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A NEW R_X IS NEEDED FOR WORLD HEALTH CARE

INTRODUCTION

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

The motivation of such an approach is admirable. And at one time, such an approach might have been justified in the face of massive poverty and newly independent nations with fragile public infrastructures. In a few of the poorest countries, this strategy still may be justified. There is no doubt, moreover, that the world health community has achieved successes. Among these are the control and eradication of major communicable diseases, the construction of clinics and hospitals throughout the world, the training of thousands of doctors and other health personnel, expanded access to clean water and sanitation, and the provision of medicines to the neediest for their day-to-day health needs as well as in emergencies. Yet there are growing doubts that public sector transfers today remain 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 education all characterize today's developing world. So does the complex and sophisticated social and epidemiological pattern which increasingly resembles that of the industrialized world. Recognition of this change has been prompting development policy leaders in agriculture and manufacturing sectors to rethink their state-centered and distributive approaches of the past. Most international health and nutrition professionals, by

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

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

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

During the second phase in the 1970s and through the present, however, AID and other donors shifted from basic investments and specific disease control to supporting the planning and operations of public sector health systems. The donor community, in effect, assumed responsibility for funding and, in some cases, running the actual health programs. In virtually all cases, this planning has reflected the public sector perspective of the international health community.

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

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

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

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

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

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

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

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

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

The sums transferred to developing nations for health purposes have been considerable. Although the most recent available figures are nearly a decade old, WHO estimated that donor agencies transferred approximately $3 billion in health sector assistance to developing countries in 1978. This excluded funds from the oil-rich OPEC countries and from the private sector. In a 1978 survey of 1,200 private U.S. companies' health budgets in the international arena, the 154 which responded were transferring some $452 million annually.

The $30 Billion Question. If the trend in AID's health budget is an indication, the total amount spent on international health has increased significantly. In 1978, AID expended approximately $75 million from its economic development budget on bilateral health programs. In Fiscal Year 1987 the figure is $240 million. General increases in most of the donor organizations health programs suggest that well over $30 billion has been spent on international health care programs over the last decade. Such expenditures ought to prompt questions:

What has been achieved for this investment?

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

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

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

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

The leverage represented by the tens of billions of donor health dollars to be spent in the next decade, especially in the face of a widespread economic and epidemiological evolution, clearly demands a careful and critical assessment of past strategies, purposes and asumptions in donor health programs. What is needed is not 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 health problems of the 1950s. Life expectancies were low then because infectious diseases--measles, tuberculosis, smallpox--took a heavy toll. Few people could pay for health care because the waged-based population was practically nonexistent. So health was proclaimed a "right" by the United Nations and many Third World governments. This was widely interpreted as a government obligation to give free health care to all. Multilateral and bilateral donors, private voluntary organizations, and corporate largesse all helped provide the vaccines and antibiotics which proved to be extremely cost-effective ways of improving health status in developing areas.

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

It has. The economic and health statistics confirm this. In all but Africa, average life expectancies have climbed and now exceed 60 years. Infant mortality rates have been reduced by one-third to one-half in most developing countries. (See Table I for some illustrative examples). No longer are the fastest growing causes of death and disability in many developing countries tropical diseases; instead they are diseases of the Western world--cardiovascular, diabetes, hypertension, and accidents. Revealingly, when asked recently what the country's major health problems were, the Minister of Health of Tunisia responded immediately, "The diseases of civilization." This Ministry cannot afford to open two newly built public sector hospitals because the higher cost of responding to the growing burden of chronic diseases is consuming the health budget.

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

The labor force in many developing countries has shifted significantly from subsistence agriculture to the wage-based industry and services sectors, thus raising disposable income and demand for various new goods and services including health care (See Table II). Growing urbanization will continue to accelerate these changes. According to a 1986 study by the New York Academy of Sciences, by the year 2000 there will be 22 mega-cities of over 10 million people in the world; 18 of these will be in the developing world. (See Table III for figures on urbanization.)

With the increasing purchasing power and changing consumer preferences of Third World citizens, it is clear that many of them would pay for health care were

Table I
Illustrative Examples of
Life Expectancy Indicators

	Life Expectancy at Birth		Infant Mortality Rate	
	1960*	1983**	1960**	1983***
Honduras	46	60	145	81
Egypt	46	57	128	102
Morocco	47	58	161	98
Philippines	51	65	106	49
Thailand	51	63	103	50
Costa Rica	62	73	74	20
Peru	48	59	163	98
Guatemala	47	61	92	67
Turkey	51	63	184	66
Tunisia	48	61	159	63
Jamaica	64	70	52	28
Dominican Republic	51	63	120	63
Ecuador	51	63	140	76
Colombia	53	64	93	53
Jordan	47	64	136	62
Malaysia	57	67	72	29
Chile	57	67	119	40
Brazil	57	63	118	70
Mexico	58	66	91	52
Indonesia	41	53	150	101

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

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.C.: The World Bank.

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

Table III
Urbanization

	Urban Population as Percentage of Total Population		Percent Increase in Urban Population
	1965	1983	
Zaire	19	38	100
Tanzania	6	14	133
Somalia	20	33	65
India	18	24	33
Togo	11	22	100
Ghana	26	38	46
Kenya	9	17	89
Sudan	13	20	54
Mauritania	7	25	257
Bolivia	26	43	65
Zambia	24	47	96
Ivory Coast	23	44	91
Cameroon	16	39	144
Peru	52	67	29
Turkey	31	45	45
Tunisia	40	54	35
Jamaica	36	52	44
Dominican Republic	35	54	54
Ecuador	37	46	24
Colombia	54	66	22
Jordan	47	72	53
Chile	72	82	14
Brazil	51	71	39
Mexico	55	69	25

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

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

The result: Public sector health programs that must offer everything but can provide next to nothing.

THE WRONG PRESCRIPTION

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

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

Affording a Choice. The problem is that this prescription as the sole remedy is relevant today for only Bangladesh, Ethiopia, and other extremely impoverished countries. The trouble is that the international health community has been unable to differentiate a Bangladesh from a Brazil, Costa Rica, Colombia, Malaysia, Indonesia, Egypt, Morocco, Tunisia, and Jordan.

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

Example: According to World Health Organization criteria, Egypt has achieved a key goal set forth in its "Health for All by the Year 2000" program; 95 percent of Egyptians now have geographic access to a Ministry of Health facility. Yet, utilization of these facilities has fallen dramatically over recent years as more and more people seek private health services.

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

Even in those least developed countries with the lowest health levels there is legitimate concern that the pattern of health services development being set now should be attentive to future diseases and a more sophisticated demand for health care. In 1970 experts from 20 African countries met at a conference sponsored by the Organization for Economic Cooperation and Development (OECD) to discuss demographic and epidemiological transitions in their countries. While admitting that data were sparse on health trends, these African experts acknowledged even then that "tuberculosis, other infectious and parasitic diseases, maternal mortality and unknown causes of death have decreased whereas the percent of other causes of mortality have increased." The experts concluded that, in addition to the continuing problems of anemia and infant diarrhea, Africa was already in the early phase of its epidemiological transition with an "increase of incidence of cardiovascular diseases and accidents."

Even the poorest countries therefore should be planning for how they will pay for health care and other social services for all those children who survive their various primary health problems. Incorporating user fees and encouraging group insurance systems wherever possible can encourage a more rational system in the least developed countries.

Insurance premiums do not even need monetized wages. Example: In India, very low income cooperative members, represented by the National Dairy Board, have their health premiums deducted when they turn their milk into the cooperative. The value of a set portion of their milk covers their employee contribution to the prepaid system.

CREATING DEPENDENCE NOT DEVELOPMENT

Despite increased demand for health and other goods and services, the vast majority of international health resources are being funneled into central government programs which are premised on "free health care for all"--even those who can afford to pay. These Ministries of Health are now so burdened with recurrent costs that they lack the funds to do the very jobs that public health systems should do--nutrition and health surveillance, providing or reimbursing services for the poorest, conducting immunization campaigns, and other public health measures. There is little 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; or,

4) Encouraging health products manufacturing.

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

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

Paying Little Attention to Cost. Instead of wisely focusing on how this Brazil case and a few others may be guides for a strategy for health care financing in a period of declining public budgets and rising health care costs, the World Health Organization has endorsed a global program called "Health For All by the Year 2000." This program is predicated on public sector outlays and systems which pay little attention to cost and finance issues. Even when donors discuss finance issues, private sector financing and management expertise is rarely involved. At the World Health Organization's annual meeting in Geneva this May, for example, the main theme was how to finance the health programs of ailing nations. Yet WHO did not invite private sector health care industry businessmen. Even more disturbing, AID turned down an offer by seasoned private sector finance and management executives to contribute their knowledge and experience to the technical sessions. While the conference paid obligatory lip service to the private sector, without involving it, the results will be the same old public sector prescriptions now bankrupting Third World treasuries.

Lacking intense financial scrutiny, donor health programs often entail recurrent costs beyond anything that impoverished Ministries of Health can afford. Example: AID designed an $80 million child survival program in Egypt. The project analysis had projected no recurrent costs yet rough calculations indicate that the entire Ministry of Health budget would have to be increased by about 20 percent for just this one program to continue after donor aid ends.

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

These countries need a much more balanced prescription than they are now receiving. Such a prescription should include:

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

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

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

4) **Exploration of the potential** for regional health sector banks which would increase capital for expanded health products and services (such as capitalizing 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 constantly changing set of disease, disability, demographic, economic, and social patterns. No worldwide prescription, no "silver bullets," no unified easy path will contribute anything but waste and chaos to the development of future health care in these countries. New and individually tailored approaches will be required.

If the resources to sustain future health systems are to be counted upon with any confidence, it is essential that the international health community immediately begin vigorous and creative discussions with Third World Ministries of Finance on the alternatives for structuring future health systems. Financial authorities must become active participants in health system development decisions, bringing much needed financial expertise to the evaluation of health and nutrition options.

LOST OPPORTUNITIES AT AID

The rhetoric of the U.S. Agency for International Development has been overtaken by a quiet but dramatic revolution in health and socioeconomic levels. Rather than advocating old solutions, as it does, the U.S. foreign aid program should be on the cutting edge of understanding changing disease patterns and providing imaginative ways to deal with them in a climate of decreasing public sector outlays. The U.S. enjoys a clear and undisputed international comparative advantage in health care technology, organization, management, and finance. Yet American donor programs have failed to capitalize on U.S. national strengths.

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

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

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

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

LACK OF ACCOUNTABILITY

The innovation needed to deal with future demand will be difficult to generate from within the international health and nutrition community. The reason: There is almost no tolerance of a critique of existing health programs by establishment health experts. The field, astoundingly, lacks a tradition of vigorous give-and-take on technical and policy issues. Technical dissent soon equates to professional betrayal with the "community" which then closes ranks against criticism. As a result, international health care institutions become monoliths; accountability for error fades. Most journalists, meanwhile, have neither the means to travel the great distances to investigate projects nor the technical expertise to analyze the problems.

Many failures are never reported or never acknowledged as mistakes by the international health community. Thus, they rarely are corrected. In some cases the results are more wasted resources. In other cases human lives are at stake. Examples:

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

◆◆ In Somalia, the EEC built a top-of-the-line pharmaceutical plant without determining whether there was any demand for this expensive facility. This plant stands unused.

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

◆◆ In Egypt, AID is currently constructing a large public hospital in Cairo, a city with 21 uncompleted public hospitals already, some dating back to 1963.

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

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

Economist cited data from a British Medical Research Council study that revealed that after four years of the primary health care program, there had been no change in the overall infant mortality rate.

A paper delivered by Dr. W. Henry Mosley of Johns Hopkins University challenges the WHO and AID approach which holds that inexpensive technologies such as oral rehydration therapy (ORS), breastfeeding, and immunizations can achieve major reductions in child mortality. He writes: "Except in circumstances where health programs can be imposed involuntarily, the lifesaving potential of most technologies will generally be severely compromised by the social and economic constraints." Nor have those so adamantly favoring an international code on infant formula acknowledged statements by leading U.S. pediatric groups and data from 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 assistance. New ways of financing health care will have to be found. New people will be needed to address these new requirements and approaches. The international health and donor community must cast a wider net in seeking skilled professionals. It will likely need more Masters of Business Administration than Masters of Public Health, more financial analysts than public health educators, and more hospital and health insurance administrators than professors.

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

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

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

AID's increasing international health expenditures have cast it into a position of global leadership. AID has the responsibility to assure Congress and the American people that these dollars are used as an international investment program 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 recipient countries, organized by their level of health and economic development, to provide a framework for breaking free from the current "universal prescription" approach to health program design and funding. This assessment would permit AID to target its program expenditures to meet the individual and locally acknowledged needs of recipient countries, financing public health interventions where those are appropriate and requested, but taking advantage of more sophisticated investment opportunities which support the expansion of emerging pluralistic national health systems.

2) **AID should "retool"** its project analysis machinery, developing more refined health finance and financial analysis skills in its health and project staff.

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

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

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

In sum, AID and the development profession must accept accountability for their efforts because increasingly high standards of accountability and excellence will be demanded, both by outside observers and by the governments that they serve.

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