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**A Review of
Colloquium Summary
"International Health in Development
in the 1990's"**

**Sponsored by
John Hopkins School of Hygiene
and Public Health**

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Colloquium Summary

International Health in Development in the 1990's

Sponsored by
Johns Hopkins School of Hygiene and Public Health

Report prepared by
W. Henry Mosley, M.D., M.P.H.

OVERVIEW

The discussion centered around the evolving role health issues are playing in development. Today, there exists an interdependency between the U.S. and LDCs. This interdependence makes both parties subject to the negative side effects of the global debt burden, rapid population growth, environmental degradation, and demographic changes such as rural to urban migration. At the same time, this interdependence facilitates transfers between countries in technical areas such as electronics.

The health care needs of developing countries were addressed in terms of primary health care and technology transfer. Various ways of solving the problems were suggested via current aid instruments, the organized private sector and multilateral agencies. Lastly, recommendations were made concerning what role the U.S. should play.

HIGHLIGHTS

Topic #1: How can primary health care be distributed most efficiently and most equitably?

Issue: What are the essential elements of success?

- Recommendations:
1. A political commitment to equity.
 2. Leadership in health ministries.
 3. Program structures which are decentralized and which emphasize training and supervision.
 4. Adequate and appropriate financial resources for both the urban employed and rural sectors. User charges and social security programs are appropriate for urban areas while health cooperatives and revolving drug funds work in rural areas.

Topic #2: What types of technologies are appropriate for developing countries and how should they be delivered?

Issue #1: What characteristics must technologies have in order to be sustainable both economically and socially?

- Recommendations:
1. Technologies must be effective and inexpensive.
 2. Technologies must be adapted to local circumstances. This can be done through a close liaison among basic scientists, epidemiologists and social scientists.
 3. "Selective" primary health care is not economically sustainable because of a lack of infrastructure and financing.

Issue #2: What is the best way to aid delivery of these technologies keeping in mind the importance of a "permanent" transfer of technology?

- Recommendations:
1. Since there is a need for experienced, trained field researchers, U.S. schools of public health should be encouraged to participate in this field.
 2. Human resource training should be population-based, multidisciplinary, quantitative and should emphasize management and communication skills.
 3. The U.S. should establish multi-disciplinary health research and training centers.

Topic #3: What types of aid instruments currently exist, and what are their relative strengths and weaknesses in terms of health care and delivery?

Issue #1: What is project aid and where can it best be applied?

- Recommendations:
1. Project aid should emphasize the delivery of services, preventive or curative, public or individual. It has a short timeframe and limited requirements for technological support.
 2. Project aid should be delivered where countries have a strong health ministry since projects can often be detrimental where there is weak technical capacity.

Issue #2: What is program aid and who should do it?

- Recommendations:
1. Program aid should emphasize strengthening and supporting the indigenous national capacity for the delivery of services. It is a long term commitment involving extensive investments in technical support and training.
 2. Program aid should be done under bilateral aid programs.

Issue #3: What is research aid and who should do it?

- Recommendations:
1. Research aid should be defined as aid which generates information on the efficacy, safety, cost and acceptability of technologies. It is a long term commitment requiring extensive professional support.
 2. Research aid should be done by small agencies since the results often have regional applicability. It is an easy way for a small arm of aid to reach a large number of people.

Topic #3: What role should the U.S. play in international health assistance?

Issue #1: What has been happening?

Recommendation: Aid has been decreasing relative to total international contributions for health programs.

Issue #2: What are the current problems in developing countries regarding spending for health care?

- Recommendations:
1. LDCs have a limited capacity currently. They also suffer from an unfamiliarity with the sources for external financing and the way to go about obtaining those finances (e.g. weak proposal writing skills).
 2. There is a reluctance on the part of LDC governments to spend on sectoral programs when funds are so thin.

Issue #3: Given the limitations listed above, what can the U.S. do to solve these problems?

- Recommendations:
1. Re-examine health priorities keeping in mind the importance of professional and technological capacities and efforts of LDCs themselves.
 2. Look at the advantages of direct technological intervention versus using professional resources and institutions for international collaboration.
 3. Find ways to use resources more efficiently. There is not necessarily a need for more resources.
 4. Invest in strengthening U.S. centers and international and regional institutions for effective primary health care programs.

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INTERNATIONAL HEALTH IN DEVELOPMENT IN THE 1990s

Colloquium Summary

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INTRODUCTION

United States policies and strategies in international health for the 1990s must take into account the profound global changes that have occurred in the last four decades, both in the developing countries and in the U.S. position in the international community. In a capsule, these could be summarized as a transformation of U.S./developing-country relationships from a patron-client mode to one of interdependency.

There are several dominant features of these changes which will affect the health and welfare of societies throughout the world. First is the stagnation of the global economy. The staggering Third World debt coupled with declining investments and deteriorating trade relationships impacts on both the developed and developing world, severely constraining social investments including health services. Rapid population growth not only places an added drag on all development strategies in many poor countries but can also have irreversible impacts because of environmental degradation. Migration, both urban-rural and international further complicates health and development efforts. New health problems are emerging with global dimensions. Two of the most serious in recent years are AIDS and substance abuse, including use of drugs, alcohol, and tobacco. On the more positive side, the revolution in electronics, particularly in the fields of communications and computers, has vastly accelerated the ability to collect, process, and transmit information. This facilitates both the buildup of technical skills

as well as the development of the global consensus and political will essential to create the social and economic transformations fundamental to improving health.

A new international health strategy must also recognize that the growing diversity of the developing world will require flexible policies by the U.S. and more mature relationships. There remain perhaps thirty to forty countries in the lowest income bracket which will require an extended period of concessional assistance even for basic health inputs. Typically the health problems of these countries will be dominated by the infectious and parasitic diseases and intervention strategies must focus on establishing basic infrastructures and delivering simple technologies. There are, however, a larger group of countries newly emerging into the middle-income category which will have a different set of health problems related to urbanization and industrialization including accidents, occupational diseases and, increasingly, the chronic diseases of modern society including cardiovascular disease, and malignancies. Many of these countries will have substantial technical and managerial capacity not only to solve their own problems but, in many cases, to address the needs of other countries in the region. New relationships in international health will require more and more partnerships joining together with health professionals from these countries to learn how to solve problems of mutual interest. These collaborative relationships will be long-term; indeed they should be permanent, given the benefits to all countries that may accrue from international cooperation.

PRIMARY HEALTH CARE - INSTITUTIONAL REQUIREMENTS

The primary health care approach to providing health services has a long history in the developing world dating back to the early decades of this

century. The Alma Ata Declaration in 1978 articulated an international consensus on the fundamental principles and values that should be considered in making decisions on policies, programs and resource allocation in the health field. These principles involve equity, effectiveness, affordability, and community participation. While it is now clear that the objective of "health for all" will not be reached by the year 2000, this does not invalidate using this goal as a basis for setting priorities and allocating limited resources.

Growing experience has highlighted certain key elements as essential in the development of effective primary health care strategies by national governments. These are:

1. Political commitment to equity in the allocation of health resources -

This commitment does not require any particular political system as attested by the health achievements in countries as diverse as China, Sri Lanka, Costa Rica, Cuba, and India's state of Kerala. The current mobilization of national governments throughout the developing world to support massive childhood immunization efforts, including the goal of eradication of polio in the Americas, illustrate the power of this commitment when it is effectively applied.

2. Integration of primary health care into overall strategies of national development -

The adverse health consequences of economic stagnation, particularly in Third World countries where debt servicing has required structural adjustments necessitating a curtailment of social expenditures, is telling evidence of the intimate links between personal health and national development. There are two important dimensions to promoting and sustaining vital links between health and development policies. First, the health system itself must be reshaped to maximize

effectiveness and efficiency in the production of health as well as to achieve equity. Second, the relationships between economic investments and the production of health on the one hand, and between the health of people and economic growth on the other, must be explicitly defined and articulated by health planners and policymakers so that limited resources can be best utilized for both ends.

3. Strengthened leadership and management capacity of ministries of health -

The primary roles of health ministries should be in establishing policies and defining strategies to improve health. Health ministries should also closely follow development efforts and investments in other sectors in order to encourage policies and programs that will be least injurious and most beneficial to human health. These activities will require vast improvements in professional and technical skills in fields such as epidemiology, operations research, economic analysis, and financial management.

4. Program structures which provide effective and affordable services to communities and families -

Health programs must be structured to assure that effective services are available and affordable to communities and families. This can be facilitated by decentralization of operations with special attention given to proper training and active supervision of health workers down to the lowest level. Essential elements in this process are epidemiological surveillance to identify problem areas and monitor program process, and skills in program design, management and logistics.

5. Adequate financial resources - Fundamental to an effective and equitable primary health care program are adequate financial resources. There is no single formula for achieving this. User charges and/or social

security programs, can be used to support services for urban employed populations, conserving ministry of health resources for more disadvantaged groups. Health cooperatives and/or revolving drug funds may generate some funds from rural populations. Ultimately, however, a strong economic rationale, coupled with a political commitment to equity, becomes essential to achieve an allocation of sufficient resources to assure a base of essential health service to the entire population.

STRATEGIC ISSUES IN INTERNATIONAL HEALTH ASSISTANCE

Technology Development and Transfer

A key underpinning of the primary health care movement is the existence of effective and inexpensive technologies. The unprecedented decline in mortality in many of the newly emerging countries, particularly in Latin America and Asia in the post World War II period, provides dramatic evidence of the power of biomedical technologies such as antibiotics and insecticides. With the new research tools in immunology and molecular biology, there is the promise of a larger array of chemotherapeutic agents, vaccines, and diagnostic tests which have the potential of markedly transforming health conditions in tropical countries where vast populations suffer from currently intractable conditions such as malaria, schistosomiasis, river blindness, filariasis, leprosy, and others.

Too often the potential benefits of biomedical advances are not realized in developing countries because of the failure to adapt the technologies to local circumstances. Within the developing countries there is a pressing need for research on the application of technologies. In this endeavor there should be close liaison among basic scientists, epidemiologists, and social scientists so that research is directed toward the production of the most appropriate tools for disease control. This effort is severely hampered by a

shortage of trained and experienced field researchers, both in the U.S. and the Third World. There is a great need for both academic training and supervised field experience. U.S. schools of public health could have a major role to play in international collaborative field research projects which would simultaneously solve operational problems while developing research skills.

Currently, the major thrust of the USAID health strategy is in "selective" primary health care. This approach involves identifying those specific diseases which exact the highest human toll in terms of morbidity and mortality and for which effective technologies are available, and then concentrating the resources and efforts on those selected technological interventions. The child survival program which is targeted to immunize 80% of the world's children against six diseases by 1990 and to make oral rehydration therapy for diarrheal diseases universally available exemplifies this strategy. While these objectives are praiseworthy, concern has been expressed in many quarters that donor pressure to introduce monolithic child survival programs as the priority in every impoverished developing country can lead to an unbalanced and fragmented health program that may be marginally relevant to the major health needs of the population. Specific weaknesses of this technology-driven strategy include the fact that in many Third World countries the life-saving impact may be far less than projected, these programs may present insurmountable management problems because of a lack of infrastructure, and these programs may not be financially sustainable.

The roots of these problems do not relate to deficiencies in the technologies but rather in the failure to recognize that the introduction of a technology into a population is a complex social process. Too often technology-driven programs are designed from a narrow biomedical perspective

with operational strategies concerned only with administration and logistics. Fundamentally, for effective primary health care programs, there is the need for health professionals who can bring both biomedical and social science perspectives to the assessment of health problems, the establishment of priorities, the design and implementation of appropriate problem-solving health research, and the management and evaluation of intervention programs. Such individuals will form the living infrastructure that must be built in each developing country to allow it adapt to changing conditions.

Human Resource and Training Needs

There is a need to reorient health training to develop a new cadre of professionals to effectively meet the requirements of primary health care programs. This training should:

1. be population-based and community-oriented;
2. be multidisciplinary, integrating the biomedical and social sciences;
3. develop quantitative skills in the measurement of health and its determinants in populations;
4. impart the principles and techniques of effective management of community-based programs;
5. provide strong grounding in communication skills for prevention and primary health care programs; and
6. incorporate the concepts of health economics, development planning and financial management.

At the present time there are only a few U.S. academic centers located in schools of public health with these capabilities. These institutions need to be strengthened. More importantly, for the development of these capacities in the Third World an international network of multidisciplinary health research and training centers should be established. These should operate as truly

collaborative endeavors between First World and Third World scientists seeking to solve health problems of common interest.

International Aid Instruments and their Comparative Advantage

International aid in the health sector can be categorized into three broad classes:

1. Project aid which emphasizes the delivery of services, preventive or curative, public or individual. Many of the most successful experiences with aid (mission hospitals, smallpox eradication) are with project aid.
2. Program aid which emphasizes strengthening and supporting national or subnational capacity to deliver services. It typically aims to assist in developing institutions or improving the policy environment in which decisions affecting health and health service delivery are made.
3. Research aid which expands range of technologies or generates information on the efficacy, safety, cost, and acceptability of technologies which is essential for their effective adaptation and utilization.

The strengths and weaknesses of each of these instruments relate very much to the capacities of both donor agencies and recipient nations. Project aid often has the most appeal to donors because of its short timeframe and limited requirement for technical support. In cases where the recipient countries have weak technical capacity, project assistance may be detrimental to the infrastructure of health services by shifting resources away from the health care system toward the establishment and maintenance of vertical projects which may not be sustainable when external support is removed. On the other hand, where there is a strong health ministry with the capacity to identify priorities and develop a coherent health program, then project assistance can be very helpful and donor support may play a critical role.

Program aid, when it involves institutional development, will require a long-term commitment of a decade or more coupled with extensive investments in technical support and training. Research aid also typically involves a long timeframe with extensive professional support from donors and fellowship training. Because research results often tend to have global, or at least regional applicability, this may be an attractive donor strategy for small agencies. Also, because of the broad utility of research findings, there is a growing trend to develop regional or international research centers, as well as networks of researchers pursuing common areas of interest.

There is no evidence that one type of aid instrument is preferable to another; rather, it should be recognized that both donors and developing countries have different interests and capacities, and the task is in finding the instruments most suitable to the countries' needs and the donors' capacities. Several general observations are relevant. Agencies such as the World Bank which have the capacity for providing a very high volume of resources may have a comparative advantage in project support. Bilateral donors such as the United States may well have a comparative advantage in program aid, especially institutional development as well as research aid, both of which require sustained professional and technical support. In particular, the United States, which has vast resources for conducting research and an extensive capacity for training and assisting researchers from developing countries, could substantially increase the volume of its research aid. An important component of this assistance strategy should be funding mechanisms to assure the long-term involvement of top U.S. scholars in this endeavor.

The Role of the Organized Private Sector

The U.S. has a history of private sector involvement in international health which extends into the last century. Much of this early work was done by medical missions and, most notably, in the early years of this century by the Rockefeller Foundation. The importance of the private support in the present day may be highlighted by the estimate that more than \$800-million in international health aid annually flow through the private organizations.

The organized private sector encompasses a wide range of institutions including private voluntary organizations (PVOs), medical missions, foundations, universities, commercial enterprises, private practitioners, professional associations, labor unions and special advocacy groups. One illustration of the important and unique roles of private sector organizations is the goal of Rotary International to collect \$200-million to provide vaccines for the EPI program. Another noteworthy development has been the gender-sensitive non-governmental organizations which have recognized the key role of women in the production of health and which are beginning to support research and education to influence health policy on the special concerns and needs of women in the Third World.

The work of non-governmental organizations is often discounted as being of lesser importance than the more visible endeavors of bilateral and multilateral agencies. And, indeed, NGO experiences and insights are not shared to the extent that they should be. This, however, highlights the need for better mechanisms for coordination and dissemination of information. The U.S. government has begun to involve the private sector in international health and this should be encouraged and expanded because these agencies tend to be effective and innovative, and their programs are usually sustainable. More importantly, NGOs are especially suitable for flexible action as well as

the conduct of creative research and training. These capacities deserve greater emphasis and support in the future.

Commercial enterprises should not be overlooked. Because these organizations have long-term interests in the countries in which they operate, they potentially represent a stable resource base to be called upon as the need arises, and better means need to be developed to effectively involve these organizations.

Multilateral Aid

The diversity of the bilateral donors is both a strength and a weakness in international health assistance. The strength is in the ability of individual donors to respond rapidly and flexibly to individual country needs. This, however, can be a weakness if countries do not have a clearly defined development strategy within which donors can function. Moreover, bilateral donors are typically constrained by their own internal political agendas which may limit the form of assistance in the countries where work may be done. Multilateral agencies such as the WHO, UNICEF, the UNFPA, and FAO do have a special role to play. Their strength is in the ability to discern a global strategy on issues which transcend national boundaries such as primary health care, child survival, population, and food security, and in their ability to mobilize the international community into collaborative endeavors either on a global or a regional level.

The WHO global program on AIDS provides a recent example of this role. The initial strategy of the WHO is to assist the Third World countries in developing their own coherent national AIDS policies as a framework for international assistance. Additionally, the WHO provides strategic guidelines to facilitate a coordinated effort by the international donor community.

THE U.S. ROLE IN INTERNATIONAL ASSISTANCE

The United States' health plans and programs for the 1990s need to be redefined in relation to the global donor effort. An important reason is that the U.S. contribution, although relatively stable in absolute real terms, has declined as a per cent of the total international contribution. In 1956, the U.S. share was about 90%; by 1986, when the total financial resources for health and health-related fields from the donor community amounted to about \$4-billion, the U.S. share had declined to only 13%. While Gramm-Rudman is squeezing U.S. support, global concessional finance for health is growing at 3.6% per year so that the outlook for a continuous increase in international finance for health is favorable.

Noteworthy, the programmatic content of U.S. international health assistance has not varied greatly from the prevailing international consensus over the past twenty-five years. As examples, the emphasis on primary health care was accepted in the early 1970s while the child survival program, with a focus on immunization, ORT, nutrition, and birthspacing, evolved in the 1980s as the result of a quest for strategies that were accessible, affordable, and acceptable.

The key issues in international health for the future do not involve a lack of external financing but rather the effective utilization of international health assistance which is limited by basic constraints to demand within developing countries. The barriers to effective utilization of external financing include:

1. limited capacity to undertake national health planning or financial analysis as a basis for determining external (or internal) requirements;
2. unfamiliarity with potential sources of external finance and the variations in pattern 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 processes of proposal development and negotiation;
5. reluctance of national planning authorities to approve social sector projects during a time of economic constraint and restructuring.

These demand constraints are compounded by the absence of an international technical advisory source from which to obtain timely guidance on sectoral financial analysis, alternative potential sources of external concessional financing, and the process of attracting and mobilizing such financing.

Assuming the U.S. will continue to support the international consensus for expansion of primary health care priorities, the fundamental issues are not only those of technical design and content in the short run but relate to assessing the basic structural requirements for sustaining health in the long-term. From this perspective, it is possible to identify those interventions that uniquely utilize the best U.S. experience in development and public health. In this context, the recommendations are:

1. The U.S. agenda for the 1990s should be based on a re-examination of international health priorities not only from the viewpoint of the greatest present problems such as infant and child mortality, but also taking into consideration the equally important underlying factors which perpetuate low levels of health. International health policies should be based on principles which accept that health improvement in developing countries will be determined primarily by the professional and technical capacities and efforts of developing countries themselves. To that end, strategies for financial assistance should reconsider the balance between

supporting direct technical interventions versus the mobilization of U.S. professional resources and institutions for international collaboration in research, planning, and capacity-building through advanced specialty training.

2. 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 that USAID develop the capacity to give greater, not less, attention to professional understanding of the technical and financial resources of all potential sources of external health financing, and that it strengthen and accelerate technical support to developing countries in setting priorities, strategic planning, financial analysis, and the articulation of demand.
3. There are a limited number of multidisciplinary academic research and training centers in the U.S. that have the capability to train the international health professionals of the future--and almost none in the Third World. Yet qualified human resources are the essential underpinnings of a coherent primary health care program. Major resources need to be invested in the strengthening of U.S. centers, and the creation of international or regional institutions to build the new professional and technical capacities required for effective primary health care programs.