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THE ECONOMIC RECESSION AND USAID FOR
INTERNATIONAL DEVELOPMENT AND HEALTH

DR. RAMESHWAR SHARMA

DIRECTOR
INDIAN INSTITUTE OF HEALTH MANAGEMENT RESEARCH
72-B DEVI PATH, JAIPUR 302 004.
INDIA

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The economic leadership of the world has changed hands. The currency in U.S.A. has depreciated by more than 50% over the past 3 years. Most observers expect it to fall further. The Organisation of Economic Co-operation and Development (OECD) and the National Institute of Economic and Social Research, London (NIESR) estimate growth for U.S. economy at slightly less than 2.5% in 1988 and around 2 percent in 1989.

There is almost \$ 1.1 trillion as the external debt to the Third World, with 40% owed by the handful of Latin American countries and unless the developing countries are given the financial resources, they will not be able to finance this external debts. They will even find it difficult to maintain their imports, since they will lack the financial capability to finance the same.

The New International Economic Order has been defined as "which shall correct in-equalities and redress existing injustices, make it possible to eliminate the widening gap between the developed and the developing countries and ensure steadily accelerating economic and social development, peace and justice for present and future generations". Keeping in view, this changed orientation, many countries in the world came forward for technical assistance in the form of a "donor" and a "recipient" country. However, the Thirty Fourth World Health Assembly rejected the concept of "technical assistance", whereby aid was provided by so called "donors" to "recipients" and recommended its replacement by the concept of "technical co-operation" founded on mutual interest of all as equal partners to define and achieve their health goals through programmes that are determined by their needs and priorities and that promote their self reliance in health development". In other words, the technical co-operation in international health work must be characterised by equal partnership among co-operating parties, the developing and developed countries alike and respect for the sovereign right of every country to develop its national health system and services in the way that it finds it most rationale and appropriate of its needs; to mobilise and use all internal and well as the bilateral and other resources to this end;

and for this purpose, to make use of scientific, technical, human, material, information and other support provided by WHO and other partners in health development". It implied "mutual responsibility of co-operating parties for carrying out jointly agreed decisions and obligations, exchanging experiences and evaluating results obtained, both positive and negative and making the information thus generated, available for use and benefit of all".

It is with this background that the subject of economic recession in a number of developing countries, and the international and bilateral technical co-operation programmes have to be considered. The World Health Assembly has repeatedly referred to this subject and has observed that "aware of the persisting tremendous differences in the health standards between the developed and developing countries and of the lack of human, material and financial resources of the developing countries to cope with their burning health problems and to build their national health services, there is a necessity of technical co-operation both through international as well as bilateral arrangements".

The question now to be considered is that with the advancing recession in the developed countries, how they should continue to promote technical co-operation activities on bilateral basis with special reference to the International aid provided by the United States.

As a matter of fact, bilateral technical co-operation is greatly influenced at political and ideological levels by the psychological preparedness of the co-operating countries. The major influencing factor is not the actual needs of the two countries to "provide" and to "receive", but it invariably, is the political relationship both direct and in the international forums. At times, the developing countries inspite of their identified needs have shown indifference to aid programmes on account of their own reservations based on mistrust, which needs to be improved upon through diplomatic channels by expressed intentions and explicit actions.

What is important for the developing countries is to identify their own needs? Some issues, which have been identified in this regard, are the population growth, urbanization, environmental degradation, un-employment and widening gap between the two extreme stratas of the society, leading to conflict, uprising, dissention and disintegration. All these factors have direct or indirect

influence on people's health. Superimposed on these could be the pressures created on the limited resources, through increasing demand on part of citizens introduction of high technology, rising cost of medical care and great disregard to the priorities of masses in comparison to the identified needs of a few. The World Development Report (1987) brings out a number of such factors. Firstly in respect of population, it refers to the high average annual growth rates ranging from 1.5 to 2.7 percent between the years 1965-1980 in countries of low income economies and middle income economies, and an average annual growth rate of 3.7 to 5.2 percent in selected developing economies of high income oil exporters. Further, the high population growth is going to continue not only during this century, but even in the first 1/3rd of the next century in a number of developing countries. The total fertility rates are also expected to continue as high as 5.3 to 4.7 in some of the oil exporting countries and low income economies.

Most of the developing countries are going to face the onslaught of urbanization. Even in a country like India by 1991 the number of metropolises will grow from 12 to 20. Bombay and Calcutta have already become megapolises with a population of more than 10 million each. Most metropolises have been growing at a disturbing average of 4-7 percent per annum - twice the nation's rate of population growth. In Calcutta 2000 migrants flow in every day and in Delhi 1.2 lac every year. The resulting outcome of such heavy immigration in urban areas has been increasing slum population, which could be as high as 1/3rd of the total population of some of the large cities in the country. Need for many of the important civil services for these slums and squatter populations has been so enormous that more often than not there is a breakdown in these services. Nearly 25 to 50% of the population has no toilets, 33 to 66% of the population has no tap water and 24 to 37% of population has no power supply. An increasing number of crimes is reported in urban areas. The growing traffic has resulted in not only congestion but also in accidents.

Similarly, with the changes in life-style, a number of new health problems have come in fore-front. This includes diseases such as metabolic disorders, circulatory problems, neuromuscular diseases, cancer and accidents and this all happens over and above the continued load of communicable and infectious diseases, and mal-nutrition. To add to this list, is the increasing danger of drug abuse and the pandemic of AIDS. The psychiatric and psychosomatic problems are also reported to be on increase.

Where lies the remedy for such a situation? To my mind, it should lie within the country itself? The total re-orientation of public policies in respect of economy, employment, distribution, social service including health, seems to be the first few major problems to be solved. How could such policy orientation for equity, justice, acceptability, availability, affordability could be put for serious consideration at the highest political level? Similarly, how could the public health be taken up as a major discipline both for manpower production and for practice vis-a-vis the high technology institutionalized, urban-oriented curative services. On similar lines what need to be done so as to make the community self-reliant? What policy changes need to be taken at the highest level in this regard?

The other point following the policy decisions would be financial allocation, production of health manpower, creation of health infrastructure and allocation of funds for the same. In India, nearly 48% of the total allocation coming in the area of health and family welfare goes for family planning and the rest is made available for public health, preventive programmes and curative services. How the priorities in these areas be laid down on sound footings with reliable information to support the decision making process?

The next area of concern would be cost of health and medical care. Except for a few places where the private sector has taken over the public sector in providing curative services, in a large number of developing countries, the health care including the medical care is being provided through the government systems. It doesn't mean that the total cost of health care is being borne by the government. A very large proportion of cost of curative services even in the rural areas is being borne by the community itself. The high cost of diagnostic measures and hospital care has made a number of countries to think of re-orienting policies in respect of health care financing. The World Bank Report of 1986 suggests some policy reforms in this regard. These include

- (a) charging user of government health facilities,
- (b) providing insurance or other risk coverage,
- (c) using non-governmental resources effectively and
- (d) decentralizing government health services.

The major problems with which the health sector seems to be suffering from are:

1. Allocation Problem : Insufficient planning on cost-effective health activities;

2. An internal efficiency problem : Inefficient public programmes;
3. An equity problem : Inequitable distribution of benefits from health services.

The World Bank Report indicates a strong possibility of a very positive effect of these proposed policy changes on the health services in developing countries. However, there has to be a mechanism for promoting such policy changes in financing of health care. Some changes are already visible. In Kerala as against 1953 governments run hospitals with a bed strength of 38133, there were 3585 private hospitals with 50766 beds. Doctors increasingly find the prospect of working with private hospitals attractive. The demand for sophisticated treatment seems to have tremendously increased not only in urban areas but even at the village levels. The Government Hospitals have suffered, because of doctors, nurses and technicians are being lured away by the private hospitals. The State Government is now trying to make the so-called hospital industrial complexes pay taxes which have been referred to as "sickness taxes". In fact, the State Government is determined to bring about some legislation to restructure and control private hospitals. On the other hand, the state Financial Corporation has agreed to provide finances to set-up private hospitals. This dilemma needs some resolution.

For all bilateral as well as international economic aid, there are different types of motivators - of these important ones are political and economic. While providing such aid, there are various considerations in the form of gap in foreign exchange or gap in national savings. Similarly, the aid is in the form of technical assistance to provide material resources or to fills up the manpower gap. The utilisation of this aid greatly depends the absorptive capacity of the recipient country. However, the major factor to be considered is that as far as donor country is concerned, economic aid is considered to be residual and a low priority area. In this connection, it is interesting to observe that as far as U.S. foreign aid is concerned, one USAID official has observed that "this consists of American equipment, raw material, expert services and food-all provided for specific development projections, which we ourselves review and approve.....; 93% of the AID funds are spent directly in USA to pay for these things. Just last year, some 4000 American firms in 50 states received \$ 1.3 billion in AID funds for projects approved as a part of the foreign aid funds programme".

Major concern in relation to bilateral relationship for promotion of health was reflected in the declaration of the Alma Ata conference held in 1978. It refers to following important areas:-

- Health status of hundreds of millions of people was unacceptable and called for new approach to health and health care.
- to shrink the gap between "have's" and "have nots"
- to achieve a more equitable distribution of health resources
- to attain the level of health for all citizens of the World that would permit them to lead a socially and economically productive life.

Other historic events which lead to collective agreements influencing the action taken by a number of states to improve health include:-

- UN decade for women - 1976-85
- International drinking water supply and sanitation - 1981-1990
- Intensification of the development of immunization programme (UIP) 1990.

A WHO Evaluation indicated a number of constraints in reaching the goal of Health For All By 2000 A.D. Some of these are:

- Limited technical and financial resources
- inability to provide adequate information support for development of managerial processes
- poor use of such information for planning, management and decision making purposes
- poor quality and quantity of information
- global economic turbulence aggravated by drought and socio-political conditions
- high population growth rate
- fast growing urban population
- un-employment
- in-equitable distribution of resources
- hunger and mal-nutrition

As regards health system development, it was found that though there was a strong political will and growing awareness of need for change, the efforts made to expand the health services infrastructure, to develop innovative approaches to reach under-served population, to strengthen community based health services and to improve access and coverage have not been very effective. There have been technical, managerial and financial problems in this process. What needs to be done seems to be to promote efforts to improve managerial capacity of the health system to involve community in health work and to give increasing recognition to non-governmental organisations. Efforts to be made to over-come difficulties in production and availability of health manpower specially to achieve an equitable distribution. The economic constraints have imposed drastic reduction in such essential items as drugs, equipments and transport. Another area of importance was increased motivation to seek alternative ways of financing the health services. The high infant mortality rate, low life expectancy, problems of diarrhoea, ARI, mal-nutrition, other preventable diseases and the high child mortality and morbidity are some of the areas which need to be taken up on priority basis. Two other areas identified are growing elderly population and a change in life style and health related behaviour. Lastly, there is a growing deterioration in environment on account of multiple sources of pollution.

Gunnar Myrdal has given an excellent exposition of the problem of developing countries and foreign aid. He has mentioned about the population explosion, that has come with the rapid spread of modern and cheap medical technology, which was unforeseen; Society has been however very un-equal; upper strata holding the real power. Reforms of the basic economy and social structure were not carried out or they were truncated. The poor were easily deprived and split. Caste and caste feelings remained a reality. Parliament was not looking to the interest of the people. Population explosion goes on; poverty is increasing. Famine becomes an even more crushing problem, increasing absolute poverty. Government seems to be in hands of rich and powerful.

Since implementation of Marshal Plan and its enormous success in Europe, it was felt that the aid to developing countries in Asia, Africa and Latin America would also provide equal success. However, it has not been true. Foreign aid has become linked with military aid, and political and military involvements. USAID commitment has come down to well below half percent of the C.N.P. This becomes important more so when most of L.D.C. are hard to pay back interest on loans already received.

Some of the areas which have been identified for bilateral and international support :

- research and development
- application of sciences and technology for health
- policy formulation
- development of health programmes for the promotion of health, prevention, control and diagnosis of diseases, rehabilitation & strengthening of health system.
- provision of valid information on health matters
- fostering mechanism for technical co-operation and co-ordination in health work
- mobilisation and rationalisation of the flow of health resources
- provision of support for development of policies, strategies and plan of action at country, region and inter-regional levels.

Some of the areas which have been referred to in a report of the World Bank include :-

- development of basic health structure
- training of community health worker and para-professional staff
- strengthening of logistic and supply of essential drugs
- promotion of proper nutrition
- provision of Maternal and Child Care including family planning
- prevention and control of endemic and epidemic diseases; and
- development of management, supervision and evaluation systems.

With reference to the possibility of the Bank supported research, some of the areas which have been referred to include: accessibility and quality of services non-governmental expenditures on health care, present health care, present health expenditures by the people and its affordability, relation of health care cost and utilization of services, relation of rising cost and declining demand and utilization by the poor. Other areas identified are to work out fee for service, health insurance programmes, involvement of non-governmental health sector including private physicians, pharmacists and other trained health practitioners in rural areas and finally the management of Government health facilities for improved performance and efficient use of resources.

There are a number of developing countries including India, which have now developed enormous expertise in finding appropriate alternatives for extending health care net-work, manpower development, alternatives for extending health care net-work, manpower development, involvement of community, inter-sectoral co-ordination and even in developing health information systems. It would be advisable if experiences of this nature are properly documented, in respect of the detailed processes rather than the product outcomes. Given the support, processes of such capacity building could be developed and made available to other developing countries in the world. There has been a limited experience of application of system analysis, data processing and use of management information. Some institutional anchorage might be of help in developing this expertise in developing countries. Processes for effective use of information for decision making and its de-centralization also needs to be gone into.

There has been un-due predominance of curative institutional, high technology based services. This is not only evident in developing countries but even in countries like au.s.a. There are about half a million women, who remain un-attended in their ante-natal period and about 25 million population in U.S.A. is not covered by insurance benefits. The high technology, curative services are being promoted by the powerful pressure groups in their own interest and of multi-national firms based in foreign countries . How far and in which direction a shift in the pattern of health financing is to be done? The possibility of privatisation of large tertiary government institutions of medical care with proper subsidy/insurance for indigent population might also be an alternative to the present commercialisation of medical care.

Problem of self-reliance, community participation, decentralization, resource allocation, health information systems, programme implementations, monitoring and evaluation still remain relatively unattended:

We need: Effective information base for decision making
 prioritization of cost effective programme
 Institutional capacity building
 Use of health manpower and experiences of developing countries.
 Transfer of technology for equipment, indigenous production of drugs
 pesticides, vaccines etc.,
 Promoting self reliance in health care delivery
 Supportive Legislation for community health.