of ADB's Strategy 2020.[2] The regionwide drive for UHC offers a means to build a long-term health practice and usher in assistance beyond health infrastructure. Building knowledge and lines of investment that will support DMCs achieve UHC provide a practice that will remain relevant as they evolve from low- to middle- to high-income countries. Consultations with DMCs at the time the new operational plan for health was being crafted defined the business lines for the health sector work and the focus of the TA. Subsequent discussions with health officials in Myanmar, the Philippines, and Viet Nam from 13 to 29 July 2015, have confirmed that several DMCs are committing to achieving UHC and recognizing that investments in health and UHC would help reduce poverty. These DMCs have enacted universal health insurance laws, crafted UHC strategies, increased investments in health services, including investments in health infrastructure, and set up and strengthened government health purchasers that purchase health services from both government and private health care providers. Given the regional nature of the TA, the large number of DMCs involved, and the broad health system areas in which it expects to engage (in close consultation with ADB's operations departments), concurrence from governments will be secured before the TA is implemented. The design and monitoring framework is in Appendix 1.[3]

II. ISSUES

2. **Access to needed health services.** People in DMCs have limited access to needed health care services with the poorest having the least access (Table 1). Access is further limited by the increasing demand for health care services due to: (i) the rapid aging of the population in the region, leading to an increase in noncommunicable diseases; and (ii) the increased health risks associated with rapid urbanization, large mobile populations, climate change and natural disasters, and emerging and reemerging infectious diseases. Addressing these issues requires an integrated health care service delivery with a skilled health workforce, improved evidence-based diagnostics and treatments, strategic government purchasing of health services, and well-informed health governance.

Table 1: Access to Needed Health Services by Income Quintile, Selected Developing Member Countries

Country	Skilled Birth Attendance (%)		Problem Accessing Health Care (%)	
	Poorest	Richest	Poorest	Richest
Bangladesh	6.8	56.5	26.2	16.8
Cambodia	56.3	97.3	84.3	55.0
India	21	89.7	67.2	15.4
Indonesia	46.5	96.1	61.7	24.5
Nepal	9.2	64.4	91.1	62.9
Pakistan	17.8	79.3	Not available	Not available

Source: World Development Indicators, 2012 (data year vary by country).

[1] Ensuring that quality health services are available to all those in need without undue financial hardship.

[2] ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank, 2008–2020.* Manila; and ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific.* Manila.

[3] The TA first appeared in the business opportunities section of ADB's website on 10 July 2015.

3. **Financial protection in accessing health services.** Despite increasing government spending in health, financial protection—as manifested as the share of out-of-pocket payment to total health spending—continues to be persistently low in several DMCs as out-of-pocket remains high (Table 2).

Table 2: Health Spending and Out-of-Pocket Spending in Selected Developing Member Countries in Asia and the Pacific

Country	2013 Health Spending Per Capita ($)	1999 OOP as % of Total Health Expenditure	2013 OOP as % of Total Health Expenditure
Bangladesh	32	57.8	60.2
Cambodia	76	79.2	59.7
India	61	64.7	58.2
Indonesia	107	47.9	45.8
Kyrgyz Republic	87	51.5	36.4
Lao People's Democratic Republic	32	63.4	40.0
Mongolia	244	9.9	37.0
Myanmar	14	89.0	68.2
Nepal	39	64.6	46.2
Pakistan	37	66.5	54.9
Philippines	122	43.3	56.7
Sri Lanka	102	44.5	46.5
Uzbekistan	120	49.2	46.1
Viet Nam	111	61.9	49.4

OOP = out of pocket.
Sources: World Bank and World Health Organization.

4. **Health system governance.** The health market is imperfect and government stewardship remains crucial if universal health coverage is to be achieved. Strengthened planning, financial management, institutions, health information, and health regulatory systems backed by information and communication technology solutions are needed to ensure quality, efficiency, effectiveness, transparency, and accountability. Stronger governance will require investing in accreditation of hospitals, licensing of health workers and facilities, implementing regulatory processes for pharmaceuticals and medical goods, and improving legal and regulatory environment for private sector engagement and public–private partnerships (PPPs).

5. Poor health remains an obstacle to full participation in economic growth for populations throughout Asia and the Pacific. DMCs are, therefore, pursuing UHC as a way to improve health. The TA will support the UHC commitment of DMCs by informing country decisions on necessary investments in health infrastructure, health financing, and health governance. ADB has accumulated valuable experience in supporting investments in health systems, such as investing in health infrastructure (i.e., hospitals, primary health care clinics, medical training institutes, and laboratories), strengthening health governance, and financing health services. Supporting UHC commitments provides an opportunity to move away from fragmented small health projects to broader health system approaches where service delivery, financing, and governance issues can be addressed at the same time. It will elevate sector dialogue to address

broader country aspirations, and open opportunities for substantial ADB health operations aligned with country needs. There is no TA project similar to this, which supports the implementation of an Operational Plan for Health, 2015–2020.

III. THE CAPACITY DEVELOPMENT TECHNICAL ASSISTANCE

A. Impact and Outcome

6. The impact will be the achievement of UHC, including financial risk protection, access to quality essential health care services and to safe, effective, quality, and affordable essential medicines and vaccines for all.[4] The outcome will be an increase in the number of DMCs implementing UHC strategies.

B. Methodology and Key Activities

7. Three main outputs will help achieve the TA's expected outcome: (i) undertaking analysis of knowledge gaps and key challenges in developing health systems to achieve and sustain UHC; (ii) disseminating knowledge on designing, implementing, and scaling up UHC interventions; and (iii) identifying investment opportunities for projects supporting UHC.

8. Output 1 includes assessments and development of working papers on national health insurance (NHI), PPPs in health, and urban health. Pertinent country briefs of DMCs identified in consultation with the operational departments will be part of these papers. Specifically,

(i) a regional paper on NHI in Asia and the Pacific, which may include country briefs on the NHI systems of India, Indonesia, Kazakhstan, Kyrgyz Republic, the Lao People's Democratic Republic, Mongolia, Nepal, Pakistan, the Philippines, and Viet Nam. The briefs shall include how the NHI or government purchaser engages the private health sector;
(ii) a review of integrated hospital systems in Asia, which may include country briefs on the hospital systems of Fiji, the Lao People's Democratic Republic, Kazakhstan, Mongolia, Myanmar, Pakistan, Papua New Guinea, and the Philippines;
(iii) a working paper on health PPPs in DMCs in Asia and the Pacific, and reviews of the private health sector in selected DMCs which may include Fiji, India, Pakistan, Papua New Guinea, and the Philippines; and
(iv) a review of urban health systems in Asia and the Pacific, which may include a country brief on urban health in Bangladesh.

9. Output 2 activities involve

(i) organizing regional meetings and training events; and
(ii) supporting regional networks, including regional meetings on urban health, health PPPs, and NHI; and training workshops on health financing and health PPPs.

10. Output 3 involves identifying investment opportunities, conducting policy dialogues on increased investment in UHC, supporting the preparation of health sector assessment, strategy, and road map, and developing concept notes for projects supporting UHC.

[4] 2015 United Nations Sustainable Development Goal on Universal Health Coverage (Sustainable Development Goal 3.8).

C. Cost and Financing

11. The TA is estimated to cost $1,500,000, which will be financed on a grant basis by ADB's Technical Assistance Special Fund ($500,000 from TASF-V and $1,000,000 by TASF-Other Sources). The cost estimates and financing plan are in Appendix 2.

12. A parallel financing (not administered by ADB) from the Republic of Korea Knowledge Sharing Program in the amount of $250,000 will support output 1, specifically by funding the assessment of NHI systems of Indonesia, the Philippines, and Viet Nam.

D. Implementation Arrangements

13. The TA will be implemented from October 2015 to December 2020. Five consultants (three international, two national) with expertise in NHI, hospital management, PPP in health, and urban health, will be recruited to help implement and deliver the TA's outputs for a combined total engagement of 42 person-months. In the interest of efficiency and timeliness, individual consultants instead of firms will be engaged.

14. ADB will be the executing agency for the TA. Consultants will be recruited by ADB in accordance with its Guidelines on the Use of Consultants (2013, as amended from time to time). The outline terms of reference for consultants are in Appendix 3. The Health Sector Group Secretariat will implement the TA in coordination with ADB's operations departments for each country to ensure that the TA outputs are fully aligned with current and planned health initiatives. This would include quarterly briefings and updates of the TA activities and outputs to ADB's operations departments. All disbursements will be made in accordance with ADB's *Technical Assistance Disbursement Handbook* (2010, as amended from time to time).

15. The TA will involve several knowledge events, and produce several knowledge products. These will be around NHI, urban health, PPP in health, and UHC (Appendix 1). Information on these events, copies of the knowledge products, as well as progress reports on the various aspects of the TA will be uploaded in the health sector page of ADB's website, and in the website of partner agencies as appropriate.

IV. THE PRESIDENT'S DECISION

16. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of $1,500,000 on a grant basis for Universal Health Coverage for Inclusive Growth: Supporting the Implementation of the Operational Plan for Health, 2015–2020, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Impact the Technical Assistance Project is Aligned with
UHC,[a] including financial risk protection, access to quality essential health care services and to safe, effective, quality, and affordable essential medicines and vaccines for all (Sustainable Development Goal 3.8)[b], is achieved.

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome DMCs implementing UHC strategies increased	By 2020, 35 DMCs are implementing national health insurance programs as part of their UHC strategies (Baseline: 24 out of 44 DMCs have some form of national health insurance)	Annual World Health Organization reports	Inadequate political support to pursue UHC
Outputs 1. Analysis of knowledge gaps and key challenges in building up health systems to achieve and sustain UHC undertaken	1a. By December 2020, at least 10 DMCs included health as part of their country partnership strategies for the period 2016–2020 (Baseline: 3 out of 40) 1b. Four knowledge products published and disseminated	1a. Country partnership strategies 1b. Published knowledge products	1a. Delays in DMCs providing concurrence to the TA, DMC nonconcurrence to the TA
2. Knowledge on designing, implementing, and scaling up UHC interventions disseminated	2a. More than 80% of the expected 800 participants in at least three regional meetings convened by October 2020 provide positive feedback to the meeting	2. Evaluation reports of regional meetings	
3. Investment opportunities for projects supporting the UHC identified	3a. More than 3% of total ADB financing for the period 2016–2020 is for sovereign and nonsovereign health projects. (Baseline: 1%–2%] 3b. At least eight DMCs with approved sovereign and nonsovereign health projects classified as "health system	3a. ADB Annual Reports 3b. ADB's Loan, TA, Grant and Equity Approvals List	3a.- b. DMCs decide to prioritize other programs

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	development," "health care finance," "health insurance and subsidized health programs," "health sector development and reform" from 2016 to 2020 (Baseline: Three approved in 2012–2014)		

Key Activities with Milestones

1. Analysis of knowledge of gaps and key challenges in building up health systems to achieve and sustain UHC undertaken

1.1 Prepare a regional paper on NHI in Asia and the Pacific, which may include country briefs on the NHI systems of India, Indonesia, Kazakhstan, Kyrgyz Republic, the Lao People's Democratic Republic, Mongolia, Nepal, Pakistan, the Philippines, and Viet Nam. The briefs shall include how the NHI or government purchaser engages the private health sector (Q3 2016).
1.2 Prepare a review of urban health PPPs in India (Q1 2017).
1.3 Prepare a review of integrated hospital systems in Asia and the Pacific, which may include country briefs on the hospital systems of Fiji, Kazakhstan, the Lao People's Democratic Republic, Mongolia, Myanmar, Pakistan, Papua New Guinea and the Philippines (up to Q2 2017).
1.4 Prepare a working paper on health PPPs in DMCs in Asia and the Pacific (Q4 2017).
1.5 Review urban health systems in Asia and the Pacific, which may include a country brief on the urban health of Bangladesh (Q2 2018).
1.6 Review the private health sector of selected DMCs which may include Fiji, India, Pakistan, Papua New Guinea, and the Philippines (up to Q4 2018).
1.7 Provide inputs into the country partnership strategies of at least 10 DMCs (up to Q3 2020).

2. Knowledge on designing, implementing, and scaling up UHC interventions disseminated

2.1 Establish a marketplace for private health companies to provide public health solutions (Q1 2017).
2.2 Support the conduct of training in health financing and health PPPs (Q4 2015).
2.3 Convene a regional meeting on NHI by Q2 2016.
2.4 Convene a regional meeting on urban health by Q2 2016.
2.5 Hold roundtable on information management and NHI by Q4 2016.
2.6 Support the conduct of a course on health financing principles with the World Health Organization by Q3 2016.
2.7 Convene a regional meeting on health PPPs in 2017.

3. Investment opportunities for projects supporting UHC identified

3.1 Support the identification of investment projects for UHC, including investments in NHI, urban health, hospital systems, and health PPPs (Q4 2015–Q3 2020).
3.2 Support the preparation of health sector assessment, strategy, and road maps, and concept notes for projects supporting UHC (Q1 2016–Q3 2020).
3.3 Conduct policy dialogues on investing in UHC (Q1 2016–Q3 2020).

Inputs

Asian Development Bank: $1,500,000

Assumptions for Partner Financing

Outputs not administered by ADB include parallel financing from the Republic of Korea Knowledge Sharing Program of $250,000 that would support the assessment of NHI systems of Indonesia, the Philippines, and Viet Nam, which are necessary to achieve output 1.

ADB = Asian Development Bank, DMC = developing member country, NHI = national health insurance, PPP = public–private partnership, Q = quarter, TA = technical assistance, UHC = universal health coverage.

[a] Ensuring that quality health services are available to all those in need without undue financial hardship.

[b] United Nations Department of Economic and Social Affairs, Sustainable Development Knowledge Platform. 2015. *Transforming Our World: The 2030 Agenda for Sustainable Development.* (11 August), https://sustainabledevelopment.un.org/post2015/transformingourworld

Source: ADB.

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Amount
Asian Development Bank[a]	
1. Consultants	
a. Remuneration and per diem	
i. International consultants	428
ii. National consultants	205
b. International and local travel	96
c. Reports and communications	7
2. Equipment[b]	5
3. Training, seminars, and conferences[c]	590
4. Miscellaneous administration and support costs[d]	94
5. Contingencies	75
Total	**1,500**

[a] Financed by the Technical Assistance Special Fund (TASF-V [$500,000] and TASF-Other Sources [$1,000,000]) of the Asian Development Bank (ADB).

[b] Equipment includes office equipment, information and communication technology hardware and software, laboratory equipment, and other health-related goods. Equipment will be turned over to government counterparts or participating research institutes once the technical assistance (TA) is completed. Office equipment to be used for project management, such as computers and printers, will be assessed further with the involvement of ADB's Office of Administrative Services and Office of Information Systems and Technology. If needed, purchased equipment will be turned over to ADB for disposal after project closing.

[c] Includes logistic arrangements; venue; travel of resource persons, including ADB staff and experts; supplies; and materials that will be used in seminars, meetings, and workshops. This may also include limited representation expenses where there are directly identifiable costs under the TA.

[d] Includes project administration costs, such as translation, printing, website maintenance, other dissemination costs associated with the publication of TA-related documents, limited representation expenses (directly identifiable with the TA, in accordance with the 26 June 2013 Budget, Personnel and Management Systems Department and Strategy and Policy Department memo on use of ADB resources), and other directly identifiable TA costs.

Source: ADB estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The Asian Development Bank (ADB), through its Sustainable Development and Climate Change Department, will be the executing agency for the technical assistance (TA) project. ADB will implement the TA through the Sector Advisory Service Division (Health Sector Group Secretariat), in close coordination with the head and members of the Health Sector Group and the regional departments. Five individual consultants will be contracted for the implementation of the TA.

A. Health Financing Expert (international, intermittent, 2 years, 8 person-months)

2. The expert will:

(i) lead the crafting of a working paper on national health insurance (NHI) systems in the Asia and Pacific developing member countries (DMCs), including the role of the private health sector, with focus on Cambodia. India, Indonesia, Kazakhstan, Kyrgyz Republic, Mongolia, Nepal, Pakistan, the Philippines, and Viet Nam;
(ii) contribute to a working paper on urban health programs in the Asia and Pacific DMCs;
(iii) coordinate the regional meeting on NHI in the second quarter of 2016 (NHI in Asia and the Pacific: From Design to Implementation);
(iv) participate in the regional meeting on urban health in the second quarter of 2016 (Achieving UHC in Urban Asia and the Pacific);
(v) provide inputs on health financing to country partnership strategies (CPS) for DMCs; and
(vi) provide inputs on NHI to the crafting of health sector assessments, strategies, and roadmaps (ASRs) and concept papers for projects supporting UHC.

3. A postgraduate degree in health economics, health financing, public health or health policy and management, and 5 years of work experience in the health sector, including work with an NHI or government health insurance agency, are preferred for this post.

B. Health System Implementation Expert (national [Philippines], intermittent, 2 years, 9 person-months)

4. The expert will:

(i) prepare country briefs on NHI for Cambodia, India, Kazakhstan, Kyrgyz Republic, Mongolia, Nepal, and the Philippines;
(ii) support the preparation of the country briefs for Indonesia, Pakistan, and Viet Nam;
(iii) contribute to the working paper on NHI in Asia and the Pacific;
(iv) support the conduct of the regional meeting on NHI in the second quarter of 2016 (NHI in Asia and the Pacific: From Design to Implementation);
(v) provide inputs on health financing and health systems to CPS for DMCs; and
(vi) contribute inputs on health system implementation to the crafting of health sector ASRs, and concept papers for projects supporting UHC.

5. A postgraduate degree in health economics, health financing, public health or health policy and management, and 5 years of work experience in the health sector, including work

advising senior management of ministries of health or government health insurance agencies, are preferred.

C. Hospital Management Expert (international, intermittent, 2 years, 8 person-months)

6. The expert will:

(i) prepare a review of integrated hospital systems in Asia and the Pacific;
(ii) prepare country briefs on hospital systems for Fiji, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, and the Philippines;
(iii) participate in the regional meeting on NHI in the second quarter of 2016 (NHI in Asia and the Pacific: From Design to Implementation) and the regional meeting on urban health in the second quarter of 2016 Q2 (Achieving UHC in Urban Asia and the Pacific);
(iv) provide inputs on hospital systems to CPS for DMCs; and
(v) provide hospital system inputs to the crafting of health sector ASRs and concept papers for projects supporting UHC.

7. A postgraduate degree in management or work experience in a management position, and 5 years of work experience in the health sector, including work in hospital management or advising hospital managers, are preferred for this post.

D. Health Public–Private Partnership and Private Sector Expert (international, intermittent, 2 years, 8 person-months)

8. The expert will:

(i) prepare a review of the private health sector in India, Pakistan, and the Philippines;
(ii) contribute to the working papers on urban health and NHI in Asia and the Pacific;
(iii) participate in the regional meeting on NHI in the second quarter of 2016 (NHI in Asia and the Pacific: From Design to Implementation) and the regional meeting on urban health in the second quarter of 2016 (Achieving UHC in Urban Asia and the Pacific);
(iv) provide inputs on the private health sector to CPS for DMCs; and
(v) provide health public–private partnership inputs to the crafting of health sector ASRs and concept papers for projects supporting UHC.

9. A postgraduate degree in management or work experience in a management position, and 5 years of work experience in the health sector, including work in a private or government health insurance agency, or hospital management, are preferred for this post.

E. Urban Health Expert (national [Bangladesh and India], intermittent, 2 years, 9 person-months)

10. The expert will:

(i) prepare a working paper on urban health programs in the Asia and Pacific DMCs,
(ii) prepare a country brief on urban health in Bangladesh,
(iii) prepare a review of urban health public–private partnerships in India,

(iv) lead the regional meeting on urban health in the second quarter of 2016 (Achieving UHC in Urban Asia and the Pacific),
(v) provide inputs on urban health of DMCs, and
(vi) provide urban health inputs to the crafting of health sector ASRs and concept papers for projects supporting UHC.

11. A postgraduate degree in public health or health policy and management, and 5 years of work experience in the health sector, including working in or advising senior management of ministries of health or local government health management, are preferred for this post.