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A NEW R_x IS NEEDED FOR WORLD HEALTH CARE

INTRODUCTION

The United States Agency for International Development and othe and multilateral donors for three decades have been assisting the health developing countries mainly by large resource transfers through public se institutions. Funds have gone from government agencies in the West to affiliated recipients in the Third World. The goal of this has been to fi answer, in effect, a mass prescription to cure the most disease and suffe greatest number of countries with the least amount of effort.

The motivation of such an approach is admirable. And at one tim approach might have been justified in the face of massive poverty and r independent nations with fragile public infrastructures. In a few of the p countries, this strategy still may be justified. There is no doubt, moreove world health community has achieved successes. Among these are the cc eradication of major communicable diseases, the construction of clinics a throughout the world, the training of thousands of doctors and other he personnel, expanded access to clean water and sanitation, and the provis medicines to the neediest for their day-to-day health needs as well as ir emergencies. Yet there are growing doubts that public sector transfers t appropriate for solving health problems in Third World countries.

Ignoring Changing Times. Steady gains in life expectancy, growing urbanization and employment, declining infant mortality, expanded educa characterize today's developing world. So does the complex and sophistic and epidemiological pattern which increasingly resembles that of the ind world. Recognition of this change has been prompting development poli agriculture and manufacturing sectors to rethink their state-centered and approaches of the past. Most international health and nutrition professi

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This is the first of a series of studies on the U.S. Agency for International Devel

contrast, have ignored the changing times and continue to emphasize p financed programs for universal application.

Typical of this is the U.S. Agency for International Development, AID. AID's approach to health care assistance to developing countries through two phases. In the first phase during the 1960s, AID funded infrastructure such as hospitals and clinics, human capital in the trainin personnel, and major disease eradication. AID, for example, has fundec dollars worth of government clinics and small rural hospitals in Pakista countries.

During the second phase in the 1970s and through the present, h and other donors shifted from basic investments and specific disease cc supporting the planning and operations of public sector health systems. community, in effect, assumed responsibility for funding and, in some c the actual health programs. In virtually all cases, this planning has refl public sector perspective of the international health community.

Creating Dependence. It now is time for AID to change its focu strategy. To refuse to do so merely will ensure in recipient nations the creation of dependence rather than development in health and nutritior taxpayer resources, moreover, needed to finance the recurrent costs of current AID health programs are limited. Nor are they likely to expan future. Nor ought they, given the economic and epidemiological change process. If past efforts have paid little attention to issues of finance an responsible future efforts will have to do better, and will, of practical r to do so by working with private health resources.

To become more responsible to the developing nations receiving assistance and to the American taxpayer underwriting this assistance, A change its programs. Such changes should include:

◆◆ A realistic assessment of the health problems of recipient cou decade from now. This will provide the forward projections needed to diversified health portfolio as compared to the current one of universal

◆◆ Retooling AID's project analysis machinery to bring health fin economic analysis, and private sector skills into the project design phas

◆◆ Utilizing advanced U.S. technology in health care organization manufacturing, and finance to develop local systems in the Third Worl flexible, growth oriented, and financially sustainable.

◆◆ Creating an independent body or institution, overseen by priv members who are not recipients of foreign aid dollars, to introduce acc and ensure excellence in AID's health and nutrition programs.

◆◆ Evaluating thoroughly U.S. resources being provided to intern agencies. Are these agencies using funds efficiently? Do they involve

health care skills and resources in their planning and project design pl
are they developing self-sustaining health and nutrition programs?

The U.S. Agency for International Development, of course, is onl
problem. Its outdated strategies simply mirror those of other industrial
such multilateral agencies as the World Health Organization (WHO), t
Bank, UNICEF, and the United Nations Development Program (UNDI

The sums transferred to developing nations for health purposes h
considerable. Although the most recent available figures are nearly a d
WHO estimated that donor agencies transferred approximately $3 billic
sector assistance to developing countries in 1978. This excluded funds f
rich OPEC countries and from the private sector. In a 1978 survey of
U.S. companies' health budgets in the international arena, the 154 whi
were transferring some $452 million annually.

The $30 Billion Question. If the trend in AID's health budget is
indication, the total amount spent on international health has increased
In 1978, AID expended approximately $75 million from its economic d
budget on bilateral health programs. In Fiscal Year 1987 the figure is
General increases in most of the donor organizations health programs
well over $30 billion has been spent on international health care progr
last decade. Such expenditures ought to prompt questions:

What has been achieved for this investment?

What sustainable, self-financed development today is attributable t
investment?

Why are so many Ministries of Health unable to even finance th
operating budgets?

How will maintaining the productivity of past investments be paid
future?

These are some of the questions that must be addressed by the c
professionals at AID and similar agencies. They have an obligation to
expenditure, in every case, maximizes the future development capabiliti
World recipients and produces the sustainable independence intended b
taxpayer.

The leverage represented by the tens of billions of donor health
spent in the next decade, especially in the face of a widespread econo
epidemiological evolution, clearly demands a careful and critical assessr
strategies, purposes and asumptions in donor health programs. What is
more money, but a better way to invest the money already available.

THE WRONG DIAGNOSIS

AID and most of the donor agencies are still addressing the heal of the 1950s. Life expectancies were low then because infectious diseas tuberculosis, smallpox--took a heavy toll. Few people could pay for hea because the waged-based population was practically nonexistent. So hea proclaimed a "right" by the United Nations and many Third World gov This was widely interpreted as a government obligation to give free he all. Multilateral and bilateral donors, private voluntary organizations, ar largesse all helped provide the vaccines and antibiotics which proved t extremely cost-effective ways of improving health status in developing a

Today, most international health analysts continue to diagnose Th nations as having the same health problems as 30 years ago. It is as t "developing world" has not evolved epidemiologically or economically.

It has. The economic and health statistics confirm this. In all b average life expectancies have climbed and now exceed 60 years. Infan rates have been reduced by one-third to one-half in most developing c Table I for some illustrative examples). No longer are the fastest grow death and disability in many developing countries tropical diseases; inst diseases of the Western world--cardiovascular, diabetes, hypertension, ar Revealingly, when asked recently what the country's major health probl Minister of Health of Tunisia responded immediately, "The diseases of This Ministry cannot afford to open two newly built public sector hosp the higher cost of responding to the growing burden of chronic disease consuming the health budget.

Shifting Labor Force. This is not to say that infectious diseases completely conquered. Clearly, the current AIDS pandemic, new strains virus which are changing frequently, drug-resistant malaria parasites anc non-B hepatitis require the attention of the international health commu evolution of the infectious disease problem has not been met by an eq in donor funding. Not until 1986 did WHO and the rest of the interna community seriously start addressing the AIDS problem. As this deadly infecting Africa in great numbers during the early 1980s, the internatio community was focusing on "GOBI," the UNICEF acronym for growth rehydration, breastfeeding, and immunizations.

The labor force in many developing countries has shifted significa subsistence agriculture to the wage-based industry and services sectors, disposable income and demand for various new goods and services incl care (See Table II). Growing urbanization will continue to accelerate t According to a 1986 study by the New York Academy of Sciences, by there will be 22 mega-cities of over 10 million people in the world; 18 be in the developing world. (See Table III for figures on urbanization.)

With the increasing purchasing power and changing consumer pre Third World citizens, it is clear that many of them would pay for heal

Table I
Illustrative Examples of
Life Expectancy Indicators

	Life Expectancy at Birth		Infant R
	1960*	1983**	1960*
Honduras	46	60	145
Egypt	46	57	128
Morocco	47	58	161
Philippines	51	65	106
Thailand	51	63	103
Costa Rica	62	73	74
Peru	48	59	163
Guatemala	47	61	92
Turkey	51	63	184
Tunisia	48	61	159
Jamaica	64	70	52
Dominican Republic	51	63	120
Ecuador	51	63	140
Colombia	53	64	93
Jordan	47	64	136
Malaysia	57	67	72
Chile	57	67	119
Brazil	57	63	118
Mexico	58	66	91
Indonesia	41	53	150

*World Development Report, 1981, Washington, D.C.: The World B
**State of the World's Children, New York: UNICEF, 1986.
***World Development Report, 1985, Washington, D.C.: The World B

Table II
Percentage of Labor Force in

	Agriculture		Industry		Services	
	1960	1981	1960	1981	1960	1981
Ghana	64	53	14	20	22	27
Indonesia	75	58	8	12	17	30
Morocco	62	52	14	21	24	27
Philippines	61	46	15	17	24	37
Nigeria	71	54	10	19	19	27
Peru	53	40	19	19	28	41
Guatemala	67	55	14	21	19	24
Turkey	78	54	11	13	11	33
Tunisia	44	35	26	32	30	33
Jordan	44	20	26	20	30	60
Malaysia	63	50	12	16	25	34
Brazil	52	30	15	24	33	46
Mexico	55	36	20	26	25	38

1960 data from World Bank Development Report 1981, Washington, D World Bank.

1981 date from World Bank Development Report 1985, Washington, D World Bank.

Table III
Urbanization

	Urban Population as Percentage of Total Population		Perce in Urb
	1965	1983	
Zaire	19	38	
Tanzania	6	14	
Somalia	20	33	
India	18	24	
Togo	11	22	
Ghana	26	38	
Kenya	9	17	
Sudan	13	20	
Mauritania	7	25	
Bolivia	26	43	
Zambia	24	47	
Ivory Coast	23	44	
Cameroon	16	39	
Peru	52	67	
Turkey	31	45	
Tunisia	40	54	
Jamaica	36	52	
Dominican Republic	35	54	
Ecuador	37	46	
Colombia	54	66	
Jordan	47	72	
Chile	72	82	
Brazil	51	71	
Mexico	55	69	

World Development Report, 1985, Washington, D.C.: The World Banl

it available. In the absence of sufficient and affordable private health
however, Third World governments must stretch their resources to serv
populations which now have more expensive, hospital-based diseases.

The result: Public sector health programs that must offer everythi
provide next to nothing.

THE WRONG PRESCRIPTION

The international health and nutrition community, including Amer
places an undue emphasis on a universal prescription for all developin
These standard formulas include centralized public planning of health
village health workers, lists that limit the number of available drugs, b
oral rehydration salts, and growth charts, among other things.

These would have been helpful and appropriate for most of the
virtually all of the developing world of the 1950s. Indeed, much of the
newly industrialized countries over the last quarter century has resulted
large-scale public sector investments in physical and human capital such
electricity, water, education, health training, and immunizations.

Affording a Choice. The problem is that this prescription as the
is relevant today for only Bangladesh, Ethiopia, and other extremely in
countries. The trouble is that the international health community has b
differentiate a Bangladesh from a Brazil, Costa Rica, Colombia, Malays
Egypt, Morocco, Tunisia, and Jordan.

In these nations, an ever-increasing portion of the population can
choice of a more expensive or slightly different drug because it has les
effect; can bottlefeed a baby safely, if they need or choose to do so, b
have electricity, refrigeration, and clean water. They are really not int
obtaining health care from a paraprofessional who has been trained for
months and who has no incentive to perform because he or she has n
by the central government in eight months. In these industrializing cou
emerging wage-based population is increasingly seeking higher quality,
medical care instead of public services.

Example: According to World Health Organization criteria, Egypt
a key goal set forth in its "Health for All by the Year 2000" program;
Egyptians now have geographic access to a Ministry of Health facility.
utilization of these facilities has fallen dramatically over recent years a
more people seek private health services.

Being Attentive to Future Diseases. A simple but largely overloo
Most of the "developing world" is more like the developed world than
Bangladesh or Mozambique. International health and nutrition provider
differentiate their products and determine the types of initiatives most
different countries in their different stages of development.

Even in those least developed countries with the lowest health le legitimate concern that the pattern of health services development bein should be attentive to future diseases and a more sophisticated deman care. In 1970 experts from 20 African countries met at a conference s the Organization for Economic Cooperation and Development (OECD) demographic and epidemiological transitions in their countries. While a data were sparse on health trends, these African experts acknowledged that "tuberculosis, other infectious and parasitic diseases, maternal mort unknown causes of death have decreased whereas the percent of other mortality have increased." The experts concluded that, in addition to th problems of anemia and infant diarrhea, Africa was already in the earl epidemiological transition with an "increase of incidence of cardiovascul and accidents."

Even the poorest countries therefore should be planning for how for health care and other social services for all those children who sur various primary health problems. Incorporating user fees and encouragi insurance systems wherever possible can encourage a more rational syst least developed countries.

Insurance premiums do not even need monetized wages. Example very low income cooperative members, represented by the National Da have their health premiums deducted when they turn their milk into th The value of a set portion of their milk covers their employee contribu prepaid system.

CREATING DEPENDENCE NOT DEVELOPMENT

Despite increased demand for health and other goods and service majority of international health resources are being funneled into centr programs which are premised on "free health care for all"--even those v afford to pay. These Ministries of Health are now so burdened with re that they lack the funds to do the very jobs that public health systems nutrition and health surveillance, providing or reimbursing services for t conducting immunization campaigns, and other public health measures. experimentation with such creative private sector health options as:

1) **Prepaid or other insurance schemes;**

2) **Privatization of certain hospital functions;**

3) **Attracting investment money for public/private partnerships;** o

4) **Encouraging health products manufacturing.**

As a result, the limited public resources are dissipated across larg rather than being focused on those in need. There are, to be sure, a exceptions.

Example: In Brazil, Hospital Corporation of America, a private A hospital management company, owns and runs the world's largest healt organization outside the United States. With 860,000 members, it oper system with only one American on-site and delivers comprehensive pre curative health care for $10 per family per month. This cost is shared company and its blue collar employees. Some 60 percent of the memb private system previously were covered under Ministry of Health auspi private sector alternative has shifted part of the cost burden of health Brazil's government to the private sector.

Paying Little Attention to Cost. Instead of wisely focusing on hc case and a few others may be guides for a strategy for health care fin period of declining public budgets and rising health care costs, the Wo Organization has endorsed a global program called "Health For All by 2000." This program is predicated on public sector outlays and systems little attention to cost and finance issues. Even when donors discuss fi private sector financing and management expertise is rarely involved. Health Organization's annual meeting in Geneva this May, for example theme was how to finance the health programs of ailing nations. Yet not invite private sector health care industry businessmen. Even more AID turned down an offer by seasoned private sector finance and man executives to contribute their knowledge and experience to the technic While the conference paid obligatory lip service to the private sector, involving it, the results will be the same old public sector prescriptions bankrupting Third World treasuries.

Lacking intense financial scrutiny, donor health programs often er costs beyond anything that impoverished Ministries of Health can affor AID designed an $80 million child survival program in Egypt. The pro had projected no recurrent costs yet rough calculations indicate that th Ministry of Health budget would have to be increased by about 20 pe this one program to continue after donor aid ends.

Major Health Problems. The point is certainly not that child sur programs be abandoned. In the least developed countries, a significant health resources should continue to go into these and other primary he programs. In a large and growing number of developing countries, how and child diseases and deaths do not represent the major health probl

These countries need a much more balanced prescription than th receiving. Such a prescription should include:

1) **More attention** to the chronic disease problems of aging popul

2) **Emphasis on cost** containment and payment systems;

3) **Studies on how** to expand affordable private sector health ser products;

4) **Exploration of the potential** for regional health sector banks v increase capital for expanded health products and services (such as ca private practices and health products manufacturing);

5) **Training in health financing** and cost analysis; and

6) **Industrial health** and safety program development.

The future of health in the developing world will entail a consta set of disease, disability, demographic, economic, and social patterns. N prescription, no "silver bullets," no unified easy path will contribute an waste and chaos to the development of future health care in these co and individually tailored approaches will be required.

If the resources to sustain future health systems are to be counte any confidence, it is essential that the international health community begin vigorous and creative discussions with Third World Ministries of the alternatives for structuring future health systems. Financial authorit become active participants in health system development decisions, brir needed financial expertise to the evaluation of health and nutrition op

LOST OPPORTUNITIES AT AID

The rhetoric of the U.S. Agency for International Development h overtaken by a quiet but dramatic revolution in health and socioecono Rather than advocating old solutions, as it does, the U.S. foreign aid p should be on the cutting edge of understanding changing disease patte providing imaginative ways to deal with them in a climate of decreasir sector outlays. The U.S. enjoys a clear and undisputed international co advantage in health care technology, organization, management, and fir American donor programs have failed to capitalize on U.S. national st

Experience reveals that it can be extremely cost effective to spen to involve U.S. health management and financial expertise in the early of Third World projects. Such expenditures give maximum leverage to for they can attract much larger investments from the private sector, b local. Among the few examples of AID supported private health activit

◆◆ In the Dominican Republic, a multinational insurance compa completed a plan for a private sector health maintenance organization. was funded with the understanding that if the venture turns out to be viable, the insurance company will then be committed to a multi-millio investment in the country.

◆◆ In Indonesia, AID funded a feasibility study to privatize the services of the nation's largest employer, the state-owned oil company, PERTAMINA. Several U.S. companies are now considering investing i

with Indonesian partners. Moreover, the business plan envisions that a health premiums be used for community health programs including imr and other preventive measures.

LACK OF ACCOUNTABILITY

The innovation needed to deal with future demand will be difficu from within the international health and nutrition community. The rea almost no tolerance of a critique of existing health programs by establi experts. The field, astoundingly, lacks a tradition of vigorous give-and-t technical and policy issues. Technical dissent soon equates to professior with the "community" which then closes ranks against criticism. As a r international health care institutions become monoliths; accountability f Most journalists, meanwhile, have neither the means to travel the great investigate projects nor the technical expertise to analyze the problems.

Many failures are never reported or never acknowledged as mista international health community. Thus, they rarely are corrected. In som results are more wasted resources. In other cases human lives are at st Examples:

◆◆ In Trinidad, a 650-bed hospital built by French foreign aid t stands unused. It has been unable to open for lack of operating funds.

◆◆ In Somalia, the EEC built a top-of-the-line pharmaceutical p determining whether there was any demand for this expensive facility. T stands unused.

◆◆ In Honduras, the Pan American Health Organization (PAHC Inter-American Development Bank have built seven hospitals, most of v unfinished and unused.

◆◆ In Egypt, AID is currently constructing a large public hospit city with 21 uncompleted public hospitals already, some dating back to

Increasingly in the field of international economic, health, and soc development, the tendency is to search for easy solutions to deeply con problems and then put extraordinary amounts of money behind those s huge sums of money, the thinking typically goes, the problems of dying stagnating economies would disappear. In turn, the money available for attracts hordes of programs and consultants, some good and some bad. drive to spend that money and the insistence on easy answers is not cc rigor in distinguishing the good from the bad, what works from what d or what is scientifically accurate from what is well-spoken ideology.

No Change in Mortality Rate. Valid critiques thus rarely find the the international health community. Those few that do raise disturbing 1986 article in The Economist examined the lack of success of primary Such care, of course, is the primary health strategy of AID and WHO.

Economist cited data from a British Medical Research Council study tl that after four years of the primary health care program, there had be in the overall infant mortality rate.

A paper delivered by Dr. W. Henry Mosley of Johns Hopkins U challenges the WHO and AID approach which holds that inexpensive t such as oral rehydration therapy (ORS), breastfeeding, and immunizatic achieve major reductions in child mortality. He writes: "Except in circu where health programs can be imposed involuntarily, the lifesaving pot technologies will generally be severely compromised by the social and constraints." Nor have those so adamantly favoring an international cod formula acknowledged statements by leading U.S. pediatric groups and scientific studies which refute the major assumptions of the code.

A STRATEGY FOR HEALTH CARE

AID should be entering a new phase of international health care New ways of financing health care will have to be found. New people needed to address these new requirements and approaches. The interr and donor community must cast a wider net in seeking skilled professi likely need more Masters of Business Administration than Masters of I more financial analysts than public health educators, and more hospital insurance administrators than professors.

AID and the international health profession must put aside their assumptions and what appears to be an inherent fear of change. They recognize that private sector resources can serve the public interest in ways, not the least of which is to liberate scarce public funds for bette neediest. Future complex problems and needs will require that the sim the past be replaced with an appreciation for the complexity of proble uncompromising demand for excellence.

There is no quick fix, no single prescription for the creation of s health systems in the developing world. The problems to be faced are rapidly. The development profession must be equally agile and flexible contributing to their resolution.

Catalytic Role. What is clearly called for is a careful examinatio direction of health changes in the developing world, the future availabi and private resources to finance the systems needed to respond to thos and the optimal catalytic role to be played by donor dollars to bring a future sustainable development.

AID's increasing international health expenditures have cast it int of global leadership. AID has the responsibility to assure Congress an American people that these dollars are used as an international investr rather than an international entitlement program.

At least five near-term actions can be taken toward this end:

1) **AID should carry out** a ten-year forward assessment with reci countries, organized by their level of health and economic development framework for breaking free from the current "universal prescription" a health program design and funding. This assessment would permit AII program expenditures to meet the individual and locally acknowledged recipient countries, financing public health interventions where those ar and requested, but taking advantage of more sophisticated investment c which support the expansion of emerging pluralistic national health syst

2) **AID should "retool"** its project analysis machinery, developing health finance and financial analysis skills in its health and project staf

3) **AID should begin projects** that use advanced U.S. technology care organization, manufacturing, and finance to develop local systems flexible, growth-oriented, and financially sustainable.

4) **Congress should create** an independent board of private secto who are not recipients of foreign aid dollars, to introduce accountabilit excellence in the health and nutrition development program. An initial should carefully examine the last five years of health assistance at the This assessment should compare project investments against the evolutic issues and the future needs of developing country health systems. The should examine where the billions of health assistance dollars went, wh the investments, and how health dollars should be targeted in the futur

5) **The U.S. should require** the health programs of the United system, including the WHO, World Bank, UNICEF, and United Nation Development Program, to apply the same standards of evaluation to th in assessing their contribution to improved health levels and self-sustain

In sum, AID and the development profession must accept account their efforts because increasingly high standards of accountability and e be demanded, both by outside observers and by the governments that t

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