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Rev. 1

TRENDS IN UNITED STATES AND INTERNATIONAL FINANCIAL SUPPORT FOR HEALTH IN DEVELOPING COUNTRIES

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The sources of external and financial cooperation for health in developing countries include the 18 industrial country members of OECD*, 5 multilateral banks and the European Community, 8 members of Eastern European countries, 12 agencies of the United Nations, 9 OPEC** Funds , at least 6 advanced developing countries, and an estimated 1500 nongovernmental organizations. In 1986, these sources disbursed an estimated \$4 billion for technical and financial cooperation in developing countries.

In the context of this colloquium, U.S. plans and programs for the 1990s will need to be defined in relation to the global effort. Thirty years ago, U.S. cooperation in health represented approximately 90% of all external concessional support for health to developing countries. In 1986, the U.S. share was only 13%. In relation to world-wide concessional and nonconcessional financing, the U.S. share is reduced to about 10.5%. While the United States remains the largest single source of concessional financing for health, is size the most important issue? Are U.S. program objectives any different from those of other major sources? Does the U.S. or any other financial source have access to an international mechanism for carefully assessing the global supply of external concessional financing for health in relation to the defined requirements of developing countries? To what degree is the U.S. financing health programs which other financial sources are just as willing to support? And if this is the case, is the U.S. using its resources in the most cost-efficient way during a period of increasing budget constraint?

This paper limits observations to the financing and program of the U.S. Agency for International Development (A.I.D.) which is the official federal agency for providing bilateral assistance to developing countries,

* Organization for Economic Cooperation and Development, Paris.

** Organization of Petroleum Exporting Countries

although there are at least 13 other federal agencies or semi-autonomous organizations which contribute to research, service, and financing for international health activities* .

Figure 1 shows the President's budget as it relates to international affairs. A.I.D. administers the sections called Development Assistance, Economic Support, Food Aid, and voluntary contributions to such UN agencies as UNDP and UNICEF(1). Military assistance and funding for a number other other organizations such as the Peace Corps and the international banks are beyond A.I.D.'s authority.

Figure 2 shows a 10-year trend for the Development Assistance and Economic Support accounts which show only modest variation in terms of constant 1979 dollars. In current dollars, the Economic Support Fund shows major increases in the period starting in 1985 which reflect the Administration's Caribbean Basin Initiative.

What is the likely trend for the 1990s? Constraints imposed by the federal deficit reduction bill (Gramm- Rudman) are not entirely predictable except that the Agency will bear a portion of the reduction. When the President's Budget was reduced in Congress by \$3 billion(i.e. down from \$19 billion in 1987), the Economic Support Funds, which reflect U.S. commitments to countries considered to be of strategic importance to the U.S., were not reduced to the same extent as the Development Account. The outlook for financing in the latter account, which contains most of the Agency's basic development financing , will depend on the policy emphases of a new Congress in 1989 and the degree of support provided by the next Administration. It is predictable, however, that as the budget squeeze continues, federal agencies without large constituencies such as A.I.D. will find it difficult to attract support within a highly competitive Congressional environment.

Table 1 illustrates the earmarked accounts within the Development Assistance and Economic Support Funds. In each of these, only modest

*Agriculture, Defense, Environmental Protection, Health and Human Services , Inter-American Foundation, Interior, NASA, National Science Foundation, Overseas Private Investment Corporation, Panama Canal Zone, Peace Corps, State, and Treasury.

declines are proposed for 1989. By comparison with 1986, there are significant declines in all DA accounts . This would produce a marked shortfall in the total health allocations were it not for the special earmarking for Child Survival and AIDS.

Note that the proportion of loans within the Development Account was 11.6% in 1986, 7% in 1987, and an estimated 4% in 1988. Economic Support Funds are provided as grants.

The distribution of Agency assistance to 75 countries for FY 1988 is shown in Table 2. Figure 3 illustrates that about one-quarter of all programmed funds in the Development Assistance account are applied for health, population, and nutrition.

Figure 4 illustrates a 24-year financing trend for all health -related accounts(2) . For comparability with definitions of other financial sources, the accounts include those which Congress has earmarked for health, population, nutrition(Agriculture, Rural Development and Nutrition), Child Survival, AIDS, the Sahel, Science and Technology, the Economic Support Fund, and the American Schools and Hospitals Abroad. The accounts exclude U.S. contributions(assessed or voluntary) for UN agencies. This melange of accounts is characteristic of Congressional practice to assure accountability of program expenditure. By contrast, no other bilateral donor is subject to this degree of legislative oversight. Other than A.I.D., most donor organizations receive only general guidelines from their respective legislatures for the disbursement of financing. Final allocations are based more directly on negotiations between donor representatives and requesting countries in relation to defined demand rather than pre-set earmarked program priorities. .

Figure 4 identifies a limited number of program markers as the overall volume has increased to a high of \$606 million in 1985 following the special earmarking for Child Survival and availability of Economic Support Funds for Central America and the Caribbean. The past three years have seen a progressive decline in the total account with the effects of the Gramm- Rudman legislation being particularly evident in 1988 and in the

1989 Congressional request. Declines have been more severe in other sectoral accounts, a trend which from the multisectoral view of health is unfortunate since agriculture, education, and rural development are of critical importance to health outcomes. In current dollars, the trend in the health account remains remarkably favorable. Although program content is normally subject to debate, the financial trends clearly indicate that health activities have received high budget priority by the current Administration. Figure 5 illustrates the actual trend in constant 1985 dollars over the past 12 years. While this figure does not include all health accounts, it suggests that financial investment in health is not yet falling although, in terms of purchasing power, the accounts represent a basically level or "straight-lined" investment. With the expected fluctuations in annual Congressional appropriations, however, there is also no evidence that the future might permit a significant increase in the combined health accounts, for example, a doubling or tripling of input. Over the period of the 1990s, current trends along with increased federal competition for declining appropriations will pose new dilemmas for the Agency in its effort to support international health goals of high global health coverage. If major increases are not likely, the effectiveness and efficiency of the Agency in support of international health will depend on how limited U.S. funds are spent in cooperation with other global sources.

Returning to Figure 4, it is useful to point out that the Agency operates basically on the development institution model, namely that the primary negotiation and decisions for financing within developing countries are carried out by the Agency's geographical regional Bureaus which maintain contact through AID Mission personnel resident in cooperating countries. The Agency's combined health-related activities are channelled through the Bureau of Science and Technology's separate offices for Health, Population, and Nutrition, through three Regional Bureaus, the Bureau of Food for Peace and Voluntary Assistance, and special offices for a Science Advisor and for the activities of the American Schools and Hospitals Abroad.

In spite of these patterns of administration which are found in varying degrees among most other large developing organizations, the program

content has not varied greatly from prevailing international consensus over the past 25 years. In 1965, there were 150 health projects(Fig.4) addressing community water supply, rural health services, malaria eradication, medical education, nursing, public health administration, health education, communicable disease control, sanitary engineering, and training of auxiliary workers. In 1965, the program included financing for smallpox eradication in Africa. Population earmarking began in 1968 and served to greatly extend access to population services on a global scale.

In the early 1970s, there was serious re-assessment of health, population, and nutrition programming goals with the intent to strengthen the capability of cooperating governments to sustain their own efforts. The Agency was fully sensitive to the magnitude of populations without basic access to services in these fields. Except for decreasing emphasis on medical and nursing school development, the Agency program portfolio addressed questions of access gap based on the theory that governments should be supported in the type of trial which would permit them to make their own management and financing decisions. Major efforts were made to develop new models of basic delivery systems for health, nutrition and population such as the Lamphang trials in Thailand. U.S. universities were invited to help in this process by providing opportunities for advanced training and participation in country trials.

Since 1970, the Agency has sponsored about 10,000 students and trainees per year, about 15% of whom were in the health fields. World-wide, DAC donors have sponsored about 100,000 trainees per year over the past 10 years, an effort which would inevitably modify the requirements for U.S. training from less specialized to more specialized assistance. After 30 years of development cooperation, and taking into account a longer history of Foundation-sponsored Schools of Public Health, excellent facilities have grown around the world and it becomes important to assess what training in the U.S. is preferable to professional training already available in developing countries.

Emphasis on primary health care design established principles during the 1970s which were later accepted into the " accessible, affordable, acceptable" criteria used in the report of the 1978 Alma Ata Conference

on Primary Health Care. Tropical disease research was being supported in the late 1960s including efforts to identify approaches to a malaria vaccine at a time when it was commonly accepted as an impossibility by most malariologists. A.I.D. financed the Rockefeller Institute trials which first demonstrated the ability to grow *P. falciparum* in-vitro. In effect, the 1970s were used to examine new ways to plan, design, research and identify unique ways to support development which could not be readily duplicated by other donors or by developing countries themselves. In general, these program priorities in primary health care have been sustained in the 1980s^{with} greater emphasis on extending the newer technologies associated with Child Survival.

The current program, which enjoys strong support by the Administration and Congress, is based on the Agency's 1986 Policy Paper on Health Assistance. Over 50% of all sector financing, excluding the population account, is allocated for Child Survival through the four main program emphases: immunization, oral rehydration therapy for diarrheal disease, improved nutrition for children, and birth spacing for high-risk mothers. The remaining half of the health accounts support health care financing (primarily focussed on effective use of alternative financing at the country level), water supply and sanitation, malaria research and disease control, and the new emphasis on AIDS.

These program activities are eligible for support from most other major development agencies and UN organizations, with differences in geographic distribution and level of financing. The consensus on international health policy is useful to keep in mind as Congressional budget constraints begin to limit the program of A.I.D. Is A.I.D. financing programs that would be willingly supported by other financing sources? By policy, A.I.D. strongly endorses collaboration with other donors. In practice, however, does the momentum of past programming practices induce a form of "historical jet lag", that is, planning for the future as if there were few or no alternative sources to fund the SAME program objectives?

Turning to international sources of financing for development, Table 3 shows trends in total resource flows which have exceed \$100 billion

annually in current dollars between 1978 and 1982 (3). The two main categories of finance are characterized by their degree of concessionality. Official Development Assistance (ODA) is composed of grants and very low-cost loans which are of particular interest to the health sector. The other categories on Table 3, other than grants by nongovernmental organizations, are loans at commercial rates or at rates, as at the World Bank, which exceed the DAC/OECD definition of concessional financing (ODA). In contrast to the distribution of financing patterns in 1982 (Figure 6) where ODA was only one-third of all financial flows for all sectors in developing countries(4), there has been a marked decline of nonconcessional flows due largely to the reduction in investments by the private banks(Figure 7). The decline in private commercial flows to about half the 1982 levels and the progressive increase in concessional financing means that ODA, as of 1986, represents over 50% of all external financing to developing countries. The significance of this trend is that concessional resources are assuming greater importance than in the past and merit far greater attention by A.I.D. to understand the potential for alternative external financing in support of those program objectives of greatest interest to the United States.

The distribution of world-wide sources of concessional assistance (ODA) for all development sectors is shown in Table 4 which illustrates three major source categories:

1) Bilaterals administer 73% of all concessional financing. The bilaterals include the industrial DAC countries, OPEC, CMEA(Eastern European countries) and other smaller industrial nations.

2) Multilaterals administer 20% of concessional financing and include the World Bank, Regional Banks, EC, the OPEC funds(13.5% as a group) and the United Nations(6.5%). International banks provide an additional \$7.8 billion in nonconcessional support for development, for example World Bank financing other than the Bank's concessional facility: the International Development Association (IDA).

3) Nongovernmental organizations administer 7% of concessional assistance through an estimated 3000 private and voluntary organizations.

Table 4 illustrates that the principal sources of health financing are

development organizations, not health agencies, a perspective useful to bear in mind in reviewing the program of A.I.D. which is also not primarily a health agency.

Multilateral agencies provide one-fifth of all concessional funds, although the coordinating role and personnel availability in these organizations greatly supplement the financing role. The 18 industrial DAC-member countries contribute about one-third of their funding to the multilaterals. While this allocation is an important factor in the operational programs of the UN agencies such as WHO and UNICEF, the current policies of DAC countries impose legal limits on the volume of multilateral funding which collectively represents about 30% of donor government concessional support. The trends do not suggest that this proportion will increase in spite of special exceptions as in the current program of Italy. (5)

Within developing organizations, the support of health is based on policies of legislative bodies or controlling boards. For the major multilateral and bilateral agencies, these policies normally cover a broad range of development objectives within which health is usually accepted as appropriate for investment if the requesting government justifies health within national development priorities. Except for the United States which, due to Congressional oversight patterns, has historically earmarked its budget, most external sources are prepared to negotiate with cooperating countries for a wide variety of health-related activities provided the requesting government articulates its proposal in a form which meets the approval of the developing country's own national financial or planning authorities. In this sense, the policies in support of health are far more favorable than the availability of demand from requesting countries in the form of proposals which have been approved by national planning authorities. The barriers to effective national development planning and proposal or program preparation are major problems for the mobilization of external financing. For this reason, traditional coordination among donors for the purpose of increasing health flows has limited value except in special emergency situations such as the Sahelian and Ethiopian famines. Official agencies cannot legally respond without host-country approved

demand. Such official approvals are usually not necessary for nongovernmental cooperation, but the demand must still be formulated.

A study of donor policies on health cooperation sponsored jointly by WHO and A.I.D. in 1980 (6) concluded that the health sector is perhaps the least competitive among the development sectors and the least prepared to compete, regardless of program content. The study argues that the supply of international financing for health far exceeds articulated demand and that one solution to attract financing is to establish an international system specifically designed to support the efforts of developing countries to identify their own priorities, to undertake the necessary financial analysis which identifies need, and to prepare proposals in a form which meets the approval of national planning authorities or, in the case of the NGOs, justifies the need. This process does not assume that external financing is essential or useful but that its mobilization, if desired by a developing country, requires a practical appreciation of the process of external financing and negotiation.

The principal sources of concessional financing for health are shown in Figure 8. Data are estimated from available annual reports and directories taking into account the frequent inconsistency of definitions and program content(7). The referenced 1980 WHO/A.I.D. donor study(6) found major differences between the DAC Creditor Reporting System and information obtained directly from financial sources.

In 1986, four principal categories of financial sources contributed an estimated \$4.006 billion for health and health-related areas such as population, nutrition, water supply, environmental sanitation. The bilaterals provided \$1.772 billion from 18 agencies and other official donor country development financial sources. The multilateral banks and EEC supplied \$625 million, supplemented by an additional \$990 million in nonconcessional financing for population, health, nutrition, water and sanitation. Nongovernmental organizations represent about one-quarter of all flows from an estimated 1500 organizations, most of which are primarily technical assistance rather than financing organizations. Foundation data is limited to the principal American institutions and will

therefore underestimate global foundation availabilities from non-US sources. The United Nations total of \$748 million represents the regular budget of the principal health-related sources and includes assessments by both developed and developing countries. As a practical classification, the WHO represents a technical rather than financial resource. Funds actually administered by WHO and its Regional Offices is about double the regular assessed budget due to voluntary contributions from multilateral, bilateral, NGO and other UN sources. The larger estimate is omitted here to avoid double-counting.

A fifth category, commercial sources, is illustrated in Table 5. In a report on World Pharmaceutical Production and Trade, prepared for the Pan American Health Organization in 1980 (8), consumption of medicines in developing countries was estimated to be \$10.3 billion. Excluding Japan from this category, which may account for \$4 billion of the Asia total, recorded consumption in developing countries would be on the order of \$6 billion. To the degree that this level of cost could be reduced by industry agreement to sell lower-cost generic drugs, the so called "essential drugs", the net effect would be to reduce high recurrent costs in developing countries which spend as high as half of their public budget on drugs. If, for example, a 30% reduction in manufacturers' prices were to occur, the savings to developing countries could theoretically total on the order of \$2 billion, an amount equal to half of the current estimated total concessional health flow of \$ 4 billion.

The first observation, taking into account the inherent problems in gathering global statistics, is that the collective health total represents less than 10% of global concessional flows for all development purposes(\$47.3 billion in 1986). Other than the United States, the magnitude of concessional flows for health represents only the level of approved demand and not the limitation of financial availability. No country other than the U.S. has a Gramm-Rudman bill. Global concessional financing is increasing in current dollars, at about 3.6% per year(3). Japan, for example, is attempting to double its concessional assistance over a five year period so that by 1990, its level of development aid will reach \$7.6 billion. In 1987 Italy increased its aid levels by 58% to become the fifth largest program among DAC countries (3). In view of

these trends, the outlook for increased financial supply for health purposes is favorable providing there is serious attention to sectoral financing through the development of a practical global system to identify, justify, and mobilize such financing for developing countries.

A second observation is that there are no predominant concessional donors. The U.S. share (\$529 million) is only 13% of all concessional flows for health, and only 10.5% of total concessional and nonconcessional flows. From the financial support perspective, effective efforts to resolve major international health priorities will require carefully analyzed joint cooperation between developing countries and external sources.

A third observation is that there are major program and administrative differences in the process of financial allocation. Most bilateral and multilateral agencies actually transfer program funds, although the French and British programs support very large contingents of technical personnel. The full time staff of A.I.D. now lists 117 civil and foreign service personnel, supported by a larger number of contract and federal inter-agency professional staff. Most European donors have few full time health staff and almost no overseas resident health staff. The banks maintain headquarters health personnel and employ consultants for overseas activities but do not place resident health advisors in developing countries except for those directly engaged in a health project. In contrast, nongovernmental organizations and UN organizations maintain large numbers of headquarters and cooperating country professional staff. WHO and PAHO jointly employ around 4000 professional and technical personnel at headquarters, regional, and country levels.

A fourth observation is the absence of an organized international system designed to mobilize external concessional financing for the health sector, as described subsequently under Recommendations.

A fifth observation is that, in terms of program content, there is already broad consensus on primary health care priorities. While the relative program emphasis on program content will vary between organizations, the objectives per se are not unique to any donor. Beyond the primary health care set of activities which have received

international attention since the Alma Ata conference, there has been less unanimity on objectives which are directed to improve and sustain the functioning of the sector as a whole. In this sense, the "whole" means those essential and sufficient conditions without which large scale programs are a great risk of failure: technical, administrative, financial, and social feasibility.

As noted earlier, these observations on external financial supply are irrelevant without considering the basic constraints to demand as expressed by the developing countries. Based on the WHO/A.I.D. study (9), and DAC experience in development, the basic barriers to effective utilization of external financing are listed:

- 1) Limited capacity to undertake national health planning or financial analysis as a basis for determining external (or internal) requirements. It is already well-established that national financial resources, not external financing, are the major resource for developing countries.
- 2) Unfamiliarity with potential sources of external finance and the variations in patterns of external cooperation.
- 3) Weakness in justifying health proposals in terms of national development, including issues of recurrent cost.
- 4) Unfamiliarity , within ministries of health, of the basic process of proposal development and negotiation.
- 5) Reluctance of national planning authorities to approve social sector projects during a time of economic constraint and restructuring.
- 6) Absence of an international technical advisory resource from which to obtain timely guidance on sector financial analysis, alternative potential sources of external concessional financing, and the process of attracting and mobilizing such financing. While guidance along these lines is available from external sources in relation to the development of a project in which the donor has a participating interest, similar support is very limited for the developing country which wishes to explore and attract alternative sources of financing for a sectoral health activity of multi-year duration. WHO and PAHO have participated closely with development organizations for many years in program and project preparation. While endorsing the need for financial mobilization, the traditional Organization role has been to provide technical rather than

financial guidance to its member countries since financial responsibility and accountability for design and performance of development projects lies with the requesting country and the cooperating external financial source.

RECOMMENDATIONS

As assumptions, the U.S. will continue to support international consensus for expansion of primary health care priorities as at present. In terms of an agenda for the 1990s, the issues are not only those of technical design and content, but at what rate and volume will U.S. cooperation be required? And for how long? Will the current range of social, cultural, economic, administrative and technical predisposing conditions to infant mortality, tropical disease, and malnutrition be subject to resolution through any combination of current technologies within the next decade or, for some countries, within the next century? Should the U.S. be thinking in terms of Health for All by the year 3000? Aside from seeking some measure of short term impact, most donors accept that health problems are inextricably related to general economic and social conditions which will require sustained effort until international cooperation is no longer of value. Given this assumption of the basic long term nature of health development, is it rational for the U.S. to concentrate on limited interventions without assessing the basic structural requirements for sustaining health in the long term and without assessing alternative financial and professional resources on a global scale? What are those interventions that uniquely utilize the best U.S. experience in development and public health?

The first recommendation, therefore, is that the U.S. agenda for the 1990s be based on a re-examination of international health priorities, not only from the viewpoint of the greatest presenting problems, such as infant mortality, but the equally important underlying factors which perpetuate low levels of health. The agenda should be based on strategies which accept that health improvement in developing countries will be determined primarily by the efforts of developing countries themselves. To that end, strategies should consider the balance between the direct technical intervention, such as the introduction of new technologies, and the

mobilization of the most unique professional resources and institutions for research, planning, and advanced speciality training.

A second assumption is based on the reality of Congressional budget constraints at a time when internationally-agreed goals propose substantial expansion of primary health care objectives. Effective and efficient utilization of increasingly tight U.S. funding will require:

- greater, not less, attention to professional understanding of the technical and financial resources of all potential sources of external health financing,

- greater acceleration of technical support to developing countries in the planning, definition, and articulation of external demand, and

- the establishment of cooperative international mechanisms, not yet in existence, which support the efforts of developing countries to match demand with the supply of financing. The DAC Chairman has recently noted that "coordination is not simply a process of lunching together with other donors once a month" but "is analysis, fact collecting, policy articulation and problem solving." (10)

The second recommendation, therefore, is that the United States should take a new initiative to bring about, in cooperation with other major external financial sources and the World Health Organization, an international system for external financial mobilization for health in developing countries. The principal elements of this system would include:

- 1) Systematic and continuous identification of potential sources of external concessional financing for health.

- 2) Documentation of external official and private sources, including their policies, financing potential, and program processes, and to assure the availability of this information to users both within developing countries and among the international health community.

- 3) Systematic and continuous identification of health sector demand for financing in developing countries, at both the national and external level.

- 4) Provision of current guidance, technical assistance, and support for training of professional personnel in developed and developing countries in the art and practice of attracting and negotiating financial support for health.

Regardless of technical program content, the mobilization process should include the several components outlined in Figure 9: Development and health planning, financial analysis, preliminary project identification, potential financial source identification, preliminary negotiation, proposal development, and final negotiation.

It is not suggested that this recommendation apply only to the U.S. program of the 1990s. It is the development-oriented organizations, world-wide, that should benefit from the effectiveness of greater organization and design in the mobilization of financing for health. Ideally, external financial mobilization should be a primary activity of the World Health Organization. As noted earlier, the Organization fully endorses the need for mobilization, although its role as a Secretariat to its member countries precludes effective action when the objectives of its ministries of health do not coincide with the intent of national development planning or financial authorities. Consequently, the Organization is often responding to the technical requests of its member ministries of health rather than strengthening the ability of governments to mobilize financing. It is a paradox that the Organization is constitutionally authorized to be the "international coordinating authority in health", but has no similar mandate to be a coordinating authority for development or those development financing organizations which serve predominantly to provide financing for the health sector. The bilateral alternative to WHO is DAC (the Development Assistance Committee of OECD). Fact collecting from donors is routine, but health data is not complete, the dialogue on health is limited, and DAC has no mandate, except through its bilateral members, to negotiate with developing countries.

For these reasons, the time has perhaps arrived for the major development oriented financial organizations, who carry the responsibility for financial cooperation with developing countries, to assume a greater responsibility for accelerating the rate of financial mobilization for health. In support of this effort, the Agency for International Development could play a significant role in catalyzing the proposed international action, in full dialogue and cooperation with other major sources and the World Health Organization.

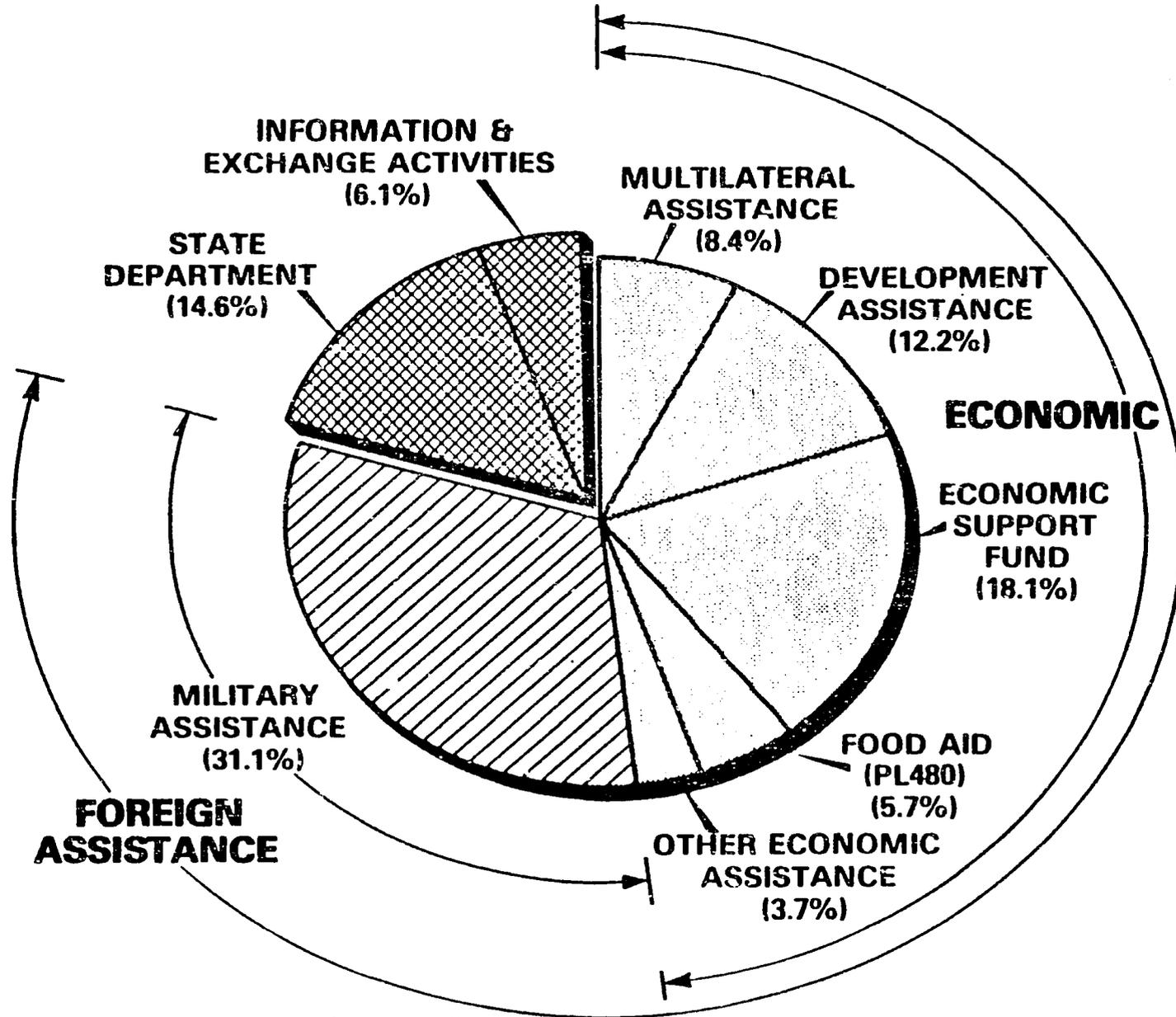
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10. See reference No. 3, p.46.

Fig.1

INTERNATIONAL AFFAIRS APPROPRIATIONS

FY 1989



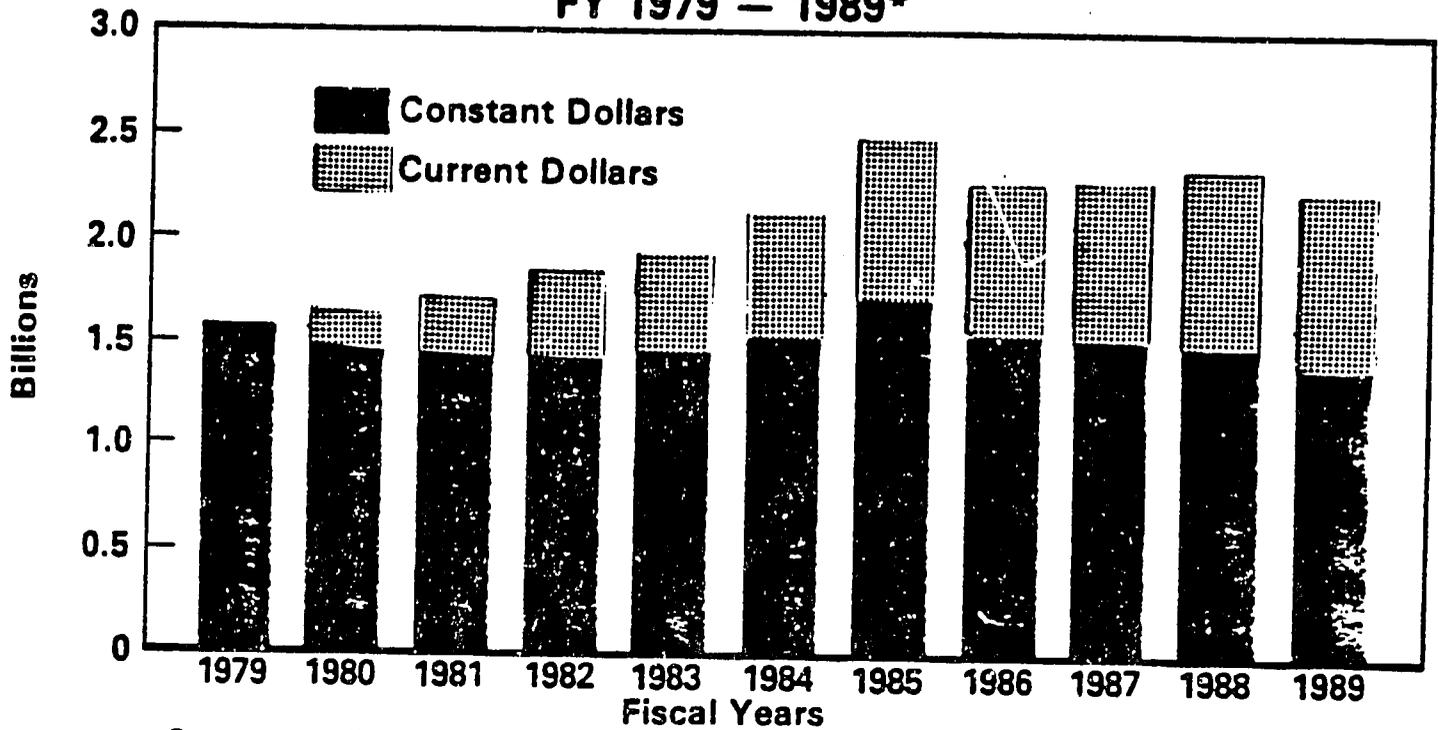
Congressional Presentation, FY 89
Agency For International Development

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Fig.2

Development Assistance (DA)

FY 1979 - 1989*

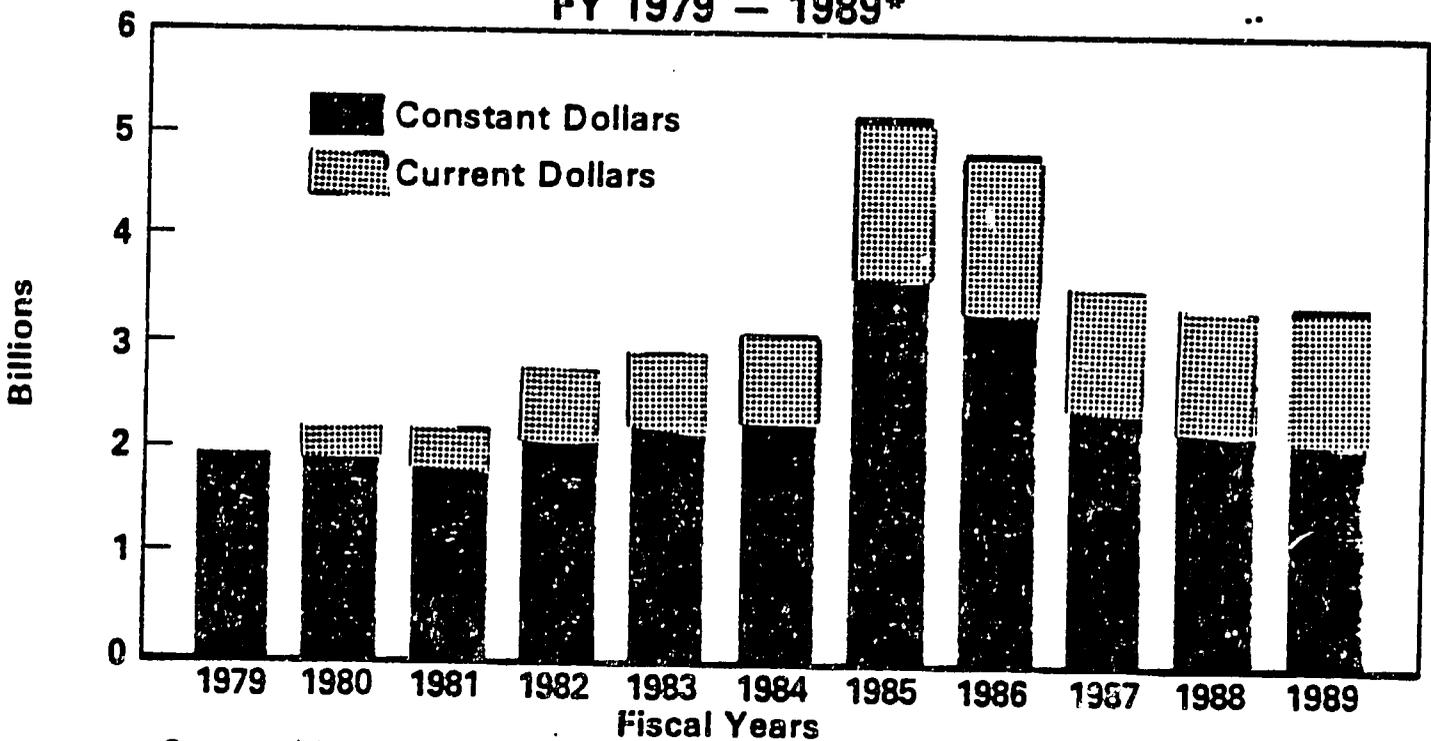


Constant dollars are calculated on FY 1979 base.

*FY 1979 - FY 1988 are program levels. FY 1989 is request level.

Economic Support Fund (ESF)

FY 1979 - 1989*



Constant dollars are calculated on FY 1979 base.

*FY 1979 - 1988 are program levels. FY 1989 is request level.

Source: Congressional Presentation, FY 89
Agency for International Development

Table 1

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROGRAM TRENDS: FY 1986 - FY 1989
(in thousands of dollars)

	FY 1986 ACTUAL	FY 1987 ACTUAL	FY 1988 ESTIMATE	FY 1989 PROPOSED
Functional Development Assistance:				
Agriculture, Rural Dev. & Nut.....	759,987	686,933	489,073	461,062
Population Planning.....	237,539	267,154	197,000	190,440
Health.....	213,249	168,117	120,070	114,000
Child Survival Fund.....	36,425	74,994	66,000	66,000
AIDS.....	--	--	30,000	30,000
Education & Human Resources Dev....	181,857	163,064	117,658	129,541
Private Sector, Environment & Energy	169,706	196,217	127,754	127,795
Science and Technology.....	15,110	14,662	8,662	8,662
Private Enterprise Revolv. Fund.....	--	--	--	[8,500] 1/
FDAP Deob/Reob.....	[52,277]	[108,956]	12,500	12,500
SUBTOTAL, Functional Accounts.....	1,613,873	1,571,141	1,168,717	1,140,000
Grants, included above.....	1,425,662	1,459,307	1,121,690	1,140,000
Loans, included above.....	188,211	111,834	47,027	--
Sahel Development Program	84,686	80,559	5,180	--
Development Fund for Africa.....	--	--	500,000	510,000
SADCC.....	--	[50,000] 5/	50,000	[50,000] 6/
SUBTOTAL, Country Programs.....	1,698,559	1,651,700	1,723,897	1,650,000
Private Enterprise Revolving Fund ...	15,400	15,150	3,950	[8,500] 1/
Private Sector Loan Guaranties.....	--	--	--	[100,000]
American Schools & Hospitals Abroad..	33,495	35,000	40,000	30,000
International Disaster Assistance....	90,736	86,357	29,785	25,000
Humanitarian Relief Transport.....	--	--	3,000	--
Housing Borrowing Authority.....	--	20,000	22,000	22,000
Housing Guaranties.....	[145,464]	[145,464]	[125,000]	[100,000]
Misc. Prior Year Accounts.....	--	--	142	--
SUBTOTAL, DA Program Funds.....	1,838,190	1,808,207	1,822,774	1,727,000
Operating Expenses.....	366,170 3/	350,462 3/	406,000	414,000
Oper. Exp. - Inspector General.....	19,784 4/	20,937 4/	23,970	23,119
Foreign Service Retirement and Disability Fund.....	43,122	45,492	35,132	40,532
Trade Credit Insurance Program.....	[239,250]	[250,000]	[200,000]	[200,000]
TOTAL, A.I.D. Development Assistance	2,267,266	2,225,098	2,287,876	2,204,651 ←
Economic Support Fund.....	4,827,028	3,887,047	3,254,386	3,268,500
ESF Deob/Reob	85,968	25,205	12,500	12,500
Total ESF	4,912,996	3,912,252	3,266,886	3,281,000 ←
TOTAL, A.I.D. ECONOMIC ASSISTANCE....	7,180,262	6,137,350	5,554,762 2/	5,485,651 ←

Source: Congressional Presentation, FY 89
Agency for International Development

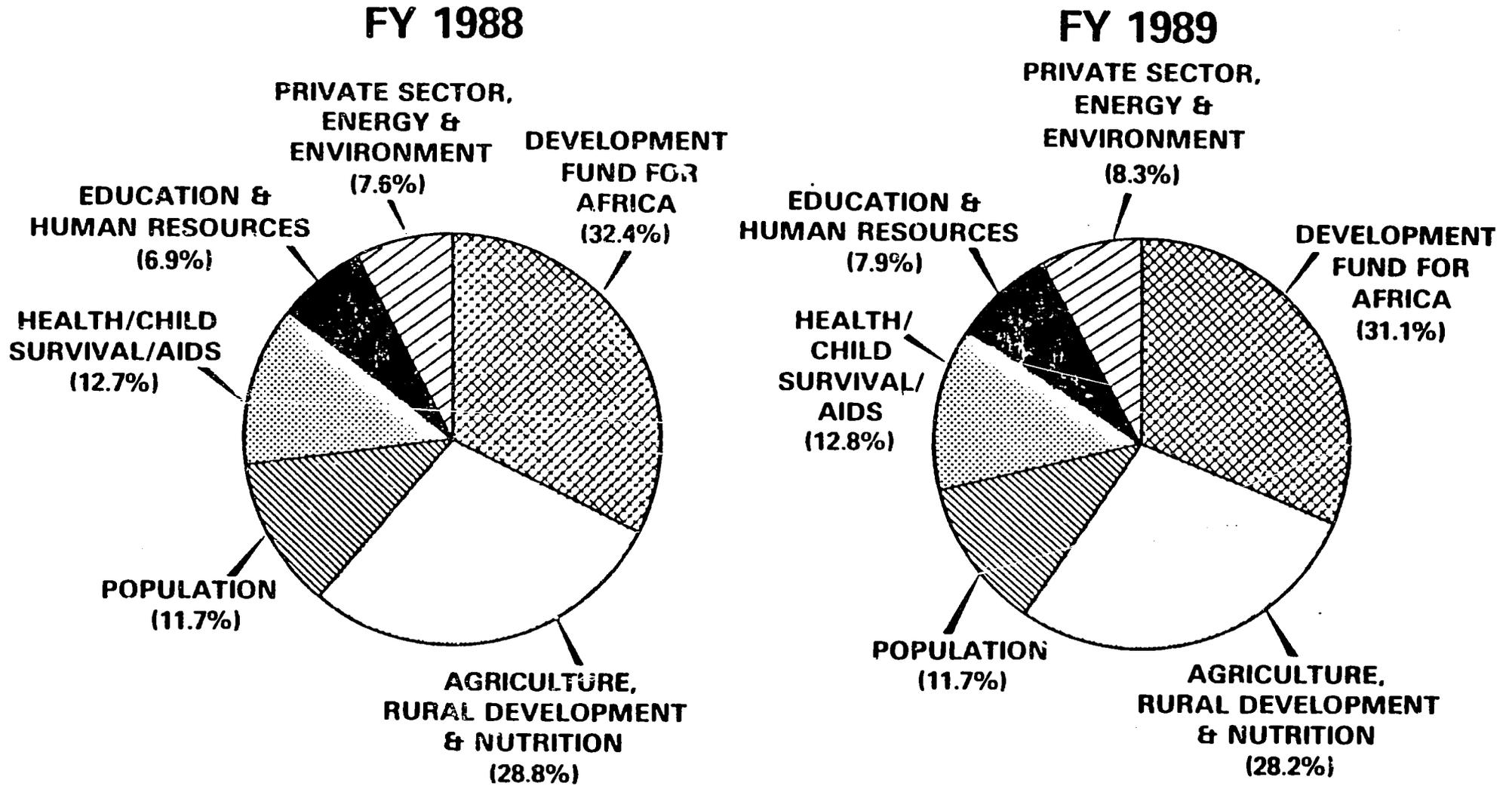
Table 2
 Development Assistance and Economic Support Fund Assistance
 Countries Assisted in FY 1988 or FY 1989

Bangladesh	Liberia
Belize	Madagascar
Bolivia	Malawi
Botswana	Mali
Burkina	Mauritania
Burma	Mauritius
Burundi	Morocco
Cameroon	Mozambique
Cape Verde	Nepal
Central African Republic	Niger
Chad	Nigeria
Comoros	Oman
Congo	Pakistan
Costa Rica	Panama
Cote d'Ivoire	Peru
Cyprus	Philippines
Djibouti	Portugal
Dominican Republic	Rwanda
Ecuador	Sao Tome
Egypt	Senegal
El Salvador	Seychelles
Equatorial Guinea	Sierra Leone
Gambia	Somalia
Ghana	South Africa
Guatemala	Spain
Guinea	Sri Lanka
Guinea-Bissau	Sudan
Haiti	Swaziland
Honduras	Tanzania
India	Thailand
Indonesia	Togo
Ireland	Tunisia
Israel	Turkey
Jamaica	Uganda
Jordan	Yemen
Kenya	Zaire
Lebanon	Zambia
Lesotho	

Source: Congressional Presentation, FY 89
 Agency for International Development

Fig.3

COMPONENTS OF PROGRAMMED DEVELOPMENT ASSISTANCE



Source: Congressional Presentation, FY 89
Agency for International Development

Fig. 4

A.I.D. HEALTH, POPULATION, AND NUTRITION FUNDING
(ALL ACCOUNTS)
1965--1989

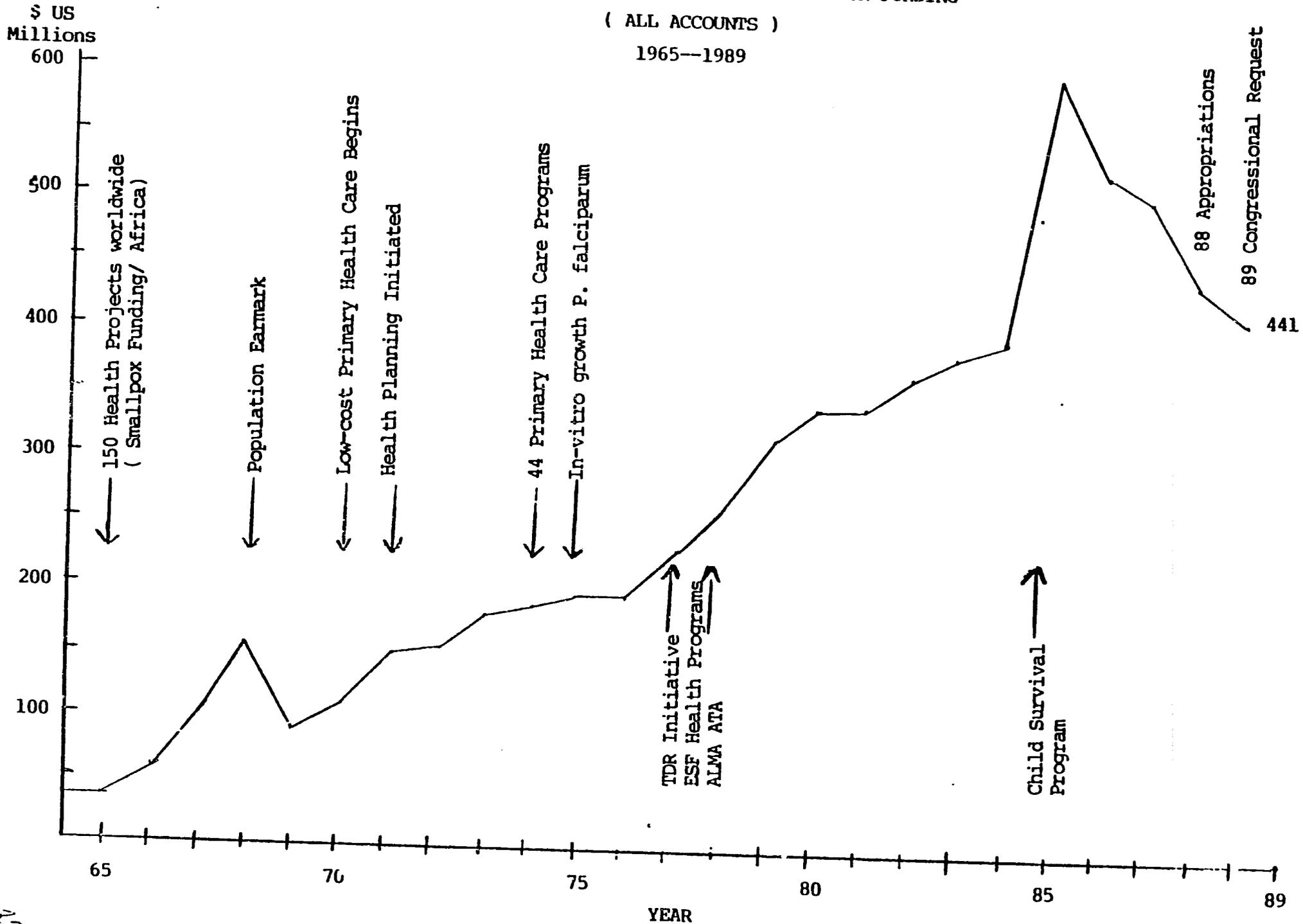
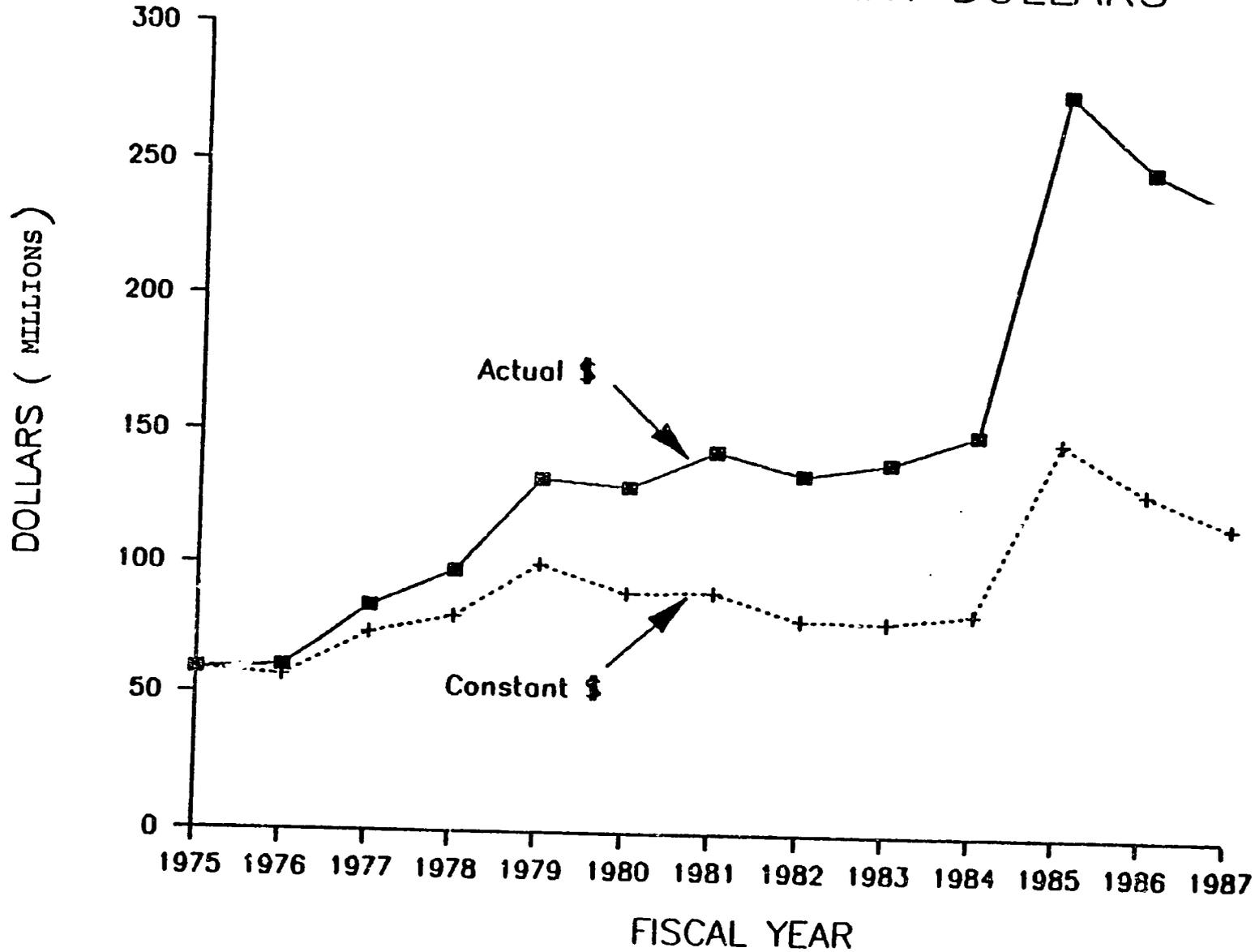


Fig. 5

HEALTH AND CHILD SURVIVAL FUNDS: FY75-87 ACTUAL VS CONSTANT DOLLARS



NOTE: Adjustment factors from U.S. Department of Commerce.

A.I.D. Health Information System
ISTI, 9/87

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TOTAL NET RESOURCE FLOWS TO DEVELOPING COUNTRIES

	Current \$ billion									Per cent of total		
	1978	1979	1980	1981	1982	1983	1984	1985	1986 ^a	1980	1985	1986
I. Official development finance (ODF)	32.7	37.4	45.5	46.5	44.9	42.0	47.6	49.0	54.8	35.5	59.5	65.2
1. Official development assistance (ODA)	27.4	31.7	37.5	37.2	34.1	33.4	34.9	37.1	44.0	29.3	45.1	52.3
A. Bilateral	22.0	25.5	29.8	29.4	26.7	25.9	27.1	28.6	34.5	23.2	34.8	41.1
a) OECD countries	13.1	16.4	18.0	18.2	18.4	18.5	19.8	21.9	26.4	14.0	26.6	31.3
b) OPEC countries	6.7	6.5	8.7	7.5	4.5	3.9	3.7	2.9	3.7	6.8	3.5	4.4
c) CMEA countries	1.6	2.1	2.7	3.2	3.3	3.2	3.2	3.6	4.1	2.1	4.4	4.9
d) Other countries	0.6	0.5	0.4	0.5	0.5	0.3	0.4	0.2	0.3	0.3	0.2	0.4
B. Multilateral	5.4	6.2	7.7	7.8	7.4	7.5	7.8	8.5	9.5	6.1	10.3	11.3
2. Other ODF	5.3	5.7	8.0	9.2	10.8	8.6	12.7	11.9	10.8	6.2	14.5	12.9
of which: Multilateral	3.1	4.1	4.8	5.7	6.6	7.2	8.2	7.9	7.8	3.7	9.6	9.3
Bilateral	2.2	1.6	3.2	3.5	4.2	1.4	4.5	4.0	3.0	2.5	4.9	3.6
Total export credits	16.1	12.8	16.9	18.4	14.6	8.3	5.4	2.9	2.0	13.2	3.5	2.4
1. OECD countries	15.8	12.4	16.0	17.3	13.8	7.7	5.5	2.5	2.0	12.5	3.0	2.4
of which: Short-term	2.6	2.0	2.4	2.6	3.0	-0.3	-0.8	1.5	4.0	1.9	1.8	4.8
2. Other countries	0.3	0.4	0.9	1.1	0.8	0.6	0.2	0.4	0.5	0.7	0.5	0.6
Private flows	56.0	53.9	66.0	74.3	58.3	47.4	33.1	30.4	27.2	51.4	36.9	32.4
1. Direct investment	11.7	13.5	11.2	17.1	12.7	9.3	11.5	7.5	11.8	8.7	9.1	14.1
2. International bank sector	39.9	35.7	49.0	52.0	37.6	34.1	17.4	13.5	5.0	38.2	16.4	6.0
of which: Short-term	17.0	16.0	26.0	22.0	15.0	-13.0	-6.0	-10.0	n.a.	20.2	12.2	n.a.
3. Total bond lending	0.2	X	1.5	1.4	5.0	1.2	0.6	3.9	3.5	1.2	4.7	4.2
4. Other private ^a	4.2	4.7	4.3	3.8	3.0	2.8	3.6	5.5	6.9	3.3	6.7	8.2
of which: Grants by non-governmental organisations	1.6	2.0	2.3	2.0	2.3	2.3	2.6	2.9	3.3	1.8	3.5	3.9
Total resource flows (I + II + III)	104.8	104.1	128.4	139.1	117.8	97.7	86.1	82.3	84.0	100.0	100.0	100.0
Information:												
ODA grants	15.7	19.5	23.4	22.1	21.0	21.6	23.5	25.8	31.5			
MF purchases, net	-0.9	0.5	2.6	6.2	6.4	12.5	5.4	0.8	-1.4			
	At 1985 prices and exchange rates											
Total resource flows	118.1	105.7	119.5	134.3	116.2	96.7	87.0	82.3	68.4			
Official development finance	36.5	37.9	42.4	44.9	44.3	41.9	48.0	49.0	44.6			
A from all sources	30.5	32.0	35.0	36.0	32.6	33.1	35.3	37.1	35.7			
A from DAC Members	(22.5)	(23.0)	25.4	24.7	27.4	27.3	29.0	29.4	29.9			

Including grants by non-governmental organisations (NGOs), and estimates of unreported bond lending and swaps of loans for direct investment.
^a Provisional.

Source: DAC/OECD 1987 Annual Report

Fig. 6

**RECEIPTS OF FINANCIAL FLOWS BY ALL DEVELOPING COUNTRIES
FROM ALL EXTERNAL SOURCES FOR GENERAL DEVELOPMENT
PURPOSES (CONSTANT PRICES)
1982**

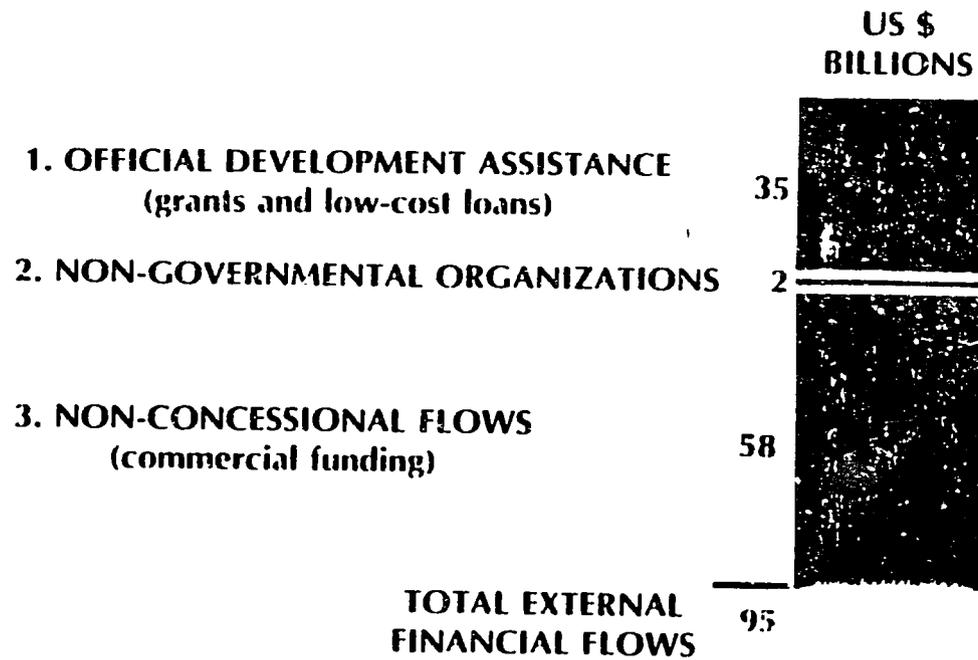
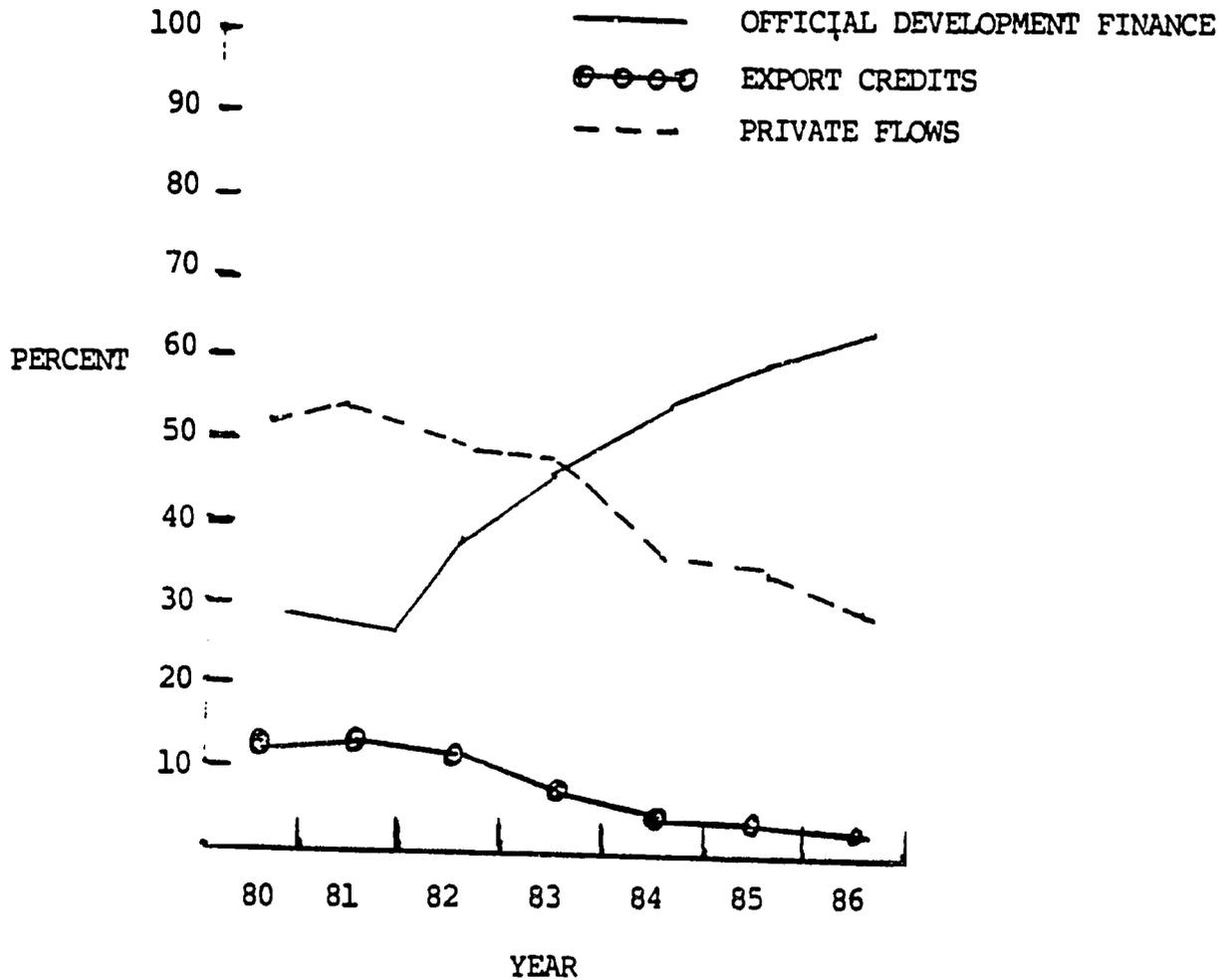


Fig. 7

TOTAL NET FINANCIAL FLOWS TO DEVELOPING COUNTRIES
BY TYPE OF FINANCE
(PERCENTAGE SHARES)



SOURCE: Development Cooperation, DAC Chairman's Annual Report
OECD, Paris, 1988

Table 4

WORLD-WIDE SOURCES OF CONCESSIONAL ASSISTANCE (ODA)
FOR ALL DEVELOPMENT SECTORS IN DEVELOPING COUNTRIES
1986

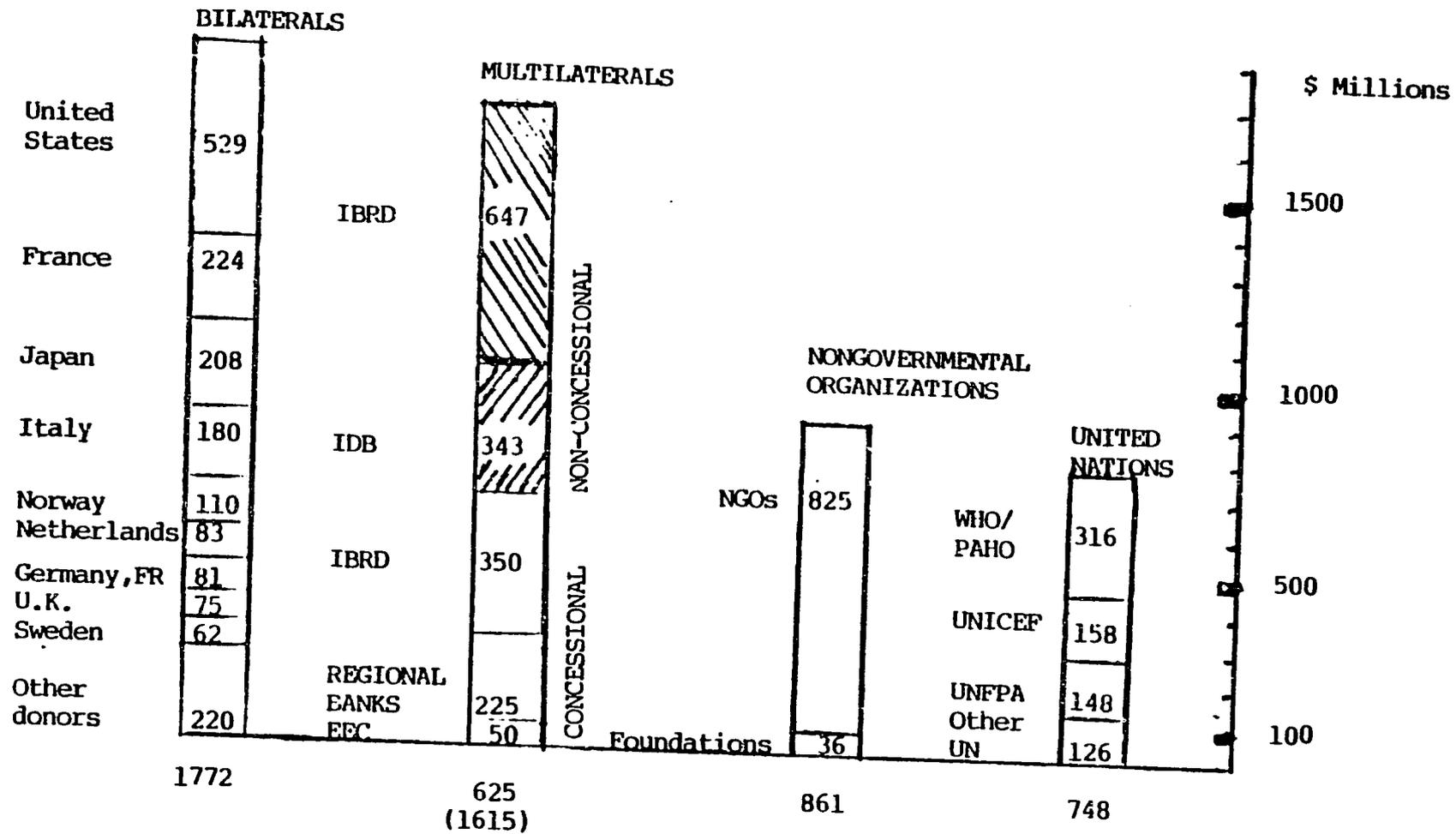
SOURCES		\$ U.S. BILLIONS	PERCENT
BILATERAL	DAC/OECD ¹	26.4	(55.8%)
	OPEC ²	3.7	(7.9%)
	CMEA ³ and OTHER	4.1	(8.7%)
	OTHER BILATERAL SOURCES	0.3	(0.7%)
MULTILATERAL	WORLD BANK, REGIONAL BANKS EUROPEAN COMMUNITY OPEC FUNDS AND OTHER	4.6 1.6 0.2	(13.5%)
	UNITED NATIONS	3.1	(6.5%)
NONGOVERNMENTAL ORGANIZATIONS		3.3	(7.0%)
TOTALS		47.3	100%

- 1/ Development assistance Committee/ Organization for Economic Development and Cooperation
2/ Organization for Petroleum Exporting Countries
3/ Council for Mutual Economic Assistance

SOURCE: Development Cooperation, 1987 DAC Chairman's Report, OECD, 1988

Fig. 8
 PRINCIPAL SOURCES OF CONCESSIONAL FINANCING FOR HEALTH

1986



TOTAL CONCESSIONAL FUNDING: \$ 4.006 BILLION
 TOTAL CONCESSIONAL AND NON-CONCESSIONAL FUNDING: \$ 4.996 BILLION

Sources: DAC/OECD Annual Report, 19 7
 World Bank Annual Report, 1986, 1987
 IDB Annual Report 1986
 Annual Reports and Budget Papers WHO, PAHO, UNICEF, UNFPA
 Foundation Directory and Annual Reports
 USAID Congressional Presentations, PPC, S&T, Regional Bureaus

Table 5

WORLD PHARMACEUTICAL PRODUCTION, CONSUMPTION AND TRADE, 1980

	PRODUCTION		CONSUMPTION		TRADE		
	US\$ MILLIONS	PERCENT-AGE	US\$ MILLIONS	PERCENT-AGE	IMPORTS	EXPORTS	TRADE BALANCE
DEVELOPED COUNTRIES							
MARKET ECONOMIES							
NORTH AMERICA	18,600	22.1	14,700	19.6			
WESTERN EUROPE	27,440	33.0	23,350	33.8			
OTHERS	11,970	14.3	12,454	16.6			
CENTRALLY PLANNED ECONOMIES							
EASTERN EUROPE	15,970	19.1	12,150	16.2			
TOTAL DEVELOPED COUNTRIES	73,970	88.5	64,650	86.2	9,473	13,187	+3,714
DEVELOPING COUNTRIES							
AFRICA	470	0.6	1,730	2.3			
ASIA *	4,690	5.6	5,320 **	7.1			
LATIN AMERICA	4,400	5.2	3,300	4.4			
TOTAL DEVELOPING COUNTRIES	9,560	11.5	10,350	13.8	4,530	602	-3,928
TOTAL WORLD MARKET	83,530	100.0	75,000	100.0	14,003	13,789	

*Excluding China

**Including Japan, Southern European Countries and Oceania.

Source : See reference 16.

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BASIC PROGRAMMING CYCLE FOR DEVELOPMENT FINANCING OF THE HEALTH SECTOR AT THE COUNTRY LEVEL

