

PART ONE

INTRODUCTION

## I MAJOR ISSUES

Assuming that these basic premises are sustained over time, the credibility of the HFA/2000 purpose will rest largely on the success with which technical and financial resources are effectively mobilized. In competition with other socially desirable sectoral imperatives, how will health fare among national authorities who must implement "political will"? Against national demands for increased food production, energy, trade, debt management, and national security which appeal to national instincts for well-being, how should the case for health be prepared and presented? Regardless of efforts by ministries of health to prepare plans and alternatives, national allocations for health and health-related sectors are normally determined by authorities outside the health sector. To those ultimately responsible national authorities, health sector planners must be prepared to answer specific questions on programme objectives, definitions, implementation strategies, evidence of cost, inter-relationships with competing sectors, and probability of success. The outlook for actual resource mobilization and, therefore, the rate of progress towards HFA/2000 will relate closely to the clarity with which the rationale for health resources is prepared and presented.

The purpose of this paper is to identify major issues which will require priority attention by member states if expectations generated by Assembly consensus are to be accomplished in so short a period as two decades.

### ARE THE OBJECTIVES OF HFA/2000 CLEAR?

The World Health Assembly adopted resolution WHA30.43 which specified the "main social target" to be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."<sup>16</sup> The key to attainment of this target is primary health care, defined as "essential care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford."<sup>17</sup>

The components of primary health care include health education, promotion of food supply, nutrition, adequate safe water supply, basic sanitation, maternal and child health care, including family planning, immunization against major infectious diseases, prevention and control of diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.<sup>18</sup> Is there evidence to suggest that this "minimum" mix of activities is economically feasible for the world's majority within the next 20 years? By what process is economic feasibility for universal coverage to be determined? Will programme design and cost vary with the interpretation given to these objectives by developed and developing countries?

The Assembly has acknowledged that countries will vary in their interpretation of an acceptable level of health.<sup>19</sup> Although current global planning by the Assembly anticipates that each member government will formulate its own national plan, the content and cost of essential health care systems are expected to differ from country to country. If varying interpretations and plans derived from those interpretations form the basis of resource requirements, prediction of costs on a global scale becomes a difficult exercise.

The objectives of HFA/2000 are phrased in general terms. As each country begins the difficult task of preparing a quantified national plan, will it become important to distinguish between the target of universal access (equity) and targets which vary with levels of health sector growth? A minimum level of socially equitable services with initial emphasis on universality of access permits definable options in terms of currently available resources. Accessibility is measurable. It offers an achievable goal within a two-decade period, even though few governments would be expected to accept minimum services indefinitely. The achievement of minimal national coverage, however, does not preclude growth. Within the limits of available resources and national political priorities for health, development and growth in the health sector would be expected.

On the other hand, the success of Health for All could be judged by progress towards targets which are beyond the fiscal, technical or political realities of countries during the next 20 years. What definitions, specificity and planning methodology can be introduced now to keep the political and social challenge of HFA/2000 in balance with actual resource availabilities?

#### WHAT IMPROVES THE HEALTH OF A NATION?

Confirming international consensus at Alma-Ata, Assembly membership acknowledges the interdependence of health with socioeconomic development as essential for progressive improvement in national health status. Stated alternatively, the improvement of levels of health are dependent on parallel progress in national socioeconomic development.

There is a need to distinguish between optimal levels of health, as implied in the WHO official definition, and the many gradations of health between optimal adjustment and the ultimate failure of adjustment (mortality). In this sense, health can be defined as the level of adaptation by a given population to its environment. The importance of systems of curative and preventive medicine, including biomedical research, are not under challenge for their obvious function in providing understanding, treatment, and adjustment to the risks and effects of disease. However, to improve the potential of a defined population to adjust to its physical, psychological, and social environment, biomedical science plays a major but insufficient role.

With reference, for example, to the appalling rates of infant mortality in the poorest countries, there is increasing acceptance that prospects for expediting improvement will require multisectoral efforts which attack predisposing causes of illness such as limited health education, low family per capita income, unemployment, food shortages, inequitable food pricing policies, inequity in distribution of national resources, absence of community participation, lack of environmental sanitation and rapid population growth. Among the adult population, there are serious problems such as exposure to vector-borne diseases secondary to increased agricultural irrigation and hydroelectric water impoundment.

At the macroeconomic level, the availability of national resources for health purposes will be dependent upon terms of trade, external debt, level of investment savings, national productivity and managerial competence. Irrespective of levels of national wealth, political commitment towards health improvement necessarily requires decisions by authorities who are not themselves expert in the field of health. National health authorities need to become familiar with general developmental influences on health in order to influence those decisions. Rural and agricultural development are a framework for community participation in the poorest countries. Participation in the education sector is essential for the rapid expansion of concepts of home and village sanitation. These relationships underline the importance of the broad approach to primary health care.

It should be evident that, at the highest decision-making level, government attitudes regarding predisposing factors for health improvement will control the direction and rate of efforts to mobilize resources. If the objective of Health for All is understood to be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life",<sup>20</sup> planning for health will require a multisectoral dimension. General development resources become as critical as biomedical resources.

It would be prudent to acknowledge de facto that donor resources for health flow predominantly from development oriented organizations which are more aware now than in the past of the real determinants of health.

Determination of health sector allocations in developing countries are made by national developmental or political authorities. If general development is the context within which national and international health status is to be improved and measured, what then is the appropriate organizational framework for implementation? Within the ongoing matrix of multilateral and bilateral transfers, what is the appropriate function for the national ministry of health and for the World Health Organization?

#### WHO IS TO DEVELOP THE PROGRAMME OF HFA/2000?

Each member state is responsible for the development of its own HFA programme. Member states are prepared to work towards a schedule which will attempt to produce a global strategy by May 1981. WHO will assist this process at headquarters, regional and country level. International donor agencies have been requested to contribute to the fullest with their support and resources.

But who, in fact, will do the work? Country Health Programming by WHO and health sector analyses by a number of donor organizations are relatively recent events which are constructively moving towards a general developmental approach. A crucial need in many countries is for more health professionals with multisectoral experience to help in national planning and coordinating bodies.

A repeated view expressed by sixteen European and Pacific donor organizations during the course of this Study is that there is no policy barrier to channelling resources for Primary Health Care country projects providing that well-prepared proposals are endorsed by the national planning commission or its equivalent. Paradoxically, donors report that often available resources exceed the current absorptive capacity of governments. In addition, the content of developing country requests continues to reflect a predominant demand for external support for secondary and tertiary levels of health service rather than for primary health care. In the light of these views, the importance of accelerated attention to health planning at the country level cannot be overemphasized. A major question for donors is how to assist constructively with national health planning leadership.

Operationally, the critical shortage of health-cum-development planners affects donor agencies who are dependent on the submission of well-prepared plans prior to disbursement. This shortage affects developing countries where health sector priorities remain low for lack of planners familiar with the health-development rationale. The shortage also becomes a constraint on the technical cooperation offered by WHO, since the total numbers of health-development planners, either in-house or available through consultation, are few.

Few educational institutions in developing or developed countries offer curricula specifically designed to provide a multisectoral orientation for health or other sector planners. Such training facilities on a substantial scale could enable health sector personnel to plan more effectively in relation to competing developmental priorities.

#### WHERE ARE THE RESOURCES FOR HEALTH?

Since measurable improvement of health within a general population is the consequence of more than one socioeconomic sector, it becomes essential to assess the total domestic and external resource base for all sectors and to identify, where feasible, the magnitude and allocation of such resources for purposes which support health improvement. Within the health sector, it is important to estimate the size and allocation of both public and private sector resources. Unfortunately, beyond aggregated general economic data provided by the UN system and OECD, current data on national health expenditures and donor health flows are difficult to obtain. Without a better understanding of the total resource base, expectations for realistic support for HFA/2000 remain conjectural.

Acknowledging the difficulty in obtaining reliable data, initial trends and problems are suggested in table I-1, which is adapted from the 1978 Review of the Work of the Development Assistance Committee of the Organization of Economic Cooperation and Development in Paris.<sup>21\*</sup>

TABLE I-1  
Estimated Public and Private Sector Health Expenditures for Selected Groups  
of Developing Countries<sup>1</sup> in Relation to GNP and per capita Income Classification  
(1976 figures, except for China)

	Low income	China (1978 estimates)	Lower- middle income	Upper- middle income <sup>2</sup>	Higher income <sup>2</sup>
Number of countries	39.00	1.00	28.00	28.0	17.0
Average annual per capita income (US\$)	<300.00	400.00	300- 700.00	1,000- 2,500.0	3,450.0
Population in 1976 (millions)	1,330.00	930.00	244.00	378.0	79.0
GNP in 1976 (\$ billion)	220.00	372.00	170.60	480.0	270.0
Average per capita health expenditure (US\$)	1.20	3.10	4.50	--	--
% GNP allocated for health: public sector	0.77	0.78	0.64	--	--
Total health expenditure: public sector (\$ billion) <sup>3</sup>	1.70	2.90	1.10	4.8	2.7
Total estimated private health expenditure (\$ billion)	6.80	--	4.40	19.2	10.8
Total estimated public/private health expenditure (\$ billion)	8.50	--	5.50	24.0	13.5
Estimated 'absolute poor' (%) <sup>2</sup>	45.00	--	15.00	8.0	5.0

<sup>1</sup>DAC/OECD classification adapted to include 68 low and lower-middle-income countries for which health expenditure data were available.

<sup>2</sup>Development Co-operation, 1978 Review, Paris, Organization for Economic Co-operation and Development, 1978.

<sup>3</sup>Sivard, L.R. World Council and Military Expenditures, New York, Institute for World Order, 1978.

### Developing Country Resources

Table I-1 adapts the OECD grouping of 107 low and low-middle income countries to include only the poorest 68 countries, defined as those with per capita incomes of less than US\$ 699. Excluding China, these countries represent over three-quarters of the population of developing countries with per capita income below US\$ 1 000, and those with the largest number of "absolute poor" (DAC/OECD definition). Although these countries have reported per capita public sector health expenditures varying between US\$ 0.58 and US\$ 27.00 for the low income group and from US\$ 0.67 and US\$ 12.00 for the lower-middle group, data from both groups and China suggest that allocations of national funds for the public sector of health do not exceed 1% of GNP. Total estimated allocations, excluding China, are US\$ 1.7 billion for a population of 1,330 million (lower income) and US\$ 1.1 billion for 244 million (lower-middle income) people. What we do not know is the magnitude of private health expenditures. Studies by WHO and others have suggested a public/private national health expenditure ratio of the order of 1:4.<sup>22</sup> This ratio, while subject to variation, is not entirely inconsistent with the common observation that public sector services among the poorest countries rarely meet the basic health requirements of more than a quarter of their populations.

\* Since this chapter was initially drafted, the appearance of the 1979 OECD/DAC Annual Review has been published. For the purpose of illustrating key issues, however, the later data are not essential.

Assuming this to be a reasonable approximation, what is the actual total availability of health resources in the poorest developing countries? Using the 1:4 ratio, would the total availability of resources (excluding China) reach an order of US\$ 8.5 billion and US\$ 5.5 billion respectively for low and low-middle income countries, a combined total of US\$ 14 billion? Assuming the upper and middle income countries spend no more than 1% of their GNP on the public sector of health; i.e., US\$ 7.5 billion, which on the 1:4 ratio would mean an estimated total of US\$ 29 billion for the private sector, total health expenditures by the two higher income groups of countries would total as much as the US\$ 37.5 billion shown in table 1. How far is it beyond the capacity of the 67 poorest countries, with a collective GNP on the order of US\$ 390 billion (excluding China) to increase total current public health sector investments above US\$ 2.8 billion? Would an increase from 1% of GNP to 2% of GNP be considered politically and economically feasible for poorest countries?

The resource base of the poorest countries may be small in relation to need. However, combined private and public sector expenditure on the order of US\$ 14 billion, if confirmed, cannot be matched readily by present or foreseeable levels of external health resources which are currently estimated to be on the order of US\$ 3 billion. The resources of developing countries themselves constitute by far the major global resource for progress in health. The necessity for planning essentially within the bounds of national limitations, using available external resources only for supplementary and unavoidable resource gaps, may require that member states reexamine whether or not their national financial allocations for health are appropriate to their commitment for HFA/2000. How far is there a need for better rationalization of the health sector by national health leadership during the normal process of intersectoral competition for funding?

In addition to financial resources, developing countries themselves provide substantial professional resources and expertise which are only beginning to be identified and incorporated into cooperative efforts such as Technical Cooperation among Developing Countries.<sup>23</sup> Scholarships are provided by at least 19 countries. Technical advisory services are offered by at least 14 countries. An example of such effort is the Indian Technical Cooperation Programme (ITEC), which was established in 1964. Just as information on the magnitude and allocation of health funding is not clearly identifiable for lack of current information systems, professional resources are also inadequately identified for the purposes of large-scale mobilization.

#### External Resources

With reference to developing countries, "external resources" imply all external public and private sector sources: developed country, developing country (OPEC, TCDC), multilateral banks and organizations, externally sponsored voluntary and nongovernmental organizations. The number and diversity of current and potential external sources for health assistance may be characterized in the following ways:

1. Donor countries with official bilateral (country-to-country) programmes which may include occasional contributions to multilateral institutions for joint multilateral programmes.
  - . 18 donor members of the Development Assistance Committee of OECD are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Federal Republic of Germany, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States of America, and the Commission of European Economic Communities.

- . 8 donor nations in Eastern Europe are: Bulgaria, Czechoslovakia, German Democratic Republic, Hungary, Poland, Romania, USSR, and Yugoslavia.
  - . Other European countries with donor activities include Ireland and Luxembourg.
  - . 13 OPEC countries include: Algeria, Iran, Iraq, Kuwait, Libya, Nigeria, Qatar, Saudi Arabia, United Arab Emirates, Venezuela, Ecuador, Gabon and Indonesia. An additional 4 oil-exporting countries offer a potential donor resource: Bahrain, Brunei, Oman, and Trinidad, and Tobago.
  - . Developing countries providing direct assistance through TCDC or other means: for example, China, Cuba, India, and Democratic People's Republic of Korea.
  - . Contributors to the WHO Voluntary Fund for Health Promotion.
2. Multilateral organizations, largely within the UN system, which draw their support from both developed and developing nations.
- . The World Health Organization, World Bank, United Nations Development Programme, United Nations Children's Fund, Food and Agriculture Organization, United Nations Educational, Scientific and Cultural Organization, International Labour Organisation, United Nations Environmental Programme, Asian Development Bank, African Development Bank and Inter-American Development Bank.
  - . European Development Fund of the European Economic Community: Belgium, Denmark, Federal Republic of Germany, France, Ireland, Italy, Luxembourg, Netherlands, and United Kingdom.
  - . OPEC Special Fund (OSF).
  - . Arab Fund for Economic and Social Development (AFESD).
  - . Arab Fund for Technical Assistance to African and Arab countries.
  - . Islamic Development Bank.
3. Nongovernmental and voluntary organizations, including foundations.
- . Estimates of contributions to health are of the order of US\$ 400 to US\$ 500 million annually out of a total reported private voluntary agency disbursement of US\$ 1 488 million (1977).<sup>24</sup> Global coverage in developing countries, extensive international sponsorship, and long experience characterize this valuable collective resource. Some governments, for example, the Federal Republic of Germany and the Netherlands, channel a significant proportion of their official concessional assistance through voluntary agencies.
4. Private sector trade.
- . International trade in pharmaceutical and medical supplies is not normally viewed as a "donor" source. In the context of identifying external concessional resources, official development assistance (ODA) is provided in the form of grants as well as low cost, long-term loans and other concessional assistance. To the extent that the private sector is prepared to offer concessional terms such as the recent proposal by the pharmaceutical industry to supply essential drugs at low cost and to offer technical training facilities, the resources of this sector in drug research, manufacture and distribution should be identified.

Aggregate data on official and nonconcessional flows from major donors is available through the Organization for Economic Co-operation and Development and, for multilateral organizations, through the UN system. Systematic information on nongovernmental programmes is more difficult to obtain. There is not at present a global system or source which provides public, private, and voluntary health statistics from all donor countries and international organizations on such basic points as the number and distribution of countries being assisted, types of health assistance provided to each country, approximate funding and official policies and attitudes towards the provision of assistance. The 18 DAC/OECD donors, for example, supply gross data on health sector support. Except for the ad hoc DAC/OECD consultations on health in 1976 and 1978, reporting has not included sufficient detail to assess investment in well-defined primary health care activities. A clearer perspective on the viewpoints of donor countries and other agencies would enable WHO, through a global information system, to respond more efficiently to requests from developing countries for external support.

Despite current limitations, the DAC/OECD system reports that total concessional and non-concessional receipts by developing countries from all donor sources for all sectors reached US\$ 63.9 billion in 1977 (table I-2).<sup>\*</sup> As large as those total flows appear, they represent less than 6% of the estimated annual GNP of all developing countries (DAC classification). Two-thirds of these receipts (US\$ 44.39 billion) represent nonconcessional flows such as loans at conventional interest rates. Concessional assistance (ODA) from which support for health, agriculture and education is usually derived, totalled US\$ 19.54 billion (1977)\*\* or about 5% of the total GNP of the 107 poorest countries. Although three-quarters of this assistance is actually received by the 50 poorest countries (table I-3), the flows are quantitatively marginal to needs, though qualitatively they may be of critical importance. Against this background it is highly desirable to identify more positively all external assistance available to help achieve HFA/2000 objectives.

The 18 DAC/OECD donors, who contribute about half of all donor concessional assistance for all sectors (US\$ 10 billion), allocate approximately 10% of their assistance to the health sector and about four times that amount to defined development sectors such as agriculture, education, trade, industry, and public administration. DAC 1978 totals reached US\$ 1 008 million, a figure which excludes significant additional amounts for technical advisory assistance. To this bilateral total for international health activities and support, the World Bank and the regional international banks add approximately US\$ 600 million; activities are carried out by PAHO to the extent of US\$ 45 million, IARC US\$ 6.5 million, WHO Voluntary Fund for Health Promotion US\$ 32 million, UNDP US\$ 14.2 million, UNEP US\$ 1.2 million and UNICEF US\$ 86.3 million. WHO's Regular Budget is currently US\$ 170 million a year. Private and voluntary contributions are estimated to be on the order of US\$ 500 million.\*\*\* To these estimates, which total around US\$ 2.5 billion, one must add the specific health sectoral contribution of OPEC, Eastern Europe and the donor contributions of developing countries themselves, in addition to health components such as water, which often appear in sectors other than health.

With present reporting systems, an accurate total of external resources cannot be confirmed since reporting is incomplete and certain multilateral contributions may be double-counted. Assuming that total annual concessional assistance for health may be as high as US\$ 3 billion, it is of interest to note that this support approximates estimated public sector allocations for health of US\$ 2.8 billion by the 67 poorest countries (excluding China). External donor flows, however, are only one-quarter of estimated public-plus-private

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\* US\$ 78.39 billion in 1978.

\*\* US\$ 22.47 billion in 1978 (\$29.9 billion 1979).

\*\*\* Excluding official donor co-financing.

expenditures of the poorest countries themselves (US\$ 14 billion). Unless the proportion of developed to developing country resources undergoes a major change within the next decade, four particularly important issues will face those who are planning seriously for HFA/2000:

1. How far can HFA goals be achieved with resources produced and allocated by developing countries themselves?
2. Given the quantitatively marginal contribution of external resources to total needs, what is the most qualitatively effective way to apply such resources?
3. How best can WHO, with only a very small fraction of the total global health resource (about 2%), help to rationalize and mobilize external resources over the next two decades?
4. By what international mechanism is it practical to rapidly engage the cooperation and support of sectors other than health, which are prerequisites to health improvement?

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TABLE I-2  
TOTAL NET RESOURCE RECEIPTS OF DEVELOPING COUNTRIES FROM ALL SOURCES

Net Disbursements	\$ billion							
	1970	1971	1972	1973	1974	1975	1976	1977
Official Development Assistance . . . . .	8.04	8.94	9.72	11.57	15.23	19.48	18.74	19.54
a) DAC bilateral . . . . .	5.66	6.32	6.63	7.10	8.26	9.81	9.51	10.08
b) Multilateral agencies . . . . .	1.10	1.33	1.39	2.00	2.85	3.84	3.87	(5.00)
c) OPEC bilateral . . . . .	(0.50)	(0.50)	(0.60)	1.21	3.02	4.95	4.54	3.76
d) Centrally planned economies . . . . .	0.78	0.79	1.10	1.26	1.11	0.88	0.82	0.70
Nonconcessional Flows . . . . .	8.66	9.92	11.90	18.42	17.73	31.70	34.20	44.39
a) DAC bilateral--nonmonetary sector . . . . .	7.16	7.44	7.01	8.43	6.97	18.08	16.08	22.60
b) Multilateral agencies . . . . .	0.69	0.90	1.00	1.28	1.80	2.58	2.73	(3.10)
c) OPEC bilateral . . . . .	(0.10)	(0.10)	(0.10)	0.14	0.92	1.50	1.61	0.86
d) International bank lending <sup>1</sup> . . . . .	0.60	1.38	3.68	8.47	7.95	9.45	13.70	17.80
e) Centrally planned economies . . . . .	0.11	0.10	0.11	0.10	0.09	0.09	0.08	0.03
TOTAL Receipts . . . . .	16.70	18.86	21.62	29.99	32.96	51.18	52.94	63.93
Memorandum Items								
Private sector grants . . . . .	0.86	0.91	1.04	1.37	1.22	1.34	1.35	1.49
Selected IMF facilities <sup>2</sup> . . . . .	--	0.08	0.33	0.14	1.26	2.76	3.03	0.42

<sup>1</sup>From banks in DAC countries and their affiliates in financial centers. Data for 1977 and 1976 are estimates of net new lending with a maturity of over one year, based on BIS figures. Data for earlier years are estimates, based on statistics of publicised syndicated bank credits, of the corresponding net flows.

<sup>2</sup>"Oil Facility", "Compensatory Drawings" and "Extended Fund Facility"; loans by the IMF Trust Fund of \$175 million in 1977 are included under ODA flows from multilateral agencies.

Note: Figures concerning non-DAC countries are based as far as possible on information released by donor countries and international organizations, and completed by OECD Secretariat estimates based on other published and unpublished sources. It has, therefore, not been possible to verify fully that they comply in all respects with the norms and criteria used by DAC Members in their statistical reports made directly to the OECD Secretariat.

SOURCE: DAC/OECD, 1978 Review, p. 189.

TABLE I-3  
DISTRIBUTION OF DONORS' ODA COMMITMENTS<sup>1</sup>  
TO NON-OIL DEVELOPING COUNTRIES BY INCOME GROUP 1977

	Total \$ million	Percent of which to:						Low-income countries		
		Higher-income countries	Upper-middle income countries	Low-middle income countries	Low-income countries		Amount \$ million	% of donor's GNP	% increase 1977 over 1970	
					All	LLDC's only				
Australia . . . . .	448	0.2	0.1	66.1	33.6	9.8	151	0.16	277	
Austria . . . . .	62	0.3	1.3	1.6	98.6	0.5	60	0.12	1,433	
Belgium . . . . .	323	--	1.9	17.3	80.7	23.6	261	0.32	215	
Canada . . . . .	794	--	3.1	21.0	76.0	42.2	603	0.31	203	
Denmark . . . . .	135	*	0.2	12.3	87.5	32.3	118	0.28	828	
Finland . . . . .	21	--	*	47.6	52.4	46.2	11	0.04	..	
France . . . . .	2,273	22.3	36.3	13.1	28.3	7.7	644	0.17	151	
Germany, Federal Republic of . . . . .	1,588	6.1	12.2	29.1	52.6	16.5	835	0.16	273	
Italy . . . . .	65	2.8	6.6	20.1	70.6	24.2	46	0.02	52	
Japan . . . . .	1,766	0.2	2.9	25.1	71.8	9.2	1,268	0.19	381	
Netherlands . . . . .	856	0.1	20.0	11.7	68.2	27.6	584	0.33	837	
New Zealand . . . . .	26	*	0.4	61.6	38.0	13.6	10	0.07	..	
Norway . . . . .	140	--	1.2	14.0	84.8	37.6	119	0.33	574	
Sweden . . . . .	685	--	1.0	12.1	86.9	36.9	596	0.76	936	
Switzerland . . . . .	121	--	5.0	5.5	89.6	28.2	108	0.17	786	
United Kingdom . . . . .	621	2.5	1.9	22.3	73.3	17.2	455	0.19	121	
United States . . . . .	3,550	22.6	9.0	16.0	52.3	10.4	1,857	0.10	28	
DAC Total . . . . .	13,474	10.6	12.1	20.0	57.3	16.2	7,725	0.16	158	
OPEC Bilateral Donors . . . . .	4,000	7.5	2.5	27.5	62.5	30.0	2,500	..	..	
Multilateral Total . . . . .	6,512	0.3	5.7	12.5	81.4	25.9	5,303	..	..	
Grand TOTAL . . . . .	(23,986)	(7.3)	(8.7)	(19.2)	(64.7)	(21.1)	15,528	..	315	

<sup>1</sup>Geographically allocated amounts only and excluding commitments from centrally-planned-economy countries.

SOURCE: DAC/OECD, 1978 Review, p. 111.

## WHAT ARE THE RESOURCE REQUIREMENTS?

In the absence of quantitatively defined HFA targets, resource requirements will vary with the interpretations, goals, and current state of development of each government. Many countries project multiyear plans, but few have estimated health sector requirements through the remaining two decades of this century. The World Health Assembly has encouraged member states to submit, by May 1981, national plans which may indicate the magnitude of global requirements.

Definitional problems remain:

1. If the cornerstone of HFA is the establishment in each country of a socially equitable and nationally affordable system to meet the most essential health needs, resource requirements (by definition) would approximate national resource availability. The need for external resources within the next 20 years would not be as critical as the size and distributional efficiency of currently available national resources. The size of the sector would reflect national political and economic priorities.
2. If, by contrast, HFA is not a rigidly time-bound target and represents, instead, a process by which health levels improve in parallel with multisectoral development, resource requirements for health would need to be adjusted to rates of growth in socioeconomic development as a whole.
3. For those countries which view HFA as a national medical care system, resource requirements could well exceed the practical availability of both internal and external sources.

For the purposes of long-term cost projection, therefore, the intent of governments becomes essential.

With respect to the first definition, namely, that resource requirements should at least be sufficient to provide a socially equitable and affordable system of essential services, preliminary cost estimates of experimental PHC models suggest that an additional US\$ 1-2 per person per year above the current US\$ 1-3 per person per year now allocated in the public sector for health may permit a minimal system for the poorest countries. The additional costs for 1.6 billion population in the poorest 68 countries would approximate US\$ 1.6-3.2 billion per year. Current public expenditure for health in these same 68 countries (excluding China) is now estimated to be at least US\$ 2.8 billion. Public-plus-private expenditure is estimated to be on the order of US\$ 14 billion. In relation to current availability, to what degree are external resources essential? At the minimum level, is the issue one of intragovernmental sectoral priorities and political commitments rather than financial resource availability? Even so, the establishment of a national PHC system at US\$ 1-2 per person extra per year would not decrease the potential need for professional cooperation in technical design, training, management, and evaluation of such a system.

If the second definition is accepted, namely, that each country should progressively accelerate its level of health improvement through health as well as other development sectors and in balance with the availability of internal and external resources, the objective of HFA/2000 becomes a continuously moving target with changing resource requirements. Estimates of requirements over the two-decade span become difficult. The process and costing adjusted to rates of socioeconomic growth is not unreasonable, but the time-frame becomes arbitrary. Social equity at minimum levels of national health change with time to social equity at progressively higher levels of health. The year 2000 then becomes not so much a "target" as a milestone en route to the year 3000.

This second definition, nevertheless, offers a reasonable approach for the coming two decades, even though it does not lend itself readily to long-term quantitative estimation. The principal issues of the North/South dialogue, the New International Economic Order (NIEO) and the New International Development Strategy relate to the conditions which permit development as a whole and not just health sector progress. These conditions, together with economic and social priorities, and rate of overall development, determine resource availability within which each country must make its own sectoral choices. In practice, development policies of individual countries at the planning commission level, together with current donor agency policies for country assistance, will largely determine the potential availability of resources for health. If PHC components such as water supply, maternal and child health, malaria control or family planning are to be globally and effectively implemented, the estimated financial requirements will be closely related to rates of developmental growth and to decisions of national leaders on how those resources are to be allocated.

The practical question in relation to HFA resource requirements is not necessarily the estimation of average per capita costs over the next two decades, but whether national health leadership will be adequately trained and prepared to adjust estimates to match the continuously changing configuration of economic growth and social commitment.

#### WHAT IS THE OUTLOOK FOR RESOURCE AVAILABILITY FOR HEALTH IMPROVEMENT DURING THE NEXT TWO DECADES?

It would be easy to dismiss resource forecasting out of hand. The next 20 years invite all the fiscal, social, and political unpredictability of history. It would not be responsible, however, to project the success of an international initiative such as HFA/2000 without regard to the outlook of resources. It is too easy to agree on objectives when there is no agreement on how the bill is to be paid.

If the achievement for HFA is based upon Alma-Ata concepts of primary health care which advocate solutions adapted to current resource availability, the principal requirement is for innovation to determine the effective use of existing resources. There is need for marginal added resources to permit innovation, testing, assessment, and the filling of country-scarce resource gaps rather than large subventions to the public sector budget. Any support to the public sector budget for health in a developing country should be seen only as a temporary, progressively decreasing process to allow a reasonable and steady development of the health strategy until the country is capable of maintaining it on its own.

If, on the other hand, HFA refers to the "attainment... of a level of health that will permit... a socially and economically productive life"<sup>25</sup> the objective becomes a continuously moving target linked to the varying developmental aspirations of each nation. With this second interpretation in mind, the Development Assistance Committee of OECD notes that 60% of developing countries have shown an annual per capita income growth of about 1.5% over the past 15 years. This trend is predicted to continue except where new resources such as oil are developed or where the terms of trade and productivity significantly improve. World Bank projects that by the end of the century vast amounts of absolute poverty will remain, largely in Africa and Asia, because the advance of agricultural growth rates through a large range of crops is a slow and difficult task.

Other countries, the "middle-income countries", will make more rapid progress. For 40% of developing countries, represented by such countries as Brazil, Republic of Korea, Taiwan, the OPEC countries, Thailand and Tunisia, rates of growth have doubled over the past 15 years to an annual 4.3%. Accepting these trends, however, few would predict that growth rates are going to double or triple by the end of the century.

Donor assistance to all sectors has grown from US\$ 8 billion in 1960 to US\$ 80 billion in 1979. The rate of ODA growth is about 7% per year. Total assistance in 1978 was equivalent to only 6% of the GNP of developing countries. It is obviously feasible for donors to expand beyond the current level of their contributions, an average of 1/600 of donor national GNP. Nevertheless, there is no prediction that the annual growth of ODA will significantly increase over current rates.

If one assumes that current trends for general development funding will continue to the end of the century, the outlook for allocation of health funds within this trend is less certain. The present trend allocates around 10% of donor concessional flows for the health sector. With no specific policy or principle restricting percentage allocation for health, the potential for increasing proportions and influencing the technical content of programmes will depend on the quality of health sector justification by cooperating governments with the support of professional personnel within bilateral and multilateral organizations.

It is not unthinkable that the estimated current ODA flow of US\$ 3 billion for health in 1978 could be increased by an additional 10% per year (US\$ 300 million) under current donor guidelines. On the basis of consultative visits to European and Pacific donors in early 1980, it is evident that the potential for health has by no means been fully explored. The potential for increase does not include all donors, some of whom are fully committed at present and are candid about their limits. Others are willing to be of help, to negotiate new agreements subject to the availability of staff in an international organization such as WHO.

A very important dimension in resource outlook is the future of sector allocations by the developing countries themselves. As noted earlier, current public sector allocations are estimated to be US\$ 2.8 billion for the 67 poorest countries, excluding China, which is estimated to allocate an additional US\$ 2.9 billion. Private sector health inputs, excluding China, are estimated to be US\$ 11.2 billion. Total public/private resource availability is on the order of US\$ 14 billion. With the low priority commonly accorded to the traditional health sector in developing countries, the outlook for increase could be substantially greater than the rate of economic growth where the quality of the health/development rationale improves. Not all developing countries are resource-poor in absolute terms. There is considerable room for an increase in health sector allocations, even at the anticipated 1.5% annual average growth rate. Reasonable effort made to support developing country leadership in their efforts to justify the health sector in relation to development may have a major impact on improving the outlook for future resources.

As important as these potentials may be for resource development, it would be erroneous to suggest that such increase will have a measurable impact on a per capita basis for the world's poor. The prospect for economic growth for the world as a whole is not bright over the next 20 years. Energy crises, increasing balance of payments deficits, external debt, food shortages, and continuing high rates of population growth will adversely influence the prospects for resources.

In the area of family planning, it is generally acknowledged that current efforts will not have a major global impact until well after the turn of the century. Assuming that the developing countries are now fully participating in a programme to achieve a net reproduction rate of one by the year 2000, an assumption which is clearly not a present fact, these countries by the end of one decade would have only 4% less population than if there were no family planning programmes at all. While family planning must remain a high priority for its health as well as for general demographic effects, the programme is not expected to yield major economic changes in the next ten years.

It is relevant, therefore, to emphasize that the total outlook for health resources does not allow optimism for major increases within the time frame of the HFA/2000 initiative. Increases, yes. But not on the scale proposed by the Brandt Commission.<sup>26</sup> A doubling of ODA to US\$ 40 billion is not beyond economic feasibility if the political commitment of industrialized countries can be obtained. As of July 1980, international response from governments has been less than heartening. In the face of economic problems in both the North and South, is it likely that the North will increase its current level of giving above an average of 0.35% of GNP? Brandt Commission proposals are also related to concurrent monetary reform, implementation of a new energy strategy, the establishment of a new World Development Fund, and new automatic levies on global investment. These new directions have received the most careful attention by the Commission and merit the fullest support. To work actively towards these objectives is not the same as assuming that the next two decades will see their fulfillment.

The achievement of HFA/2000 should take into account the worst economic and social scenario, not the best one. The design for HFA must at least fit within prevailing constraints. These constraints take into account that the major resources for health are within developing countries themselves. The relatively marginal potential increases from donors will need to be used with the greatest care to provide knowledge, training, and preparation for the rigorous planning requirements at the country level.

To create expectations beyond the wisdom of self-reliance and self-sufficiency would effect a genuine disservice to the underlying goodwill and sincerity of the Assembly's initiative.

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## II. TRENDS IN RESOURCE MOBILIZATION for World Health Assembly Priorities

The constitution of the World Health Organization states that one of the functions of the Organization shall be "to act as the directing and coordinating authority on international health work."<sup>1</sup> For both technical as well as resource coordination, the necessary approval for WHO to carry out this mandate has varied over the past thirty years with the willingness of WHO member states to participate in such coordination.

With respect to technical coordination, this constitutional principle has been progressively applied. For example, global and regional programmes for malaria and smallpox have traditionally relied on Expert Groups or technical discussions sponsored by WHO. New programmes such as the Expanded Programme of Tropical Disease Research and Training illustrates the acceptability of WHO by member states as the focus for formulation of technical judgements.

Parallel to the progressive evolution of technical coordination, extrabudgetary resource mobilization has not received the same degree of organized, systematic global attention. Within the reported total of global bilateral and multilateral resources for official development assistance in 1978 (US\$ 22.47 billion),<sup>2</sup> the operational activities of the entire UN system provided US\$ 2.63 billion (11.7 %).<sup>3</sup> WHO obligations for the same year totalled US\$ 333.475 million, about one-third of which represented extrabudgetary support (US\$ 110.305 million).<sup>4</sup> The total WHO budget represents about 1.5% of available total ODA resources for all sectors.

In relation to total estimated global resources for defined health sectoral purposes (i.e., predominantly biomedically-related curative and preventive programmes) which may be on the order of US\$ 3 billion<sup>5</sup> annually, the WHO total budget represents an estimated 11%, of which, as noted above, about one-third is derived from extrabudgetary resources. Whether the boundary of resources for health are to be limited to the traditional health sector allocations or, in view of accepted relation between development and health, to the larger pool of potential official development assistance, current WHO regular and extrabudgetary resources represent only a fraction of the global availability.

The financially modest role of WHO is not a new or surprising phenomenon. It is generally accepted that WHO is not a "donor" agency in the capital assistance sense. The Organization has used its resources in catalytic ways to generate technical coordination. It is equally evident, however, that the mobilization of extrabudgetary resources for WHO itself is constrained by the limited availability of funds within the UN system and by official government donors who restrict the proportion of their ODA contributions to multilateral agencies. Even with the favourable increase in support of the UN system (Part Two, Section III), the net receipts of developing countries from bilateral sources (DAC members) were US\$ 13.12 billion against US\$ 1.6 billion contributions by the same members to the UN system.<sup>6</sup>

Since the members of the WHA have requested that WHO should take an active role in health resource mobilization, at least three points are clear. First, resources within the UN system do not offer major room for rapid expansion even though they are expected to increase progressively. Second, the major proportion of potential resources for health lies with the bilateral donors who, by policy, are restricted in disbursing, on the average, more than 40% of their assistance through multilateral organizations. Third, a formal systematic mechanism for facilitating bilateral, multilateral, and NGO health resources mobilization has yet to be developed.

Retrospectively, the seeds of more inclusive resource coordination date from the inception of WHO. For example, the earliest efforts to mobilize resources for malaria during the early 1950's were marked by WHO-sponsored annual meetings for countries and regions where participants included affected countries, WHO, UNICEF, and interested bilateral donors.

## II TRENDS

Intramural WHO efforts to mobilize resources for both general and specific programmes led to the Voluntary Fund for Health Promotion and later to the more substantial international collaborative funding efforts for the Smallpox Programme.

During the 1970's, international resource coordination through WHO made two types of significant advances. The first of these was the convening of consultative groups which included representatives from donor agencies and developing countries for the purpose of mobilizing resources for a specific programme. Special programmes for Tropical Disease Research and Training (TDR), Human Reproduction (HRP), and Oncocerciasis Control (OCP) characterize the current appeal made for extrabudgetary resources which may or may not be channelled directly into a WHO-controlled fund. For TDR and OCP, the World Bank serves as the Funding Agent.

The second advance was the encouragement of an increasing number of donor organizations to exchange views with WHO on a broad range of health issues. For example, at USAID request, a full exchange of views between USAID and WHO has occurred annually or biannually since 1974. Other consultations among UN donors, bilateral agencies, funding institutions, and developing countries have centered around a specific country (e.g., Sudan), a region (e.g., the Sahel) or a technical theme (national health, planning, MCH, disease control). These efforts should, of course, be continued and encouraged.

At the same time, during the 1960's and 1970's, international opinion representing many bilateral, multilateral, and nongovernmental sources drew attention to major health-related problems such as malnutrition, rapid population growth, and the inadequacy of water and sanitation. However important these issues were for health improvement per se, the focus for global action was often assumed by entities other than WHO within the UN system such as FAO, UNFPA, and UNDP.

Reasons for the shift of such health priorities away from WHO are complex. The World Health Assembly agenda focuses primarily on the regular programme of WHO. Ministries of health which represent member states on the World Health Assembly are understandably more oriented toward domestic health issues and seldom represent responsibility for national decisions relating to public works, agriculture or demographic effects on national economies. Official delegations to the World Health Assembly do not consistently include representation from development assistance organizations and, consequently, opportunity for multidonor and multisectoral dialogue is limited.

It may be assumed that official delegations to the World Health Assembly represented by health ministries will automatically communicate health resources requirements of developing countries to responsible funding and planning ministries within their own governments. To the contrary, evidence suggests that a far greater need exists for communication between ministries of health and official development and planning agencies in member states.

Not all health ministries are aware that the primary sources of external funds for health are the official bilateral and multilateral organization development funds which are considered beyond the constitutional purview of the WHO mandate for coordination.

Whatever the cause, the historical result is that the mobilization of funds for nutrition, family planning, and water are now in large measure the accepted responsibility of organizations other than WHO. Is it possible that the focus of action for other major health initiatives may also shift away from WHO as "the directing and co-ordinating authority on international health work" for lack of a process by which major health issues can be regularly raised with both international official and nongovernmental development assistance and planning agencies?

The dimensions of the UN Conference on Primary Health Care (Alma-Ata) and its follow-on global consensus to achieve "Health for All by the Year 2000" calls for a much greater dialogue than has heretofore taken place. There is need for a more formal system to encourage the magnitude of requisite support for this initiative. Such an effort could not

depend on intramural WHO actions alone since a very large number of external donor organizations are already engaged in direct relationships with developing countries. Resource flows are authorized by a widely differing spectrum of official legislative organs and boards. A review of the policies and viewpoints of donors is therefore essential in order to formulate a mutually agreeable organizational structure or process.

A number of questions require in-depth study.

1. Given the wide variety of on-going arrangements between agencies and recipients, would donors and recipients be willing to participate in a new system for acceleration of "Health for All" goals?
2. Would donors and recipients be prepared to share information which would help identify needs, gaps and duplications?
3. As a practical matter, are donor agencies and planning ministries committed to the concept of "Health for All" as Assembly resolutions would suggest?
4. Do donor agencies consider that new collaborative mechanisms are useful or necessary in the light of multiple prevailing systems?
5. Do multisectoral donor agencies accept that acceleration of health objectives can be achieved by policies other than general development where health is combined with rural development, education, and other multisectoral approaches?

As an initial step, in November 1978, the WHO convened for the first time in its history, a meeting of all interested international donors (bilateral, multilateral, nongovernmental) to review all major health priorities declared by the World Health Assembly. On that occasion, the Director-General Dr. H. Mahler, reaffirmed that the financial role of the Organization was modest compared with total available international resources for health. He indicated that, subject to the wishes of member governments, WHO was prepared to explore new mechanisms and to work in constructive and catalytic ways to increase the flow of international resources for health, whether or not those resources are channelled through WHO.

At this first global meeting on health resources, a further step was taken. A decision was made to form a consultative Health Resources 2000 Group to explore collaborative mechanisms for the acceleration of health resources in support of HFA. In December 1979 a Health Resources Mobilization preparatory committee reinforced the need for an in-depth study of donor policies, programmes and perspectives. In response to this need and to lay the groundwork for a possible new international system for health resources mobilization, A Study of Donor Policies, Programmes, and Perspectives was undertaken.

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### III. A STUDY OF DONOR POLICIES, PROGRAMMES, AND PERSPECTIVES Background, Process, and Resources

#### BACKGROUND

A global health effort of considerable proportions is already in progress. In 1978 some fifty official donor agencies together with a much larger number of nongovernmental organizations were transferring health assistance estimated at US\$ 3 billion annually to developing countries (Part One, I. Assistance Policy; Part Two, VII. Health Funding). The largest portion of this flow was directed towards the poorest countries who were themselves estimated to be spending as much as US\$ 14 billion of their own public and private resources on medical and health problems. External sources represent a largely inherent and inseparable element of general development (concessional) assistance which reached on the order of US\$ 22 billion in 1978<sup>1</sup> and almost \$30 billion in 1979.<sup>2</sup>

In response to the World Health Assembly objective "Health for All by the Year 2000", recommendation No. 21 of the Alma-Ata Declaration requests "that international organizations, multilateral and bilateral agencies, nongovernmental organizations, funding agencies, and other partners in international health acting in a coordinated manner should encourage and support national commitment to primary health care and should channel increased technical and financial support into it, with full respect for the coordination of these resources by the countries themselves in the spirit of self-reliance, as well as with the maximum utilization of locally available resources."<sup>3</sup>

The exploration of alternatives for resource acceleration should include more than a review of donor policies and practices. Resource systems of developing countries need also to be reviewed. Anticipating that donors will continually raise the question of developing country commitment as a requisite for the magnitude and rate of development assistance, concurrent studies of health resource mobilization within developing country are essential. For both donor and developing country, public as well as private resource systems need to be assessed.

In view of the current level of bilateral, multilateral, and NGO transactions and the reasonable expectation that assistance for health will continue at some progressively increasing level, the Alma-Ata recommendation nevertheless raises serious questions: Is it feasible to increase resources for health above currently expected modest increments and if so, by what possible alternative processes? Will joint donor-developing country resources ultimately be able to meet the minimum requirements of "Health for All by the Year 2000"?

A Study of Donor Policies, Programmes, and Perspectives represents an initial effort to review the current magnitude and distribution of external health resources and to assess the outlook and potential alternatives for increased funding for health purposes in the immediate future.

#### PROCESS

The Study was carried out over the period of one year (August 1979-August 1980) and included five general stages:

1. Review of current literature and official data sources on donor policies, programmes, and funding
2. On-site consultations with health, development, and foreign affairs representatives with responsibility for external, financial, and technical assistance
3. Preparation of sixteen illustrative profiles on individual donor policies, programmes, and perspectives

4. Cross-sectional analyses of the data contained in the profiles
5. Preparation of recommendations

To obtain the views of donors, on-site consultations were convened with over two hundred individuals in fifteen cities in Europe and the Pacific. Consultations also included discussions with senior staff at WHO Geneva Headquarters, WHO Regional Offices in Copenhagen, Delhi, and Manila; with members of the OECD Development Assistance Committee Secretariat in Paris, and with individual representatives of the World Bank, UNDP, UNICEF, and CMC. During the May 1980 World Health Assembly in Geneva, discussions with an extended range of donor, multilateral, and developing country representatives served to strengthen and support the Study.\*

In preparation for initial consultations, the WHO Division of Coordination in Geneva corresponded with selected donor institutions indicating that the Director-General of WHO was actively exploring alternative mechanisms for mobilization of resources on a global scale in accordance with the Assembly consensus on Primary Health Care and "Health for All by the Year 2000". Without proposing that any single mechanism is feasible or desirable, WHO indicated that it would be difficult to develop mutually-agreed systems for resource mobilization without ascertaining the views of donors. WHO therefore invited donors to join in an informal and candid exchange of views with the writer who was retained as an official consultant to the Director-General.

Within the relatively brief four-to-five days time available for each consultation, a full, comprehensive, and official view of each donor was neither feasible nor appropriate. It was hoped, however, that a frank exchange of views would elicit guidance from donors on acceptable means for improving coordination, on expediting resource mobilization, and on alternatives for an international mechanism which might achieve those purposes. Donor views on the potential role of WHO were also invited.

Based on consultations and review of available official publications and data, a summary profile was prepared on sixteen separate donors. The profile outline suggests the types of useful information that donors themselves might be prepared to provide on a continuing basis. For example, a basic knowledge of official development policy is essential to an understanding of health policy from which it is derived. Patterns of distribution, categories of technical and sectoral assistance, and general orders of magnitude of funding are of obvious relevance. Organizational structure and programming process are also important topics if recipients are to understand acceptable ways to prepare and submit proposals.

For some sections of the profile such as Section IV, Assistance to Nongovernmental Organizations, it was possible to obtain only fragmentary data. On the other hand such gaps in information are useful in assessing the limitations of data availability. However brief and incomplete, the profiles serve as illustrative samples of the types of data which might be useful and acceptable and which might provide the basis for an ongoing system of data information gathering.

PART TWO of this Study presents a cross-sectional analysis of the data obtained from sixteen of the interested donor agencies and organizations. Recommendations are found in PART THREE. Individual donor profiles used in the cross-sectional analysis are arranged alphabetically in PART FOUR.

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\*Subsequent to Study completion in August 1980, additional consultations were convened with UNICEF in New York, with the Pan American Health Organization, and with the US Agency for International Development in Washington.

## DATA SOURCES

In contrast to the substantial official donor and multilateral agency literature on general development policies and funding, there exists little published literature on health policies and funding per se from those same sources. A review of the literature at the Institute for Development Studies, University of Sussex, and at the World Health Organization, Geneva, indicates the very limited availability of data on donor policies and practices as related to health. The Sussex studies by de Kadt, White, Cole-King and Andersson review the United Kingdom, Netherlands, and Sweden and concentrate on primary health care-related programme content in contrast to sector funding.

During the Study, the author enjoyed the fullest cooperation from individual donor representatives in the provision of available data. Data gathering for health purposes, nevertheless, proved to be difficult because of the inherent organizational characteristics of development cooperation.

1. Most development organizations are organized around geographic units (country or regional) since the objective is to cooperate with specific countries or groups of countries. Health programmes are included within a country or regional development programme and are reported as such. Although functional sectors such as health are often considered to be important components, statistical reporting is not organized consistently along functional lines.
2. Limited numbers of health staff are engaged in providing technical counsel to geographic offices. Statistical services for institution-wide sectoral programmes such as health are not necessarily given high priority.
3. Official publications (required for national or parliamentary purposes) are printed in many different languages and only to a limited extent in English or French.
4. In the absence of common definitions among donors for health activities, health-related programmes appear under multiple programme categories such as bilateral country assistance, multilateral support, regional programmes, personnel assignments, agriculture (nutrition), engineering (water and sanitation), education, disaster, rehabilitation programmes, and family planning.
5. A number of donor countries administer development cooperation through more than one government ministry without preparation of a national annual summary of health assistance from all government sources.
6. Donor agencies are able to provide general estimates of health sector assistance but given limited donor professional staffing, periodic reports tend to be ad hoc and vary in definition, completeness, and comparability.
7. Funding for provision of technical cooperation personnel, a major health item for some donors, is often not included within health funding totals.
8. Co-financing of voluntary agencies which in turn may provide health service is often omitted from reporting as a health contribution.

Such characteristics do not imply defects in statistical design on the part of donors in relation to their general development purpose. In order to assess support potential in the health sector, however, current development patterns of reporting pose a significant difficulty. Since development funding constitutes the primary external source for international health funding, it becomes essential that a mutually-agreed upon pattern of health reporting be developed. Recognizing this point, a number of donors have informally urged that such a statistical system be developed.

At the present time, outside of donor government sources, the DAC/OECD Chairman's Annual Review and its supporting DAC documentation constitute the two major sources of regular bilateral and general development information. Although DAC Members\* comprise the regular reporting sources, additional data includes major multilateral funding institutions and, to a lesser extent, OPEC countries, Eastern Europe, nongovernmental organizations, and donor activities among developing countries themselves. For example, the 1979 DAC Chairman's Report provides a summary of net resource receipts of 1978 official development assistance (ODA) defined as concessional assistance to developing countries from all sources for all development purposes including health.

Net Resource Receipts by Developing Countries of  
Official Development Assistance from all Sources

Source	Net disbursement in \$ billions
DAC bilateral . . . . .	13.12
Multilateral Agencies . . . . .	5.91
OPEC bilateral . . . . .	2.52
Centrally-planned economies (Eastern Europe) . . . . .	0.82
Other donors, bilateral . . . . .	0.10
<b>TOTAL ODA</b>	
	<b>22.47</b>

In spite of highly useful aggregate development reporting, the DAC Creditor Reporting System does not as yet provide sufficient detail on the type, distribution, and magnitude of health sector funding, particularly as it applies to primary health care. Health sector programme content is not well defined. Funding magnitude tends to be underestimated. Again, these limitations are not statistical errors but constraints imposed by common agreement among DAC members on the detail of reporting. Subject to the agreement of members, the potential for improving health reporting is substantial.

It is clear there now prevails no satisfactory global system for reporting funding trends related to the health sector. To adapt the current statistical systems of bilateral and multilateral agencies in ways which permit a more defined system for following health trends is an important task which remains to be done.

\*Members of the OECD Development Assistance Committee (DAC) are: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Federal Republic of Germany, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States, and the Commission for European Economic Communities. Observers: IBRD/IMF.

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PART TWO

CROSS - SECTIONAL ANALYSIS OF  
SIXTEEN DONOR PROFILES



## INTRODUCTION

For the purpose of achieving global objectives in health, it is well accepted that practical plans for achieving those objectives must be built upon country-specific programmes. It is equally valid that efforts to improve donor cooperation for global health goals must be built on the specificity of individual donor policies and programmes and on donor perception of those goals. The practical utility of resource mobilization will depend as much on specific differences between individual governments as upon common threads of effort. A workable resource mobilization system will require a well-managed and mutually agreed-upon pattern of country-specific data for both donor and recipient countries.

In the absence of an agreed-upon system to provide such specifics, what general trends and observations can be identified? In particular, what observations may be helpful in the design of a new international financial and technical resource mobilization system? The cross-sectional analysis of sixteen donor profiles which follows attempts to address these questions.

Based upon informal consultations with representatives of donor agencies, ministry of health officials, and a review of available current literature, an individual profile was developed for sixteen donors interviewed during the course of Study. Each profile outline is divided into twelve Sections (see PART FOUR Introduction). The cross-sectional analysis draws on findings and observations from corresponding sections in individual profiles. In each sectional analysis, tables and maps are provided where indicated to illustrate available information. At the end of each analysis, corresponding excerpts from donors profiles are arranged alphabetically.

## PROFILE OUTLINE

### SECTION:

- I. ASSISTANCE POLICY
  - A. Official Development Policy
  - B. Official Health Policy
- II. DISTRIBUTION OF BILATERAL ASSISTANCE
  - A. Distribution of Bilateral Development Assistance
  - B. Distribution of Bilateral Health Assistance
- III. DISTRIBUTION OF MULTILATERAL ASSISTANCE
  - A. Distribution of Multilateral Development Assistance
  - B. Distribution of Multilateral Health Assistance
- IV. ASSISTANCE TO NONGOVERNMENT ORGANIZATION
  - A. Development Assistance to Nongovernment Organizations
  - B. Health Assistance to Nongovernment Organizations
- V. TYPES OF ASSISTANCE
  - A. Types of Development Assistance
  - B. Types of Health Assistance
- VI. DEVELOPMENT FUNDING
- VII. HEALTH FUNDING
- VIII. PROGRAMMING PROCESS
- IX. ORGANIZATION STRUCTURE
  - A. Responsible Donor Agency(s)
  - B. Country Representation
  - C. National Health Ministry
  - D. Official Correspondence
- X. DONOR PERSPECTIVE ON HFA/2000
- XI. VIEWS ON ACCELERATION AND COLLABORATION
- XII. VIEWS ON THE ROLE OF WHO

## LIST OF PROFILES

1. ASIAN DEVELOPMENT BANK
2. AUSTRALIA
3. AUSTRIA
4. BELGIUM
5. DENMARK
6. EUROPEAN ECONOMIC COMMUNITY
7. FEDERAL REPUBLIC OF GERMANY
8. FRANCE
9. JAPAN
10. NETHERLANDS
11. NEW ZEALAND
12. NORWAY
13. OPEC SPECIAL FUND
14. SWEDEN
15. SWITZERLAND
16. UNITED KINGDOM