Health system strengthening in FSM and RMI: engagement challenges and strategic perspectives for the 2023 transition

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Executive Summary

The U.S. Freely Associated States—the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau—maintain a unique long-term relationship with the U.S. Government (USG). Through the Compacts of Free Association these foreign nations receive significant amounts of USG economic assistance to support their island government services, including a substantial portion for the support of critical health services. In addition to these Compact funds, the FAS receive additional financial assistance for health programs through grants from the Department of Health and Human Services (HHS). FSM and RMI are particularly dependent on USG health financing; just 5-15% of these nations' FY 2018 planned health expenditures were supported by local revenues. In this context, the 2023 financing shift from direct Compact economic assistance to Trust Fund financing may impact health systems development in the FSM and RMI as well as potentially reshape relationships between these sovereign nations and the USG/HHS. FSM, RMI, the USG (DOI, HHS), and partners must navigate uncertainty around and the changing modality of ongoing USG health-related financial assistance and engagement. This transition provides an opportunity to strategically review and identify opportunities to strengthen FSM-RMI health systems and USG support for them.

This report first considers the current health system landscape in FSM-RMI, with emphasis on the engagement between HHS and FSM-RMI. It then compares HHS engagement in FSM-RMI with three alternative USG health system support models for health programming in sovereign contexts: USAID, PEPFAR, and USG support for American Indian/Alaskan Native communities through HHS' Indian Health Service (IHS). USAID and PEPFAR are based in international authorization/appropriation structures, while IHS programming is based in a domestic system but targets American Indian tribes, which are sovereign entities. Lastly, this report raises policy considerations for FSM, RMI, USG (/HHS), and other health system development partners.

By including FSM-RMI in HHS' domestic authorization/appropriation structures— thereby making these sovereign nations eligible grant recipients in the same way that states are eligible grant recipients— current HHS engagement implies an expectation that these sovereign nations can implement health programs as states can. FSM and RMI's US-based health systems may support their inclusion in a domestic system. However, with their limited health capacities, significant workforce challenges, developing-world disease burdens, small and isolated populations, and sovereign status, these nations may be more similar to developing countries, rural communities, or AI/AN populations than they are to states. HHS engagement in this region may benefit from a subset operating strategy that considers these nations' developing world context, increases coordination among USG stakeholders, and promotes greater ownership of their respective island health care systems. FSM-RMI health system development may benefit from more local health revenue and improved financial management structures, as well as greater domestic legislative advocacy.

The purpose of this report is to present a high-level strategic perspective on HHS-FSM-RMI engagement that can be used to inform internal FSM-RMI discussions, internal HHS discussions, and joint planning efforts leading up to and through the potential shift in USG engagement in FSM-RMI in 2023. This project was conducted between February 2018 and October 2018. Research drew on published economic, health, and budgetary data; public and private sector documents; academic literature; and interviews with individuals across FSM, RMI, Palau, the USG, and non-governmental organizations.

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1: Background

1.a: Basics: geography, population

Located more than 7,000 miles west of Washington, D.C., are a cluster of three island nations: the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau. Within the U.S. government (USG), these independent nations are known as the Freely Associated States (FAS). These three Pacific Island Jurisdictions (PIJ) constitute half of the US-Affiliated Pacific Islands (USAPI); the other three—Guam, American Samoa, and the Northern Mariana Islands (CNMI)—are territories.[1]

The FAS constitute a land area of roughly five hundred square miles and are spread over two million square miles of the central Pacific.[2] The Federated States of Micronesia is the largest FAS, with 65 occupied islands and a population of 104,937 across its four states (Yap, Chuuk, Pohnpei, and Kosrae); Palau has 8 populated islands and a total population of 21,503; and the Marshall Islands consist of 24 inhabited islands with a total population of 53,066.[3] For context, these nations' total population would be the equivalent of less than 1% of Texas' 2017 population spread out over an area of sea roughly five times the land area of Texas.[4]

There is significant outmigration from the FAS to Guam, CNMI, Hawaii, and the US mainland, and population growth in all three nations is stagnant.[5] The FAS are culturally and linguistically diverse with more than 10 distinct ethnic groups and many distinct languages, though English is common and, on some islands, predominant.[6]

[1] There are 24 populated small island countries and territories in the Pacific; 14 are independent countries and 10 are territories. French Polynesia (population 285,000), New Caledonia (280,000), and Wallis and Futuna (11,680) are associated with France; Norfolk Island (2,170) is an Australian territory; Tokelau (1,380) is a territory of New Zealand; Easter Island (5,600) is a Chilean territory; and Pitcairn Island (48) is a British territory. The Cook Islands (17,500) and Niue (1,600) are freely associated with New Zealand. "Oceania Countries by Population (2018)."
[2] "Federated States of Micronesia"; "The Marshall Islands"; "Republic of Palau"; Utz et al., "Pacific Possible; Long-Term Economic Opportunities and Challenges for Pacific Island Countries."
[3] "Palau"; "Micronesia, Federated States Of"; "Marshall Islands."
[4] "List of US States By Size."
[5] "Kiribati, Nauru, Marshall Islands, Micronesia, Palau, Samoa, Tonga, Tuvalu, and Vanuatu Regional Partnership Framework; FY2017-2021."
[6] "Palau"; "Micronesia, Federated States Of"; "Marshall Islands."

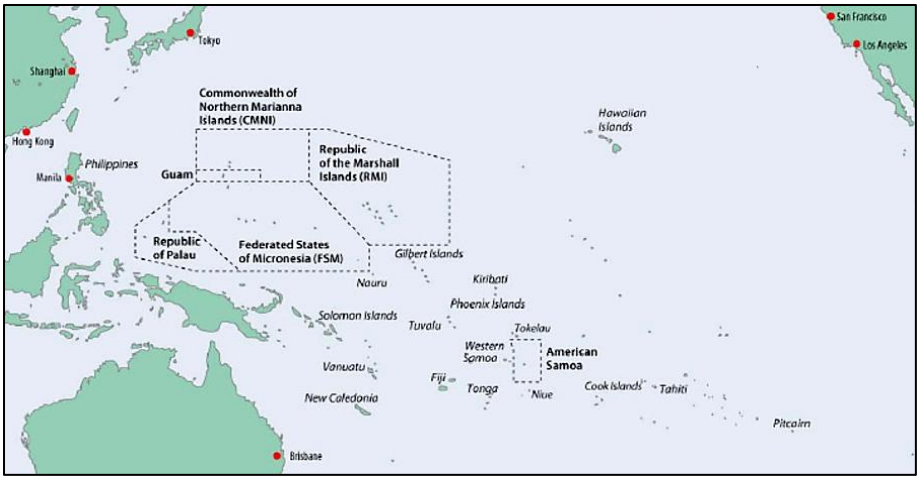


Figure 1: Map of the US-Affiliated Pacific Islands[7]

1.b: Economic development

The FAS' relative isolation, small population size, dispersed populations, and environmental fragility limit these nation's economic opportunities. Fisheries—specifically tuna fishing fees from the Parties to the Nauru Agreement—appear the most promising source for growth in FSM and RMI, bringing in roughly $18 million and $26 million in FSM and RMI in FY 2016.[8][9] FSM and RMI are significantly dependent on external financing, with more than half of government expenditures coming from external sources. Palau is less dependent on foreign assistance, thanks in part to more significant levels of tourism. For FY 2019, FSM is considered a lower-middle income economy, RMI an upper-middle income economy, and Palau a high-income economy.[10]

Though economic development has been limited, the FSM national government has had a budget surplus each of the last five fiscal years. In FY 2016, the national government recorded a surplus of $26.6 million, equal to 8% of the FY 2016 FSM GDP, while the four states had a combined deficit of roughly 2.5 million.[11] This statistic illustrates the disconnect between national and state governance: available resources have not been fully utilized to address significant financial needs at the state level. RMI has had a budget surplus each of the last four fiscal years. In FY 2016, the government recorded a surplus of $8 million, equal to 4% of GDP.[12] Palau recorded a budget surplus of $13.4 million in FY 2016, equal to nearly 5% of GDP.[13] Even with these reported budget surpluses, FSM, RMI, and Palau are not

[7] "Image from U.S. Affiliated Pacific Islands (USAPIs), Pacific Cancer Programs."
[8] The Parties to the Nauru Agreement is an agreement between FSM, RMI, Kiribati, Nauru, Palau, Papua New Guinea, the Solomon Islands, and Tuvalu to conserve and manage the world's largest sustainable tuna purse seine fishery. The countries limit the number of fishing days per year, and fishing days are allocated by country then sold to the highest bidder. "About Us."
[9] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[10] "World Bank Country and Lending Groups."
[11] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[12] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[13] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."

attractive sites for external investment, as shown by their ranks in the bottom third of the World Bank's Doing Business Survey. Together, these factors indicate a lack of economic growth potential at present and in the future.

Table 1 presents further economic indicators for FSM, RMI, and Palau.

Table 1: Economic indicators[14]			
Indicator	**FSM**	**RMI**	**Palau**
GDP per capita (PPP US$)	$3,343	$3,817	$13,966
GDP (PPP, current US$ millions)	$336	$199	$291
Average growth in GDP per capita, 2000-2015	0.1%	0.8%	1.2%
Taxes as a proportion of GDP (FY 2016)	13%	18%	20%
Debt as a percentage of GDP (FY 2016)	26%	43%	26%
Formal employment as a share of total population	15%	20%	65%
2018 WB Doing business survey (out of 190 countries)	#155	#149	#130

1.c: USG and the broader Pacific

Recent administrations' emphases on the Indo-Pacific region indicate significant foreign policy efforts will continue. The most recent National Security Strategy lists economic stability in its Pacific Island partners as one of the priorities within the US' Indo-Pacific Strategy.[15] Approximately one third of global trade and half of energy commerce pass through the region around the FAS as commodities transit through the East China and South China Sea.[16] Asian trade is vital for US economic interests, and securing this system—from natural disasters, technological failures, or potential security threats (i.e., North Korea)—is an important driver for US engagement in the region. The islands' geography also underlies important maritime security issues: the FAS are the bridge to the Philippines and Taiwan, neighbor Guam and the military bases there, and are (comparatively) close to Taiwan and Japan amongst concerns around China and North Korea. The U.S. Army Garrison at Kwajalein Atoll in the Marshall Islands is home to the Ronald Reagan Ballistic Missile Defense Test Site.

Current political discourse suggests that China's growing engagement in the region could influence US commitment to the FAS and its Asian partners in the coming decades. Chinese-funded development projects are common in the USAPIs, and many people interviewed for this report raised concerns about China's growing influence in the region. One example of their concerns is a proposal outlining the "leasing" (for 99 years) of much of the state of Yap to a Chinese company to develop a large resort, with plans to move island residents to "Islandtown," deepen the harbor, and extend the runway of the local airport to allow for bigger ships and planes and more tourists.[17] As two global superpowers' development and military efforts meet in these islands, their geopolitical value to the US will grow.

[14] Economic Monitoring and Analysis Program, "Economic Policies and Performance In the Freely Associated States"; Utz et al., "Pacific Possible; Long-Term Economic Opportunities and Challenges for Pacific Island Countries"; "Doing Business 2018: Reforming to Create Jobs"; "GDP (Current US$)."
[15] Trump, "National Security Strategy of the United States of America."
[16] Matelski, "America's Micronesia Problem."
[17] Lin, "This Pacific Island Is Caught in a Global Power Struggle (And It's Not Guam)."

1.c.i: USG and the USAPI: historical ties

Despite their small populations and land masses, the USAPI have played a significant role in several important events in USG history: the Pacific front of World War Two (WW2) was staged among these tiny islands, with the Caroline Islands (now part of the FSM) home to some of the most intense fighting.[18] Planes that dropped the atomic bombs on Hiroshima and Nagasaki departed from Tinian Island in what is now CNMI.[19] After WW2, the islands were governed by the US Navy and brought into the Trust Territory of the Pacific Islands (TTPI), which the USG administered on behalf of the United Nations from 1947 through 1978. As opposed to the "trusts" administered by other WW2 victors in the region, the Trust Territories were classified a "strategic trust," which allowed the US to maintain its military presence in the region as it administered and helped to develop the fledgling territories.[20]

Through USG efforts to support self-determination for territories, FSM, RMI, and Palau chose to become independent nations in the 1980s. The Compacts of Free Association (COFA) were the products and binding agreements of these negotiations.

1.c.ii: Compacts of Free Association

FSM and RMI entered into COFA with the US in 1986, and Palau entered into a similar COFA in 1994.[21] Under these public laws, the USG agreed to provide economic and technical assistance, ensure US military defense support, and allow unrestricted travel to/from the US for these non-resident FAS citizens. In return, these FAS agreed to give the USG unlimited and exclusive use of their land and waterways for strategic purposes. This strategic denial has remained a crucial element of the Compact as China's influence and concerns around North Korea have grown. The Department of the Interior, Office of Insular Affairs (OIA) is responsible for the administration of Compact assistance.

The COFA were extended and amended in 2003/2004 to preserve direct economic assistance through 2023 and to put in place trust funds to replace direct USG economic assistance post-2023.[22] This extension also introduced amendments to strengthen federal oversight.[23] Total USG financial support is fixed through 2023, but direct assistance decrements each year while trust fund contributions increase each year; the decrement promotes self-sufficiency among FSM-RMI recipients (by requiring more local funding to maintain programs begun with Compact funds), while the increased trust fund contributions act as a long-term investment to provide revenue in replacement of the economic assistance provided by the USG post-2023. In this way 2023 presents a planned shift in the modality of financial assistance.

Today, the USG plays an active role in FSM and RMI economic assistance oversight: the US-FSM Joint Economic Management Committee (JEMCO) and US-RMI Joint Economic Management and Fiscal Accountability Committee (JEMFAC) are comprised of three USG representatives and two FSM or RMI

[18] Matelski, "America's Micronesia Problem."
[19] "Hiroshima and Nagasaki Bombing Timeline."
[20] Fischer, *A History of the Pacific Islands*.
[21] Compact of Free Association Act of 1985 (Federated States of Micronesia, Republic of the Marshall Islands); "Republic of Palau."
[22] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[23] Compact of Free Association Amendments Act of 2003.

representatives.[24] These joint committees collectively allocate and manage FSM and RMI Compact economic assistance and review annual audits.[25] While there is USG oversight of the Palau Compact agreement, it differs from the others in that the day to day management rests with the COFA Trust Fund Board, a five member committee appointed by the Palauan president and confirmed by the Palauan Senate.[26]

Compact funds are distributed by DOI/OIA through six sector grants: education, health, infrastructure, environment, private sector development, and public sector capacity building. More than half of the economic and technical assistance provided to the FAS through the Compacts is typically devoted to health and education services. The Federal Programs and Services Agreement within the Compacts also makes the FAS eligible for some domestic programming, including but not limited to programs administered by the Federal Emergency Management Agency, Federal Deposit Insurance Corporation, Postal Service, National Weather Service, and Federal Aviation Administration.[27] FAS eligibility for HHS programming does not fall under the Programs and Services Agreement.

Due to differences in USG oversight of the Palau Compact agreement, a different timeline for the termination of economic assistance, and a lesser reliance on USG financing, this report will focus on only FSM and RMI.

1.d: 2023: Changes, Continuities, and Concerns

In 2023, the majority of DOI/OIA economic assistance to FSM and RMI will end.[28] The amount of annual funding will be replaced by revenues from a separate Compact trust fund. However, recent reports have found that the trust funds are not likely to be a sustainable source of income in the long term. It is increasingly likely that trust funds will not fully replenish Compact financing volumes, nor will they sustain their value.[29] Additionally, it remains unclear whether individual sectors will retain the

[24] "Compacts of Free Association: Micronesia and the Marshall Islands Continue to Face Challenges Measuring Progress and Ensuring Accountability."
[25] "Compacts of Free Association: Micronesia and the Marshall Islands Continue to Face Challenges Measuring Progress and Ensuring Accountability."
[26] "COFA Trust Fund Board."
[27] Compact of Free Association Amendments Act of 2003.
[28] Compact sector grants—which make up the majority of compact health financing— will end in 2023. However, not all forms of economic assistance referenced in the Compacts will end in 2023. Kwajalein-related grants for RMI, for example, will continue for as long as the Military Use and Operating Rights Agreement is in effect. Other programs identified in the amended Compacts' implementing legislation or the compacts' programs and services agreement may continue because the countries' eligibility for programs now provided under compact legislation will continue under current U.S. law or could continue under other legal authorities; further information on these programs can be found in GAO 18-415. For the purposes of this report, its sufficient to state that the vast majority health-related economic assistance through the Compacts will end in 2023.

[29] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."

levels of funding currently distributed through sector grants. The shift in modality, thus, could result in a significant decrease in health assistance over the next few decades.

This is concerning because FSM-RMI depend heavily on USG economic assistance for most of their governmental operations: Compact funding supported a third of FSM's and a quarter of RMI's *total* expenditures in FY 2016.[30] As Figure 2 shows, in FY 2019, Compacts and federal grants are predicted to support 57-95% of total expenditures in *health*.[31] FSM and RMI contribute proportionally fewer local funds in these sectors, possibly because substantial funds have always been available from the USG; the health and education sectors are prioritized in COFA direct assistance.

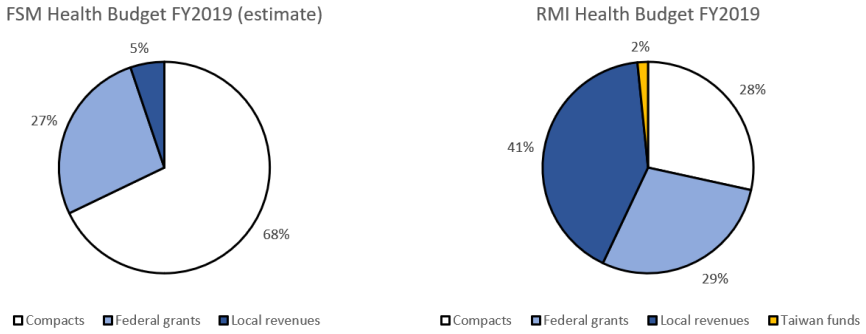


Figure 2: USG, local, and other contributions to planned FY 2019 FSM-RMI health expenditures

DOI/OIA financial assistance for health and education has been complemented by significant financing from the Department of Education and HHS. The amended Compacts (P.L. 108-188) authorized a supplemental education grant (SEG) for FSM and RMI in FY 2005-2023; funding for the SEG is appropriated annually to the Department of Education and transferred to DOI, to be distributed in place of grants formerly awarded to the FAS under several U.S. education, health, and labor programs.[32] When the SEG ends in 2023, the Department of Education is not expected to remain financially engaged in FSM-RMI. With respect to HHS grant assistance, a recent GAO report has stated that HHS intends to preserve FSM-RMI eligibility for its domestic grant programming beyond 2023.[33]

Previous analysis has documented ongoing outmigration from FSM-RMI. Substantial economic hardship or health challenges on island may prompt increased outmigration to the US and territories. There is already significant outmigration from FSM-RMI to the territories or states, with an estimated 61,000 migrants residing in the US/territories in 2015.[34] A 2010 report concluded that the 13,000 COFA migrants in Hawaii alone were associated with a social, health, and welfare cost of $90 million in 2007.[35]

[30] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[31] "Medium-Term Expenditure Planning, JEMCO Mid-Year Meeting"; "Medium Term Planning and Budgeting Framework FY2019-2023."
[32] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income"; Compact of Free Association Amendments Act of 2003.
[33] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[34] "Interior, Census Launch 2018 Enumeration of Compact Migrants in Hawaii, Guam, Northern Mariana Islands and American Samoa."
[35] Riklon et al., "The 'Compact Impact' in Hawai'i: Focus on Health Care."

The costs associated with an influx of these underinsured populations into Guam or CNMI would strain already under-reimbursed territorial healthcare systems, as well as heavily impact Hawaii's healthcare system and the healthcare systems of other states with large Marshallese or Micronesian populations (such as Arkansas and Washington).

1.e: Impetus for this report

Weak economic growth over the time of the Compacts has limited the availability of local financial and development of human resources that would enable FSM and RMI to become self-sufficient. In this environment, the transition away from direct USG economic assistance to a revenue source reliant on returns from Trust Funds raises concerns regarding the continued viability of health programming which up to this point has been largely dependent on USG assistance. This uncertainty and potential shift in USG involvement in the region presents an opportunity to strategically review FSM-RMI-HHS engagement, as well as identify opportunities to strengthen FSM-RMI health systems and USG support for them.

This report reviews FSM-RMI and HHS engagement in light of the 2023 benchmark because: (1) the discussions and processes that will be undertaken independently and together by the USG and FSM-RMI over the coming years to prepare for 2023 will require HHS[36] input; (2) HHS, FSM, and RMI should capitalize on the "systems improvement" headspace that may accompany this transition planning to spark innovative solutions to FSM-RMI-HHS engagement challenges; (3) FSM's and RMI's efforts to integrate USG support into local financing efforts and strategic action plans over the next five years and post-2023 will benefit from a better understanding of USG processes and an ability to elucidate clear, feasible needs to USG counterparts; (4) this report may inform ongoing FSM-RMI efforts to establish themselves in more financially secure positions in advance of 2023 through FSM-RMI engagement with other partners; and (5) HHS should be aware of and consider potential courses of action should any negative repercussions accompany the 2023 transition.

2: Methods

2.a: Overview

This mixed-methods research project occurred from February through December 2018. Figure 3 shows the progression of this project throughout that timeline. An initial literature review included academic, government, and private-sector documents related to the FAS' health status, geopolitical history, culture, and governance structures; the health status, geopolitical history, and foreign relations of other Pacific Islands (including Guam, CNMI, and American Samoa); the history of USG engagement in the region; the USAID model; the Indian Health Services model; the PEPFAR model; multilateral organizations' efforts in the region; and developmental theories as related to small island economies.

[36] Including both operating divisions and staff divisions to incorporate the wide range of legal, legislative, programmatic, project-based, and diplomacy-based capacities within HHS.

Data on Pacific, FAS, US, and tribal health indicators and health system strength were gathered from a variety of sources, including the WHO Global Health Observatory Data Repository, Pacific and Virgin Islands Training Initiatives at the USA Graduate School (PITI-VITI), and the World Bank database.

Lastly, this project relied on interviews: efforts to understand USG engagement and HHS' role in the region sought a broad range of perspectives, while efforts to compare alternative health system support models to HHS actions sought more detailed interviews with a small number of people well-versed in their respective models.

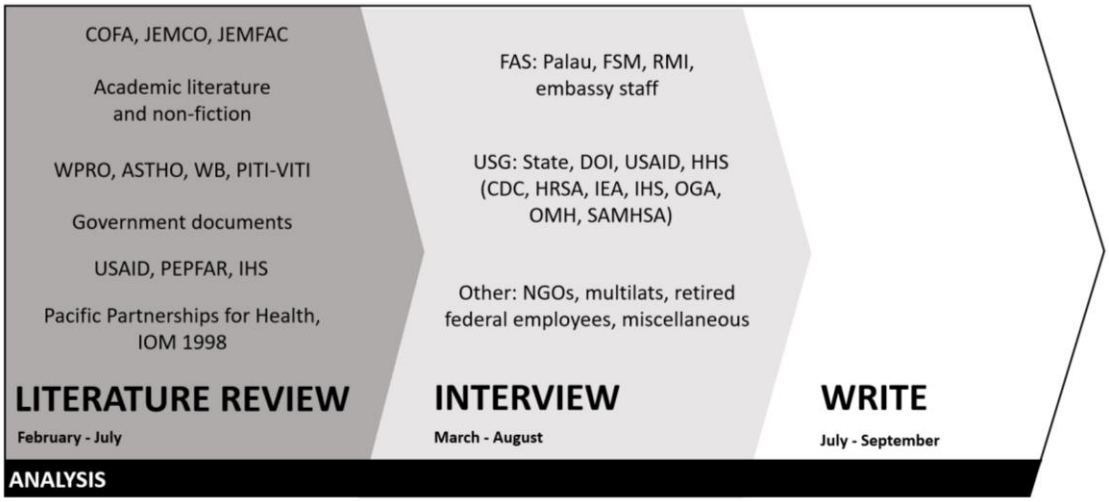


Figure 3: Report process

2.b: Interview sources and timeline

Between March and July, the author interviewed representatives from the federal government, Freely Associated States, and non-state actors present in the region. As illustrated in Figure 3, a wide range of federal employees were interviewed in person, over the phone, or through email/online survey. Within the federal government, the author interviewed individuals from the Department of State (including desk officers and PEPFAR), DOI (OIA), and HHS (including CDC, HRSA, SAMHSA, OMH, OASH, IEA, OGA, and IHS). Within the FAS, the author interviewed individuals from the Ministries of Health in FSM (including all four states), RMI, and Palau, as well as RMI and FSM embassy staff in DC. The author also interviewed individuals in healthcare-related NGOs based in the Pacific or continental US, including the Pacific Island Health Officers' Association (PIHOA), the Pacific Islands Primary Care Association (PIPCA), the Asian and Pacific Islander American Health Forum (APIAHF), the Association of Asian Pacific Community Health Organizations (AAPCHO), and Payu-Ta. Author also engaged with large multilateral organizations and banks in the region, including ADB and WB. Positions represented in these interviews include regional directors, program directors, project officers, grants management specialists, health analysts, and policy advisors, among others. A list of interviewed officials is located in Appendix A; note that several interviewees requested anonymity and are not included in this list.

In total, the author completed 45 discrete interviews with a total of 58 people, yielding more than 40 hours of conversation and an average interview length of 53 minutes (range: 30 minutes to 90 minutes). The author also collected 28 online surveys or email questionnaires, bringing the total engagement for this project to 84 unique perspectives. More than 115 people were engaged in the research for this project through interviews, briefings, email consultations, and online surveys.

2.c: Interview structure

Semi-structured interviews emphasized three guiding themes: engagement, challenges, and perceptions of ownership. These were believed to be most crucial to a constructive review of the engagement between HHS and FSM-RMI. Responses were later analyzed for common criticisms, requests, and suggestions. Appendix B provides further detail on interview methods.

2.d: Scope and limitations

Variety in the quantity of responses gathered from different groups (USG, FAS, and NGOs) are functions of schedule compatibility, the efforts of champions for this project within a given agency, and luck. A concerted effort was made to increase participation from individuals based within the FAS; internet connectivity and time zone differences made it difficult to coordinate phone calls or complete online questionnaires, and if given more time the author would seek additional FAS perspectives. This report was also limited by financial constraints; a visit to FSM-RMI was not feasible but would have added significantly to this report.

Lastly, this report does not consider in depth how conclusions related to RMI and FSM might affect Palau, the broader Pacific, or the Insular Areas; the scope was limited to emphasize efforts in the region that may be most impacted by financial shifts in 2023. The perceived value of this report was its potential use as a resource for upcoming 2023-focused conversations within the federal government, within HHS, and within FSM and RMI. Although not targeted in the report, lessons from this report may be valuable to Palau, Guam, CNMI, American Samoa, and the US Virgin Islands as well. Lessons could also apply to similar state to state relationships in the region, including states freely associated with New Zealand (the Cook Islands and Niue) or France with its overseas collectivities/territories (French Polynesia, Wallis and Futuna, and New Caledonia).

3: Health systems in FSM and RMI

3.a: Health context

FSM and RMI struggle with health burdens often associated with both developing and developed countries. Infectious disease and poverty-related maladies, as well as issues like obesity and chronic diseases, are all significant challenges in these islands. Table 2 provides a snapshot of key health indicators in these jurisdictions. Compared to the US, life expectancies are lower, maternal and child mortality are higher, vaccination rates are lower, obesity rates are higher, health expenditures per capita are lower, and reliance on external health financing is higher. Compared to other Pacific Islands, FSM and RMI maintain higher levels of external health financing and slightly higher rates of infant mortality, but have comparable life expectancies, obesity rates, immunization rates, and health expenditures. Compared to American Indian and Alaska Native (AI/AN) tribes— other examples of sovereign entities participating in the domestic health financing system—FSM and RMI have similar age structures and obesity rates but significantly higher maternal and infant mortality rates.

Table 2: Selected summary health statistics, FSM, RMI, US, regional, tribal comparisons[37]					
Indicator	**FSM**	**RMI**	**US**	**Region***	**AI/AN**
Median age (years)	**25.1**	**22.9**	**38.1**	32.9	25
Life expectancy (years)	70	72	79	71.5	73
Maternal Mortality (per 100,000)	100	-	14	81.9	23.2
Infant mortality rate (per 1,000 live births)	**27.5**	**29.1**	**5.6**	21.8	7.6
Incidence of tuberculosis (per 100,000 population per year)	**177**	**422**	**3**	181[+]	5.9
Immunization coverage rate for DTP3 (three doses)	69%	71%	84.6%[38]	82.6%[+]	79.6
Immunization coverage rate for measles-containing vaccine (first dose)	70%	75%	92%	84%[+]	92.5
Prevalence of obesity among adults (age 18+)	40.1%	48.4%	36.2%	44%**	43.7%
Physicians per 1,000 population	**0.18**	**0.46**	**2.57**	0.96	-
Nurses and midwives per 1,000 population	**3.32**	**3.55**	**9.88**	4.73	-
Current health expenditures per capita ($USD)	$458	$863	$9,500	$1000	$3,851[39]
Domestic government health expenditures (as % of GDP)	3.4	11.8	8.48	5.56	-
Domestic private government health expenditure (as % of general government expenditure)	6.09	21.2	22.6	11.5	-
Domestic private health expenditure (PVT-D) (as % of current health expenditure)	2.73	13.2	49.6	13.7	-

[37] "Federated States of Micronesia, Country Dashboard"; "Marshall Islands, Country Dashboard"; "United States, Country Dashboard"; "Trends in Indian Health; 2014 Edition"; Mathews, MacDorman, and Thoma, "Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set"; "Global Health Observatory Data Repository: Tuberculosis Incidence by Country"; "Global Health Observatory Data Repository: Full Child Immunization by Country"; "Global Health Observatory Data Repository: Measles, 1st Dose (MCV1) Immunization Coverage Estimates by Country"; "Global Health Observatory Data Repository: Overweight and Obesity"; Bloss et al., "Tuberculosis in Indigenous Peoples in the U.S., 2003-2008"; "Percent of Children Aged 19-35 Months Receiving Vaccinations For:"; "Vaccination Coverage for Selected Diseases among Children Aged 19–35 Months, by Race, Hispanic Origin, Poverty Level, and Location of Residence in Metropolitan Statistical Area: United States, Selected Years 1998–2015"; "Summary Health Statistics: National Health Interview Survey: 2015: Table A1"; NCD Risk Factor Collaboration, "Trends in Adult Body-Mass Index in 200 Countries Ffrom 1975 to 2014: A Pooled Analysis of 1698 Population-Based Measurement Studies with 19.2 Million Participants"; "Fact Sheets: IHS Profile."

[38] "Percent of Children Aged 19-35 Months Receiving Vaccinations For:"

[39] "Fact Sheets: IHS Profile."

Table 2, continued					
Indicator	**FSM**	**RMI**	**US**	**Region***	**AI/AN**
External health expenditure (as a % of current health expenditure)	71.3	33.3	0	20.4	-

* where not otherwise noted, regional ("Oceania") average includes: Australia, Fiji, Kiribati, FSM, Nauru, NZ, Palau, Papua New Guinea, RMI, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu

+: average rate across small Pacific Islands: Cook Islands, Kiribati, RMI, FSM, Nauru, Palau, Samoa, Tonga, and Tuvalu

**: average rate across American Samoa, Cook Islands, French Polynesia, Kiribati, RMI, FSM, Nauru, Niue, Palau, Samoa, Tokelau, Tonga, and Tuvalu

The most pressing health concerns commonly cited in interviews with individuals based in the jurisdictions were non-communicable diseases (NCD), especially those related to obesity and diabetes, and for communicable diseases, tuberculosis (TB). Obesity is a serious problem in the region: Oceania hosts nine of the ten countries with the highest prevalence of obesity. As shown in Table 2, FSM and RMI's rates are comparable to those of the broader region with an estimated 83.5% of RMI adults being overweight (48.4% of adults further classified as obese) and 75.9% of FSM adults being overweight (40.1% classified as obese). For comparison, the US is often considered one of the heaviest nations in the world with 67.9% of the population classified as overweight (36.2% obese). Obesity rates have steadily increased over the last twenty years.[40] Comorbidities associated with obesity—including diabetes, cardiovascular disease, and stroke, as well as kidney and joint issues—are likely to increase in prevalence as the young populations (median ages: 25 and 22) age. The Marshall Islands had the highest prevalence of diabetes in the world in 2017, with 33% of its population aged 20-79 suffering from the disease.[41]

Table 2 also illustrates the estimated TB incidence in the FSM (177 cases per 100,000 population) and in RMI (422 cases per 100,000 population); for comparison, the US rate is 3 per 100,000 and "high burden" TB countries identified by WHO range from 150 to 400 cases per 100,000. FSM and RMI are rarely cited among the high burden countries in TB reports; this may stem from their small populations and/or their close ties with the US. These high rates combined with high outmigration pose a threat to nearby Guam, CNMI, and Hawaii, as well as to the broader continental US.

Beyond NCDs and TB, other health-related concerns commonly raised in interviews included climate change—notably its potential to impact crops/food security, delay shipments of food or medical supplies, and increase the frequency of natural disasters— and organizational issues— including concerns around shortages of human resources and trained staff, complicated financial processes on island, and IT issues.

3.b: Health program organization and priorities

In interviews, 90% (40/44) of respondents who were asked about the ideal relationship between HHS and FSM-RMI stated that the ideal relationship would support local efforts to develop a strong, independently sustainable health care system, much in the same way HHS engages with the fifty US states. The remaining 10% suggested either that financially independent health systems were an

[40] "Global Health Observatory Data Repository: Overweight and Obesity."
[41] Doran, "Curbing Type II Diabetes in the Marshall Islands."

unrealistic goal or that the "ideal" relationship should evolve as FSM-RMI develop. Informed by these conversations, this report assumes that an ideal health system in FSM-RMI is self-financed, strategically informed by local health priorities, sustainable, and supported by HHS as states are.

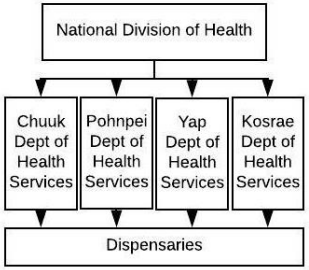
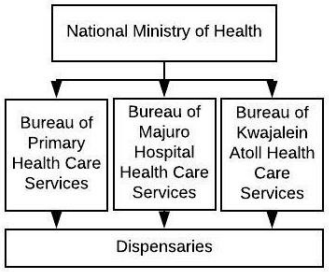
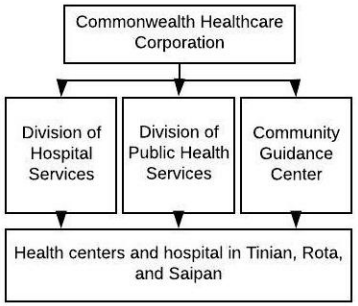
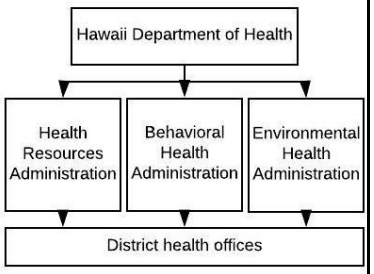
Because HHS' role is to support local health efforts, it is important to outline the structures and priorities that define local and regional health efforts in FSM and RMI. Table 3 presents an overview of FSM, RMI, a territory's (CNMI), and a state's (Hawaii) health structures and priorities. CNMI was chosen as a reference point because of the territory's unique health approach; the CNMI health department was reestablished as the Commonwealth Healthcare Corporation (CHCC), a public corporation, in 2009. As stated in their strategic action plan, "the Commonwealth Healthcare Corporation is intended to be a professionally managed, nationally accredited, independent public health care institution that is as financially self-sufficient and independent of the Commonwealth government as is possible." [42] Hawaii was chosen as a reference point because it is also a Pacific island. Key takeaways from Table 3 are summarized below.

The structure of FSM's health system is less centralized than that of RMI, with influential state health departments alongside the national Division of Health. The Marshall Islands' health system structure is more centralized: within the national Ministry of Health, two bureaus target geographic regions (Majuro and Kwajalein) and one bureau coordinates primary health services for the remaining atolls. FSM and RMI have similar health budgets that are notably smaller than the health budgets of CNMI and Hawaii. In FY 2018, local revenues made up 5% and 15% of FSM and RMI health budgets; in FY 2019, RMI's contribution is expected to grow to more than 40%, while FSM's contribution is expected to remain at 5% (shown in Table 4 below). The health priorities of the four entities share emphases on improving access to care, reducing disease burdens, and improving financial/administrative capacity; they differ in the balance of these priorities and the relative detail. Not shown in Table 3 is Hawaii's second level of priorities, which add seven statements to each of the first three priorities.

Several core services are offered across all four entities. As stated in the ASTHO 2016 Profile report, all offer immunizations to children and adults; all perform regulation, inspection, and licensing activities for food services; and all perform environmental health activities related to food safety and vector control.[43] CNMI surpasses FSM and RMI in access to care, the breadth of vaccine services, and number of regulation/licensing activities. FSM, RMI, and CNMI offer a similar array of services for maternal and child health, primary prevention services, screening/treatment, and epidemiology/surveillance (a comparison with Hawaii for these services was not available).

Geography differentiates these four jurisdiction's health system operations from standard state health system operations. Service provision to these populations can be challenging because of their isolation over hundreds of miles of ocean, particularly in atolls across RMI and FSM. Primary care for these populations may require equipment less commonly needed for domestic primary care (e.g., boats). Frequent natural disasters in these regions also disrupt services, facility function, and supply shipments.

[42] "Commonwealth Healthcare Corporation (CHCC): Strategic Plan 2015-2020."
[43] "ASTHO Profile of State and Territorial Public Health, Volume 4."

Table 3: Comparison of FSM, RMI, CNMI, and Hawaii health systems [44]				
	FSM	**RMI**	**CNMI**	**Hawaii**
Leader	Magdalena Walter, *Secretary of Health*	Kalani Kaneko, *Minister of Health*	Esther Muña, *Chief Executive Officer*	Virginia Pressler, *Director of Health*
Health structure				
Guiding document[45]	*2014 Framework for Sustainable Health Development in the Federated States of Micronesia: 2014-2024* *FSM 2023 Action Plan*	*RMI Ministry of Health Medium-Term Planning and Budgeting Framework FY 2019-2021*	*CHCC Strategic Plan 2015-2020*	*Hawaii Department of Health Strategic Plan 2015-2018*

[44] 2023 Planning Committee, "FSM 2023 Action Plan"; "Framework for Sustainable Health Development in the Federated States of Micronesia: 2004-2023, Volume I: Policies and Strategies for Development"; "Medium Term Planning and Budgeting Framework FY2019-2023"; "Commonwealth Healthcare Corporation (CHCC): Strategic Plan 2015-2020"; "Auditor's Summary: Financial and Compliance Audit of the Department of Health; Financial Statements, Fiscal Year Ended June 30, 2017"; "Hawaii Department of Health Strategic Plan 2015-2018"; "ASTHO Profile of State and Territorial Public Health, Volume 4"; "Commonwealth Healthcare Corporation, Financial Statement, May 21, 2018 and September 30, 2017."

[45] The RMI guiding document cited here is addressed to the appropriating body of RMI (the Nitijela or parliament) and includes monetary commitments. FSM has a similar document with monetary commitments, but the 2014 framework was more frequently reported among high level documents (i.e., WPRO's 2018-2022 Country Cooperation Strategy for FSM) as the guiding strategy for FSM.

Table 3, continued				
	FSM	**RMI**	**CNMI**	**Hawaii**
Stated priorities	1. Improved **accountability, sustainability and quality** of health service delivery 2. **Universal access** to essential healthcare services 3. Improved **financial sustainability** 4. Improved availability, accessibility, quality, and use of **health information for evidence-based decision-making** across the health sector 5. Reduced **morbidity and mortality** 6. Supportive and sustainable **social and physical environments to improve health**	1. High **quality health care in the outer islands** 2. **Universal access** to high quality care for people with communicable diseases 3. **Integrate NCD services**, tools, and support to help people manage their health 4. Improved **maternal, infant, child, and adolescent health** 5. Care for adults and children with **mental illness and/or substance use disorders** 6. Increased **immunization** rates **7.** Increased **health education** 8. Improved **coordination and administration** of preventive and public health care services	1. **Fully accredited** hospital, public health, behavioral health and community guidance center 2. **Financially stable** operations with newly added funding streams annually and full and appropriate usage of all U.S. federal and local government funding 3. **Clean audits and full compliance** to all contracts/grants 4. **Certified, licensed, trained workforce** supported by **competitive and fair wages** **5.** Increase in **consumer satisfaction and community partnerships** **6.** Decrease **incidence of the top six major causes of death and debilitation** in the CNMI	1. Invest in **healthy babies and families** 2. Take health into where people live, work, learn, and play 3. Create a **culture of health** throughout Hawaii 4. Address the **social determinants of health** 5. Use **evidence-based practices and make data-driven decisions** 6. Improve core **business services and customer satisfaction**

Table 3, continued				
	FSM	**RMI**	**CNMI**	**Hawaii**
Priorities as stated in 2016 ASTHO Profile of State and Territorial Public Health	1. Chronic diseases 2. The decreasing COFA funding 3. The aging health workforce 4. Pathways for qualified students into health/medical fields 5. Upgrading the quality of medical care	1. TB (including multi-drug resistant TB) 2. NCDs and their major risk factors 3. Childhood malnutrition 4. Leprosy 5. Vaccine-preventable diseases	1. Reorganizational plan with clear reporting and authority lines 2. Recruitment and retention plan 3. A service plan code of ethics 4. Facility plan 5. Full implementation of electronic health records	1. Maternal and child health 2. Mental health 3. Telehealth
Health financing* (% local)	$33,622,388 (5% local) FY 2016	$31,062,129 (15% local) FY 2016	$67,843,163 (78% local) FY 2018	$802,000,000 (48% local) FY 2017
Health agency FTEs (per capita)	83 (1 per 1,000)	570 (11 per 1,000)	50 (1 per 1,000)	2,631 (2 per 1,000)

*FSM and RMI financing tallies represent FY 2016 expenditure data; CNMI financing tally represents the projected annual expenditures based on expenditure data from the first eight months of FY 2018; and Hawaii financing tally represents FY 2017 revenue data while the "48% local" stems from FY2015 revenue data.

Beyond the health system approaches of these four entities, a prominent regional health system framework is the Healthy Islands concept. This framework was first defined by Pacific health ministers in the Yanuca Declaration of 1995 and is particularly relevant in the South Pacific.[46] A developing world model, this approach reflects the special geographical, social, economic, and health features of small island nations in the Pacific and prioritizes human resources development, health promotion and health protection, and the supply and management of pharmaceuticals and other medical supplies.[47] Health system priorities in FSM and RMI, as well the efforts of large regional players like SPC and WPRO, largely align with the ideals of the Healthy Islands concept.

3.c: Healthcare financing

FSM-RMI rely on external financing to maintain their healthcare services. The USG is involved in healthcare financing in the FSM-RMI through the DOI's administration of health-related Compact funding and HHS grants. These funding streams have significantly different authorities, funding mechanisms, and timeframes. Table 4 breaks down local and USG financing for FY 2016.

3.c.i: FSM-RMI financing

As highlighted in the background section, each national government maintained a significant government surplus (4-7% of their respective GDPs) in FY 2016. However, there has been limited local revenue made available for healthcare financing, perhaps in part because significant health financing has always been available through the Compacts. According to JEMCO and JEMFAC documents, FSM and RMI financed between 5% and 15% of their most recent healthcare expenditures with local funds.[48] The remaining 85-95% came from external financers, primarily the USG in the form of DOI/OIA Compact assistance and related funds or HHS grant funds. In 2019, RMI plans to support 40% of their healthcare expenditures with local funds, while FSM is expected to remain at 5% local financing.[49]

Limited local expenditures in health do not appear to be driven by a lack of available revenue, but rather prioritization of other sectors for local financing and limited financial absorptive capacity. Revenue from the Parties of the Nauru Agreement (tuna revenue) in FSM-RMI has increased over the last decade and is largely to credit for government surpluses in recent years. It is unclear to what extent FSM-RMI governments have allocated these revenues toward sustaining core health services or supporting additional/expanded services. Tuna revenue may not be a sustainable source of long-term financing.

More generally, FSM and RMI struggle with low levels of financial management; in 2016, both countries required tax reform and maintained information systems considered "at risk."[50] Additionally, FSM lacked a medium-term framework, a performance management plan, and increased public expenditure and financial accountability among its states.[51] It's unclear to what degree these issues have

[46] "Healthy Islands; South Pacific Situation Summary."
[47] "Healthy Islands; South Pacific Situation Summary."
[48] "Medium-Term Expenditure Planning, JEMCO Mid-Year Meeting"; Dammar and Savage, interview.
[49] "Medium-Term Expenditure Planning, JEMCO Mid-Year Meeting"; Wase, interview.
[50] Economic Monitoring and Analysis Program, "Economic Policies and Performance In the Freely Associated States."
[51] Economic Monitoring and Analysis Program.

been resolved. These factors, alongside FSM and RMI's historical financial management challenges, indicate that limited financial absorptive capacity and limited finances compound upon each other to negatively impact local healthcare financing.[52]

3.c.ii: DOI financing

Over the twenty years of economic assistance ending in 2023, the USG will have provided roughly $3.6 billion to FSM and RMI through Compact grants, trust fund contributions, and other grants.[53] These funds are used to promote economic development and support health, education, infrastructure, environment, public capacity building, and private sector development efforts. Much of this financing is managed by DOI/OIA. To give a sense for recent DOI support for health, in FY 2016 DOI/OIA provided roughly $20.7 million and $9.3 million to healthcare systems in FSM and RMI, respectively.[54]

Most DOI/OIA health-related financing to FSM-RMI goes toward operating expenses and construction purposes. A small minority of this health-related financing, roughly $2.5 million in FY 2016, comes through the Technical Assistance Program (TAP) and Maintenance Assistance Program (MAP) grants. [55] These programs support technical assistance and the improvement and maintenance of island infrastructure.[56] The remaining $27 million come from health sector funds. More than 90% of OIA health sector funds in both FSM and RMI go to recurrent operational expenses for hospitals—personnel, medical equipment, electricity, etc.[57] Figure 2 above shows the relative contributions of DOI/OIA and HHS to health budgets in FSM-RMI. Table 4 below shows the TAP/MAP and health sector financing to each country in FY 2016.

Annual financing amounts are delineated in the amended Compacts; these funds are divided among the sectors and allocated through JEMCO/JEMFAC (§217, §211). The Compact requires only that health grant assistance "support and improve the delivery of preventative, curative and environmental care and develop the human, financial, and material resources necessary for [FSM-RMI] to perform these services" (§211(a)(2)). This direction is more clearly defined through the medium-term budgets and investment frameworks required by the Compacts for FSM and RMI; JEMCO and JEMFAC use these frameworks to inform funding allocation (§211). JEMCO and JEMFAC allocate grants and attach terms and conditions—accountability and control standards—to grant awards through resolutions, which are discussed and voted upon at their annual meetings.[58]

[52] "Compacts of Free Association: Issues Associated with Implementation in Palau, Micronesia, and the Marshall Islands"; "Compacts of Free Association: Micronesia and the Marshall Islands Continue to Face Challenges Measuring Progress and Ensuring Accountability."
[53] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[54] Banerji and Ottley, "FY2016 Report on Federal Financial Assistance to the US Pacific and Caribbean Islands."
[55] Banerji and Ottley.
[56] Banerji and Ottley.
[57] Dammar and Savage, interview.
[58] "Compacts of Free Association."

3.c.iii: HHS financing

HHS provided roughly $14.8 million and $9.9 million to health systems in FSM and RMI, respectively, in FY 2016.[59] The three HHS agencies most heavily engaged in FSM-RMI—CDC, SAMHSA, and HRSA—each awarded 8-10 grants with at least one FAS recipient in FY 2016.[60]

Generally speaking, all HHS grants to the FSM-RMI are authorized by various sections of the Public Health Service (PHS) Act and the Social Security Act and take the form of cooperative agreements, block grants, and traditional (formula or discretionary) grants. Two examples might be SAMHSA's substance abuse prevention and treatment block grants (authorized under section 1921 of the PHS Act) or the CDC Child Immunization grant program (authorized under section 317(j) of the PHS Act).[61] To illustrate how HHS authorizing legislation fundamentally differs from the DOI health sector grant authorizing language and JEMCO/JEMFAC processes highlighted above, consider the language of the PHS Act authorizing the SAMHSA substance abuse and treatment block grant: the legislation specifies which disorders and activities may be funded and further requires state recipients to create plans to provide services that will comply with criteria set forth in the PHS Act (§1921). This block grant is one of the more flexible types of HHS grants, but at its highest level its authorizing legislation is more narrowly defined than is Compact health sector grant legislation.

In contrast to DOI and Compact funds—which can be used for public health, service delivery, or construction, among other functions— HHS grants used in FSM-RMI and states are more narrowly focused on public health, preparedness, and primary care. HHS grants rarely authorize construction-related projects. Authorities and appropriations for HHS grants are also defined through domestic processes which stem from national health priorities and policy: whereas DOI/OIA funds derive their authorities from the JEMCO/JEMFAC processes—which involve FSM-RMI leadership— HHS financing derives its authorities from Congress, in which FSM-RMI leadership are not represented.

Lastly, HHS financing and DOI Compact Sector grant financing are awarded to FSM/RMI under different Congressional and Agency authorizations: DOI financial assistance allows for advance funding whereas HHS grants are awarded under a reimbursement model. In the advance funding model, FSM-RMI are awarded a portion of funds and are able to obtain additional funds after submitting financial status reports on previously awarded funds. In the HHS reimbursement model, grantees incur expenses for program implementation and then submit requests to HHS to access grant funds. This difference causes significant program implementation delays for HHS programs in FSM and RMI, which may not have sufficient local revenue (in FY 2016, $9-14 million dollars) to upfront HHS grant amounts. Additionally, limited human/administrative capacity in these developing nations—from substandard education systems through paperwork-intensive Congressional grant processing requirements—contribute to slow project implementation. In comparison, US states are able to obtain upfront funding from their larger respective state treasuries.

Table 4: USG Healthcare Financing in the FSM and RMI, FY 2016[62]		
	FSM	**RMI**

[59] Banerji and Ottley, "FY2016 Report on Federal Financial Assistance to the US Pacific and Caribbean Islands."
[60] Banerji and Ottley.
[61] Public Health Service Act.
[62] Banerji and Ottley, "FY2016 Report on Federal Financial Assistance to the US Pacific and Caribbean Islands."

OIA Compact health sector grant funding	$20,492,187	$7,230,142
OIA MAP and TAP grant funding	$233,000	$2,036,000
HHS grant funding	$14,785,967	$9,901,601
Sum healthcare financing from USG	*$35,511,154*	*$19,167,743*

3.c.iv: Other nations

Lastly, the USG is not the only external financer involved in health efforts in FSM and RMI. Taiwan has contributed significantly to RMI's trust fund—with a commitment of $40 million by 2023—and provided half a million dollars to the RMI health department in FY 2016.[63] In FY 2018, RMI also received small amounts of additional financing from multilateral organizations, including the WHO, the Global Fund, and the UN Population Fund; these contributions together summed to less than $400,000.[64] In FY 2019, FSM is expected to receive health financing from other foreign governments and multilateral organizations UNFPA, WHO, and GF, but comparable documents were not obtained within the timeframe of this report.

3.d: Engagement challenges: communication and technology

Communication issues define many of the challenges in HHS-FSM-RMI relationships. Some of these issues are unchangeable. Time zones, for example, will always be a significant challenge: 5 pm on a Tuesday in DC is 7 am, 8 am, or 9 am on a Wednesday in FSM and RMI. HHS agencies have responded to this challenge by scheduling calls more optimal for FSM-RMI schedules. The distance between the domestic US and FSM-RMI also presents significant financial and logistical hurdles for site visits and frequent in-person communication (i.e., a roundtrip flight from California to the Marshall Islands is roughly $2,000). Hawaii is a centrally-located, crucial resource for triage and high-quality treatment for FSM-RMI citizens, as well as a base for USG presence in the region. However, the state is still comparatively isolated: Hawaii is at least a five-hour flight from both FSM/RMI and the continental US.

Language and cultural differences also affect relationships between stateside and Pacific populations. Three issues came up frequently in interviews. The first is different standards around timely email responsiveness between FSM-RMI and HHS. This issue, compounded by spotty internet services, often leaves grantors and island health staff out of touch. The second is language: FSM-RMI staff described challenges writing applications and reports in English, which is not their native language. The third affects advocacy: FSM-RMI and the US do not share a mutual culture of advocacy. As several HHS employees stated, Pacific Island staff do not advocate in a way that their USG counterparts understand as forceful. An FSM employee further stated that while FSM and RMI are getting better at stating what they need, they must improve at stating what they do not need.

3.e: Engagement challenges: leadership and health governance

Four leadership and health governance challenges are highlighted here: financial management within FSM-RMI governments, data management, staff turnover, and misperceptions around the nature of HHS financial support.

[63] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income"; "Medium Term Planning and Budgeting Framework FY2019-2023."
[64] "Medium Term Planning and Budgeting Framework FY2019-2023."

3.e.i: Financial management

Financial management challenges within FSM and RMI governments affect the ability of their respective ministries of health to efficiently process and spend external healthcare financing. While the nature of the administrative challenges differs between FSM and RMI, largely because of the significant autonomy of FSM states, these challenges stem from FSM and RMI's dependence on external (especially USG) financing, limited cash flow, and financial absorptive capacity. A detailed review of financial management compliance issues and their potential remedies is beyond the scope of this paper, but examples are raised here to highlight how both FSM-RMI and HHS financial leadership/governance can influence ongoing health system development efforts. These examples may not be representative of all financial management processes across FSM, RMI, and agencies within HHS.

Consider the process through which a state in FSM receives external non-Compact funding, as described by FSM staff in an interview: (1) the national government is notified of a grant awarded to a state health department, (2) the FSM Congress approves and appropriates the use of funds, (3) paperwork is processed by the national Department of Health, Department of Budget, and Department of Finance to set up an account to allot the grant funding, (3) the money is allotted to the state, (4) the state legislature approves and appropriates the use of state funds to upfront the grant amount, (5) the state-level Departments of Health, Budget, and Finance create an account to allot the grant funding, (6) money is made available to the grantee. Personality politics and paperwork errors often slow these national and state-level processes. As a result of these processes—some implemented to address financial management issues or otherwise ensure accountability and transparency—a grantee in FSM could wait up to four months for this process to occur before it gains access to HHS grant money. These processes can impede robust financial absorption and timely use of federal funds, which in turn contribute to fragmented implementation of a federally funded health program. These administrative structures may also underlie some misconceptions among HHS staff: headquarters staff may assume that once HHS approves an FSM grant recipient's application, the recipient is able to spend the monies awarded (as in states). In reality, there may be additional local processes that restrict local access to financing (i.e., the national or state legislature is not in session).

These processes illustrate how local administrative structures limit FSM-RMI health departments' financial absorptive capacity. FSM and RMI have begun to address these processing issues through partnerships with ASTHO, PIHOA, and World Bank.[65] These efforts are described in more detail later in this report. In sum, financial management is a challenge in these jurisdictions, where multiple streams of funding from multiple sources must be patched across a wide array of health needs.

3.e.iv: Data management

Another issue related to leadership and health governance is data collection and management: data empowers local policymakers to more effectively address the problems faced in their communities through targeted programs and data-based advocacy. FSM-RMI have largely lacked reliable health data to inform health governance decisions, and a reliance on external data structures may have undermined the development of local data capacity and data-based advocacy. Some large-scale data reports utilizing

[65] ""The RMI Ministry of Health and Human Services Tackle down Spending Issues with Support from the ASTHO, CDC and PIHOA"; "Project for Strengthening Public Financial Management (P161969)."

data from FSM and RMI have included caveats to question the reliability of data collected in these jurisdictions.[66] Recent efforts by PIHOA and others have helped to improve the quality and quantity of data for decision making: as of September 2018, nine of ten USAPI jurisdictions maintain and share weekly communicable disease data with health departments, local providers, and some regional surveillance systems (including the WHO's Pacific Syndromic Surveillance System and the joint SPC-WPRO Pacific Public Health Surveillance Network). However, FSM-RMI health data is still missing from or underrepresented in broad health databases like the WHO Global Health Observatory database and disease-focused initiatives like the WHO's annual Global Tuberculosis Reports. FSM-RMI health data is also missing from many HHS systems; it's unclear whether the data is simply not displayed in national databases (perhaps because FSM-RMI are sovereign) or the data is not sufficiently collected/analyzed. Excluded from these national databases, FSM-RMI health data is less visible to potential health data analysts (such as the Kaiser Family Foundation or the Trust For America's Health), advocacy groups, and policymakers; FSM-RMI health systems may suffer from this gap in visibility and data accessibility.

Much of the data available from FSM-RMI has been collected to support external grant requirements; this hodgepodge of grant data was seen as (1) difficult to collate across the broad array of units, sampling techniques, and populations targeted, (2) not always reflective of local staff's sense of community wellbeing, (3) dependent on consistent external funding to maintain relevance and usefulness, (4) potentially requiring more manpower or time to maintain than would a scenario in which grant data was drawn from a stable, centrally coordinated and maintained data warehouse. These perceptions underscore a crucial difference between FSM-RMI and states for HHS engagement and health system development: there is not a robust local data and health systems infrastructure in FSM-RMI. The lack of a data infrastructure (and, more broadly, data culture) impacts the scope, accuracy (in reporting), sustainability, and functionality of health programs in these jurisdictions, including those supported by HHS or other external financers.

For comparison, US states maintain state-level databases for many health indicators. These databases also include data for national initiatives like the Healthy People 2020 initiative. Though data collection and capacity is improving in FSM-RMI, the nations have not yet established similar local databases. They're also not included in national initiatives like Healthy People 2020, which further contributes to a lack of awareness of FSM-RMI health issues among domestic policymakers.

Lastly, better data empowers leaders to better protect the health of their populations. Unless data standards and norms improve, current data management challenges may magnify post-2023 if US direct assistance is replaced by an even broader array of grants from multilateral players like WB, SPC, ADB and others.

3.e.ii: Staffing

Staff-related problems also present challenges for both sides' engagement efforts. HHS employees often cited the frequent turnover of FSM-RMI health staff as a significant challenge to successful grant implementation and sustained progress. FSM-RMI health staff similarly lamented turnover in HHS staff,

[66] "Compacts of Free Association: Improvements Needed to Assess and Address Growing Migration"; "Compacts of Free Association: Micronesia and the Marshall Islands Continue to Face Challenges Measuring Progress and Ensuring Accountability"; "Compacts of Free Association: Issues Associated with Implementation in Palau, Micronesia, and the Marshall Islands."

as well as a lack of ministerial-level staff with whom health leaders could discuss HHS' strategic engagement and middle-managers could discuss grant problems. Additionally, personalities—rather than institutional practices—seem to drive successful HHS-FSM-RMI engagement. FSM-RMI voices credited improved communication with HHS in recent years to HHS' larger presence in the islands. HHS voices emphasized agencies' recent efforts to cater to USAPI challenges, including scheduling calls outside of standard working hours and increasing the frequency of reverse site visits or grants-management calls. Taken together, these comments emphasize: (1) the value of trust, consistency, and frequent communication between FSM-RMI-HHS counterparts, and (2) the impact these relationships have on program success and broader departmental engagement.

3.e.iii: Miscommunication

Misunderstanding or misperceptions about the nature of HHS financial support present another governance challenge in FSM-RMI. For example: when there was conflict between what health leaders *wanted* to finance and what available funds *allowed* them to finance—as defined by US Congressional appropriation language— local staff described challenging situations where they either confronted political leadership regarding the correct use of funds (potentially risking their job) or followed orders that could have jeopardized funding.

3.f: Engagement challenges: advocacy

The US Congress defines HHS authorities. FSM and RMI staff appear to often underappreciate the role that the US Congress —not HHS nor the operating and staff divisions within it—plays in determining much of the availability and flexibility of financing that reaches FSM and RMI. HHS grants in FSM and RMI will always have requirements mandated by the US Congress that HHS officials cannot change. While there is some room for adjustment by awarding agencies within HHS, much of HHS' financial engagement is tied to this Congressional authorization. This Congressional system ensures that states maintain high standards of transparency, accountability, and evidence-based health programming as they adapt health programs to their local context. In this Congressional system, strong advocacy—through individuals, membership organizations, and state representatives that pressure legislative bodies—is required to prompt change. In interviews, individuals raised concerns that health efforts benefitting FSM-RMI populations suffer from of a lack of effective legislative advocacy to the US Congress. FSM and RMI do not have "state" representatives to pressure Congress. However, they do have embassies in DC that have expressed an interest in being more heavily engaged in health advocacy, especially as related to 2023. Relatively few NGOs and membership organizations advocate on behalf of Micronesians and Marshallese living in the US or on island, especially when compared to how many groups advocate on behalf of other minority populations within the US. These NGOs will be considered in more detail later in this report. Advocacy to alter the scope of federal funding (toward agencies and programs that support FSM-RMI) and the legislative language that governs the use of funding (toward FSM-RMI populations and FSM-RMI issues) must be addressed to these state and national legislative bodies. Without this advocacy element, the relationship between the federal government and FSM-RMI will not significantly change.

Advocacy efforts are also hindered by a lack of data. Advocacy groups, governments, and communities can utilize population health data to craft powerful and effective narratives that justify calls for change. This data provides the foundation for evidence-based decision-making by policymakers

and financers in the US and elsewhere. Data that illustrates the scope of the problem can help advocacy groups to secure resources to address the problem; data that illustrates the impact of a policy or program can be used to fine-tune and justify ongoing support. In short, better data can facilitate better advocacy. Improvement in one will foster improvement in the other.

The challenges described in this section—financial management, staffing, bilateral misperceptions, and data/advocacy—underscore how deep-seated, government-wide organizational capacity and governance issues affect the functioning of the ministries of health and health system more broadly.

3.g: Engagement challenges: work force development and retention

Three workforce-related issues were commonly cited as hurdles to sustainable health systems and FSM-RMI health system functionality: limited educational pipelines, a shortage of trained staff, and brain drain.

At present, pipelines for health professions and educational pipelines on island are slim. Basic science training in grades K-12 is of lower quality in FSM and RMI than in the US, with fewer students reaching proficiency and fewer students seeking college-level coursework.[67] Direct comparisons are difficult due to the lack of standardized testing across FSM-RMI and US. Figure 4 illustrates some of the common educational pathways sought out by FSM and RMI students; ellipses are meant to denote additional pathways not shown in the diagram.[68] While students from FSM and RMI can also apply for college anywhere a US student can apply, admission to external educational programs is often hindered by subpar secondary education on island and language barriers (especially medical vocabulary in English, Mandarin, or Spanish). In interviews, individuals bemoaned brain drain, explaining that when exceptional students do go on to medical school (especially if they attend medical schools in the US), they often do not return to the region and instead pursue better salaries and opportunities in the US or elsewhere.

[67] Desilver, "U.S Students' Academic Achievement Still Lags That of Their Peers in Many Other Countries"; "Education for All 2015 National Review Report: Marshall Islands."
[68] Dever, "Human Resources for Health Update."

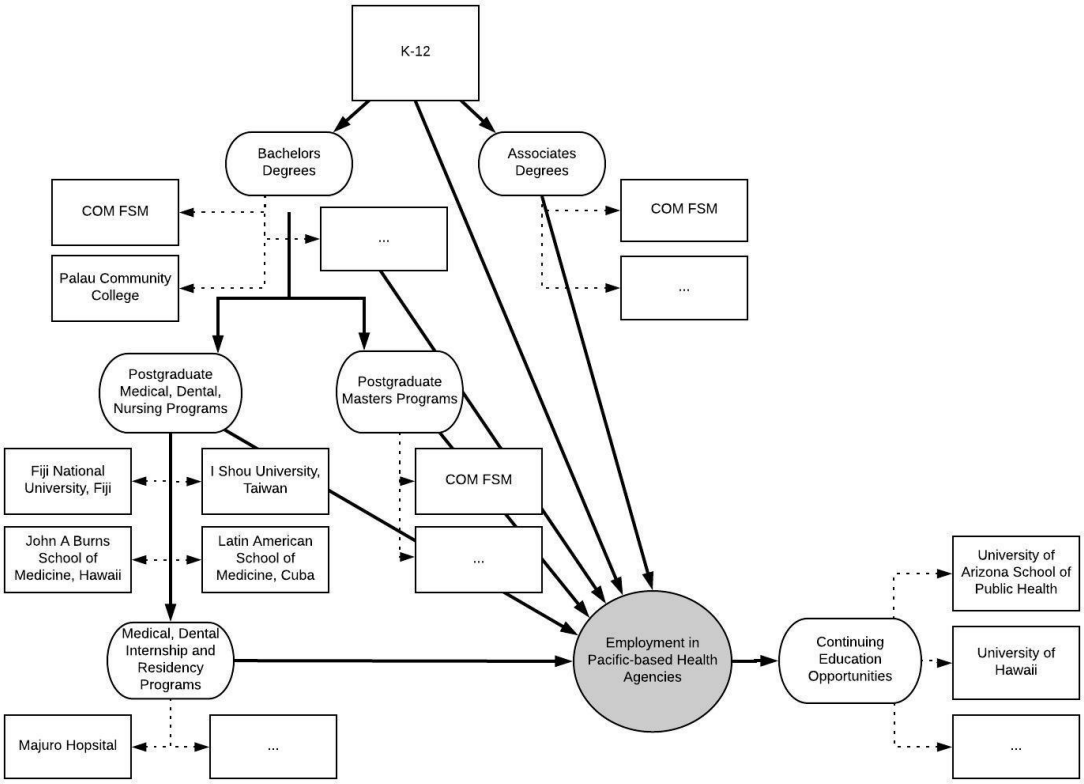


Figure 4: Educational Pipelines in FSM-RMI

The need for educational pipelines is growing as the health workforce ages: Table 2 on page 16 shows how few medical professionals serve these communities as compared to the US (this shortage would appear even worse if the metric were per 1000 miles rather than 1000 population), and many of these medical officers are nearing retirement. Many currently practicing in the region were trained through the Pacific Basin Medical Officers Training Program (PBMOTP). Though now defunct, the PBMOTP is still viewed as an extremely successful workforce development and retention program supported by HHS (HRSA). The program was established to address a chronic shortage of physicians. The 1998 IOM report *Pacific Partnerships for Health* called the program a "remarkable success", citing the 70 graduated students that all returned to practice in the region, the secondary benefits of improved health care for local communities, the significant number of women physicians trained and practicing, and their positive impact in the community as role models for local students.[69] The PBMOTP's authorizing legislation had a ten year sunset clause; when local funds did not support the program after 1986, it ended. It's also worth noting that when FSM and RMI were part of the TTPI, federal public health service officers were able to serve these populations; this may have set a standard of care difficult for FSM and RMI to maintain without integration into US healthcare networks.

However, education opportunities are expanding for health professionals in the FSM-RMI. In June, the first class of RMI's Nurse Practitioner Training Program graduated and received their post-

[69] Feasley and Lawrence, *Pacific Partnerships for Health: Charting a New Course*.

graduate diplomas as primary care nurse practitioners in Majuro, RMI. Community colleges in both RMI and FSM now offer health-related degree and certification programs. Recent partnerships with Taiwanese and Cuban medical or dental schools (as shown in Figure 4) also offer opportunities for the next generation of medical professionals in FSM and RMI. These improved opportunities were often attributed to the work of regional academic institutions and NGOs like PIHOA.

Lastly, it's important to keep in mind the challenges of small populations when considering workforce development and health system functionality. With fewer than 200,000 people to draw from, expectations of PhD-staffed lab departments and highly trained health professionals may be unrealistic for FSM and RMI. Healthcare management—how to coordinate healthcare financing to best support health system functioning—is also lacking, perhaps due to a relative lack in training opportunities or less ability to recruit experienced individuals to fill these positions. Small, rural communities in the US share many of these challenges. However, these rural communities may meet HHS assumptions around service delivery and health system function better than do FSM-RMI because of their comparatively lower costs of doing business (shipping samples, supporting hospital expenses), greater access to workforce, and easier access to regional medical care.

Telehealth could substantially improve access to quality healthcare in rural settings across the Pacific and continental US. "Telehealth" refers to a wide range of diagnosis, management, education, and clinical services conducted through telecommunications technologies. Telehealth's ability to increase access to quality care, improve training opportunities for physicians and healthcare professionals, and provide technical assistance will be immensely valuable for these disperse, isolated populations. Efforts to incorporate this into existing health infrastructures thus far have been spearheaded by the University of Hawaii in partnership with PIHOA and largely funded by HRSA: currently, the University of Hawaii offers behavioral health and endocrinology/diabetes training opportunities to clinicians through two pilot Project ECHO (Extension for Community Healthcare Outcomes) clinics.[70] The clinics have established relationships with Pohnpei Clinical Hospital in FSM and a number of hospitals in the territories but seek to expand into RMI and other states in FSM.

4: Lessons from alternative health support systems

The first half of this project sought to illustrate how FSM-RMI engage with HHS, how HHS engages with FSM and RMI, and the challenges that have defined this engagement. This second half explores best practices that might be taken from alternative global health support system models within the federal government or partner organizations. Each model is described briefly below; key points that may be applicable to FSM-RMI are highlighted. Table 5 displays the mission and target population of each federal model considered within this project, as well as their current involvement in FSM-RMI. The three alternative models were chosen because they illustrate USG support for health delivery and services in sovereign contexts: USAID is the traditional lead for international health/development assistance, PEPFAR leads the USG response to HIV/AIDS around the world (alongside the Global Fund), and IHS targets tribal units within the US, which are sovereign political entities. None of the five models in Table 5 perfectly fits health system development in FSM-RMI at present: direct involvement by DOI/OIA is ending in 2023, HHS structures are built for mature health systems, FSM-RMI are not eligible

[70] Dever et al., "Opportunities for Telehealth and Telemedicine Expansion Panel."

for IHS services, USAID does not engage in health in FSM-RMI, and PEPFAR's vertical health programming is directed at an epidemic less salient in FSM-RMI. That said, concepts from each could inform HHS engagement moving forward.

Table 5: Federal health-related models considered in this project[71]				
Agency or Initiative	**Current Mission**	**Focus**	**Target population**	**Health support in FSM-RMI**
DOI (COFA)	Advance the economic self-sufficiency of FAS populations	Development	Pacific	Funding through 2023
HHS	Enhance and protect the health and well-being of all Americans	Health	US	Yes
IHS	Promote the physical, mental, social, and spiritual health of American Indians and Alaska Natives	Health	AI/AN populations	No
USAID	Foster sustainable development	Development	Developing world	No
PEPFAR/GF	Achieve an AIDS-free generation	HIV/AIDS	Target countries	No
FSM and RMI: where does their "special relationship" leave them?				

4.a: USG health support for American Indian and Alaska Native populations

The Indian Health Service (IHS) is authorized and appropriated by the US Congress to do a wide variety of tasks to meet the federal government's trust responsibility to provide health services to American Indian/Alaska Native (AI/AN) persons. AI/AN individuals are identified as registered members of any of 573 federally recognized tribes, a total of roughly 2.3 million people.[72] Governmental health support for these populations includes but is not limited to construction and maintenance of facilities; provision and training of health staff through the U.S. Public Health Service; direct clinical services; and management of contracting/compacting tribes.

IHS authority is based in the Indian Health Care Improvement Act, which was permanently re-authorized in 2010 with the Affordable Care Act.[73] The concepts put forth in the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 are also important, as these first allowed tribes to assume any program, function, service, or activity of IHS through contract or compact.[74] Figure 5 shows the variety of financing mechanisms available to tribes through IHS.

[71] "Compacts of Free Association"; "About HHS"; "About IHS"; "Mission, Vision and Values"; "PEPFAR 3.0, Controlling the Epidemic: Delivering on the Promise of an AIDS-Free Generation."
[72] "Fact Sheets: IHS Profile."
[73] Indian Health Care Improvement Act, as enacted through the Patient Protection and Affordable Care Act.
[74] Indian Self-Determination and Education Assistance Act (ISDEAA).

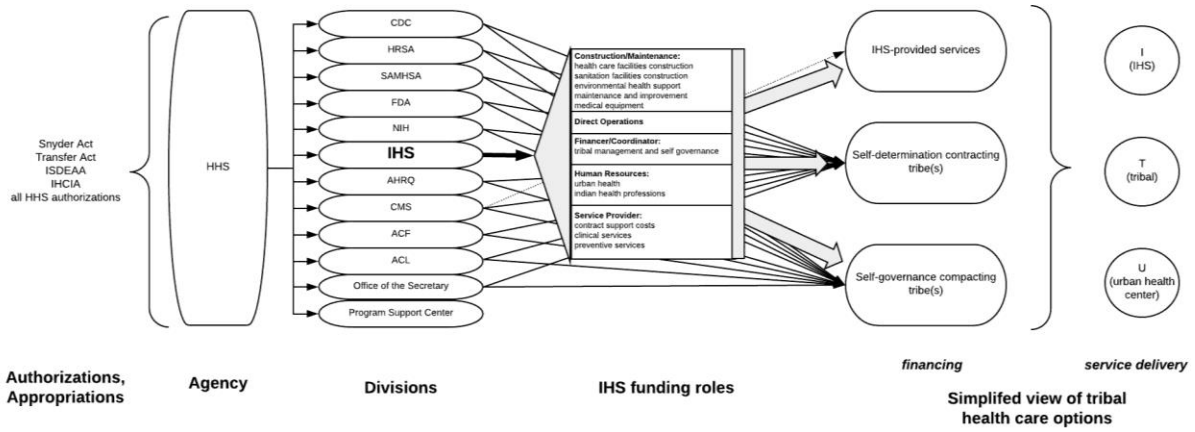


Figure 5: Overview of the IHS model

For the purposes of this project, mechanisms set in place by the ISDEAA are crucial comparators for FSM-RMI health engagement. Under Title I of the ISDEAA, a tribe may contract with IHS to provide services as outlined in the IHS line item budget for a given clinic or hospital (known as a "638 Contract" and self-determination contracting). Under Title V of the ISDEAA, a tribe may compact with IHS to assume full funding and control over programs, services, functions, or activities that IHS would otherwise provide; in other words, the tribe receives essentially a block grant for the total budget amount IHS would have used to take care of the population (known as a "638 Compact" and self-governance compacting).[75] Tribes must have completed a planning phase, submit official communication from the tribal governing body to request participation in the program, and have demonstrated three years of financial stability and financial management capability before they are eligible to enter into a 638 Compact.[76]

As of July 2016, 60% of federally recognized tribes were receiving funds appropriated through a 638 program.[77] In Alaska—similar to FSM-RMI in its relative isolation, poverty, and at one point poor population health indicators—99% of tribes operate through a 638 program. The ability of Alaska Native tribes to build a robust and successful health system through IHS compacting mechanisms was credited to political savvy developed through Alaska Natives' historical involvement in the for-profit organizations created in place of reservations, as well as the transfer of federal staff to tribally-operated organizations when 638 agreements were adopted.[78] The proportion of tribes nationwide receiving funds through a 638 program has been steadily increasing since the model's inception; its growing popularity speaks to the effectiveness of this framework.

Another advantage of 638 programs over traditional IHS provided programs is a larger pool of potential federal health financing. When IHS administers and provides health services (the original framework), the regional offices of IHS—as branches of a federal agency—cannot apply for additional financing from CDC, HRSA, or other agencies to further support AI/AN-focused health efforts. When tribes enter into a 638 program and take control of some or all of their health budget, tribes can apply to the federal grants open to states and state implementing partners. These grants, as well as any

[75] Warne and Frizzell, "American Indian Health Policy: Historical Trends and Contemporary Issues."
[76] "Eligibility and Funding; Eligibility for the IHS Tribal Self-Governance Program."
[77] "Fact Sheets: Tribal Self-Governance."
[78] Mandregan, interview.

supplemental third-party financing, do not affect the dollar amounts negotiated in 638 agreements. Additionally, tribes that manage otherwise-IHS-funded programs receive contract support costs and technical assistance to help them effectively manage these programs. In these ways, 638 programs increase tribes' access to federal health financing.

That said, while the volume of funding available to a given AI/AN community varies alongside eligibility and competition for other HHS grants, IHS per capita expenditures for health services average just 40% of the national healthcare spending per capita, or roughly $3,850 relative to the national average of roughly $9,500.[79] For comparison, this per capita rate is still significantly higher than current HHS per capita expenditures in FSM-RMI: based on a variety of data sources, current HHS per capita expenditures in the FSM-RMI appear closer to $200.[80]

The IHS model depends on Medicaid/Medicare financing for direct services. In Alaska, for example, Alaska Natives make up 20% of the state population but 40% of the population eligible for Medicaid.[81] FSM-RMI residents are not eligible for federal Medicaid funds.[82] This difference may stymie the degree to which best practices for AI/AN populations can be applied in an FSM-RMI context.

Lastly, it's important to understand how advocacy and high-level legal action has shaped the current array of services available to AI/AN populations. The federal trust responsibility and "moral obligation" language derives from Chief Justice John Marshall's 1831 Supreme Court decision in *Cherokee Nation v Georgia*, and the ongoing evolution of the ISDEAA has been a product of lobbying from a number of AI/AN groups, including the National Indian Health Board (NIHB).[83] NIHB is a non-profit membership organization that represents tribal governments through advocacy, legislative and regulatory tracking, policy formation and analysis, program development and research, and project management, among other activities.[84] Tribal organizations like NIHB have played an important role in raising the profile of AI/AN health and prompting legislative change to benefit these populations.[85] These advocacy voices on Capitol Hill aggressively protect and pursue the best interests of AI/AN populations in the federal sphere. In comparison, FSM-RMI—while supported by some similar membership organizations—have not realized this legislative advocacy.

4.a.i: Takeaways

From an FSM-RMI perspective, the self-governance or self-contracting model may seem a panacea for island concerns about piece-meal financing and local ownership, among other things. These models are not panaceas. First and foremost, because HHS does not have an agency dedicated to advancing the physical, mental, social, and spiritual health of FAS populations, there is no equivalent infrastructure that would support the "line item" contracting or "block grant" compacting within HHS for FSM-RMI populations. Bringing together the current collection of HHS grants into one compact-style block grant that could be turned over to local administration would be difficult if not impossible in light of different authorizing legislations, sources of appropriations, lack of a coordinating body within HHS, and diverse array of implementers, partners, and special relationships involved. The current landscape

[79] "Fact Sheets: IHS Profile."
[80] Banerji and Ottley, "FY2016 Report on Federal Financial Assistance to the US Pacific and Caribbean Islands."
[81] Mandregan, interview.
[82] Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
[83] Warne and Frizzell, "American Indian Health Policy: Historical Trends and Contemporary Issues."
[84] "About NIHB."
[85] Shelton, "Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States."

already supports mechanisms similar to 638 contracting: HHS grants are bilateral mechanisms to support public health activities, and Compact health sector grants are bilateral mechanisms that support service delivery (through hospital operations support). However, recipients' authority to redesign or reallocate the program funds, repercussions for poor or untimely implementation, the degree of oversight, and local capacity/manpower may vary between FSM-RMI and tribal contracting mechanisms; these are unlikely to change. Additionally, AI/AN populations have different development prospects than do FSM and RMI. These include but are not limited to: different sources of local revenue; different degrees/mechanisms of USG support for economic development; and a significant network of health- and development-focused partners and advocacy groups.

Generally speaking, direct translation of AI/AN mechanisms to the Pacific is unlikely given the difference in magnitude of AI/AN populations and FSM-RMI populations, islanders' ineligibility for Medicaid, and the nature of the hard-won legal and legislative victories by AI/AN advocates over the last forty years. However, conceptually these mechanisms remain a source of inspiration for intergovernmental health system strengthening efforts post-2023.

The last takeaway from an analysis of USG support for AI/AN populations is the importance of domestic advocacy. As has been detailed above, NIHB is a powerful voice for AI/AN populations and advocacy by tribes, particularly for legislative advocacy in DC. Other groups—including the National Congress for American Indians and local tribal organizations—have been powerful voices in state level advocacy targeting Congressional representatives. While FSM-RMI residents living in the continental US have benefited from legislative victories in the states in which they reside, FSM-RMI populations in the US and on island would benefit from stronger legislative advocacy at both the state and national level.

Box 1: An IHS model in the Pacific

Components of the IHS model, including more local control to redesign programs and redistribute funds, seem to solve many of the problems identified in HHS engagement in FSM-RMI. However, significant translational hurdles impede IHS-FSM-RMI comparisons.

Pacific Islanders are not likely to be brought into the IHS framework: it's difficult to imagine how a "Native Micronesian" tribal designation could be limited to some of the insular areas while excluding others, and how it would gain political traction in any form.

Components of the IHS would not function in isolation from the broader IHS model: compacting and contracting are nestled among a web of uniquely holistic authorizing legislation for AI/AN populations and FAS populations' ineligibility for Medicaid/Medicare eligibility would undermine the feasibility of IHS-style services in these populations.

Histories don't match: the ability of Alaska Native tribes (similar to FSM-RMI in their relative isolation, poverty, and poor health indicators) to build a robust and successful health system through IHS compacting mechanisms may stem from historical and legal trends not shared in the Pacific context.

On the whole, the IHS model remains attractive because it represents a successful example of how HHS has partnered with sovereign entities within a domestic framework, but lessons taken from the model would require creativity and strong legislative advocacy to apply in a Pacific context.

4.b: Foreign Assistance Models

4.b.i: United States Agency for International Development (USAID)

USAID leads the USG's international development and disaster assistance efforts. For the purposes of this report, it's sufficient to understand headquarters staff as organized around either a function (i.e., "Bureau for Global Health") or a region (i.e., "Bureau for Asia"); these technical and geographic bureaus overlap to oversee and administer a variety of programs that are implemented through regional and country-level USAID programs. Within each target country, a Mission office traditionally based in the embassy operates this multisectoral portfolio of USAID development assistance activities. The goal of USAID is to support development; health is one aspect of this development strategy.

USAID is generally structured to develop, fund, coordinate, and evaluate programs in developing countries. A country or regional development cooperation strategy (created in coordination with the host government) guides the USAID projects and activities offered within country, and these activities are implemented by third parties or through the host government with oversight by USAID staff. Third parties operate through contracts, grants, or direct agreements with USAID and are often based outside of the target country but locally staffed.

The USAID mission that covers the Pacific Islands, including FSM and RMI, is based in Fiji. Through this mission, a variety of community-level USAID programs implemented by organizations like Catholic Relief Services and the National Red Cross/Crescent help communities to prepare for, adapt to, and respond to climate change and environmental threats.[86] USAID operates no health programs in the FSM and RMI, though OFDA is identified within the Compacts of Free Association as the lead agency for disaster mitigation, relief, and reconstruction in the countries.[87]

For the purposes of this report, two related characteristics of the USAID model are crucial for comparison with HHS. The first is USAID's emphasis on health for development: health is not the primary focus of USAID's work in country but rather a critical component of development. Efforts to reduce health burdens and improve a health system's human, physical, and technological capacity fit within USAID's broader development schema. This is different than the HHS model, which focuses on reducing health burdens (without direction from development goals) and expanding capacity within mature state health systems.

The second characteristic is USAID's ability to leverage federal funding toward broad health system strengthening efforts (not just disease-specific objectives). The agency receives congressional appropriations for both horizontal and vertical programming, including money for mission-based technical assistance, development, and in-country partner development. To illustrate the benefits of this horizontal financing, consider USAID's Office for Health System Strengthening. This office was created in 2011 to target deep-seated organizational capacity and sustainability issues affecting health programs in mission countries. Its broad mission addresses challenges that lay outside of the health realm but can stymie health efforts, such as financial management and country ownership.[88] HHS' international authorities and appropriations are not so broad.

[86] "Pacific Islands; Our Work."
[87] Compact of Free Association Amendments Act of 2003.
[88] Saxena and Frere, interview.

Figure 6 shows the flow of funding through this traditional foreign health assistance program. Though not represented in the figure, USAID implementing partners also include host governments and local health departments.

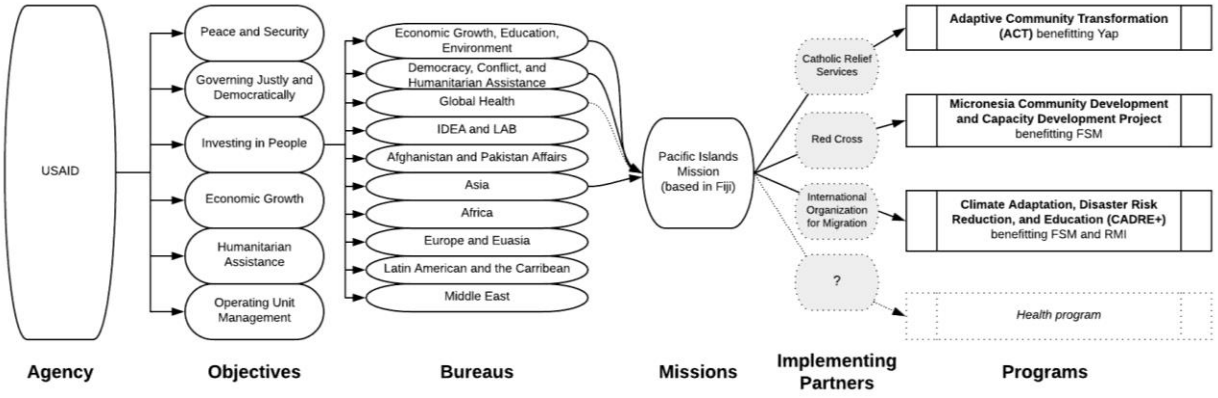


Figure 6: Overview of the USAID model, Pacific region

4.b.i.1: Takeaways

Key takeaways from USAID are the importance an underlying focus on development. At its core, HHS's role is to support state efforts to reduce health burdens and increase capacity. In contrast, USAID has a "health for development" approach that seeks to support more formative health system building.

USAID is active in the region, but not currently engaged in health system strengthening efforts in FSM and RMI. There may be a base for USAID health engagement, but significant start up hurdles remain.

4.b.ii: President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR is unique for its whole of US government approach to reduce the burden of HIV/AIDS worldwide. The program seeks to leverage the comparative advantages of many different USG agencies to advance USG efforts to reduce and control HIV/AIDS. The State Department's Office of the Global Affairs Coordinator distributes funds to missions within target countries. These missions pass funds to USAID, DoD, HHS (including CDC, HRSA, SAMHSA, and NIH), Peace Corps, Labor, and Commerce to utilize their unique capacities and authorities in support of the goals and plans set forth in guiding documents called Country Operational Plans (COPs), which are created in conjunction with the host government and local stakeholders. Figure 7 illustrates the PEPFAR model as relevant to a possible Pacific context. PEPFAR was most recently reauthorized in 2013 through the *PEPFAR Stewardship and Oversight Act*.[89] Total PEPFAR funding was $6.56 billion in FY 2017, representing 62% of US global health funding.[90]

[89] "The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)."
[90] "The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)."

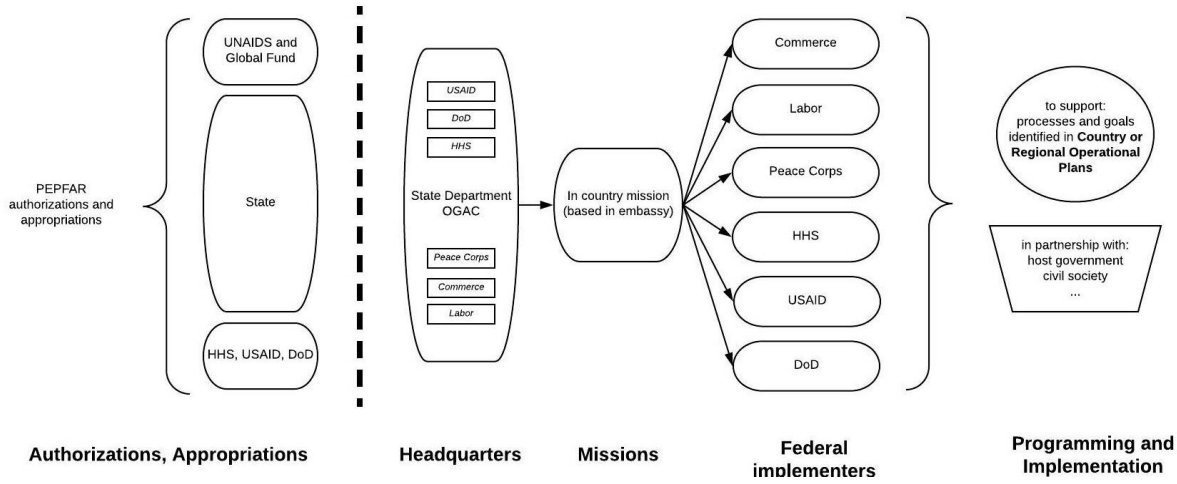


Figure 7: Overview of the PEPFAR model

FSM and RMI do not have an HIV epidemic. As such, PEPFAR will not engage in this region. However, elements of PEPFAR could inform HHS strategies in FSM and RMI. These are highlighted below.

PEPFAR has helped to build sustainable health system capacity in host countries by investing in critical infrastructure like laboratories, training health care workers, and establishing the types of organizational infrastructure that enable local health systems to better address HIV. This infrastructure also helps local health systems to address malaria, tuberculosis, maternal and child health, immunizations, and outbreaks.[91] PEPFAR has been able to do this thanks to its whole-of-government approach, a broad mandate from Congress, its base within the State department, a foreign operations framework with fairly flexible funding pathways, and direct access to ambassadors and high-level leaders in country. In the same vein, PEPFAR, like IHS, is one of fairly few federal programs with authority to build structures. The PEPFAR toolbox appears to be more extensive than that of most other federal health or development programs.

Other interesting elements of PEPFAR/GF are the Country Operating Plan (COP) and Sustainability Index Dashboard (SID) processes. These annual and biennial endeavors engage communities (including host government, bilateral donors, civil society, faith-based groups, and multilateral organizations) and evaluate data collected through PEPFAR engagement. They are used to define and then guide progress toward epidemic control and graduation from PEPFAR assistance in country.[92] They also support and perpetuate the data-based decision-making associated with PEPFAR engagement. For the purposes of this report, these documents are valuable because they support countries' understanding of their sustainability landscape, inform priority areas for PEPFAR investment, serve as diplomatic advocacy or negotiation tools in dialogue with partner government and multilateral counterparts, and communicate progress towards sustained epidemic control to external stakeholders.[93]

[91] Fauci and Eisinger, "PEPFAR-- 15 Years and Counting the Lives Saved."
[92] "The HIV/AIDS Sustainability Index and Dashboard 3.0; Measuring Sustainability for Planning, Implementation and Tracking."
[93] "The HIV/AIDS Sustainability Index and Dashboard 3.0; Measuring Sustainability for Planning, Implementation and Tracking."

These action plans are costed and funded through another important element of the PEPFAR/GF approach: Country Coordinating Mechanisms.

PEPFAR's impact is extended through its partnership with the Global Fund (GF), a global partnership of governments, the private sector, civil society, and people affected by AIDS, TB, and malaria to collect resources and invest strategically in programs to end AIDS, TB, and malaria as epidemics. Where PEPFAR and GF operate in tandem, they mutually benefit from the Global Fund's Country Coordinating Mechanism (CCM).[94] These mechanisms are staffed by individuals from public, private, and civil society groups. Their role is to coordinate a diverse stream of funding to achieve the goals stated in the PEPFAR and GF country plans, thus reducing duplication and increasing efficiency. They also initiate the dialogue around the plans' use and evolution. In all, they are an important voice for local ownership within the PEPFAR system. There is no CCM equivalent in FSM and RMI, and the medium-term budget plans are not of a similar style or quantitative-rigor as COPS and SIDs.

Lastly, much like with IHS, strong advocacy efforts have shaped PEPFAR's and USAID's work abroad and perception domestically. These efforts stem in part from PEPFAR's heavy emphasis on data: in a political environment that values "evidence-based" and efficient financial decisions, PEPFAR's rigorous health data and analyses attract and justify financial/political support. PEPFAR has exceptionally strong advocates on Capitol Hill; it enjoys bipartisan support and has been able to sustain high levels of funding for fifteen years. Partners in or around DC that benefit from PEPFAR and USAID funding are also champions for these programs, advocating for these models to the policymakers that ultimately determine the fate and financing levels of these programs.

4.b.ii.1: Takeaways

Key takeaways from PEPFAR are a holistic approach to USG health support, the country ownership process, the importance of good data, and the value of advocacy and legislative support.

A "whole of HHS" approach, defined by increased coordination and communication among operating/staff divisions, may facilitate more effective HHS engagement in FSM-RMI and better provide for the long-term sustainability of these health systems. More broadly, HHS engagement post-2023 will benefit from interagency coordination and elements of PEPFAR's "whole of government" approach: even as (or if) DOI ceases to engage in the region, alternative USG partners can contribute to improved health outcomes in FSM-RMI. These capacities should be considered in HHS discussions around 2023. These partners could include: the Department of Defense, which is currently engaged in health through the Pacific Fleet's annual humanitarian assistance and disaster relief missions; the Peace Corps, which has been active in the region but recently pulled out of all three FAS; and USAID, which currently supports a variety of environmental and disaster-relief programs in FSM and RMI.

Though limited funding may undermine this comparison, PEPFAR's ability to build broader health system capacity through efforts to combat a single disease may be amenable with HHS' prescriptive grant infrastructure. In FSM-RMI, TB or NCDs are more relevant targets for this sort of health system scaffolding than is HIV/AIDS.

As has been detailed above, PEPFAR has excelled at promoting local leadership of in-country operations. The COP, SID, and CCM processes bring together health leaders from the host-country, the broader donor community, and civil society to ensure there is buy in for PEPFAR activities and goals in the mission country. Stringent, top-down data requirements can be a heavy lift for teams in country and at headquarters, but this data allows health leaders to isolate and address problems quickly, thus

[94] The Global Fund, *Introduction to the Global Fund and CCMs*.

ensuring continued progress. Combined, these processes develop local ownership and define pathways to achieve clearly defined "success". These are key steps toward self-sufficiency and graduation from PEPFAR assistance. They're also important for effective advocacy.

Lastly, PEPFAR illustrates the financial value of popularity and effective advocacy. PEPFAR's good work has been broadcasted effectively through advocacy and by supportive policymakers; this has facilitated consistently high levels of annual funding. PEPFAR has the political goodwill to continue seemingly indefinitely.

Box 2: A foreign appropriations model in the Pacific

A foreign appropriations model seems well-suited for USG health efforts in the sovereign nations of FSM and RMI. Takeaways from USG healthcare support through domestic (DOI, HHS) and foreign (USAID, PEPFAR) healthcare support models are considered below.

Economic assistance through the COFA aims to promote **self-sufficiency and budgetary self-reliance**. These funds have supported significant island development since 1986, but have not supported budgetary self-reliance in the health sector.

USAID likely has the programmatic expertise and capacity to foster health system development in FSM-RMI, but cannot replace HHS' technical expertise and existing relationships. A developmental approach that addresses health as one component within a broader systems improvement framework may be needed for significant and sustainable healthcare improvement in these jurisdictions.

PEPFAR will not engage in FSM-RMI because these nations have very few cases of HIV/AIDS. That said, HHS' role within PEPFAR illustrates the value of local ownership and a holistic approach to USG health support. These concepts may translate to a Pacific context.

In sum, these foreign appropriations models illustrate the value of local ownership and a development approach in USG support for health systems abroad. HHS engagement may benefit from efforts to better integrate these principles into departmental support for FSM-RMI.

4.c: Non-federal players

HHS-FSM-RMI engagement does not occur in a vacuum. More effective engagement leverages the resources, networks, or capacities of other players in the region, including NGOs, multilateral organizations, private groups, and foreign governments.

4.c.i: NGOs and multilateral organizations

4.c.i.1: NGOs

NGOs can be powerful players within a health system. They're based in grass-roots processes and community involvement: as such, they may have greater access to vulnerable populations than would a government agency, and they are incredible resources for education and advocacy. They can also provide technical assistance to grant recipients within governmental organizations and coordinate services or programs for direct service providers.

This research considers several prominent Pacific-based NGOs, including the Pacific Island Health Officers' Association (PIHOA), We Are Oceania, the Pacific Islands Primary Care Association (PIPCA), Youth to Youth in Health, Women United Together Marshall Islands, Pohnpei Women Advisory Council, and Payu-Ta. There are also a number of continental-US-based NGOs whose work benefits

Micronesians and Marshallese citizens; these include the Association of Asian Pacific Community Health Organizations (AAPCHO), the Asian and Pacific Islander American Health Forum (APIAHF), and the Center for Pacific Islander Health Northwest, among others. Fairly few of the prominent NGOs engaged in health are based in FSM and RMI at present; one possible explanation for this is a disincentive to compete with government entities for staffing and funds.[95] These NGOs play a variety of roles in the health systems of FSM and RMI, as described briefly below.

ASTHO, AAPCHO, and APIAHF are examples of US-based NGOs that offer legislative advocacy, technical assistance, and coordination (of resources, initiatives, and priorities) to FSM-RMI populations. These organizations are not specifically geared toward FSM-RMI, but their efforts on behalf of states/territories/FAS or stateside Asian/Pacific Islander populations also benefit FSM-RMI populations. Advocacy efforts by organizations like these have helped to secure state-level legislative victories such as Medicaid coverage for FSM-RMI populations in Washington state. They also maintain national legislative advocacy efforts: the APIAHF has a campaign to restore federal Medicaid coverage for COFA migrants.[96] ASTHO and AAPCHO have campaigns to increase funding to CDC and HRSA, including programs within these agencies that benefit FSM-RMI populations on island or in the US.[97]

Youth to Youth in Health, Pohnpei Women Council, and We Are Oceania are examples of Pacific-based NGOs whose work benefits vulnerable populations in the Pacific. Youth to Youth empowers young people in RMI (with programs targeting teen pregnancy and sexual health) and We Are Oceania empowers the Micronesian community in Hawaii.[98] Other Pacific-based NGOs are resources for public health efforts; PIPCA supports primary care services and provides training/technical assistance to island populations, while Payu-Ta is an umbrella organization that coordinates and strengthens the NGO community in the Pacific.[99] Additionally, the Pacific Behavioral Health Collaborating Council (PBHCC) is a resource and advocacy platform for behavioral health; with representatives from all USAPI and support from SAMHSA and jurisdiction funds, the organization seeks to provide a forum to strengthen local behavioral health capacities and to advocate for Pacific behavioral health with a unified voice.

HHS' engagement with NGOs in the Pacific is primarily oriented toward the Pacific Island Health Officers Association (PIHOA). This organization is based in Hawaii and began as an advocacy group for the USAPI in the 1980s.[100] Today, it has grown to include technical assistance. Recent PIHOA initiatives have supported lab capacity, workforce development, and data collection/surveillance, as well as inter-island communication/coordination and advocacy within HHS and DOI. These projects are largely supported by HHS, with 78% of FY 2018 revenues (roughly $4.5 million) coming from the CDC alone.[101] Some respondents expressed concern that PIHOA has shifted away from advocacy as its reliance on technical assistance funding has grown. Others expressed concern that HHS support for PIHOA undermines the "market" dynamic present in federal-state relationships; by aligning closely with one NGO in the region, HHS misses an opportunity to promote local ownership and foster competition within the technical assistance, capacity building, and advocacy groups who work on health-issues relevant to FSM-RMI. That said, PIHOA was viewed by many as a catch all organization: interviewees

[95] Nededog, interview.
[96] "Medicaid Restoration for Compact of Free Association Communities."
[97] "2018 ASTHO Advocacy Priorities"; Quintana, "AAPCHO Urges Congress to Support Key Programs for AA&NHPI-Serving Health Center."
[98] "Youth to Youth in Health"; "Who We Are."
[99] "About"; "About Payu'ta."
[100] Chutaro, interview.
[101] Dunlap and Perez, "PIHOA Financial Status and Membership Dues Update."

from the FAS and HHS described beneficial PIHOA activities in conversations around technical assistance, lab capacity, workforce capacity, HHS advocacy, and inter-island communication/coordination. Developing partnerships with a broader array of NGOs may help to expand efforts undertaken by FSM-RMI and complement those undertaken by PIHOA thus bringing the breadth and depth of diverse NGO expertise to support current and future FSM-RMI strategies.

These NGOs are just a selection of the many NGOs benefitting the health of FSM-RMI populations in the US or on island. They're highlighted to show some of the ways NGOs can contribute to healthcare efforts: NGOs advocate, educate, coordinate, provide technical assistance, and improve access to vulnerable populations.

4.c.i.2: Multilateral organizations

In comparison with NGOs, multilateral groups appear more valuable for their networks and financing capabilities. In these small nations, the influence of broad multilateral organizations can be critical for advancing island priorities and overcoming financial barriers. Prominent multilateral organizations active in the Northern Pacific include but are not limited to the Western Pacific Regional Office of the World Health Organization (WPRO), the Pacific Community (SPC), the World Bank (WB), the Asian Development Bank (ADB), and the United Nation's Development Program (UNDP) in partnership with the Global Fund (GF). The roles of these organizations are briefly described below.

WPRO is engaged in FSM-RMI through activities that voice and advance regional priorities, finance health programs, and provide technical assistance, including policy/governance-oriented assistance. WPRO's current programs target health sector development, NCDs, communicable diseases, and preparedness.[102] WPRO is also important as a leadership forum: it hosts a biennial meeting for health ministers from Pacific Islands (including FSM and RMI) to discuss shared issues and priorities. ADB and WB are important for their potential development financing. Though not particularly engaged in health efforts in FSM-RMI at present (ADB did not have health projects in FSM-RMI when contacted and World Bank is working with RMI on one project focused on malnutrition and stunting), these multilateral organizations are poised to play a significant healthcare financing role post-2023: the next tranche of IDA allocations will quadruple the WB funds available to FSM and RMI from roughly $15 million to more than $60 million in 2018.[103]

A last multilateral organization, SPC, is relevant for its regional network and developmental approach to the health system strengthening. Traditionally more active in the South Pacific than the North Pacific, SPC is a key institution for regional development across all 22 Pacific Island countries and territories and is looking to become more engaged in the North Pacific. Like USAID, development undergirds SPC's health portfolio; in the North Pacific, the organization's developmental priorities are statistics, biosecurity (e.g., invasive species), food security, health, gender, human rights, and disaster mitigation. As part of this developmental framework, SPC maintains substantial regional and country-level health financing and technical support activities focused on diabetes, tobacco, infectious disease, and NCDs.[104] Looking ahead, multilateral engagement in the northern Pacific will be most effective if SPC and WHO efforts can come together seamlessly. The Pacific Public Health Surveillance Network—a

[102] "About WHO; What We Do"; "Health Topics."
[103] "ADB's Work in the Federated States of Micronesia"; Mikkelson-Lopez, "FW: Inquiry from ADB.Org"; "Kiribati, Nauru, Marshall Islands, Micronesia, Palau, Samoa, Tonga, Tuvalu, and Vanuatu Regional Partnership Framework; FY2017-2021."
[104] Studzinski, interview.

voluntary network of countries, areas, and organizations developing surveillance and sustainable response capacity throughout the region—exemplifies SPC-WPRO collaboration.[105]

Public-private partnerships are another resource for health systems; these partnerships are often a source of financing and technical expertise for health systems. One example of a successful public-private partnership in the USAPI is with Honolulu-based Diagnostic Lab Services. Through this collaboration, FSM and RMI benefit from state-of-the-art TB testing services, as well as co-funded technical monitoring and quality assurance visits to each of the USAPI laboratories.

4.c.ii: Other Pacific players

Though the scope of this report was narrowly focused on FSM and RMI, this section raises instances in which the broader geographic context appears important for understanding and effectively leveraging health efforts in FSM and RMI.

The USG finances the North Pacific (FSM, RMI, Palau, Guam, and CNMI) alongside other smaller contributions from Japan, Korea, Taiwan, and China. Australia and New Zealand play the dominant financing role in the South Pacific. Past efforts to synchronize foreign assistance in the South Pacific and US domestic assistance in the North Pacific have failed due to financing structure incompatibility.[106] The Australian (and Japanese) strategy of embedding Australian (/Japanese) nationals into the health departments it supports differs from current USG engagement in the region: there are virtually no HHS staff working in health systems in FSM-RMI. However, like state grant recipients, FSM and RMI grant awardees can consider redirecting financial assistance to direct assistance and hiring the services of federal employees. This mechanism for technical assistance has never been utilized in FSM-RMI. Conversations with Australian or New Zealand officials about the health system development strategies employed by their agencies, as well as increased promotion of direct assistance by FSM-RMI, may prove fruitful for HHS engagement moving forward.

The Philippines have been significantly represented among FSM-RMI health professional workforces in the past, and currently receive many migrants and travelers from FSM-RMI for health-related reasons.[107] However, the Philippines expat population appears to have shrunk in recent years (perhaps replaced by an influx of East Asian immigrants). Guam and CNMI also receive significant numbers of COFA migrants. Residents of the territories are eligible for Medicaid and must comply with Centers for Medicare and Medicaid Services (CMS) accreditation standards; these different financing mechanisms and regulations are integral components of territorial health systems. For these reasons, this report does not draw significant or detailed best practices from the Philippines, CNMI, or Guam.

As the third FAS, Palau seems ripe for comparison with FSM and RMI. However, Palau has a notably stronger economy and smaller population on a single island than either FSM or RMI; these characteristics are important for the relative strength of its health system. Palau was also perceived to be better than FSM and RMI at capturing external health financing and direct technical assistance, and the nation has developed its health system with significantly less USG oversight written into its Compact. Some regions—i.e., an FSM state without outlying atolls like Kosrae or cities in RMI with high population densities like Ebeye/Majuro— are more geographically similar to Palau and may benefit from closer collaboration with Palauan health officials. More broadly, Palau could be an important hub in Pacific

[105] "The Pacific Public Health Surveillance Network."

[107] Feasley and Lawrence, *Pacific Partnerships for Health: Charting a New Course*; "Medium Term Planning and Budgeting Framework FY2019-2023."

networks of healthcare as connectivity (telehealth) and healthcare centers in the region develop. This report does not attempt to raise further best practices from Palau.

4.c.iii: Takeaways

NGOs, multilateral groups, and public private partnerships are resources for FSM-RMI governments to expand their reach into vulnerable populations, engage in stronger advocacy, procure technical assistance, and accelerate development. Partnerships—with NGOs, multilateral organizations, businesses, academic institutions, other governments, and even "sister cities" in the mainland US—will be important for financing, supporting, and improving health systems in FSM-RMI through and after 2023.

5: Implications for HHS and FSM-RMI health policy and programs

Health policy and program development in FSM-RMI is a partnership between these sovereign nations, HHS, and DOI. Health system development is the responsibility of FSM and RMI health leaders, but HHS and DOI facilitate many health programs through technical expertise and financing. The value of this report stems from its use as a holistic review and strategic perspective on healthcare efforts in the region and as a resource in upcoming conversations among and between FSM-RMI and USG policymakers.

The first portion of this section briefly reviews health-related changes and continuities over the period of DOI/HHS engagement in FSM and RMI. The section then reviews themes and questions for HHS and FSM-RMI. The last raises future considerations for ongoing engagement.

5.a: Changes and continuities

Post-WW2, the US took over trusteeship for the Trust Territory of the Pacific Islands, comprised of what were then Japan's pre-war colonial territories and what are today FSM, RMI, Palau, Guam, American Samoa, and the Mariana Islands. After FSM and RMI's independence in the early 1980s, USG health engagement continued through the Compacts of Free Association. The Compacts codified significant economic and technical assistance to FSM and RMI, as well as opened the door to assistance from some domestic agencies, including HHS. Four decades of direct USG assistance from HHS and DOI, with more than $3.6 billion (in overall assistance) from DOI alone, have facilitated some health sector growth and success in FSM and RMI. Anecdotally, over the past forty years access to pharmaceuticals and basic supplies has improved and hospitals run more efficiently, and funding has allowed for the development and maintenance of limited public health services.[108] Education/career pipelines for medical professionals are still limited, but have grown over the last decade. Maternal mortality rates have also improved, from 188 per 100,000 in FSM in 1990 to 100 per 100,000 in 2015.[109] However, FSM-RMI health systems are still far from "self-sufficient" and many health indicators have not improved: TB rates remain high, obesity rates have gotten worse, and vaccination rates have not significantly

[108] "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income."
[109] "Global Health Observatory Data Repository: Maternal Deaths Data by Country."

improved, and jurisdictions are still heavily dependent on external financing. Data reliability issues hinder comparative perspectives on many health indicators.

Despite planned budget reductions outlined in the Compacts and goals of budgetary self-reliance by 2023, FSM and RMI continue to rely on USG assistance. Inflation adjustments and increased revenue from other sources have offset reduced sector grant funds such that in FY 2018, local revenues contributed just 5% of FSM's national health expenditures and 15% of RMI's national health expenditures.[110] In FY 2019, RMI plans for local revenue to support 40% of its national health budget. In FSM, national contributions are expected to remain at 5% of the national health budget. External financing is expected to remain a critical element of FSM-RMI government expenditures: for example, RMI external developmental assistance surpassed a record $200 million in 2018, equal to 100% of RMI's GDP.[111] External assistance awarded to FSM in FY 2018 is estimated at roughly $122 million, equal to 36% of FSM's GDP.[112]

The nature of HHS' regional efforts has also shifted over the last forty years. HHS maintained a more regional approach through the 1990s.[113] After this period, project officers were withdrawn from regional offices and chains of command became more centralized in DC. During this period, evolving departmental responsibilities brought territory-focused work more in line with IEA efforts while FAS-focused work fell in line with OGA's work abroad. Since the 1990s, the department has maintained the HHS Insular Health and Human Services Policy and Work Groups. These groups have worked to promote USG workforce development programs, improve USAPI administrative capacity, and address veteran healthcare coverage in the FSM-RMI.[114] Both are currently in a lull, though discussions on these topics continue through alternate means within the department. Lastly, the departmental presence in FSM-RMI has increased in the last decade, thanks in large part to the efforts of the regional staff within the HHS Region 9 Office of the Regional Director (including IEA, OASH, and others) to communicate with and establish relationships with health leaders throughout the USAPI. FSM-RMI voices credit improved FSM-RMI-HHS communications to this larger HHS presence.

HHS-FSM-RMI engagement efforts are and will continue to be shaped by priorities, personalities, and policies on island and those within the department.

Looking ahead, telehealth has potential to spring forward healthcare in the Pacific. Telehealth expansion will rely on improved connectivity in FSM-RMI; reliable access to these web-based platforms has become possible elsewhere in the Pacific with recent switches from satellite to fiber optic connectivity, as in Palau in December 2017.[115]

The current situation presents a fork in the road. The combination of low levels of local financing, limited health system development, and uncertainty around the financial transition from

[110] Dammar and Savage, interview; Wase, interview; "Compacts of Free Association: Actions Needed to Prepare for the Transition of Micronesia and the Marshall Islands to Trust Fund Income"; "Medium-Term Expenditure Planning, JEMCO Mid-Year Meeting."
[111] Dolan, "Embassy Majuro End of Week Report - August 10, 2018."
[112] "20th Congress Standing Committee Reports."
[113] Araki, interview.
[114] Novotny, "Healthy People-- Healthy Pacific; Health Security."
[115] Kesolei, "Palau Gets Ready for Fiber Optic Connectivity."

Compact financing to trust fund revenues raises questions for HHS-FSM-RMI engagement moving forward. Some of these questions are illustrated in Figures 8 and 9 below.

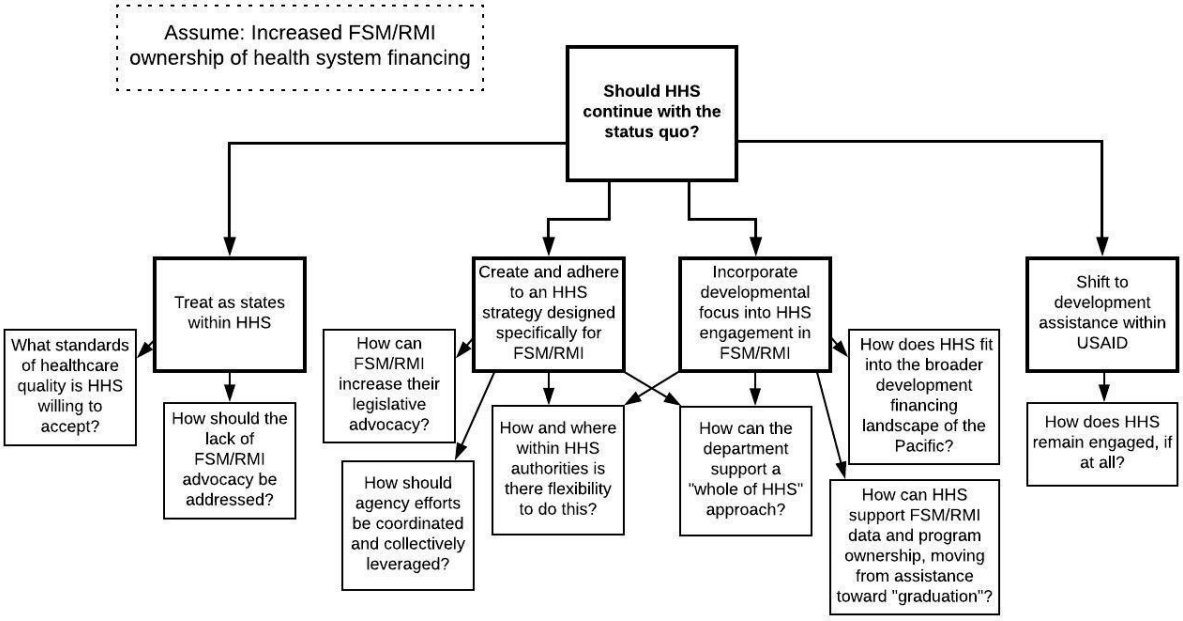


Figure 8: HHS decision making flow chart

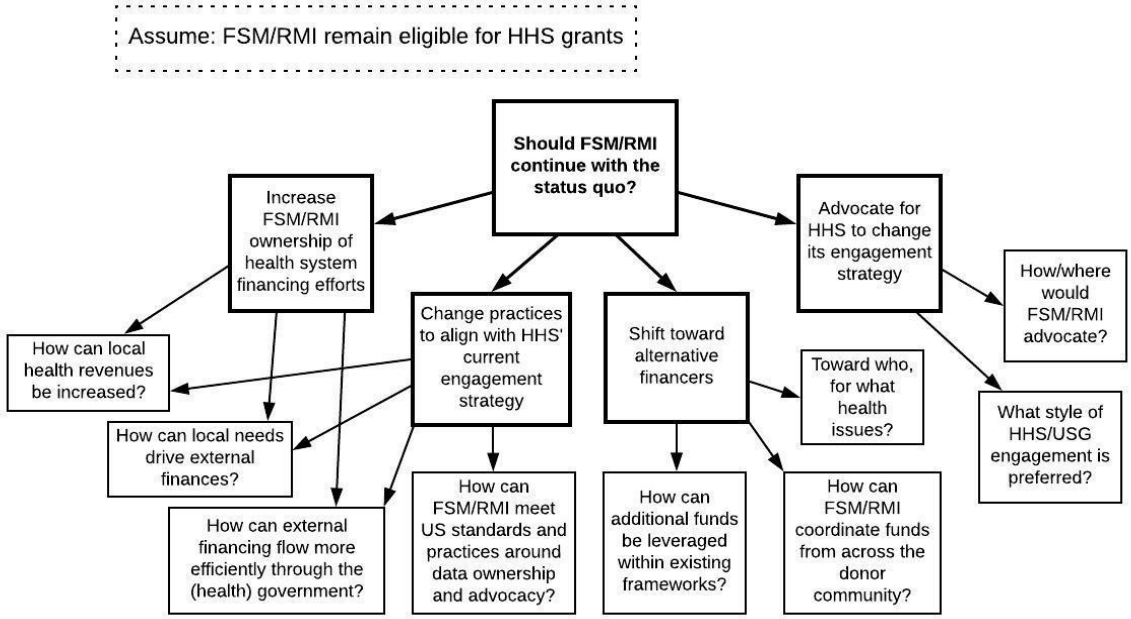


Figure 9: FSM-RMI decision making flow chart

5.b: Themes for ongoing engagement

Discordant operating environments and differing health priorities between FSM-RMI and the stateside population challenge the efficacy of the traditional HHS domestic model. Health departments in FSM-RMI and states balance local and external financing differently; the 2016 ASTHO Profile report suggests that on average states locally finance roughly 48% of their health systems, while FSM-RMI locally financed just 5-15% in FY 2018.[116] Comparable grants (a sum of HRSA, CDC, and other HHS) make up roughly 16% of state health revenues; these grants supply more than 25% of FSM-RMI national budgets.[117] Without significant local revenues, grant availability may influence the health priorities ultimately pursued by local health leaders. Figure 10 illustrates how these different contexts can affect how grants are used in states and FSM-RMI. By including FSM-RMI in domestic authorizations/appropriations structures, HHS assumes that these sovereign nations can implement health programs as states can. Is this a realistic expectation and the ideal engagement strategy? This report presents resources and context for FSM-RMI and HHS to consider their ideal relationship. If the current situation is not "ideal", (1) HHS must consider what a better strategy would look like and whether that strategy is feasible within the departments' authorizations, appropriations, staffing, and capabilities; and (2) FSM-RMI policymakers must consider how they can take ownership of and fix health systems reliant on external financing. These two concepts—FSM-RMI "leadership" and HHS "strategic engagement"— have policy implications for HHS and FSM-RMI.

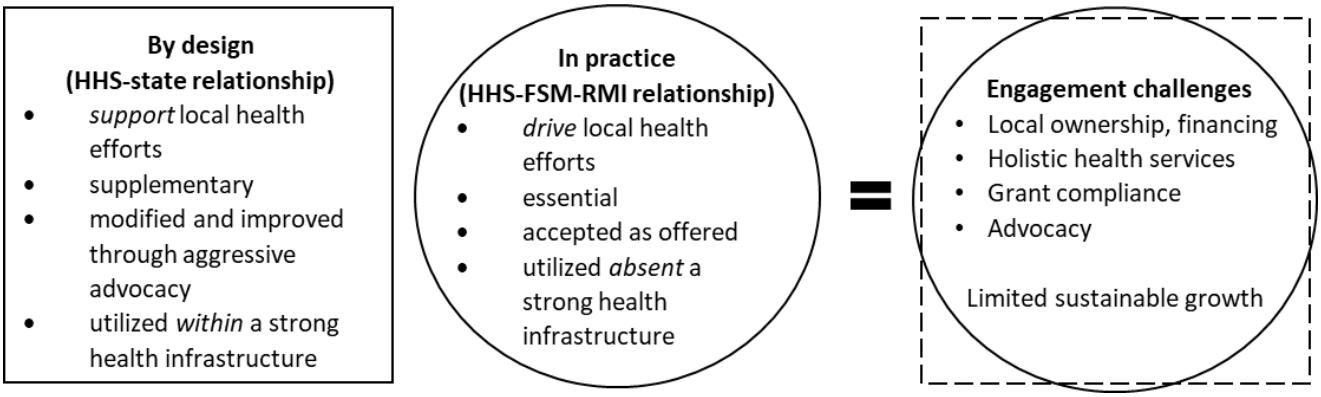


Figure 10: A square in a circle: fitting HHS support into FSM-RMI operating environments

5.c: HHS engagement with FSM-RMI

"Disorganization" was often raised as one of the biggest public health problems in the Pacific. Bureaucratic processes within FSM-RMI and within HHS offer opportunities for growth; a departmental strategy presents an opportunity to improve HHS processes. Understanding that HHS grants play a critical role in supporting health system strengthening efforts in FSM and RMI, and that these jurisdictions are in many ways distinct from the populations served by HHS within the US, departmental efforts and FSM-RMI populations stand to benefit from greater direction and strategy for ongoing HHS engagement in the Pacific.

[116] "ASTHO Profile of State and Territorial Public Health, Volume 4."
[117] "ASTHO Profile of State and Territorial Public Health, Volume 4."

5.c.i: Review: FSM-RMI do not perfectly match other populations supported by HHS

At present, the inclusion of FSM-RMI in HHS' domestic authorization/appropriation structures implies an expectation that these sovereign nations can operate like states. FSM and RMI's US-based health systems (created during the TTPI) may justify this assumption. However, these nations may be more like developing countries, rural populations, or AI/AN populations than states: they have limited health system capacities, developing-world disease burdens, small/isolated populations, and sovereignty. FSM and RMI cannot be perfectly categorized as a state, developing country, rural area, or tribe. This section briefly reviews how the relationship between HHS and FSM-RMI would need to change to more closely mimic a relationship between the USG and developing countries, states, tribes, and rural communities.

If they're best understood as developing countries, USAID may be best equipped to facilitate their health system development. USAID, more so than HHS, has the federal mandate to support health system strengthening within a developing world operating context (PEPFAR excluded). HHS does not share USAID's multisectoral portfolio or developmental approach. This concept is considered later in this paper.

If they're best understood as states, FSM and RMI must meet the norms upheld in traditional HHS-state interactions. To meet these norms would require FSM and RMI to, among other things, support significantly more of their health systems with local finances, to utilize state and national pathways for health advocacy (including legislative advocacy and direct communication between island leaders and state/federal representatives), and to map health system strategic goals to a wide variety of potential funders. They must also improve their compliance with grant requirements and regulations, as well as significantly improve their data collection and analysis capabilities.

If they're best understood as rural populations, HHS should leverage more of its rural-focused resources in FSM-RMI and consider how to replace or substitute for the types of support a state would supply to rural communities within its borders/region. HRSA's Office of Rural Health is not currently active in FSM-RMI but is designed to address health issues important to rural areas, including access to quality health care and health professionals, the viability of rural hospitals, and the effect of the Department's proposed rules and regulations on access to and financing of health care in rural areas.[118] Though definitions of "rural" vary, definitions used by both the Census Bureau and Office of Management and Budget would likely classify even larger cities within FSM and RMI as "rural" because of their small population sizes.

If they're best understood as AI/AN populations, FSM and RMI may be better served through the IHS system or through a similar framework catered to the opportunities and challenges of HHS support for sovereign entities. A catered framework of this sort could also draw on HHS' support for foreign health systems through PEPFAR. Without legal changes, FSM-RMI are not eligible for the IHS system and IHS mechanisms would not translate well to FSM-RMI populations. If best understood as rural or AI/AN, FSM and RMI would benefit from substantially stronger advocacy efforts.

Because FSM-RMI and HHS interactions do not perfectly adhere to a standard state, developing country, rural, or tribal relationship, HHS engagement in FSM-RMI may warrant a coordinated departmental strategy that is catered to their sovereignty, low health system capacity, and isolation. In

[118] "About FORHP."

this case, HHS must consider how it can work within its authorities and appropriations to best meet the needs of this population.

5.c.ii: Strategies

At minimum, a departmental strategy provides a framework through which to coordinate and share existing resources within HHS, to FSM and RMI, and across the government. These activities can likely be achieved through administrative will. Such a strategy also serves to institutionalize HHS-FSM-RMI relations—making them less dependent on individual relationships among FSM-RMI-HHS staff—and facilitate pathways for advocacy and health diplomacy moving forward.

Any efforts that would change the nature of HHS engagement in FSM-RMI will require legislative action to expand authorizations or create new flows of information/funds. It is unclear how much and to what degree HHS can change its practices (in grants, in operating procedures, in structures, in communication, etc.) to accommodate the unique circumstances of FSM and RMI without a change in legislation. However, a mandate that clearly defines HHS support for FSM-RMI may facilitate sustainable health system growth better than the current personality-driven, legacy-based approach. This mandate must be strong enough to ensure the sustainability of this programmatic priority.

Three engagement strategies are presented here. The first can likely be achieved through administrative will. The second, partnership with USAID, would require significant legislative change. The third, partnership with IHS, would also require significant legislative change.

Strategy #1: a focus on communication and coordination

The department is heavily engaged in FSM-RMI. Figure 11 illustrates some of the ways in which HHS is involved in the region. These include grants resources, personnel, policy workgroups, and health diplomacy. While departmental strategies could take many forms, one feasible option is a framework through which to coordinate and advertise existing HHS/USG activities in the region, with a goal of more effective implementation and local utilization. This variant of a departmental strategy would require significant administrative effort but is likely within the authority of the department and staff/operating divisions within it. To be successful, this framework will require high level endorsement and the allocation of appropriate resources to carry out the initiatives, as well as strong accountability requirements among HHS operation divisions and/or sister agencies.

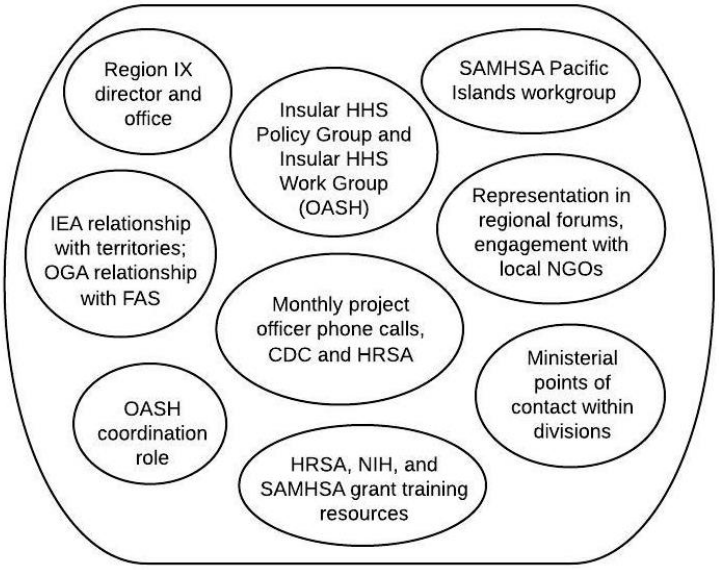


Figure 11: Sample of HHS engagement in FSM-RMI

This coordination- and communication-focused strategy would rely on the existing coordination/communication roles of various divisions within HHS. Staff divisions, or the agencies that make up the Office of the Secretary (such as the Office of the Assistant Secretary for Health, the Office of Global Affairs, and the Office for Intergovernmental and External Affairs), coordinate across the department. In contrast, HHS operating divisions (such as CDC, SAMHSA, and HRSA) administer health and human services. Each division brings a unique and critical mix of capacities to health system strengthening efforts in FSM-RMI; effective synchronization and management of these different divisions standards, expectations, and best practices will ensure more effective engagement.

The strategy is inherently valuable to HHS as a potential blueprint for HHS engagement in low-resource, isolated, developing-world contexts. It is valuable in this situation for six reasons: as a framework to *simplify communication* between HHS and FSM-RMI; to *foster local ownership* among FSM-RMI; to *establish common markers/goals* (in both operations and health priorities) around which agencies can coalesce; to *institutionalize best practices*; to *break down siloes* inherent in HHS appropriations; to *improve interagency communications* in the lead up to 2023; and as a tool for *advocacy*.

First, this strategy can *simplify communication* between HHS and FSM-RMI. By establishing common metrics and goals, coordinating across staff/operating divisions, and maintaining strong accountability standards, a strategy allows the department to more effectively leverage its resources. This, in turn, allows healthcare financing opportunities to be presented within a consistent departmental context/approach rather than as a hodgepodge of available grant opportunities spread across different agencies with different strategies and approaches to FSM-RMI engagement. A less complex, more consistent package of HHS support may promote *local ownership* because it can be more easily integrated alongside domestic resources into costed strategic action plans (as described later in this section).

The establishment of common metrics or goals is not meant to negate the unique strengths of agencies within HHS. HHS engagement is best when operating/staff divisions leverage complementary capacities and priorities. However, many officials within HHS operating divisions appeared to know very

little about the activities of their counterparts in other staff/operating divisions. As shown by structures like PEPFAR's Country Coordinating Mechanisms, increasing communication/coordination to *illuminate shared metrics, goals, and operations* can make HHS engagement in the region more efficient. Increased coordination and communication may also *offset siloes* inherent in HHS' financing structure. Additionally, agencies maintain different operational approaches for engagement with FSM/RMI, with different "workarounds" and norms. *Institutionalizing these best practices*— including logistical solutions that agencies have developed to address challenges like incompatible time zones, cultural barriers, and FSM-RMI's developing world context— can make HHS engagement in these nations more efficient.[119]

The process of illuminating and working toward shared goals could inform departmental discussions about issues like: if and how HHS remains engaged in the region post-2023; how PIHOA and other NGOs are best supported within the domestic appropriations framework and/or HHS' priorities for the region; how to promote local ownership; and how to engage ministerial level staff within HHS with FSM-RMI leadership and ensure they can speak to holistic departmental support. These discussions, in turn, make an HHS strategy valuable for *interagency efforts* around 2023: an HHS departmental framework for continued health investments in the region would be easily integrated into high-level strategic discussions on USG investments in the region. This would be particularly valuable in light of shifting DOI and USG engagement in the region over the next decade. As a resource for interagency efforts, an HHS communications framework could also expand the reach of other agencies' health-related efforts. For example, DOI/OIA maintains a public relations campaign to communicate to FSM-RMI leaders the ways in which their concerns are voiced and addressed within the USG; an HHS communication- and coordination-based strategy could forward these messages through its communication network. Additionally, the Insular HHS Policy Group and Insular HHS Work Group—both comprised of individuals from both operating and staff divisions—are further resources/platforms for interagency discussion in the lead up to 2023.

Lastly, this framework also becomes a tool for *Congressional advocacy*, should stakeholders seek legislative change to structurally adapt to better serve FSM-RMI populations. Advocacy efforts—from champions within the department or external voices— will be crucial to define the narrative around ongoing USG support for FSM-RMI. They will also be critical to improve the engagement between these three nations, both within health and more broadly. For example, partners may seek to shift HHS data management practices to ensure FSM-RMI data is more frequently included in departmental national health reports or accessible in departmental national databases, which would in turn increase the visibility and awareness of FSM-RMI health challenges among USG policymakers.

More generally, a strategy holds federal stakeholders, and perhaps FSM-RMI health leaders, accountable. Clarity and transparency around HHS engagement in the region may spur greater progress toward locally sustainable health systems and improved healthcare outcomes.

Strategy #2: Consider a shift toward development

The domestic grants system in HHS is not a traditional development framework; it typically supports narrowly health system strengthening efforts in (developed) states rather than health system

[119] Examples of these include: flexible hours for project officers to schedule FSM-RMI communication outside of the standard work day; reverse technical assistance and proportionally more funding toward face to face interactions; and education for HHS project officers to make space for FSM-RMI cultural and language differences.

strengthening in the developing world. Support for the FAS and HHS' engagement with PEPFAR are the exceptions to this rule.

HHS, rather than USAID, runs health assistance efforts in FSM-RMI because USG assistance began in the domestic sphere: the Trust Territories were administered by the navy and supported through domestic appropriations. DOI/OIA's administration of the Compacts draws on domestic appropriations. The supplementary education grant that FSM-RMI receive is supported by the Department of Education (domestic appropriations). Despite FSM-RMI's sovereign status, most USG support for these nations comes from domestic appropriations.

As the USG lead for international development and health strengthening, USAID mechanisms may more efficiently foster health system development and facilitate economic self-sufficiency and budgetary self-reliance in the health sector than do HHS mechanisms. USAID's advantage lies in its multisectoral, development-focused portfolio. USAID supports horizontal (government-wide) and vertical (disease-specific) programs address deep-seated organizational capacity issues and foster health system capacity. HHS support is traditionally skewed toward vertical programs. Conceptually, USAID may be as equipped, or better-equipped, than HHS to meet the health needs of FSM-RMI. However, current health financing for FSM-RMI may not be sustainable within a USAID appropriations and organizational framework. Through grants, HHS assistance to FSM-RMI is roughly $200 per capita; this per capita health assistance is more than USAID expends in other countries.[120] Were USG support to be transferred from HHS to USAID, USAID's global responsibilities and multisectoral portfolio may undercut its ability to sustain the high levels of health-focused funding that these small populations currently enjoy through HHS support. Current per capita healthcare financing levels appear more secure in an HHS model rather than a USAID model. The strengths of traditional USAID health engagement versus current HHS health engagement in FSM-RMI are considered in Table 6 below.

Table 6: Benefits and Disadvantages of HHS and USAID approaches in FSM-RMI	
Benefits of HHS	**Benefits of USAID**
Health-centric technical expertise	Development expertise
Established relationships	Broader funding authorities to operate internationally
Overlap of health burdens, rural-related issues	Multisectoral approach
Disadvantages of HHS	**Disadvantages of USAID**
Disease-focused financing structure	Health funding for FSM, RMI might lose out to other development priorities
No developmental mission; built to support mature state health systems	Health funding for FSM, RMI might lose out to larger countries (even within Pacific)

A partnership between HHS and USAID—for example, one in which HHS funds were implemented with a more developmental approach— could bring the best of both models to FSM-RMI: a developmental perspective with HHS' existing financing and health-centric technical expertise. This partnership would also promote ongoing USG support for multisectoral development efforts if or when

[120] Saxena and Frere, interview.

economic assistance through the Compacts end. Some of the legislative changes needed to support this partnership and joint engagement strategy would be (1) modified grant requirements that reflect the developing world operating context in which HHS grants are used in FSM-RMI; and (2) a partnership mechanism that would allow joint USAID-HHS programming in these jurisdictions and/or financing through USAID foreign assistance appropriations rather than HHS domestic appropriations. A review of HHS actions authorized within the PEPFAR foreign appropriations framework may inform the development of a USAID-HHS partnership. Figure 12 illustrates this potential partnership, drawing on Table 6 and Figure 10.

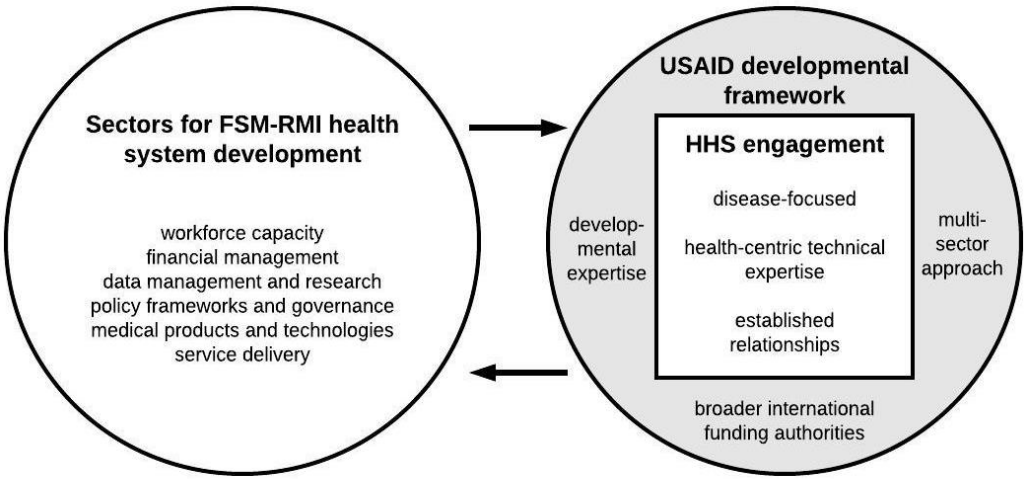


Figure 12: Matching FSM-RMI health system development needs through an HHS-USAID partnership

Strategy #3: Consider a shift toward USG support for AI/AN populations

The most effective mechanism for healthcare support in FSM-RMI may be the inclusion of Micronesian and Marshallese populations into IHS or an IHS-like contracting/compacting mechanism. This compacting/contracting mechanism gives the nations more authority to redesign HHS funds for their own purposes; this arrangement may foster local ownership of external financing and accelerated health system growth. Inclusion into IHS would also provide Marshallese and Micronesians access to the IHS networks of quality care (including US Public Health Service Staff) and a basis for continued governmental support in the legal framework that buttresses the USG's "moral trust responsibility" for AI/AN populations. Lastly, it catapults FSM-RMI into a strong advocacy network and history of legal action.

However, this strategy requires significant legislative change. To effectively fit within the IHS system, FAS populations need to be (1) eligible for Medicaid, and (2) federally recognized as a tribe or the development and protection of a compacting mechanism for FSM-RMI other than that of IHS. These legislative changes are unlikely.

The IHS model remains attractive because it represents a successful example of how HHS has supported sovereign entities within its domestic framework. To translate components or concepts from HHS support for AI/AN populations to FSM-RMI populations will require creativity and strong advocacy, but doing so could ultimately lead to more effective HHS healthcare support.

5.d: FSM-RMI engagement with HHS

This section considers three themes critical to FSM-RMI health system strengthening efforts and effective FSM-RMI engagement with the US (or other external financers): local ownership, advocacy, and financial management within FSM-RMI governments.

5.d.i: Local ownership

Ultimately, FSM and RMI cannot locally "own" the external financing on which their health systems currently rely. This external financing will always be tied to the goals and standards of the financer. Thus, local financing must succeed external financing for FSM-RMI to truly own their health systems. Self-financed systems can better address local health priorities and invest in long-term growth.

Until local revenues increase, FSM and RMI must consider how they can increase local ownership and foster local development as they rely on external financing: if FSM and RMI currently exist between a developing world operating context and a domestic, state-focused HHS model, a culture of ownership must ensure that FSM and RMI do not look to HHS to *lead* island-centric health efforts or define health priorities. HHS *supports* local health efforts. This section describes how a culture of ownership may improve absorptive capacity, promote the strategic use of resources, and promote local capacity while FSM-RMI are reliant on external financing, as well as help FSM-RMI to engage most productively with HHS in preparation for 2023. More resources alone may not be the answer.

Formally, HHS engagement in FSM-RMI is undertaken for purposes consistent with the Compacts and their authorizing legislation (which includes a goal of economic self-sufficiency).[121] Some interviewees cited the Compact as a guiding strategy for HHS' engagement in the region. However, as with states, HHS does not define the health or developmental priorities that would ultimately guide FSM-RMI to apply to a cross-section of grants that might support a holistic health system strengthening approach. HHS engagement stems from a domestic appropriations/authorizations system that targets specific health issues; the style of engagement is not structured to promote development, but rather to provide the tools that can help state governments to achieve their health/development goals. HHS engagement without direction from a strategic action plan may not contribute to sustained health for development. As FSM-RMI reduce reliance on HHS financing, they must understand the intended supportive role of HHS (also illustrated in Figure 10 on page 47) and seek to incorporate HHS engagement into strong local health priorities and administrative structures; they must "lead" rather than "grant chase." Figure 13 illustrates this concept in a comparison of the processes by which FSM-RMI establish the medium-term budget frameworks required by the Compacts and the process by which a state defines its health budget.

[121] Gianturco, "Continuation of HHS Grant Awards to the Freely Associated States."

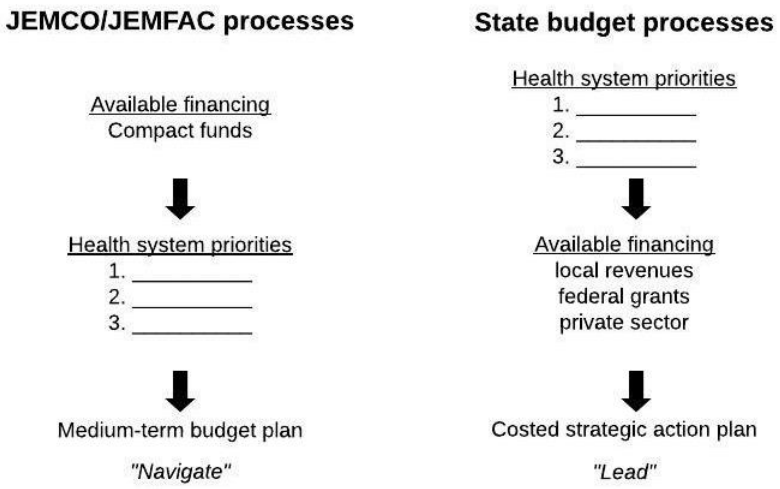


Figure 13: Leading versus navigating

Medium-term budget frameworks are used to inform JEMCO/JEMFAC decisions. They're created by FSM and RMI health leaders who begin with a sense for the available Compact health sector grant funding for a given year and then work backward to prioritize and assign available funding to health programs. Leaders then create projects and apply for funding through JEMCO/JEMFAC structures. Funding for projects is awarded upfront; project and funding periods vary, typically ranging from financing for a conditional six-month project period to a three-year project period with funding dispersed in annual increments. In a state budget process, state health leaders first define state priorities and the funding needed to achieve them through a costed strategic action plan; they then seek funding from local revenues, federal grants, the private sector, and other sources to fill the monetary commitments defined in the plan. In this sense, the state "leads" with its health priorities and costed strategic action plan rather than chases available grants; strategies are informed by health needs before they're informed than available financing. In situations where easily available grants do not match local priorities, a costed strategic action plan is critically important for local financial management. Having a costed strategic action plan—which defines local goals and specifies exactly how much (and what kinds) of funds will be needed to achieve these goals—allows states to seek out the financing and support they need, rather than accepting offered or familiar financing and trying to match it back to their priorities. A costed strategic action plan, preferably with input from civil society (as in PEPFAR's COP process), also keeps health leaders accountable to the priorities and progress defined therein. These processes exemplify the value of strategic action plans for effective use of HHS (and external) financing and as building blocks for sustainable healthcare financing.

More resources alone may not foster health system development in FSM-RMI; indeed, budget surpluses indicate that more local revenue is available. Instead, political barriers and the availability of Compact and HHS financing for health may stymie the use of local revenues for health. In this context, local priorities are sometimes overshadowed in the search for additional resources. Financial absorptive capacity is also low. Understanding these factors and in hopes of economic self-sufficiency, a shift in perspective toward more local ownership and processes like costed strategic action plans may contribute to sustainable health system development. Improved funding flows within the government and costed strategic action plans can promote local leadership of health system financing efforts.

One success story in the evolution of local ownership is TB programming in RMI.[122] In the early 2000s, the CDC, WHO, and SPC provided technical assistance to begin a TB intervention. For two years, the partners worked closely with RMI to build out TB programming, improve regional diagnostic capabilities, and increase testing, all of which led to more reporting across FSM and RMI. This reporting was included in national TB reports, thereby increasing domestic awareness of these nations' high TB burden. The intervention also helped to train local staff and to build long-term TB infrastructure. In 2006, sustained progress and widespread reporting allowed the region to identify and respond to an outbreak of MDR-TB in Chuuk, a state in FSM. That progress and local ownership, seeded by a time-limited intervention in 2003-2004, continues today. The RMI Ministry of Health recently completed two large-scale TB screening drives in Ebeye (2017) and Majuro (2018). Though CDC staff were available for support, the drive was run by RMI health leaders and staff.

5.d.i.1: NGO support and assistance for local ownership

HHS engagement in the region should not limit FSM-RMI engagement with other funders and NGOs; costed strategic action plans that solicit funding from a wide variety of sources to support these efforts—including the World Bank, other governments, and increased tax or other local revenue—might alleviate the sense of "navigation" that defines FSM-RMI engagement with HHS health care financing. As FSM-RMI articulate a clear need for additional services/networks/resources, NGOs and other organizations can partner with local governments to provide them.

Beyond a financing role, non-federal groups can also assist and contribute to increased local ownership through technical assistance, coordination, and advocacy. Holistic healthcare can be achieved by leveraging the unique strengths of a wide variety of partners. FSM-RMI health policymakers should seek out this broad network of NGOs, multilateral organizations, and private sector groups as they seek to "lead" their healthcare system and address gaps in health-related services, operations, and finances. Local partnerships with businesses, academic institutions (in the model of Academic Health Departments), or civil society groups can integrate health services into established relationships and institutions, thereby contributing to the health programs' long-term sustainability and development. US-based organizations (such as NGOs, faith groups, or community action organizations) could also help to establish "sister cities" between these jurisdictions and counterparts in the US. In partnership with host governments, NGOs could also improve grants compliance through campaigns like raising awareness of and encouraging the use of grants guidance available from HRSA, SAMHSA, and the NIH; seemingly underutilized, these tutorials may help with compliance and grant security through periods of leadership turnover. NGOs could also fulfill the oft-requested "clearinghouse" of HHS grants, which would list all grants for which FSM-RMI are eligible, or more generally provide assistance in identifying and applying for relevant opportunities across the donor community. This "clearinghouse" can be used within a "local leadership" approach: RMI: FSM-RMI should not look to a list of available HHS grants to comprehensively define the array of health priorities available to them, but rather consult this resource alongside a variety of private sector, multilateral, and other governments' options for each priority in their costed strategic action plan.

In summary, many forms of partnerships contribute to local ownership. As FSM and RMI articulate a need for a wide variety of partners, HHS may be able to help local health leaders to efficiently leverage available resources and technical assistance. Looking ahead to 2023, these regional players are important for ongoing health for development efforts.

[122] Banerji, interview.

5.d.ii: More advocacy and better data

Whether best understood as developing countries, states, rural populations within states, or AI/AN populations, FSM and RMI populations would benefit from (1) a stronger presence on Capitol Hill and in lobbying efforts around Congress to push for island-centric concerns, (2) continued advocacy within states to improve health situations for Micronesian and Marshallese citizens who have emigrated to the US, and (3) louder and more frequent advocacy for the strategic use of funds on island rather than simply additional funds to the islands (for example: programs to increase absorptive capacity). A department—in this case, HHS— cannot legally engage in these types of advocacy.

Advocacy is a critical component of effective health system financing. FSM and RMI citizens who have migrated to the US have successfully pushed for policy change in their communities. This has occurred through community action in places like Oregon and Washington, where states currently or plan to cover COFA migrant Medicaid costs. This has also occurred throughout the advocacy efforts of NGOs like APIAHF and We Are Oceania, which have pushed for Medicaid restoration for COFA migrants nationally and in Hawaii. However, FSM-RMI populations living on island have not benefited from such staunch legislative advocacy. This absence was noted in the 1998 Pacific Partnerships for Health; the concept of PIHOA was raised to address this lack of advocacy. Relative to tribes, which benefit from the powerful advocacy efforts of groups like NIHB, FSM-RMI populations still lack a legislative advocacy presence. Lastly, advocacy is important for its role in shaping the narrative around USG assistance to FSM-RMI. Prior to 2023, FSM and RMI—or organizations that advocate on their behalf—should understand and shape policymakers' perception of the USG health assistance they receive.

Successful advocacy will require better data. As highlighted above, data helps leaders to evaluate the needs of their populations and the capacities of their health systems. It also helps advocacy groups to craft more powerful and effective narratives that can justify calls for change. Efforts are underway to improve the data culture of these nations. In FSM-RMI, technical assistance and education-based groups like PIHOA, SPC, and the University of Hawaii have undertaken projects to improve data systems. Newly established programs to collect and report weekly surveillance data have contributed to a growing local health database. However, FSM-RMI data remains unavailable in many national governmental health databases and in many large-scale multilateral or disease-specific databases. Future research should seek to understand why the data is not included.

In short, low data capacity and a relative lack of internal data collection/reporting structures impede advocacy efforts within the USG, to other external financers, and within FSM-RMI. Moving forward, efforts should be made to expand data collection, reporting, and sharing (in national, regional, and topic-focused databases).

5.d.iii: Improved financial management

With limited sources of local healthcare financing, FSM and RMI rely on external financing to support their health systems. In this environment, perhaps the biggest impediment to FSM and RMI absorptive capacity are time consuming financial management processes on island. These processes, including but not limited to grant processes, are not contained within the Ministries of Health; interagency coordination and cross-government improvement will be required to improve health-related financial processes. To improve absorptive capacity, FSM and RMI must make these processes faster or simpler. Both have already begun efforts to do so.

RMI has recently partnered with PIHOA, ASTHO, and CDC to improve the flow of funding within the government, including the timely drawdown and use of HHS funds. In May 2018, the Ministry of

Health, Ministry of Finance, the Public Service Commission, the Office of the Attorney General, and the Office of the Chief Secretary in RMI signed a Memorandum of Understanding to express their commitment to addressing these issues and pursuing some of the recommended actions, including changes to key business processes, garnering support from ministry partners, and developing an action plan.[123] In fall 2018, RMI will begin a pilot program in four departments that handle four grants that seeks to improve processes around procurement, hiring, and grant processing more generally. As FSM and RMI plan for 2023, discussions around financial flows may also benefit from a review of US government-funded programs that have been successfully managed through work plans, accountability, good communication/networking, and the full obligation of funds.

FSM is working with WB to address similar issues. A project appraisal released in May 2018 by the World Bank describes an FSM project for strengthening public financial management from May 2018 through September 2023.[124] The stated goal is to improve tax administration and the completeness, reliability, and timeliness of financial reports of the national and state governments. If this project can streamline budget execution processes and oversight of public finances (including HHS grants), FSM's relationships with external health-financers may improve, thereby raising the health system's long-term development prospects.

5.e: Future Considerations

Barring a change in legislation, it is assumed that HHS will remain engaged in the region past 2023. The 2023 financing shift from Compact to Trust Fund revenue provides an opportunity to evaluate the ideal HHS-FSM-RMI engagement strategy moving forward. Understanding that sustainable health system growth will require more local ownership of health system strengthening efforts and not just more funding, discussions among and between FSM, RMI, and USG stakeholders must consider how to most effectively advertise, leverage, and translate HHS resources for the FSM-RMI context now and after 2023. HHS support for these nations' development is directly in line with HHS' values and mission: to promote the health and wellbeing of all Americans. Additionally, a strategic analysis to reduce risk and most effectively utilize HHS resources aligns with the department's "ReImagine HHS" initiative, which seeks to create efficiencies and improve customer service throughout the department. As these nations' health systems continue to develop, local capacity in FSM and RMI will contribute to a healthy, free, and open Indo-Pacific as well as reduce health-motivated migration among these populations to the US. With this perspective, this report recommends preserving FSM-RMI eligibility for HHS support after Compact financial assistance shifts to trust fund revenues in 2023. This eligibility should be paired with significantly more local ownership and financing (perhaps including the allocation of a larger proportion of each nation's significant government surplus to the health sector), as well as improved reporting and financial management, to foster improved health outcomes for FSM and RMI.

As HHS' partnership with the islands continues, three long-term trends will gain relevance: an NCD crisis in an aging population, climate change, and global health security.

NCDS are already a problem on the islands; the prevalence of these diseases will likely rise as this young population ages. This increase in prevalence will exacerbate current health delivery challenges, including how to properly address these issues without a strong mental health workforce,

[123] ""The RMI Ministry of Health and Human Services Tackle down Spending Issues with Support from the ASTHO, CDC and PIHOA."

[124] "Project for Strengthening Public Financial Management (P161969)."

frequent disruptions to procurement systems as they impact long term medication regimens, and a lack of sufficient financing. Financial concerns about dialysis—treatment for kidney failure— in FSM-RMI illustrate many policymakers' financing concerns around NCDs. Two NCDS, diabetes and high blood pressure, are the primary causes of kidney failure; as these conditions continue to rise in prevalence, so too will the need for dialysis to treat kidney failure. Typically, patients requiring dialysis need treatment multiple times a week for the rest of their lives. As the prevalence of this disease and the need for treatment has grown over the past decade, health systems have struggled to find space for these expensive treatments and facilities in their budgets. Dialysis is one example of how, as chronic conditions become more prevalent in society, health systems face higher costs and an ever-greater need for services. Without a shift toward local revenues, this dynamic could leave FSM-RMI even more dependent on external financing. It may also prompt greater outmigration to Guam and Hawaii for these services.

Climate change is another forward-looking concern. FSM-RMI, HHS, and the broader USG must be cognizant of how climate change will affect health in FSM-RMI and FSM-RMI-US relations. Over the next fifty years, these nations will be affected by rising sea levels and more frequent extreme weather. These climate-related problems pose significant health threats on island, including the destruction of crops/crop land and the disruption of medical shipments and primary care services. They also raise questions for the continental US, should climate change result in increased migration from FSM-RMI to the US. FSM-RMI health leaders are planning for these issues; the USG must do more to acknowledge and plan for them.

One example of USG efforts to plan for climate change in FSM-RMI is the Department of Agriculture's efforts to protect taro crops—a central component of FSM-RMI diets— through support for the development of a salt-water resistant taro plant that can handle more frequent inundation by rising seas.[125] The USG is also supporting research to define the risks posed by climate change in this region: the Pentagon's Strategic Environmental Research and Development Program recently published a report on the influence of climate change on Kwajalein army base in RMI which predicts that between 2035 and 2065, many low-lying atolls will lose potable water and become uninhabitable.[126] The report emphasizes that significant geopolitical issues could arise if these impacts are not addressed or adequately planned for, as it may become necessary to abandon or relocate these island nations. This will impact US health systems, as underinsured populations from regions without high rates of vaccination or quality healthcare can be expected to migrate to the US. This raises domestic security concerns as well economic concerns for state health systems.

Lastly, though 2023 presents a shift in economic assistance, migration between FSM, RMI, and the US (territories and states) will continue and likely increase in the coming decade. It's important to situate this shift in light of the USG's Global Health Security Agenda (GHSA) priorities. The GHSA is a growing partnership of more than 64 nations, international organizations, and non-governmental stakeholders that strives to build countries' capacity to help create a world safe and secure from infectious disease threats and elevate global health security as a national and global priority.[127] Small island nations historically struggle to building infectious disease response capacity because of their disperse/isolated populations. However, they are crucial to the success of this agenda. Pacific islands'

[125] College of Micronesia, "Product Development for Food Security as Palau Adaptation to Climate Change."
[126] Storlazzi, "The Impact of Sea-Level Rise and Climate Change on Department of Defense Installations on Atolls in the Pacific Ocean."
[127] "Global Health Security Agenda."

emergency preparedness is particularly important because of their proximity to flu hot spots in East Asia. FSM was the first small Pacific Island to complete a Joint External Evaluation (JEE): it transparently assessed its own prevention, detection, and response capacity in August 2018.[128] The USG can and should support RMI (and Palau) to take similar steps. As long as there is open migration between these nations and the USG is in a position to support efforts to build response capacity, the GHSA must be part of the conversation.

6: Conclusion

6.a: Summary

This report has presented an overview of HHS engagement with FSM-RMI; FSM-RMI engagement with HHS and the broader USG; and alternative health system support models that could inform ongoing health system strengthening efforts in the region. Five years away from a potential shift in financing in 2023, its hoped that this report can become a resource for the discussions and planning efforts that must begin in earnest in the coming years.

Sustainable health system development in FSM and RMI must be locally owned and financed. Thus, the first steps toward sustainable development will be local efforts to reduce FSM and RMI's reliance on external health financing. This could be done through mechanisms like the incorporation of tuna and fishing revenues into health budgets. Leadership must also address and adhere to costed strategic action plans that promote a comprehensive health systems approach driven by local health priorities rather than readily available financing. Long-term health system development efforts will also benefit from greater advocacy on behalf of FSM-RMI populations in the US and in the islands. US state and national advocacy should utilize a variety of pathways, including state-level campaigns, embassy involvement, and NGO legislative advocacy efforts directed to Congress (especially Senate and House committees on health and education) and state legislatures. Additionally, ongoing efforts to improve funding flows on island, internet connectivity to the jurisdictions, data collection/management practices, and workforce training/retention will foster development that benefits health systems through greater capacity and greater ability to attract the types of external support health leaders may need.

By including FSM-RMI in HHS' domestic authorization/appropriation structures— through which these sovereign nations become eligible grant recipients for grants geared toward mature state health systems— current HHS engagement expects that these sovereign nations can operate like states. This expectation is justified in their US-based systems—established during the Trust Territory period—and some health system development over the last few decades. However, this ignores the mismatch in operating context between FSM-RMI and the domestic US. In states, local revenues contribute almost half of all health expenditures; in FSM-RMI, local revenues contributed just 5-15% in FY 2018. Domestic populations benefit from Congressional representation and legislative advocacy through state representatives, NGOs, and collective action within their communities; FSM-RMI populations do not have the same Congressional pathways for advocacy and have not yet achieved similar levels of legislative advocacy through NGOs or representation in DC. FSM and RMI face bigger challenges around

[128] As of September 2018, JEEs had not been completed by the following small Pacific islands: Cook Islands, Kiribas, Marshall Islands, Niue, Nauru, Palau, the Solomon Islands, Tonga, Vanuatu, or Samoa. The larger Pacific islands of Australia, Papua New Guina, and New Zealand have completed a JEE, while Fiji has not.

workforce development and retention with their small, isolated populations and high cost of doing business than do small or rural states within the US. Geographic isolation, a relative lack of internet connectivity, and language barriers further differentiate FSM-RMI populations from stateside populations.

If a developing world context, sovereignty, and isolation challenge standard HHS support for FSM-RMI, lessons from PEPFAR, USAID, and IHS may be able to inform a modified HHS engagement strategy. PEPFAR's COP processes and data culture promote sustainability and facilitate ongoing progress and congressional support. USAID's broader development schema suggests a holistic view of health for development; partnership between USAID, HHS, and FSM-RMI on issues of health system development may foster sustainable development and improved healthcare outcomes. Lastly, IHS' compacting and contracting mechanisms underline the value of local ownership and a "whole of HHS" support portfolio; USG support for AI/AN populations remains a potential source of inspiration for ongoing HHS support in FSM-RMI, though solutions will need to be adapted to address a lack of Medicaid eligibility.

Lessons can also be drawn from agencies currently engaged in the region, notably CDC, HRSA, and SAMHSA. As 2023 approaches, the department must actively consider how it can define its role in ongoing FSM-RMI health system development and, in doing so, best support FSM and RMI health system development efforts through and after 2023. Ideal HHS engagement may entail a subset operating strategy that institutionalizes best practices established within agencies and coordinates among them and other USG partners. Promising practices currently maintained by some agencies include a greater reliance on reverse technical assistance, condensed grants applications, and acknowledgement of the higher costs of doing business in these jurisdictions. Ideal HHS engagement may also involve a shift toward development through concepts inspired by or through partnership with USAID. Alternatively, ideal HHS engagement may require a shift toward more local ownership through concepts inspired by or through partnership with IHS. The next section presents action items HHS, FSM-RMI, and partners may pursue over the next four fiscal years.

As has been alluded to above, non-governmental partners have a role to play in HHS-FSM-RMI engagement and health system development efforts in the region. Regional players like WPRO, SPC, PIHOA, ASTHO, APIAHF, AAPCHO, and other NGOS/multilateral organizations, as well as public private partnerships and "sister city" programs, are resources for health system strengthening activities like: administrative and technical assistance; advocacy to state and national legislative bodies, as well as in global or regional forums; innovation and technological capacity building; and education. Additionally, banks like WB and ADB are poised to play a greater financing and development role in the coming years.

2023 brings an opportunity for FSM, RMI, HHS, DOI, the broader USG, and partners to discuss how these dynamics influence the health systems of FSM and RMI and USG support for them. Figure 14 illustrates some of the concepts above and the hope of this paper: that these discussions can feed into sustainable health system development in FSM and RMI.

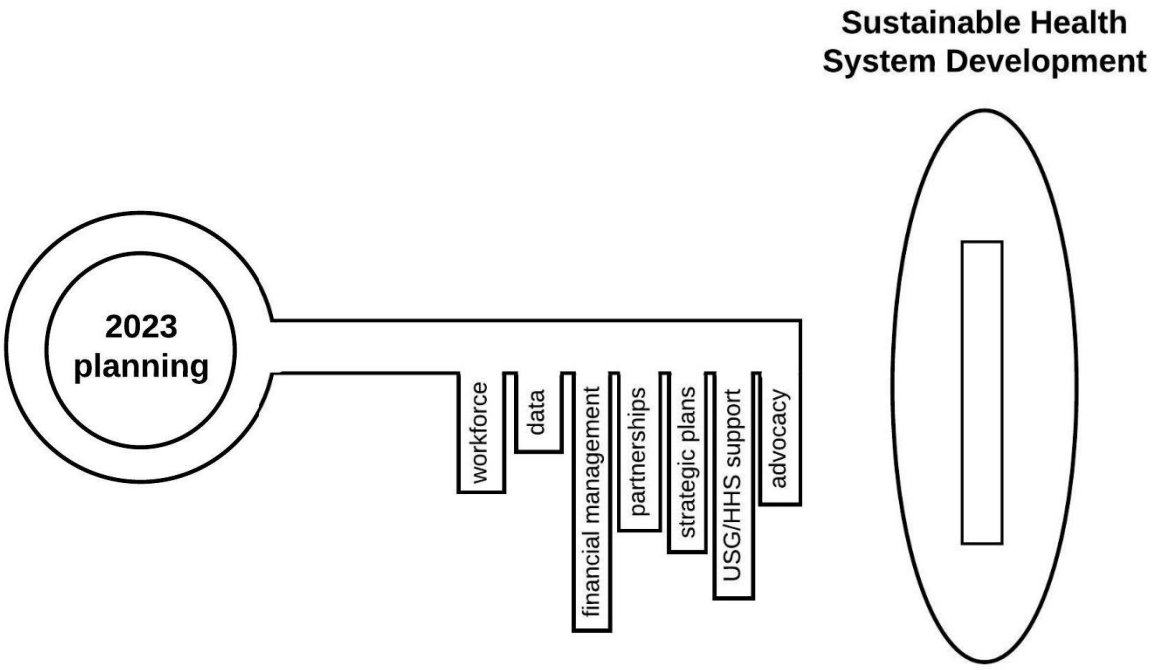


Figure 14: Discussions around 2023 can unlock sustainable health system development

6.b: Mapping the next five years

As we approach 2023, several steps can be taken by HHS, the USG, FSM, and RMI to prepare for the expected shift in financing and contribute to improved health system strengthening efforts. Some of these potential steps are illustrated in Table 7 below.

Significant planning and difficult decisions will be required over the next five years to successfully navigate the 2023 transition and to contribute to improved healthcare outcomes and sustainable health system development in the long term. However, there is reason to be optimistic: discussions and preparations for 2023 have begun and progress in health system development over the last four decades has been slow but steady. Through their support for this project, FSM, RMI, HHS, and partners in the region have shown their willingness to engage as necessary over the next five years to ensure improved future health outcomes in FSM and RMI.

Table 7: Action Steps for FSM-RMI, HHS, and NGOs, 2018-2023			
	FSM-RMI	**HHS**	**NGOs**
Short-term (2019 - 2020)	1. Determine the Compact trust fund allocation mechanism, which will allow all partners to better plan for any shifts in financing in 2023 2. Begin processes to establish costed strategic action plans and improved local financing 3. Increase local revenues for health; consider integrating government surpluses and tuna revenues into health budgets 4. Engage with partners— including HHS and NGOs— to embrace administrative and technical assistance; consider converting financial HHS assistance to direct assistance 5. Advocate now for the 2023 budget cycle. 6. Develop a coordinating mechanism for external health financing	1. Reinvigorate the Insular Area working group and policy group 2. Proactively define HHS' ideal role in ongoing health system development efforts in FSM-RMI; consider developmental approaches, partnerships 3. Consider innovative financing mechanisms for FSM-RMI health support, including: in-kind support, set-asides, partnerships 4. Partake in and help to guide interagency discussions regarding ongoing health support in FSM-RMI 5. Engage with other donor partners in the Pacific (such as Australia) to compare models and consider collaborative assistance	1. Work with FSM-RMI to establish legislative advocacy priorities and plans 2. Work with FSM, RMI, and HHS to explore whether/how NGO assistance funding should/could be allowable as in-kind support 3. Target financial management and workforce capacity across FSM and RMI 4. Advocate now for the 2023 budget cycle.
Medium-term (2021 - 2022)	1. Propose and organize a meeting for all health partners to discuss plans for engagement through and past 2023. 2. Identify alternative financers and begin shifting and/or reducing jurisdictions' reliance on external financing, in alignment with priorities defined in costed strategic action plans	1. Continue engaging with interagency partners to prepare for the 2023 transition 2. Realize the roles and activities defined through discussions highlighted above, in communication with and as led by FSM-RMI health leaders' health system development goals.	1. Continue advocacy efforts in preparation for 2023 transitions 2. Evaluate and build upon short-term progress made by FSM, RMI, and HHS.

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Appendix A

The author thanks the following individuals for their insights.

USG input

1. USAID
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    b. Jean-Jacques Frere
2. DOI
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    b. Tanya Joshua
    c. Joseph McDermott
    d. Steve Savage
3. HHS
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            2. Tom Novotny
        ii. IEA
            1. Jim Mason
            2. Bonnie Preston
        iii. OGA
            1. Erika Elvander
            2. Jin Park
        iv. OMH
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            2. Matthew Lin
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        ii. Suzanne Auerbach
        iii. Charles Darr
        iv. Austin Demby
        v. Kristen Jackson
        vi. Nidhi Jain
        vii. Katherine McDowell
        viii. Kerry Nesseler
        ix. Angela Powell
    c. SAMHSA
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        ii. Steven Dettwyler
        iii. Donna Hillman
        iv. Winnie Mitchell

    d. CDC
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        ii. Celeste Chung
        iii. Stacy De Jesus
        iv. Mikayla Farr
        v. Derrick Felix
        vi. Bill Gallo
        vii. Andy Heetderks
        viii. Tamika Hoyte
        ix. Nicole Kuiper
        x. Paran Pordell
        xi. Vicky Rayle
        xii. Charissa Rivers
        xiii. Dawn Satterfield
        xiv. Betsy Thompson
        xv. Patricia Thompson-Reid
        xvi. Margaret West
    e. IHS
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4. State
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    d. Jenny Morell

Pacific Islands input

1. FSM
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    c. Caroline Kelly
    d. Moses Pretrick
    e. Martina Reichhardt
    f. Marcus Samo
    g. Jack Soram
    h. Akillino Susaia
    i. Livingston Taulung
    j. Magdalena Walter
    k. Sam Witten
2. RMI
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    b. Julia Alfred
    c. Giff Johnson
    d. Kalani Kaneko

    e. Todd Mulroy
    f. Francyne Wase-Jacklick
    g. Gerald Zackios
3. Palau
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    b. Darnelle Worswick
4. American Samoa
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NGOs, multilateral organizations, and other input

1. PIHOA
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    b. Emi Chutaro
    c. Esther Muña
    d. Boz Tucker
    e. Vasiti Uluiviti
    f. Roylinne Wada
2. PIPCA
    a. Clifford Chang
3. World Bank
    a. Annette Leith
4. AAPCHO
    a. Jeffrey Caballero
5. APIAHF
    a. Kathy Ko Chin
6. University of Hawaii
    a. Lee Buenconsejo
    b. Neal Palafox
    c. Christina Tiga
7. ASTHO
    a. Karl Ensign
    b. Leah Silva
8. WHO/WPRO
    a. Eunyoung Ko
9. SPC
    a. Lara Studzinski
10. Princeton
    b. Heather Howard

Appendix B

Initial interviews from the PIHOA conference (March 27-29, 2018 in Pago-Pago, American Samoa) and day of interviews with HRSA were recorded and a transcript produced and shared along with a summary of key points. Other interviews may or may not have been recorded (if recorded, author always had permission from the speaker); author always took notes and shared a summary of those notes with the speaker. When necessary, author sought clarification from the speaker. Informal conversations, where core questions were not asked but HHS-FAS issues were discussed, often resulted in personal notes that were most commonly were not shared with the speaker (unless requested).

Three core themes, highlighted in the generic questions numbered below, were raised in each formal interview. The first question addresses strategic engagement in the region; the second addresses HHS/FAS grievances; and the third addresses perceptions of ownership. The wording of these questions varied, but these ideas were broached in each interview.

1. Would there be value in a broader strategy guiding HHS engagement in the Freely Associated States? Why or why not? What would this strategy look like?
2. How could the current approach (agency-specific or department-wide) be improved to benefit FAS populations and HHS?
3. Which better describes the current relationship between FAS health systems and HHS financial support: FAS programs implemented by FAS staff supported by HHS (financial) assistance, HHS programs implemented by FAS staff supported by HHS (financial) assistance, a mix, or neither? Why?

Condensed interview notes were shared so that speaker could review for accuracy, especially as related to the core questions highlighted below. Not all speakers reviewed notes or responded with corrections, but all were given the opportunity.

All interviews were reviewed at least twice: first immediately afterward to condense notes into themes to share with the speaker, and then again prior to writing to consider within the larger body of research (interviews and literature review completed by July). Additional reviews of particular interviews or groups of interviews occurred during the drafting process.

To analyze interviews, author re-read all summaries and transcripts from in person interviews, phone interviews, email conversations, and online questionnaires. Common themes were identified within each core question; these included common complaints, historical events or structural impediments referenced, misconceptions, and frames of reference. Also noted in this review were suggestions for improvement (for grant coordinators or recipients, an agency within HHS, HHS, FAS state or national government, some combination of these, or a general call for change). This process helped the author process, become familiar with her body of evidence, and attempt to incorporate a large volume and variety of commentary into this report. During this process, the author also quantified responses to the multiple choice questions and tallied common complaints and suggestions by grouping.

Quantitative conclusions from these interviews should be drawn with caution; the semi-structured nature of the interviews meant that conversations with individuals were not uniform or entirely comparable. While a core set of themes were always addressed and the array of questions were largely constant, the order of questions/subjects broached and the detail with which they were discussed varied significantly. Quantitative tallies expressed in the report are intended to give readers a sense for the nature of these interviews, not an objective summation of their content.