

PN - HAU - 64,  
46571

AID FUNDING AND STAFFING:

DOING MORE WITH LESS

A PARADOX OF PLENTY

Donald C.E. Ferguson, Ph.D., M.P.H.  
Department of Preventive Medicine and Biometrics  
F. Edward Hebert School of Medicine  
Uniformed Services University of the Health Sciences  
Bethesda, Maryland 20814-4799.

Jean W. Pease  
International Science and Technology Institute  
Washington, D.C.

Presented During Symposium Entitled:  
How USAID Has Spent it's Health Dollars  
November 18, 1985, 1400 - 1530 hrs.

113th Annual Meeting  
American Public Health Association  
Washington, D.C.

- 1 -

AID FUNDING AND STAFFING:  
DOING MORE WITH LESS  
A PARADOX OF PLENTY

Donald C.E. Ferguson, Ph.D., M.P.H.  
Department of Preventive Medicine and Biometrics,  
Uniformed Services University,  
Bethesda, Maryland.

Jean W. Pease  
International Science and Technology Institute  
Washington, D.C.

"I wish I could manage to be glad" the Queen said. "Only I never remember the rule. You must be very happy living in this wood, and being glad whenever you like!"

"Only it is so very lonely here!" Alice said in a melancholy voice; and at the thought of her loneliness, two large tears came rolling down her cheeks. "Oh don't go on like that cried the Queen wringing her hands in despair. "Consider what a great girl you are. Consider what a long way you've come today. Consider what o'clock it is. Consider anything only don't cry!"

Alice could not help laughing at this, even in the midst of her tears. "Can you keep from crying by considering things?" she asked.

"That's the way its done." the Queen said with great decision: "Nobody can do two things at once, you know. Let's consider your age to begin with —how old are you?"

"I'm seven and a half exactly."

"You needn't say exactly," the Queen remarked. "I can believe it without that. Now I'll give you something to believe. I'm just one hundred and one, five months and a day."

"I can't believe that." Alice said.

Can't you." the Queen said in a pitying tone. "Try again: draw a long breath and shut your eyes."

Alice laughed. "There's no use trying" she said: one can't believe impossible things."

"I dare say you haven't had much practice" said the Queen. When I was your age, I always did it for half an hour a day. Why sometimes I've believed six impossible things before breakfast..."

Lewis Carroll..Through the Looking Glass...

The health staff of the Agency for International Development being well practiced at the survival skill of at least appearing to believe at least six impossible things before breakfast, were advised last year that they would soon receive much more money to program, but that quite logically they would be given fewer people to manage it. That is the headline, and now the details.

As many in the audience know, I was associated with the Agency for International Development for 10 years, but am now on the medical faculty of the Uniformed Services University in Bethesda. For this reason I will speak with more candor than I would have a few months ago. In theory it would have been possible to say what I will say today, but it would have been necessary to soften my remarks...considerably. Points of view expressed today are mine alone. I no longer represent the Agency in any way.

Jean Pease, coauthor of this presentation, is Director of the ISTI health project data base system under contract for AID. Much data reported today was prepared by Ms. Pease and the ISTI group. Some data on personnel however came from other sources. Ms. Pease should not be held responsible for my points of view since they go well beyond data, and reflect my personal experience.

It has been observed by at least one person in this audience that AID is a frustrating, bureaucratic organization that does interesting things. It does these interesting things through contractors, consultants, host governments and an often harassed and overextended, but nonetheless dedicated staff.

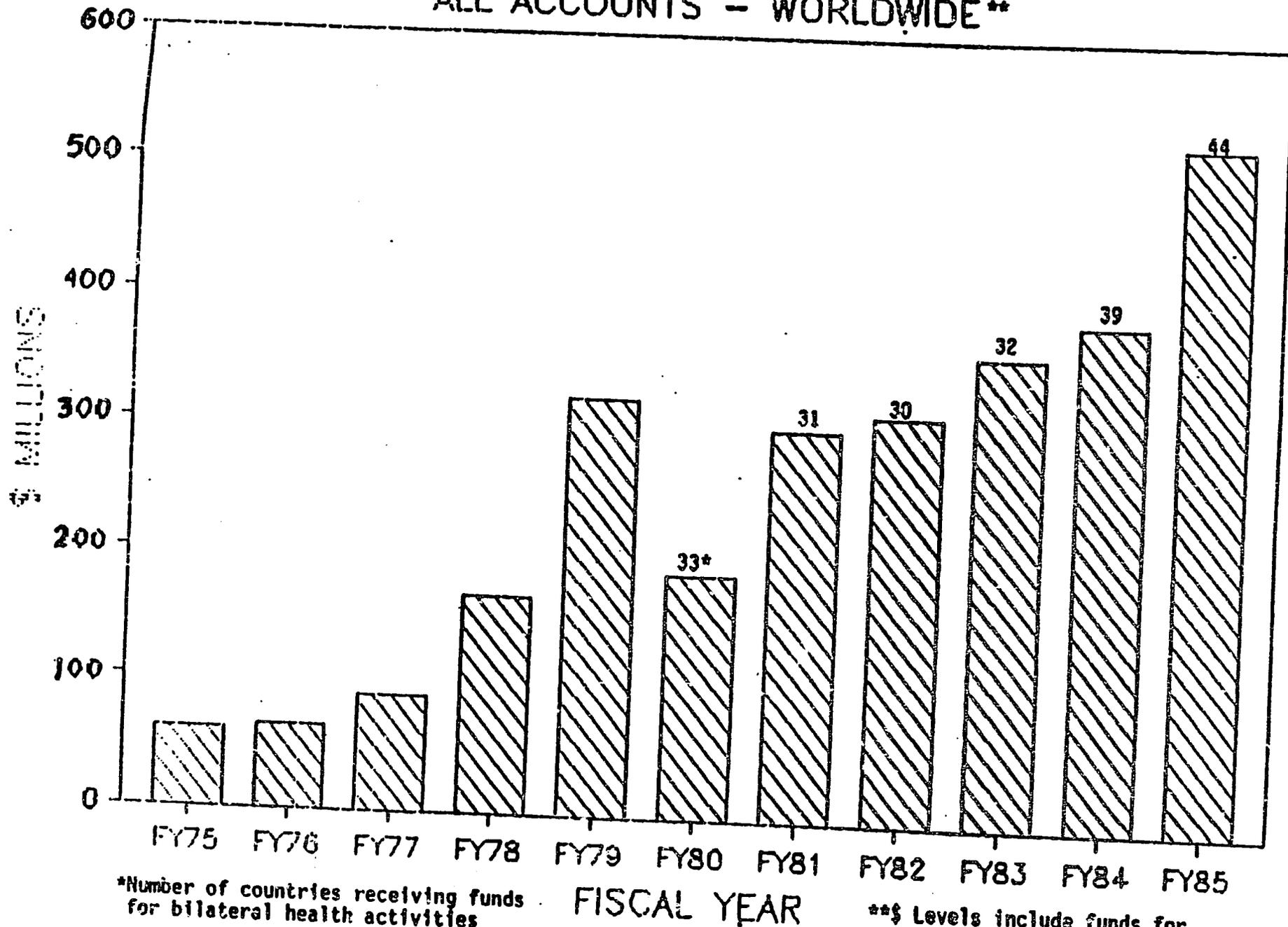
The year I joined AID, I asked one of our contractors who was being given a rough time procedurally why he put up with us. His answer was interesting. He laughed and compared working with AID to playing baseball in Yankee stadium. It's big league ball, rough going and a tough city, but it's where most action in international health begins and ends if you're talking about sizeable activities likely to make a difference. That is still true.

I have both good news and bad news today. The good news is that AID funding worldwide has seen growth in both absolute and relative amounts of money allocated and spent for health over the past decade. The bad news is that the number of staff needed to technically manage this larger pot of gold has been stretched to the breaking point. I believe many difficulties people in this audience have had with AID have directly or indirectly been as much a function of short staffing as anything else.

### AID Global Health Sector Funding

Let's review good news first. To begin, it has always been difficult to obtain an overall summary picture of AID's total health spending. This situation springs from the circumstance that there have always been many account names other than health from which health funds have been expended. A new AID Health Projects data base managed by ISTI and directed by Jean Pease has made possible an accurate view of Agency health spending irrespective of the formal account from which health expenditures or obligations were made. This overall picture is useful, not only for planning and tracking purposes,

# A.I.D. HEALTH FUNDING ALL ACCOUNTS - WORLDWIDE\*\*



\*Number of countries receiving funds for bilateral health activities

Source: ISTI Health Funding Database

\*\*\$ Levels include funds for regional and worldwide projects

but for a strategic and tactical sense of how health resources are being deployed. As logical as it may seem it has proven difficult to obtain internal senior management approval to expend funds for this purpose, and continues to require efforts from Dr. Bart to keep funds flowing for it. The data base is proving useful to Agency-wide health staffers for many purposes, and while I don't have a picture of their perception of it, they are very actively using it for many purposes as we will this morning.

Our first slide shows the total amount of money from all AID accounts spent for health over the past decade has risen from \$50 million in FY '75 to nearly \$550 million in FY'85. Roughly 11 times more money was spent on bilateral health sector activities in FY'85 as compared with FY'75. Although an accurate count of the countries in which these activities took place was not available for an earlier period, Slide 1 indicates an increase from 33 countries assisted in the health sector from bilateral funds in FY'80 to 44 countries in FY'85. This represent a 25% expansion in the numbers of countries assisted over this 5 year period.

As a proportion of total development assistance, the health sector has gained in relative terms from 11% of total in FY'80, as shown in Slide 2, to 15% of total in FY'85 as shown in Slide 3. Since absolute and relative amounts have increased, you would be correct in assuming that increases have come out of the hide of other development sectors and activities. As a health partisan, I shed no tears over this gain, not even for the sake of good manners. As an English Cockney might say I not only think its "bloody marvelous" but about time as well! Health assistance is wanted not only by persons like us whose rice bowl depends on it, but by the many disadvantaged beneficiaries with little hope without our assistance. As the Hill Street Blues desk sergeant might say "it's pretty unhealthy out there" in much of the world.

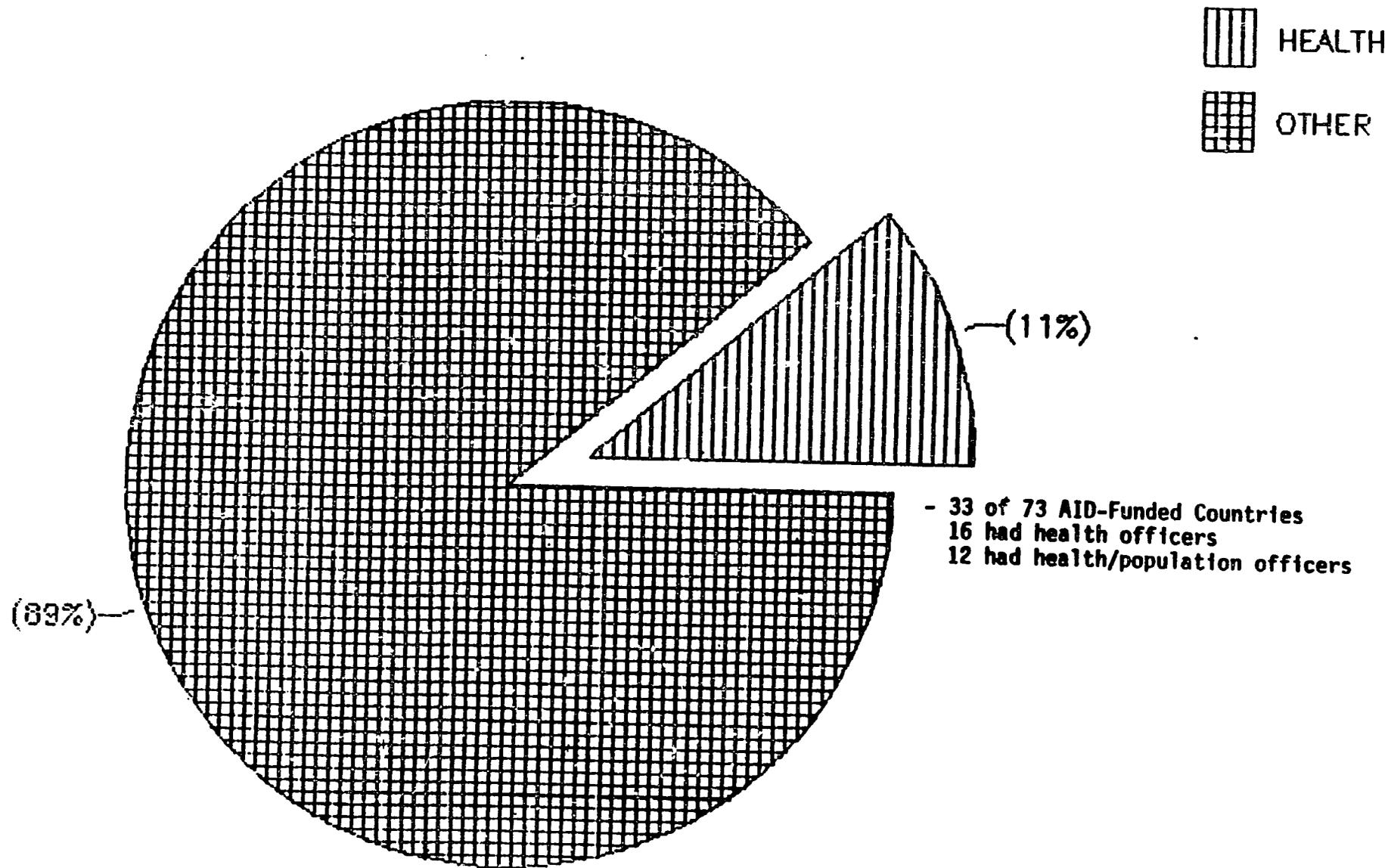
Economists and Mission Directors have to had to swallow hard to choke the expanded health activities down since they have other priorities. As may be expected it has taken political sugar to make this medicine go down in anything resembling a delightful way.

There have been larger and larger amounts of health money from the Economic Support Funds or ESF category spent in recent years. In years past this kind of funding was programmed differently, but the differences are fewer than before. ESF money can be used to fund large quantities of such medium term expendables as ambulances, equipment for cardiac surgery and bricks and mortar. I need not tell this audience that these are not the highest priority long term needs for health development, but the flexibility is welcome.

ESF funds are usually "softer" funds in same sense that we use the term soft money and is used to help to put out political fires or pay off IOU's in the geopolitical sense. Yes Virginia, I am suggesting there is no Santa Claus..and only occasionally a free lunch. A certain amount of ESF money is geopolitical "quid pro quo" money. Projects funded by this category are often used to meet short range political exigencies of many kinds.

4

# HEALTH PROGRAMS AS A PERCENT OF TOTAL DA FOR FY 1980



Source: ISTI Health Funding Database

More troublesome to me however are those little numbers sitting on top of the bars in the bar graph of Slide 4. These numbers indicate the number of countries receiving ESF funds by year. If your eye was quicker than my hand you will have noticed that of the total health funding of about \$550 million in FY'85 which went to 44 countries, shown in slide 1, nearly \$250 million, or 55% of that \$550 total million went to just 6 countries, and the bulk of that to only 2 countries, Egypt and Jordan, as shown in slide 4. The bulk of these funds are for large scale urban water and systems.

Geopolitical considerations necessarily enter into foreign aid. Funds allocated by the political process (read Congress and President) also have had a tendency to become lopsided. Despite these realities somehow the size of the slice of the health pie for Egypt seems excessive nonetheless. While recognizing why it got that way, most of us would prefer to see health shares allocated more even-handedly, and as health people, differently.

### Regional Health Funding

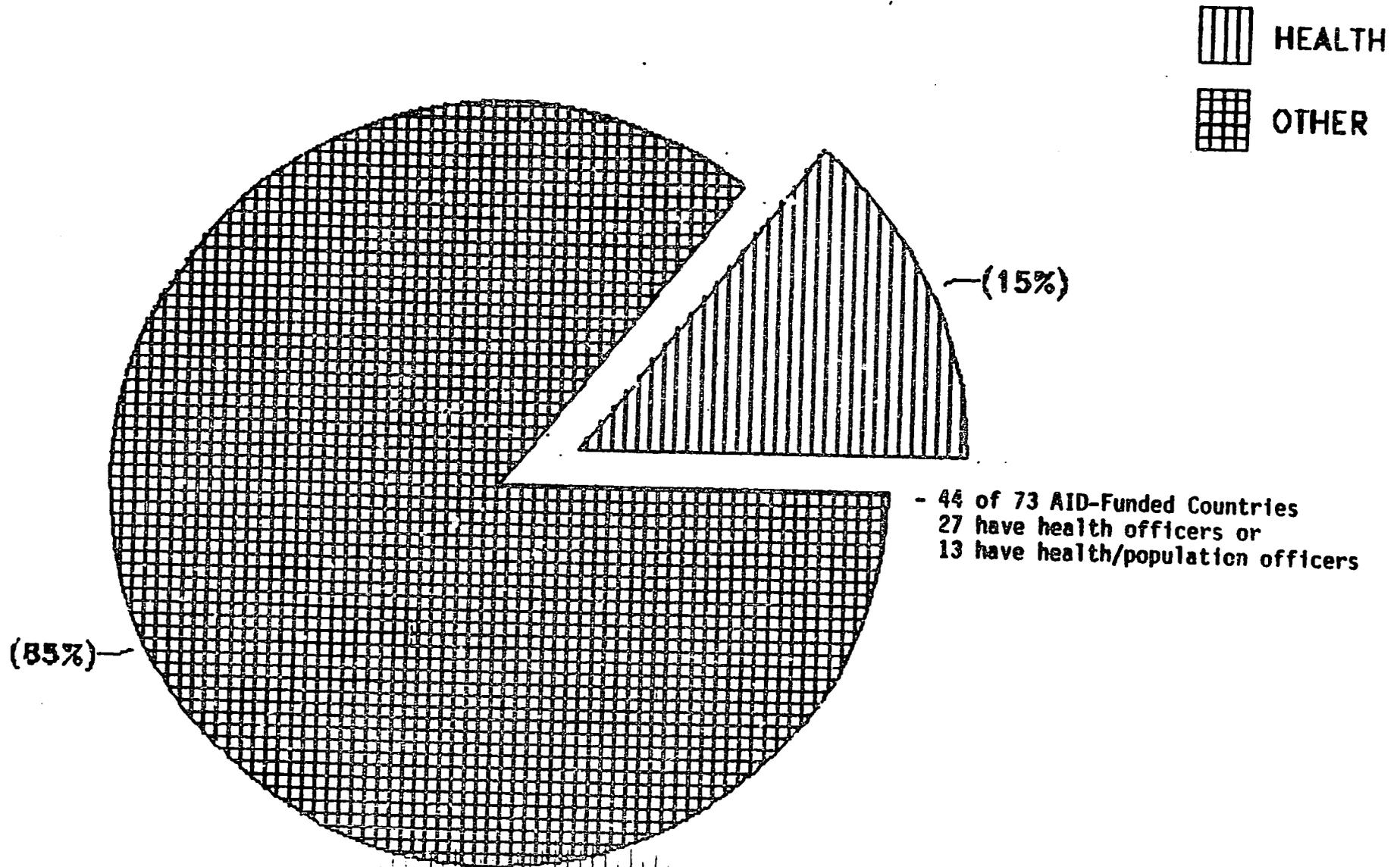
Turning to expenditures by region, generally rising levels of funding for all geographical regions has been the case recently. The dip in FY'84 health funding levels we were all so alarmed about a few years back has been corrected favorably. Congress has not only made it clear to the Agency that Health is a priority, but for several years running has emphasized it by giving the Agency more money for health than it has requested while simultaneously trimming appropriations for other sectors.

AID country Mission Directors inclined to resist health projects are now hearing the message from the Hill and the Administrator more clearly. The effect of the new political batteries in their hearing aids has been reflected in the increase in the increase in AID assisted countries requesting approval for health projects. Mission Directors in the past diminished such requests by choosing not to appoint health staffers to their Mission teams or by phasing out those on board. It is astounding how many health requests you do not receive when you don't have a health officer in-country.

You have noticed we have spent little time discussing slides on Geographical Bureau funding. Year to year variations in geographical bureau funding levels may largely reflect new project starts, or perhaps forward funding of ongoing projects, but not necessarily actual expenditures of funds in a particular year. A rack up of expenditures per project by sector per year is not easily available because of the way AID's books are kept as well as the many slides it would present the information. Please bear in mind that slides shown for the Regions were for the purpose of illustrating the overall upward trends in obligations of regional health funding, but were not expenditure data.

One graph I especially commend to your attention is one illustrating the increase in funding levels for Centrally Funded Projects. These projects fund and service inter-regional and multi-country health activities. Many of them are the large projects known by acronyms such as DEIDS, ADSS, PRICOR, MEDEX, PRITECH, ORT-HELP and others with world wide scope. Many in this room 'ave been associated with one or more in some way.

# HEALTH PROGRAMS AS A PERCENT OF TOTAL DA FOR FY 1985

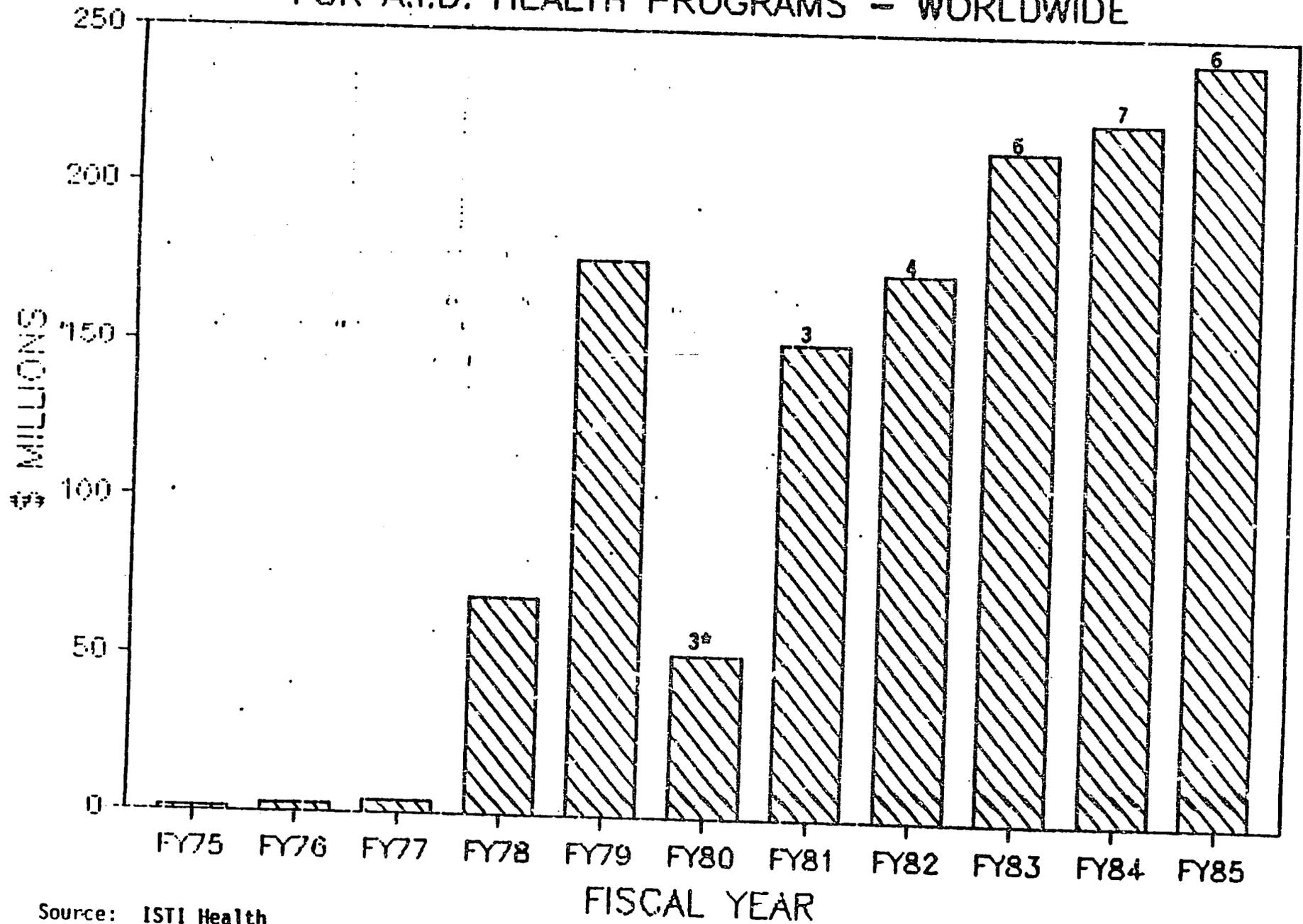


- 44 of 73 AID-Funded Countries  
27 have health officers or  
13 have health/population officers

Source: ISTI Health Funding Database

# ECONOMIC SUPPORT FUNDING FOR A.I.D. HEALTH PROGRAMS - WORLDWIDE

59

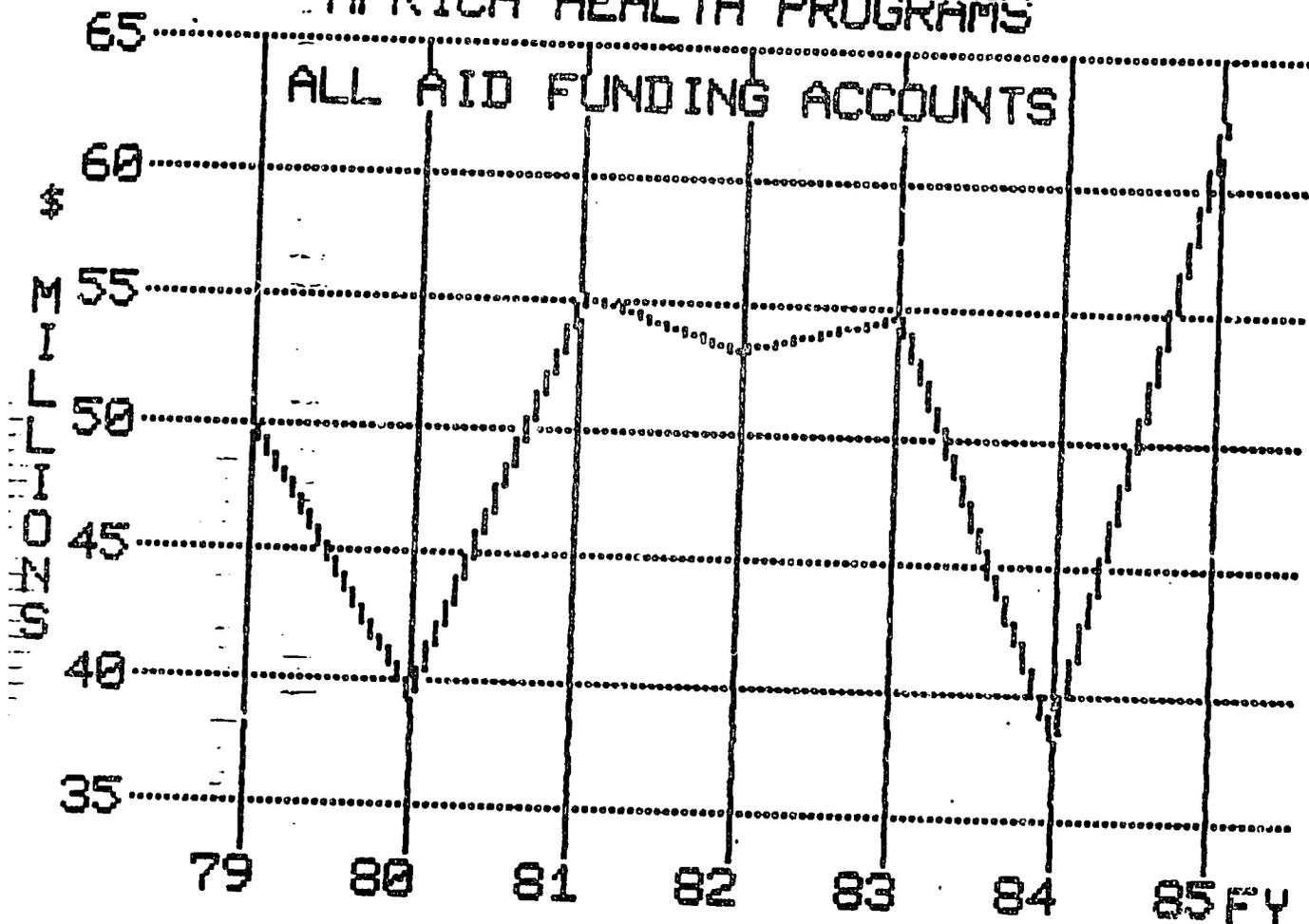


Source: ISTI Health  
Funding Database

\*This graph does not include regional or centrally funded countries

# AFRICA HEALTH PROGRAMS

## ALL AID FUNDING ACCOUNTS

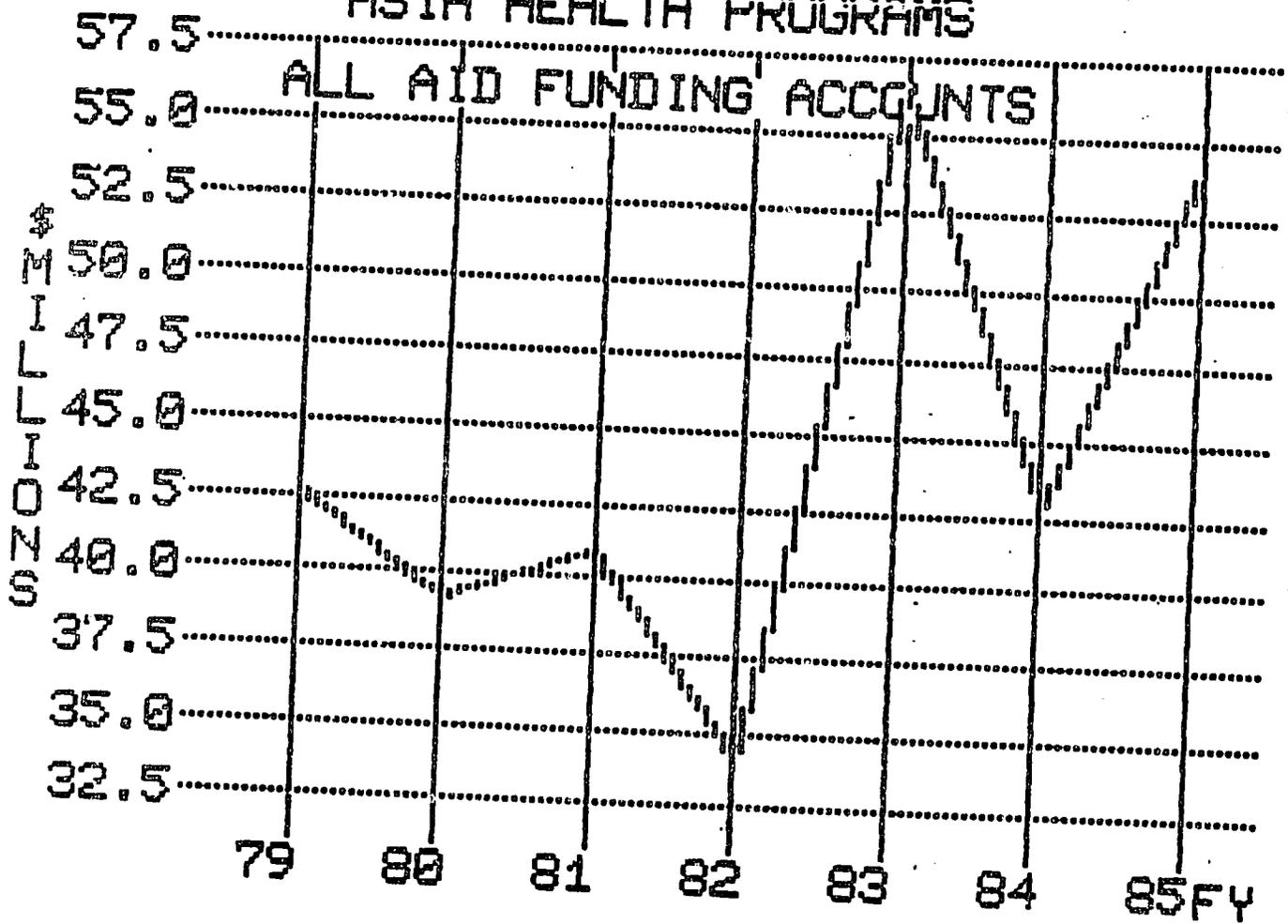


SOURCE: ISTI Health Funding Data Base

September 4, 1985

# ASIA HEALTH PROGRAMS

## ALL AID FUNDING ACCOUNTS

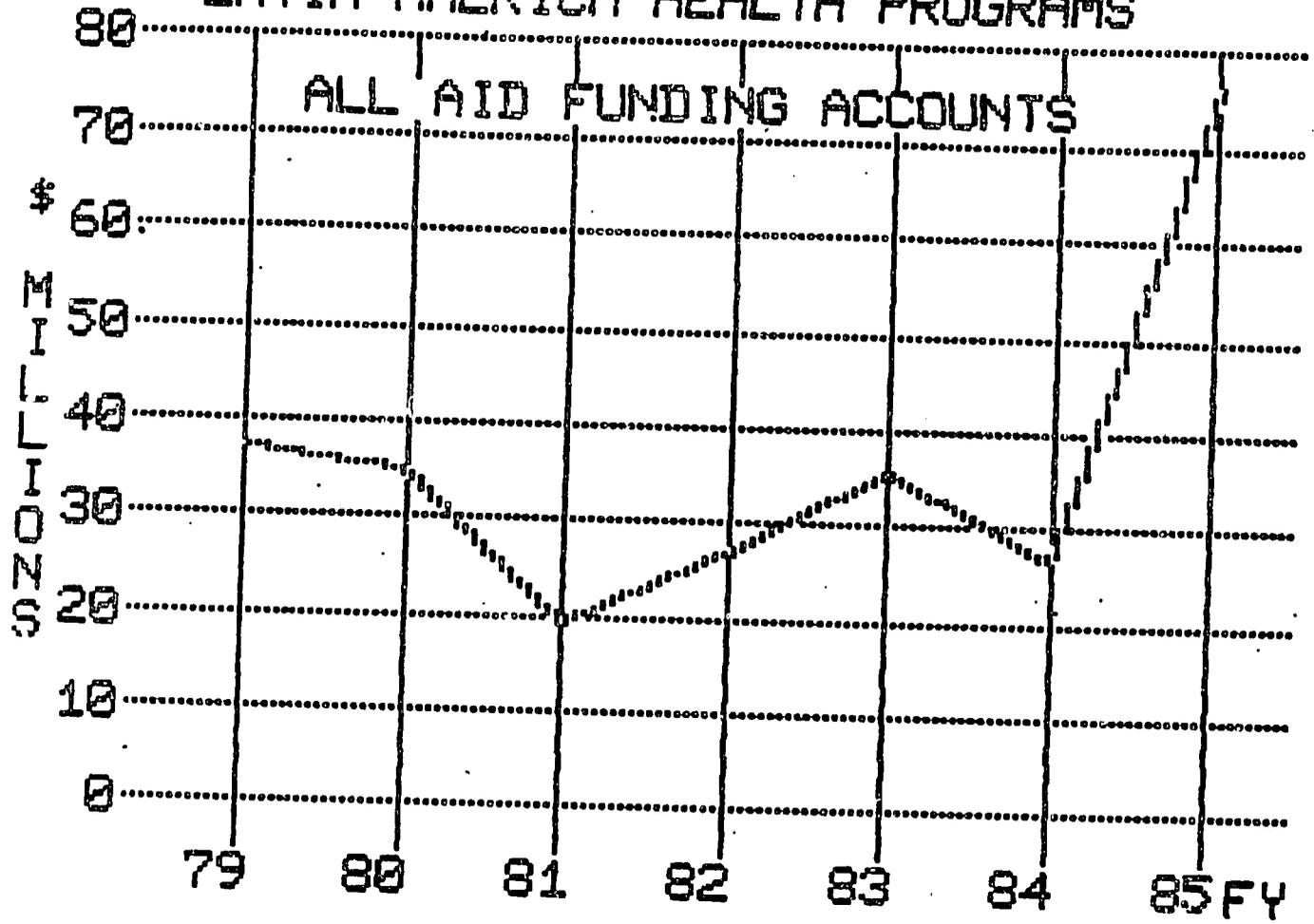


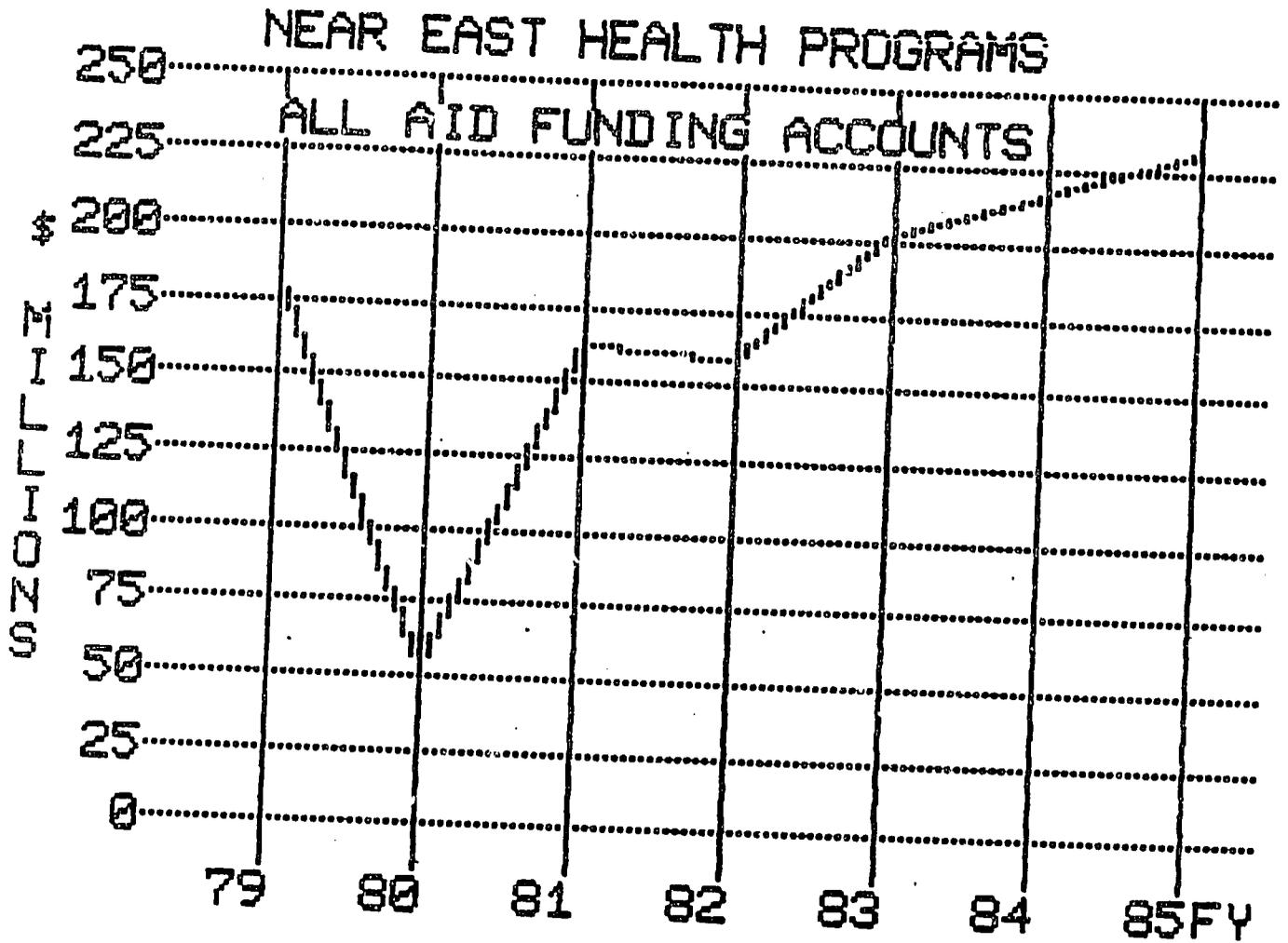
SOURCE: ISTI Health Funding Data Base

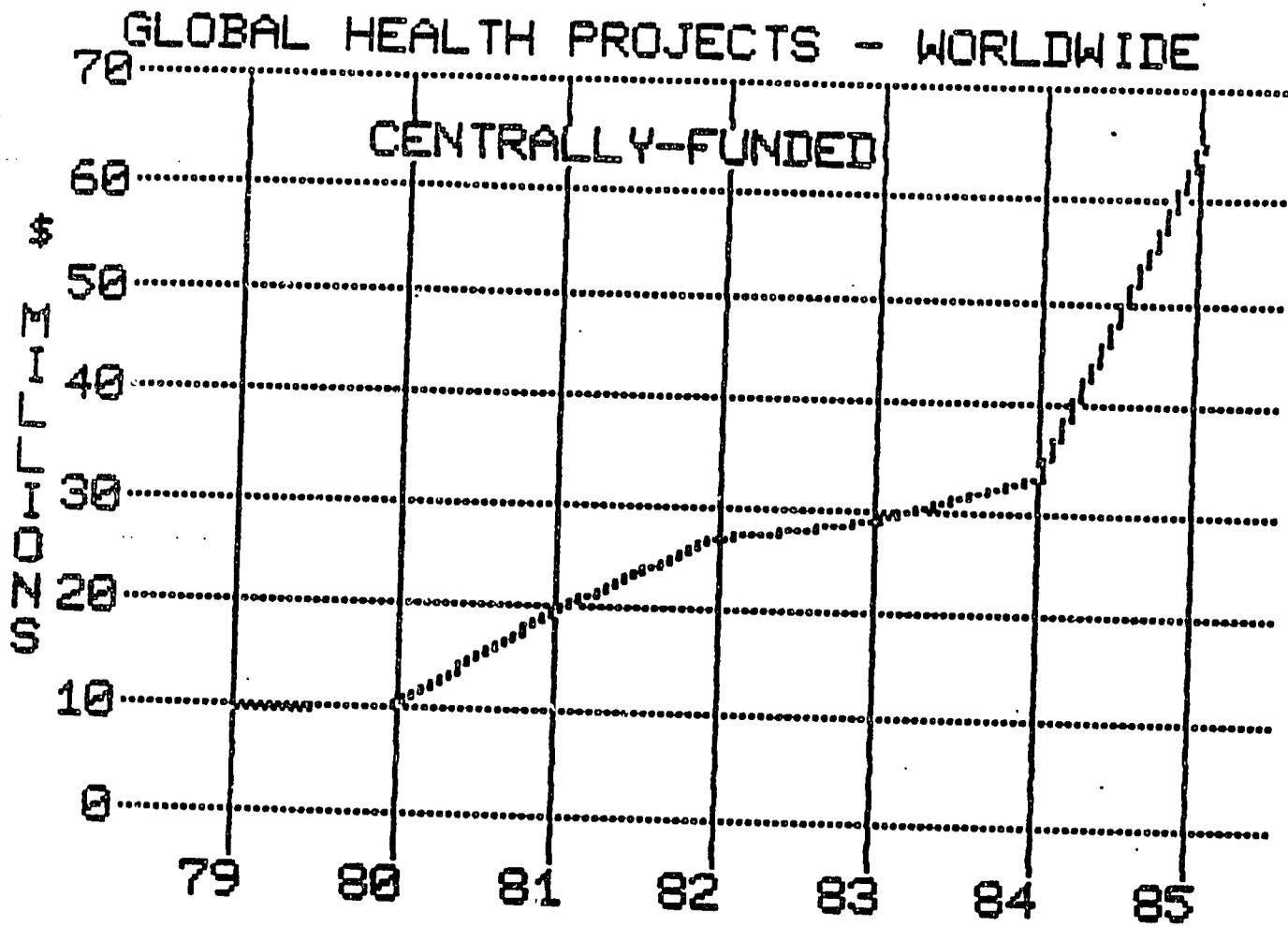
September 4, 1985

16

# LATIN AMERICA HEALTH PROGRAMS







SOURCE: ISTI Health Funding Data Base

September 4, 1985

12

November 18, 1985

After remaining relatively flat for three years there was a significant increase in funding levels for Centrally Funded Projects for 1985. This increase reflects healthy new levels of funding for special initiatives such as oral rehydration, diarrheal disease control, vaccine development, and the child survival initiative about which you will hear more from Dr. Pamela Johnson later in another paper during this session.

For a time it was difficult to obtain concurrence from Regional Bureau staffs to begin a new centrally funded activities. Many of you may not be aware that it is an internal requirement that at least a simple majority of Geographical Bureaus concur in development of any new centrally funded project. In the period from about 1979-83 it was difficult to obtain such concurrence. Passage of time, coupled with promotions, and transfers coupled with shrinking numbers have made Washington staff more willing to pull together than formerly.

It will be of interest to see whether growth of Central Projects which service all Regions and countries continues, or whether the pendulum will swing backwards. Two or three key people in bureaus able to block forward movement of new central projects in the recent past are now elsewhere. By way of contrast or three or four new people in those same positions have made forward movement possible once more. Individuals can and do make a difference even large organizations.

Overall, news on health funding levels has been good for the AID health sector. There is every indication that Congress will continue its support for health. The Gramm-Rudmann deficit reduction bill could of course affect everything. So much for good news. Let us turn to the darker side.

#### AID Health Staffing

A Canadian colleague observed a few months ago that federal bureaucrat bashing seems to have become national pastime in the U.S. What he found peculiar was that Congress often passed faulty legislation, then turned around and transferred the heat by pointing accusing fingers at the folks charged with administering the programs legislated by Congress when things didn't work out, but that even the professional public did not seem to be wise about this.

The most apt description of present day federal agency situation would be to describe them as in a 'crisis and convoy' state. Each day federal staffers, AID included, are confronted with one or more new crises and attacks from within or without. Like a World War II flotilla of cargo vessels, they attempt to convoy each day through the mine fields. Carrying out conflicted ambitions and conflicting ideologies of the administration they serve, they must all the while observe constantly changing laws and regulations, mollify powerful non-government constituencies seeking one-issue ends, and cope with individual hidden agendas of ambitious colleagues seeking promotion and hierarchical advantage, and despite all of this still get a job done. Not a pretty picture, but an accurate one. I do not miss this part of my former working life!

14

November 18, 1985

Add to these vicissitudes the game of musical chairs ordered by OMB and OPM, in which periodically but regularly, positions are eliminated, and you begin to have the sense of the siege mentality that is experienced by folks in AID.

The phrase doing more with less is often heard in the halls of AID. Translated this means fewer and fewer people to manage more and more projects and larger amounts of funds within the same regulatory, legal and accountability standards. As our English cousins would observe, the concept is basically rubbish since it ignores management realities associated with administratively supporting federally funded projects. But let's look at a few particulars and put some numbers to them to give this meaning.

Overall numbers of AID health staff plotted against worldwide AID health funding trends over several years is shown in the next slide. It is clear from this slide that although the level of funding, and the number of projects has multiplied nearly 11 times, the health staff to service these activities has been reduced markedly in real terms. Please do not think some technical fix will obviate the need for technical staff. Until computers can talk to developing country ministry staff, and make evaluation and monitoring visits as well as work out new project possibilities I suspect we will need old fashioned mentating humans to do many jobs for a long time to come.

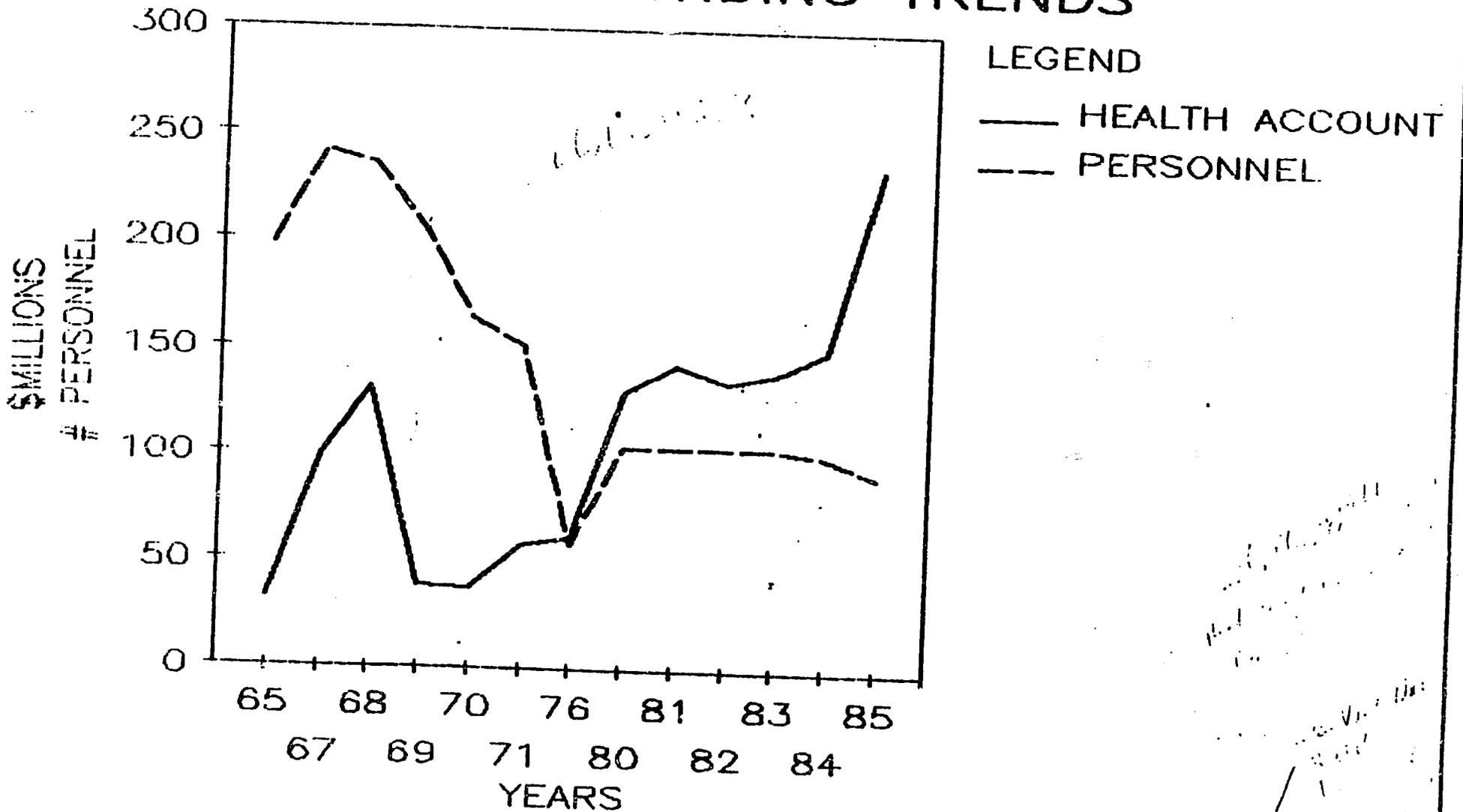
Let us next look at the staffing situation from another vantage point. The following data is not from the ISTI data base, but from another government department source that is tracking manpower. While not right up to date this data reveals the shape of things to come. Rather quietly across most of federal government there is a silent process going on that gets little attention in the press since it is not visible. This is the strategy of position deletion to effect work force shrinkage. Positions are marked for deletion and when the incumbent leaves, the position permanently disappears leaving the losing office to take up its belt another notch.

This slide details the number of AID employees as of August 1985. There were a total of 3867 employees world wide. Of these, 1528 or 40% were physically overseas, and 2339 or 60% were based in Washington. There were 274 additional part time employees, 88% of whom (243) were based in Washington.

The largest number of foreign service employees were in Africa (470) followed by Latin America and the Caribbean (327), with Asia having 282 and the Near East Region 196. AID/Washington has many employees who service all regions, or perform Agency wide functions such as accounting, personnel, payroll, legal, communications, logistics, congressional liaison, senior administration, and security, as well as backstopping country missions and technical sectors. There are also scientific and technical specialists who service all AID-assisted countries, but are based in Washington.

Lest you think the 3867 represents continuing positions, it should be pointed out that in August of 1984 335 overseas and 393 Washington positions for a total of 728 positions have been deleted. The persons in them have not been terminated, but these positions will disappear whenever an incumbent leaves, transfers to another position within the Agency, or retires. Late last summer another 260 positions were further deleted and will disappear in the

# A.I.D. HEALTH STAFFING COMPARED WITH HEALTH FUNDING TRENDS



Personnel numbers 1960-71 for Vietnam

Figure 6  
 Agency for International Development Employees  
 August 31, 1984

Location	Full Time		Total	Part Time
	Continuing	Deleted		
<u>Overseas</u>				
Africa	397	73	470 (13%)	9
Asia	254	28	282 ( 7%)	11
Latin Am./ Caribbean	280	47	327 ( 9%)	9
Near East	168	28	196 ( 5%)	1
Reass/Comp.	94	159	253 ( 6%)	1
<u>Overseas Total</u>	1193	335	1528 (40%)	31
<u>AID/Washington</u>	1946	393	2339 (60%)	243
<u>World-Wide</u>	3139 (81%)	728 (19%)	3867 (100%)	273
Additional Cuts 2879 (74%) 988 (26%) 3867 (100%) FY 86				

November 18, 1985

near future. If my arithmetic is correct this will represent a loss of nearly 988 positions in the near term. Since reductions are by attrition, not by reduction in force, changes will be slow and undramatic, but relentless. If AID/health takes an equal share of these personnel cuts despite funding increases it will lose from 25-28% of its positions over the next 2 to 3 years.

Over the past five to seven years another process has been going on which may turn out to be more ultimately destructive to the overall quality and character of health work supported by the Agency. I am referring to the erosion of the ratio of professional specialists to generalist managers. The "buzz-words" senior management use are that AID needs more process managers and fewer subject specialists. The strategy will be to contract out for thinking, and skills associated with subject expertise. The fly in the ointment is that there is not enough contracting staff to do the work.

On the surface contracting out as an idea is seductive. The conclusion may be drawn that it may not be such a bad idea to "privatize" (another buzz word) this kind of thing. Reflect for a moment on how difficult it is now to persuade a harassed AID manager-professional to stop running long enough to help iron out a contract problem, to read a report or listen to a new though technically complex idea which deserves a try. Now visualize the probability of being able to convince a generalist manager under coming conditions (whom we should grace with the title of omniologist since he will be expected to know all and do all) under coming conditions, and who has modest knowledge of medicine or public health to comprehend the value of the new proposition without having to contract for someone to advise him. I am not talking about incompetence but about time and professional background. As you will remember the specialist is a man who comes to know more and more about less and less until finally he gets to know everything about nothing. In contrast the AID generalist manager will come to know less and less about more and more until finally he knows nothing about everything. My sentiments are expressed only partly in jest since like Dickens I would present you with the ghosts of Christmases to come.

For those of you now AID contractors, to get what you need in order to carry out your tasks abroad, professional people must be in place within the Agency who understand the validity of your agenda and what you are about, and must be available to carry out tasks legally permitted only to federal staff. There must be a reliable cadre of long term feds who know how to work within, catalyze, facilitate, and understand the federal labyrinth, and most importantly who are also professionally qualified and can understand and serve as an inside advocate for the health sector to support what is going on in the larger international health community and not just the AID company.

Certain operations cannot be done by outsiders. Banks, for instance, rarely allow their customers to establish their own credit rating, approve their own loans, or go behind the counter and help themselves from the tellers cash drawers. It is no different in federal government. There are minimum numbers needed to carry out legally required actions. Have you noticed that there are many fewer such souls these days than a few years ago? Enough of the self-evident, let us examine another problem in the health sector.

November 18, 1985

Civil servants take much heat for rules they implement but did not invent. Many such rules were made by Congress or the Executive. Federal employees are implementors of the law, not framers of it. There are nonetheless many choices within the purview of Department or Agency "top brass." While the top men no longer determine the size of their work force, OMB and OPM does that, they do determine how authorized positions are distributed in their Agencies. There has been a reluctance within AID senior management to staff health commensurate with funding levels. Men such as Kenneth Bart on this platform make a strong case for needed health manpower. Regrettably however it may not be enough given the way things work. Such changes must come from the very upper most rung on the ladder in these times.

This audience has been influential in many ways. The reversal of shrinking health funds of FY'84 were brought about in part through the influence of some in this room. It is possible that the staffing issue can also be addressed and improved in like manner. Perhaps lightning can be made to strike again..in the same place but for different purposes. In our common interest we must not only be prepared to persist,...but to endure.

While no longer part of AID, I submit it is in our mutual interest as international health people to concern ourselves with AID's problem and take whatever steps we can to assist our AID colleagues. As one of our patriot forefathers reminded our forbears, we must all hang together if we wish to avoid hanging separately. Ask not for whom the bell tolls.....