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INTERNATIONAL HEALTH IN DEVELOPMENT IN THE 1990s*

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INTRODUCTION

United States' policies and strategies in international health for the 1990s must take into account profound global changes that have occurred in recent decades, both in the developing countries and in the U.S. position in the international community.

In the developing countries, a number of problems and characteristics dictate an agenda for the 1990s which differs from that of the 1980s. Most critical are the incrementally accelerating problems associated with population growth and the still limited success in dealing with these in many countries, especially in Africa. Environmental degradation, deterioration of expanding urban environments, rising unemployment, lack of educational facilities, diminishing biological diversity, hunger and stagnating economies are all associated with rapidly growing populations. Serious health problems such as malaria, malnutrition and respiratory infections continue to be of real concern. New health problems with global dimensions are emerging, of

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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 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 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 partnerships which join health professionals from this and other countries to learn 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. Although 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.

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.

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 have merit, concern has been expressed that donor pressure to introduce narrowly-based child survival programs as the priority in every impoverished developing country can lead to an unbalanced and fragmented health program which may be less relevant to the overall health needs of the population than it could be. Other weaknesses of this strategy include the realities that in many Third World countries these programs may present insurmountable management problems because of a lack of infrastructure, and they 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, and must be concerned with far more than the administration and logistics of the programs themselves. 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 represent the living infrastructure that must be built in each developing country to allow its adaptation to changing conditions.

Human Resource and Training Needs

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

3. Research aid which expands the 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 can be detrimental to the infrastructure of health services if it shifts resources away from the health care system toward the establishment and maintenance of single-purpose 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, 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 longer 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'

beginning to support research and education to influence health policy pertaining to special concerns and needs of women in the Third World.

The work of non-governmental organizations (NGOs) 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 often 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 such 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 have a special role to play. Their strength is in the ability to discern a global

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 souces of external concessional financing, and the process of attracting and mobilizing such financing.

Assuming the U.S. continues 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 that:

creation of international or regional institutions to build the new professional and technical capacities required for effective primary health care programs.