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THE SUSTAINABILITY OF HEALTH CARE IN DEVELOPING COUNTRIES

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The development of health systems within developing countries is affected, to varying degrees, by the wider international framework and the influences of external investment. Regardless of other contextual factors such as political instability and conflict, governments and local NGOs who choose to work with donors and international NGOs, share a certain commonality in their vulnerability to the influences which these relationships entail. A vulnerability which increases correspondingly with a growing dependence on external investment. The influence of the international aid industry on health system development can be seen as not always being conductive to the creation of a sustainable, self-reliant system. This paper will outline the implications of external influences, drawing from the results of two cases studies carried out by SCF UK in Uganda and Nepal.

SCF's sustainability research

SCF UK is currently running a research program to examine policy, decision-making, and planning strategies and the different interventions of governments, donors and NGOs in the health sector of five countries (Uganda, Ghana, Nepal, Pakistan and Vietnam) over the past ten years, and the relative influence these have had on the creation of sustainable

health systems. This research program has arisen from the current crisis now facing many governments and donors working in the health sector: although massive amounts of capital and technical assistance have been invested in health, still, in many countries, services are inadequate and national capacity has not been developed.

For the purpose of the research program, SCF defines sustainability as: the capacity of the health system to function effectively over time with a minimum of external input. By 'health system' we mean one in which governments play a pivotal role, at least in a coordinating capacity (a mixture of public and private services may be inevitable), in all components of sector development, and the overall system is one in which the health needs of the people, as defined by them, are met as far as possible. On referring to a sustainable health system, we are imagining an ideal to a certain extent, and recognize that there is no formula for an ideal system which is appropriate for every country. However, it is only by creating a sector which is self-reliant, and has the capacity to address the needs of communities over the long- term, that any form of overall sustainable system can be developed.

This research program aims to provide a critical analysis of past activities in the health sector in the case study countries, in order to heighten understanding of the comparative impact of different approaches, and to ensure that the future work and investment of both SCF and other actors in health sector development is appropriate for supporting the creation of sustainable systems.

SCF is not alone in exploring the issue of sustainability, the sustainability of activities is increasingly being referred to by some donors and governments as of fundamental importance when planning health interventions although it must be recognized that differing definitions of sustainability are in operation. Health sector reform and alternative approaches are now heading the agenda. So why this current interest in sustainability?

Economic context

Recession, debt, and in some cases, structural adjustment programs, have all taken their toll on government health expenditure. Health expenditure, as a proportion of public expenditure, has declined over time in both Uganda and Nepal. During this critical economic period a growing dependency on external aid to support their health sectors has developed. This has now generated into an even more worrying situation whereby governments depend on external input not only for sector development work, but even to cover recurrent costs. All this takes place in a climate where donor funding is decreasing in many countries: funds for health, nutrition and family planning declined as a component of total aid from 7.5% to 5% between 1979 and 1987.

Reduced financing capacity has brought the issue of sustainability to the fore: donor funds are being cut and agencies are no longer willing to pour funds into inefficient systems. The question arises: if the system would fall apart if donors pulled out, then what sort of self- reliant capacity has the massive amounts of external assistance over the past thirty or so years been building, and what implications does apparent failure have for future investment?

Beyond the economic context

The problem of sustainability can be seen to extend far beyond the reality of a shrinking resource base. Even if international donors conceded to funding recurrent costs for health sector activities indefinitely, it is debatable whether this fact alone would be enough to ensure that the most appropriate and effective long-term system would be established. The economic crisis has, to a certain extent, only served to reveal the significant influence of the process of investment in the sector. It is this process which SCF is examining.

Case studies : Uganda and Nepal

Data for SCF's research program is still being gathered, but the case studies of Uganda and Nepal are now near completion. While recognizing the danger of generalizing too widely from specifics (these case studies are obviously very specific to country political and economic situations), some clear patterns emerge which are of relevance to health sector work. Obviously, when data-gathering has been completed we will have a fuller idea of the comparative issues, but the two existing case studies raise some interesting questions.

Emergency approach/short-termism

When donors and international agencies first began work in both countries (this was during the 1950s in Nepal; in Uganda this took place in the early 1970s during the emergency period of civil war, and later intensified during the Karamoja famine between 1980 and 1982), their interventions were focused on the delivery of services. Intervention was primarily a method of filling-gaps - providing services when the government was not in a position to play national provider. Services need a solid support system: management, trained staff etc. Where governments could not provide this, then international agencies established their own. In addition to physical services such as health posts, clinics etc., in many cases 'vertical programs' were established, focussing on the delivery of one service/facility (such as immunization or family planning) through programs running parallel to government services. This can be identified as an emergency approach, with the aim of offering vital services quickly and effectively, with tangible results over the short-term.

Although this initial involvement was considered vital to compensate for and support poor infrastructures in-country, it can be seen to have set a precedent for external approaches to health sector work. Some vertical programs and service-delivery work are still in operation and, in terms of delivering services in the short-term, are considered more effective than

attempts at integration to date. But in both case study countries, the consensus by those interviewed was that this emergency focus, operating in parallel to the public system, detracted from the development of the capacity of the overall system. Key factors of this approach were identified. These reveal how the behavior of donors and international NGOs working with the governments in both countries may have impeded the development of health sector capacity and the creation of a sustainable health system. Although all of these factors can be seen to be inter-related, as a functioning system consists of various interactions and relationships, they can be described as follows:

- **Policy-making: priorities often defined through donor conditionality**

As governments have become more dependent on external aid, so donors have had an increasing role in policy-making. This can be seen particularly starkly through the development of structural adjustment programs in both countries, as a result of which the World Bank has played a more active role in policy-making and planning systems (for instance the three year plan drawn up in Uganda in 1991 was primarily written by a World Bank consultant and can be seen to follow World Bank priorities concerning the future development of the health sector). Donors are selective in the activities in which they invest, leading to the development of a range of (often parallel) activities and a sector focus which may not necessarily follow country priorities, but instead follow the latest donor trend.

- **Forced pace of sector expansion**

Donors and many international agencies have operated in parallel to government activities according to the assumption that, ultimately, governments will take over financial and managerial responsibility for these activities. The health sectors in Uganda and Nepal can be seen to have expanded beyond existing capacity through external investment, with activities collapsing or running inefficiently on government take-over. PHC offers a good example of an area of work supported by both

governments and donors as a priority, then pushed into prominence by donors through donor funding. Although it is evident that some countries were not ready for the immediate pace of expansion of the sector which PHC plans brought with them, PHC received the lion's share of donor funding (currently in Uganda, donors are funding about 80% of PHC activities, with government funding about 80% of curative/hospital services). Sectoral development is most effective if run at a pace a country, and its communities, can afford. Donor work to date has been seen to force the health sector to expand government capacity to absorb, and ultimately take over, recurrent costs, activities, personnel etc., and, hence, has created a growing dependence on further donor support.

- Fragmentation and duplication

With a focus on particular projects and programs, the development of the sector as an entirety is not taken into account. Programs are often run in isolation with their own self- fulfilling aims and targets. Although this may serve some purpose in offering a measurable impact over the short-term, it ultimately results in fragmentation and problems of final integration.

With many donor-initiated vertical programs operating in both countries, many activities are duplicated, running in parallel to each other, with very little coordination. Numerous examples were elicited of the duplication of training courses, health education activities, budgeting system etc., a strikingly inefficient use of scarce resources. Even in Nepal, where some attempts have been made to integrate some vertical programs, integration only took place at service-delivery points; other activities continued in tandem.

Often donor and NGO health services rival government services to the extent that, in both countries, government services are under-utilized. Although obviously this may be related to levels of quality (or perceived quality), under-utilization impedes the local support necessary for the development of public services to full capacity. The operation of alternative structures can be seen as expression of democracy, in some

cases providing valuable alternative approaches, but effective coordination needs to be developed to avoid the undermining or unnecessary duplication of public health services.

- **Personnel issues**

Although it is generally recognized that civil service salaries are insufficient and staff are forced to take on at least one other form of work to survive, the incentives offered by donors (salary top-ups for attending workshops, meetings etc.; vehicles; travel expenses) ensure that staff (whose initial training is often financed and run by the public sector) will be drawn to work for these agencies. This pull to work for international agencies depletes the capacity of the public sector and, together with under-utilization of public services and lack of a living wage, only serves to demoralize government staff.

As donor parallel activities require high levels of staff, this lead to a corresponding increase in the number of staff requiring payment when the government is required to take over the running of these services. With economies under strain, the recurrent cost implications of this approach can be impossible for the governments to address.

- **Ownership**

The high-profile of donor involvement in selected areas of work can create a confusion as to the ownership of work, and lead to associated assumptions as to the nature of activities and responsibilities. This has implications both for hand-over to government and the grass roots involvement of communities to health sector activities.

This sense of ownership also impacts upon staff perceptions of responsibility, with staff allegiances often aligned to the donor/employer. In Uganda this was cited as an impediment to effective planning as staff operate within particular donor health information systems with their perceived priority being to report back to their employers with valuable information, rather than feeding it back into the sector as a whole.

I have reported these actions by the World Council not to provide any illusion of strength, but to tell you where we stand. We welcome wholeheartedly the emergence of the International People's Health Council. We are proud and honored to participate in this most important conference. We stand with you in a common struggle for a better future for all humanity. We look forward to working closely with you to bring that future closer.