"INVESTING IN HEALTH": FOUR YEARS ON

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For SCF and many other NGOs the 1993 World Development Report (WDR), "Investing in Health", was a cause of dismay. At a stroke it appeared to dismiss all the investment by Governments and NGOs since the 1978 Alma Ata primary health care (PHC) declaration. Taken at face value the report proposed a shift from the PHC commitment to equitable, locally controlled and sustainable systems of basic health care to a policy based on the priorities of international experts, with the primary objective of the cost-effective use of resources. A lengthy response, attached, was made by the SCF to the World Bank at that time.

The worst features of the WDR seemed to us to be two. Firstly, the proposal was to put the provision of health care, beyond some minimum to be provided by the State or through charity, on the same economic basis as any other commodity. Government resources would be allocated on the basis of the "disability adjusted life year" (DALY) in order to maximise the "health return" on expenditure; other services would be available to the extent that the patient could pay, or NGOs and Churches might provide free services.

In the twenty or so poorest countries, chiefly in Africa, which have health budgets in the range of $1-3/person/year it was evident that, carried through to practice, such a policy would mean effectively no services for the poor. Assuming that the DALY would prioritise immunisation, some national budgets were scarcely sufficient to provide this alone.

Secondly, there was no discussion in the WDR as to how the funding gap for the provision of basic services in the poorest communities might be met. The financial argument in the WDR was that the total health funding i.e. the sum of Government, external donor and private provision, in many countries was sufficient to provide the basic service envisioned. The cause of under-provision in health was therefore to be found in the inefficient use of resources. The SCF view was that this argument was spurious. Donor funds were frequently spent without reference to and sometimes in conflict with Government policy e.g. the verticalisation of immunisation, area-based projects, capital projects which entailed greater recurrent costs for the Government etc. Although it was true that in some countries the sum of all known expenditure was sufficient to provide basic services for all (e.g. Uganda), in reality the resources were not available to the health services which depended largely or wholly on the national health budget and could often find no more than starvation wages for health workers and grossly inadequate material supplies.

Clearly, many poor countries have no effective basic health services. However, the most pessimistic reading of the WDR - a major international political statement - implies that the combined denial of health services to the poor has become an officially acceptable ideology. As and if, but not until, poor countries and poor people became richer could they have access to health services. The public argument was that the problem was inefficiency and that the international effort should now be directed to 'capacity building' and other remedies for this. The most optimistic view we could take of the WDR was that at least it contained an attempt, possibly the first from a major organisation to calculate the true cost of providing basic services.

SCF Experience since 1993

In fact, major international policy documents are rarely as important as they seem when first published. Even after a short period of four years it is clear that our early pessimism was not wholly justified and that events have turned out in a rather different, and in some cases more positive way than we feared. With hindsight, it is easy to see that the World of even four years ago seemed, at least for those steeped in PHC, a dangerous place. Just after the end of the Cold War, with structural adjustment in full and unobstructed flow, and the economists in seemingly absolute control of international ideology it seemed almost inevitable that in the poorer states all social policy might give way to a pattern of commerce and charity.

However, it is clear that the international system has continued to change and to adjust rapidly and in a variety of ways, and that the worst expectations of 1993 have not in our experience occurred. Quite what has occurred since 1993 in international policy terms is not known in any formal sense - the position is different in each country; each observer has a different perception and in some countries the question of health policy has been muddied by war, major political change and other events. But the SCF experience, largely in some of the poorer countries in Africa, South and South East Asia (but excluding many of the former Eastern Bloc countries where the experience has often been very different) and of close observation of the international system suggests that the current situation, although far from satisfactory-huge populations remain without any access to useful health care - is, in some basic policy respects, at least better, and more hopeful, than it was in the mid to late 1980's.

The reasons for this are beyond the scope of this note and can be no more than a conjecture, but I would identify three main underlying drives. Firstly, is the reality which follows any revolutionary change. Forcing through the basic reforms of ESAP and the 'democratisation' was perhaps comparatively straightforward. But these reforms, (if in fact they ever achieve their intention of making countries and people more prosperous), are proving slow to deliver. Mass personal and state poverty and the lack of health services remains a current problem, and the practical difficulties of improving this situation remain much the same as before. Secondly, donors are now under very different pressures. Both the quantity and the political prominence of international aid have fallen sharply. The basic political priorities of aid during the cold war - crudely to buy political advantage - have gone, and (to the extent that a much reduced aid budget is directed to the poorest countries at all), it is, for the first time in decades, a priority for many donors to use this effectively. Many of the donors have themselves gone though major internal restructuring, often towards the decentralisation of budgets and decision making. Lastly, (and perhaps paradoxically), there is an increasing tendency for external donors to accept and work with Governments - or more precisely those Governments that have embraced reform - on less directive and conditional terms than before. This is perhaps because Governments are (post reform/ by definition) more acceptable to the donors; the political pressure on donors and therefore the sense of urgency, is less; and because now, as always before, there is no real alternative if the aim is to build national systems.

Whatever the reasons, our experience has been that since 1993 the evolution of the donor/national Government relationships has often been more in the direction for which SCF and others have wanted than toward the aims of the WDR. It is difficult to find a case, at least in Africa, where our chief concerns around the WDR can be observed in practice. This is not to say that the health problems of the poor countries, particularly in respect of health financing have been solved; that can only occur when the poor become richer and control their own policies. There is arguably now a greater consensus amongst the various players - Government, donors and NGOs than before about what should be done. In many instances a move towards the more efficient use of resources; and a realism about the practical constraints and time required which was not evident pre WDR.

Our impressions are that:

1. There is a wide, if still less than universal acceptance that in the poorest countries the only practical and economic way in which basic services can be provided is through some national system. The donor tendency to the 'verticalisation' of services with the aim of showing short term results which was so evident in the 1980's has sharply diminished.
2. In many countries donor funding is increasingly co-ordinated with, one may assume, an improvement in the efficiency with which resources are used.
3. In some countries donors are increasingly willing to meet recurrent costs, even if only through indirect means, for example, by providing budgetary support to Government to ensure the continuity of specific projects, where these cannot be met locally.
4. An increased trend to accept and to support local NGOs and other organisations and to bypass the larger international NGOs.

However, limited resources remain the basic problem of the provision of health in poor countries